

# Real-Time Virtual Support: Six-Month Evaluation Report

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Reporting period:  
April 1, 2020 – September 30, 2020 (Q1 & Q2)

*Prepared by:*

UBC Digital Emergency  
Medicine

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THE UNIVERSITY OF BRITISH COLUMBIA

**Department of Emergency Medicine**  
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## Introduction

We are pleased to share this Six-Month Interim Report on the Real-Time Virtual Support (RTVS) pathways, providing an update on Q2 utilization and other evaluation findings, as well as an overview of planned activities over the next several months as RTVS reaches the one-year mark.

In the past three months (July through September, 2020), we have seen tremendous uptake in the use of the different RTVS pathways – notably, increased utilization of the Rural Urgent Doctor in-aid (RUDi), Rural Outreach Support (ROSe), First Nations Virtual Doctor of the Day (FNVDoD), and HealthLink Emergency iDoctor in-assistance (HEiDi) pathways, and access by approximately 20 new rural/remote communities in BC. As well, the Child Health Advice in Real-time (CHARLiE) and Mother and Baby Advice Line (MaBAL) peer-to-peer pathways, bringing specialized pediatric and maternity support to BC healthcare providers, have launched and their evaluation is included in this report. The table below summarizes key utilization metrics of the six RTVS pathways included in this evaluation report.

	Number of Virtual Physicians	Number of Q2 consultations	Cumulative consultations	Growth from Q1
<b>*CHARLiE (launched July 1)</b>	16	60	60	-
<b>*MaBAL (launched August 17)</b>	18	15	15	-
<b>ROSe</b>	7	177	269	+92%
<b>RUDi</b>	23	291	408	<b>+149%</b>
<b>FNVDoD</b>	37	1265	1949	+85%
<b>HEiDi</b>	40	6002	11449	+10%
<b>Overall</b>	<b>141</b>	<b>7810</b>	<b>14150</b>	<b>+23%</b>

Other evaluation activities for this period include key informant interviews, which have primarily focused on First Nations Health Authority Community Nurses at remote stations. These interviews elucidated important themes related to why healthcare providers need and want access to RTVS, as well as challenges in using RTVS and opportunities for growth.

The evaluation team collaborated with UBC Continuing Professional Development (CPD) to align evaluation with CPD needs assessment survey. We co-developed items, further added questions to align with our evaluation framework, continued awareness-building for adoption of RTVS pathways, and capacity-building at individual and community levels through simulations, as well as formal and less formal CPD and mentorship activities.

Our findings highlight how RTVS supports rural providers: Availability of RTVS positively impacts healthcare professionals' quality of life, sense of teamwork, and reduces isolation. RTVS supports high-impact cases and provides opportunities for mentorship, simulation, and education. From

Virtual Physicians' and other providers' perspectives, RTVS is replacing old barriers with a call a friend mentality. All of which translate to improved provider experiences and better patient-centred care, especially during the COVID-19 pandemic.

In the sections below, we have provided more detailed findings for each RTVS pathway and other evaluation activities. Finally, we conclude by laying out our proposed evaluation activities for the remainder of RTVS's first year. This will culminate in a one-year summative report, which will fulsomely showcase RTVS's successes in its inaugural year, including the extensive collaboration amongst stakeholders and partners, increasing equity for vulnerable patients and providers in BC, how RTVS advances culture change, and the scale-up and spread of RTVS in our healthcare system.<sup>1</sup>

## Methods

We briefly describe the methodology used for this six-month report (further details in F90D report with appended evaluation framework). This six-month interim evaluation used mixed methods, relying on various sources of internally collected operational and administrative data that speak to RTVS utilization, as well as interviews, field notes, and meeting minutes that shed light on the broader narrative and impacts of RTVS.

## Characteristics of each RTVS Pathway

### Peer-to-peer pathways

The aims of the four peer-to-peer RTVS pathways can be briefly summarized as: to **support rural, remote, and Indigenous practitioners in their local communities**, thereby decreasing isolation and stress, improving practitioner recruitment and retention, and strengthening interprofessional and collegial relationships. The four peer-to-peer support pathways are:

1. **Child Health Advice in Real-time (CHARLiE):** Launched July 1, pediatricians are available 24/7 by Zoom and phone to support rural healthcare providers facing urgent pediatric cases.
2. **Mother and Baby Advice Line (MaBAL):** Launched August 17, specialists with maternity and neonatal expertise are available 24/7 by Zoom and phone to support rural healthcare providers.
3. **Rural Outreach Support group (ROSe):** Intensivists and critical care specialists are available 24/7 by Zoom, mobile app, and phone to support rural healthcare providers looking for a consultation, second opinion, or ongoing virtual support for patients.

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<sup>1</sup> For additional background information on RTVS or the detailed methodology for this evaluation, please refer to our First 90 Days Report (available from Helen Novak Lauscher upon request, [helen.nl@ubc.ca](mailto:helen.nl@ubc.ca)).

4. **Rural Urgent Doctor in-aid (RUDi):** Launched April 1, physicians with emergency medicine and rural experience are available 24/7 by Zoom and phone to support rural healthcare providers with generalist medical problems, as well as education and simulation opportunities.

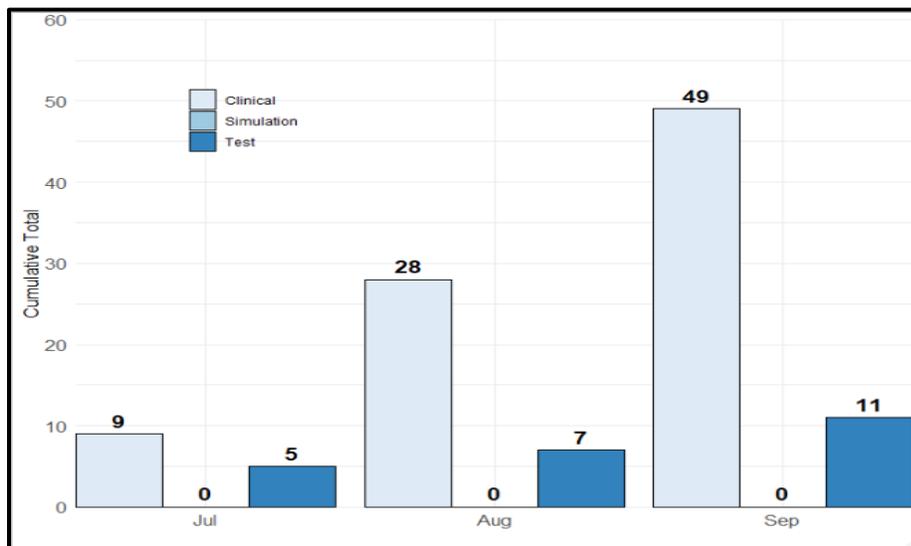
## Patient-facing pathways

The aims of the two patient-facing RTVS pathways can be briefly summarized as: **to increase patient equity and access to timely, necessary care**, thus improving patient-centered continuity of care and linkage to existing primary care networks. The two patient-facing pathways are:

1. **First Nations Virtual Doctor of the Day (FNVDoD):** Launched April 1, the FNVDoD pathway provides any Indigenous person in BC access to scheduled consultations with a Virtual Physician (VP). The service runs seven days per week from 8:30am-4:30pm, is supported by several Medical Office Assistants (MOA) and is divided so that one VP is available per Health Authority.
2. **HealthLink Emergency iDoctor in-assistance (HEiDi):** Launched April 6, HEiDi saw the integration of VPs into the standard telephone call flow for HealthLink BC’s 811 Nursing Services. BC residents calling 811 and triaged with a “yellow” disposition (i.e., “seek care within 24 hours”) can be referred immediately to a VP for a virtual consultation and additional clinical advice. VPs are available 10:00am-10:00pm daily.

## Interim Findings

### CHARLiE



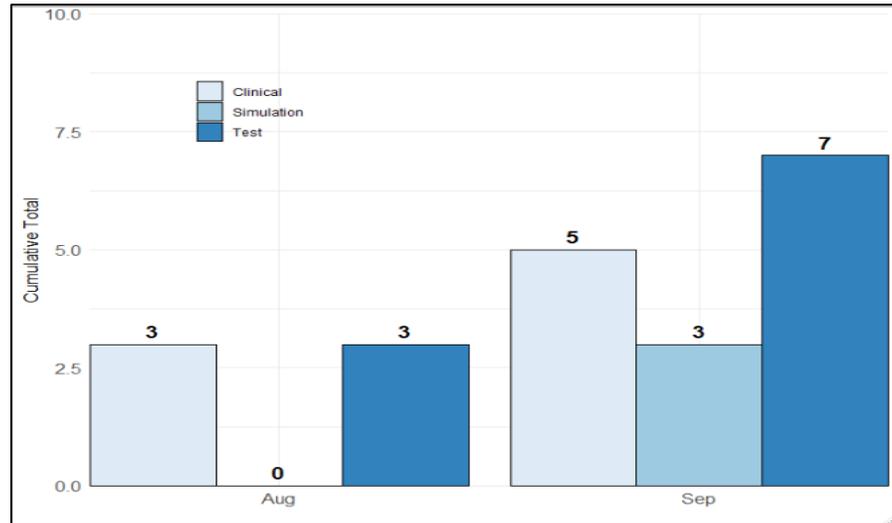
This pathway has been live for all of Q2 (July 1 – September 30), with its Virtual Physicians available 24/7, offering 2208 hours of continuous peer-to-peer support. CHARLiE VPs have provided 60 consultations, with 82% of them being clinical in nature (versus test/education

calls). End-user healthcare providers have called CHARLiE from 24 different BC communities, with the most common being Terrace (n=12), Hazelton (n=6), and Bella Bella (n=6). CHARLiE VPs have provided support for a variety of pediatric cases, from more urgent matters (e.g., a

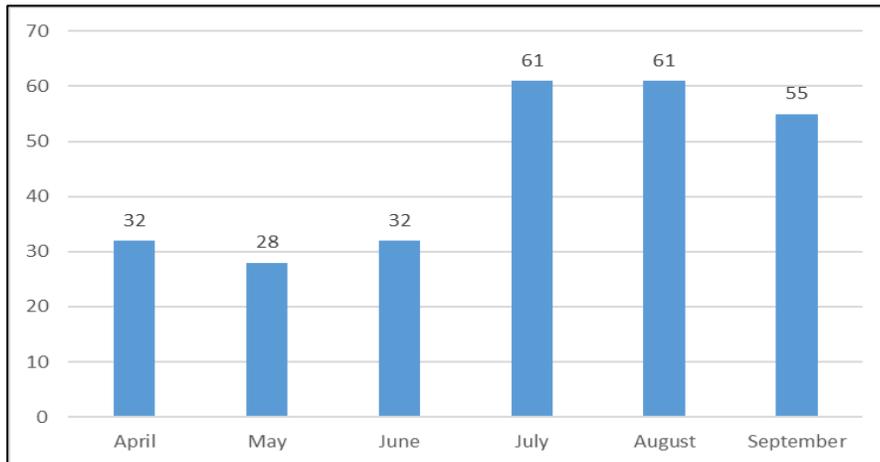
newborn with respiratory distress) to substance use/mental health concerns to reassurance and advice for more minor issues (e.g., viral gastroenteritis). CHARLiE has also connected with other RTVS pathways to provide support to colleagues (e.g., HEiDi) and to reach out for assistance (e.g., COMPASS), thus highlighting the strong interprofessional collaboration of RTVS.

## MaBAL

The pathway was launched August 17, being live for 45 days during Q2, with VPs offering 1080 hours of 24/7 support. VPs have fielded 15 calls, providing five clinical consultations and three simulations. End-users of the MaBAL pathway have called from six distinct BC communities, including Takla, McBride, and Hartley Bay.



## ROSe

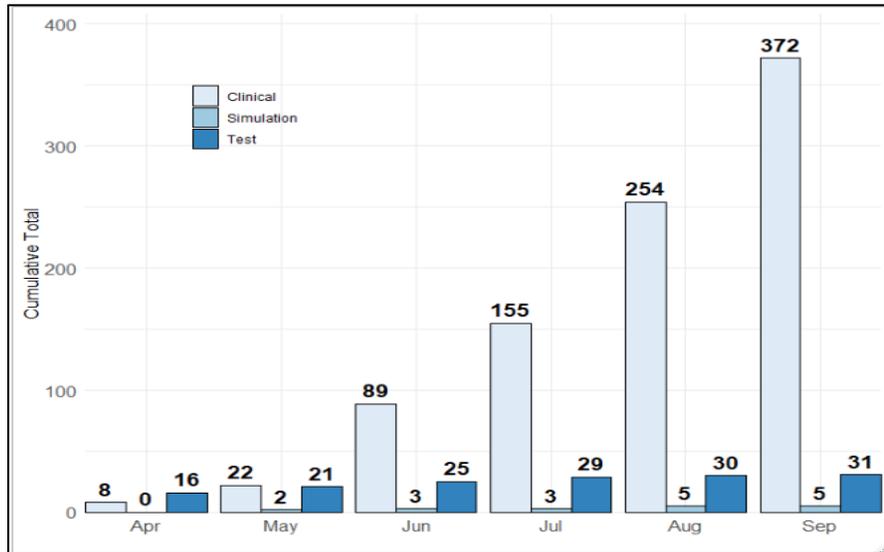


This critical care support pathway has been included in this evaluation since the launch of RTVS (though ROSe has been in service pre-RTVS). Since April 1, ROSe VPs have offered 4320 hours of 24/7 support, including a doubling of shifts in early

July. A total of 269 consultations have been provided by ROSe VPs, with 177 in Q2, representing a 92% increase in volume.

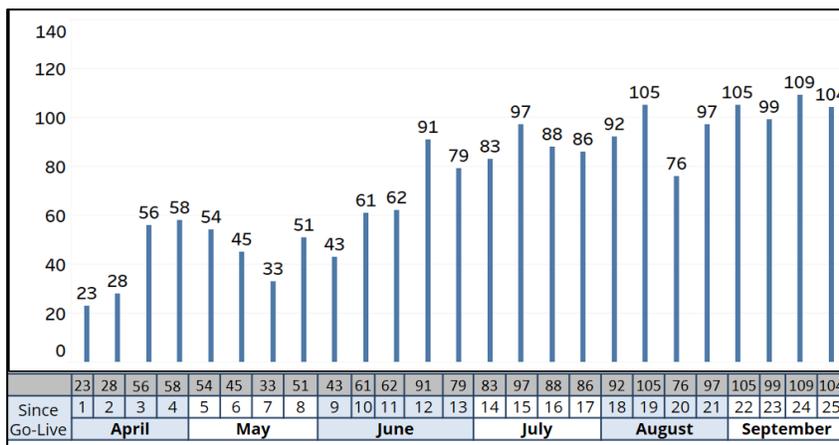
## RUDi

The rural generalist support line has similarly been operating since April 1, with VPs offering 4392 hours of continuous support. Call volumes have substantially increased in Q2, with RUDi VPs providing 291 consultations (versus 117 in Q2 – a 149% increase). Of the cumulative total of 408 consultations, 91%



have been clinical in nature. RUDi VPs continue to support a wide range of medical concerns in a diverse group of patients, such as management of alcohol withdrawal or substance use disorder, various head injuries and traumas in both children and adults and treating complications from chronic conditions. Importantly, we have seen an increase in the number of new BC communities contacting RUDi: 14 new communities, up to 45 unique communities using RUDi. Further, several communities have continued to be consistent users of RUDi for support, including Lax Kw'alaams (Port Simpson; n=53), Kitkatla (Dolphin Island; n=38), Takla (n=25), and Kwadacha (Fort Ware; n=22).

## First Nations Virtual Doctor of the Day



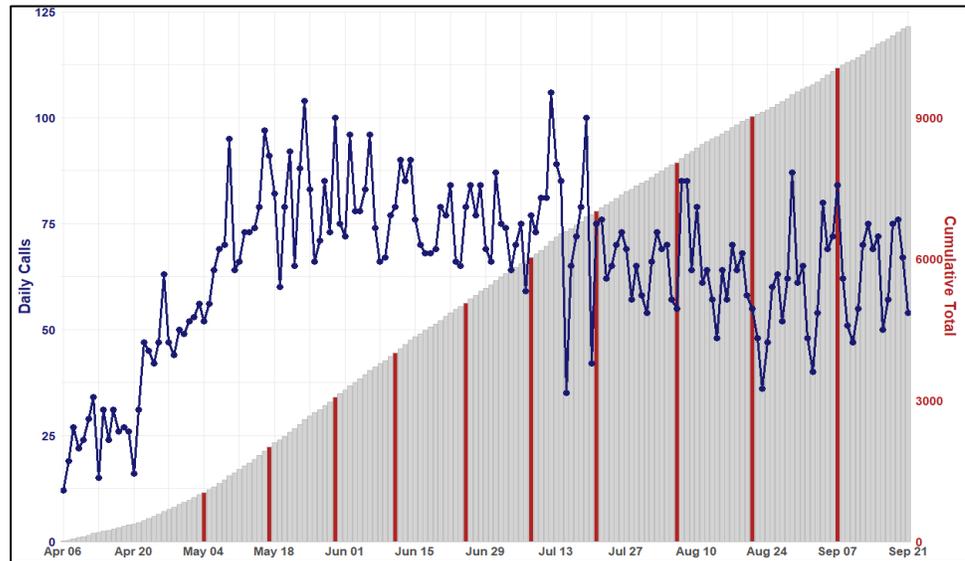
Similar to the above trends, the First Nations Virtual Doctor of the Day pathway has seen similar uptake by Indigenous patients seeking timely, culturally safe care for their health concerns. The 37 VPs (supported by four Medical Office Assistants and three pharmacists) have provided

a total of 1949 consultations to patients, with an increase of 85% in the number of Q2 consultations. The busiest days of the week on average are Thursday and Friday and the majority

of consultations are provided to Indigenous patients living in Northern (668, 34%) and Island (529, 27%) health authorities.

## HEiDi

Finally, we observed that HEiDi has seen similar utilization and outcomes in Q2 as in Q1: a total of 11449 virtual consultations have been provided by VPs, with 6002 in Q2. HEiDi VPs field an average of 71 calls per day, with weekends having higher volumes



typically. We have seen continued interprofessional collaboration between the HEiDi VPs and 811 Nurses and vMOAs, leading to positive outcomes for patients and high satisfaction. Importantly, 72% of callers are downgraded to a less urgent disposition, either being advised to schedule a follow-up in-person appointment with their usual healthcare provider or to try treatment at home. And, 15% of callers are escalated to a more urgent disposition, being advised to seek care immediately (e.g., visit the ED). In terms of patient feedback, callers are now emailed a link to an anonymous survey and we have seen an approximate response rate of 20%. Based on this, patients are overwhelmingly satisfied with their HEiDi experience; for instance, 97% were satisfied with their overall experience, 87% satisfied with the wait time, 79% felt much better after their consultation. Patients' comments highlighted their appreciation of being able to quickly access a doctor, while also noting technical limitations of the virtual consultation process.

## End-user Interviews

Four participants shared experiences using RTVS (primarily RUDi and ROSe) in their health practice as FNHA community nurses. They practice in remote, low-resource settings, where it requires extensive travel (hours-long drive or flight) to the nearest hospital/doctor. The frequency which the end-users use RTVS varied from several times per year up to 5 times per week.

Main themes identified:

1. RTVS providers are readily available and connect with more patience and reassurance for end-users.
2. End-users are respected and recognized as qualified individuals to assess patients competently, unlike previous invalidating experience with non-RTVS doctors.
3. There is a desire to maintain relationships/rapport with doctors to improve patient care.
4. There is a need for technology improvement and additional outreach to inform providers of the multitude of specialist pathways within RTVS service.

## RTVS Strengths

The RTVS pathways, in particular RUDi, are characterized to be a reliable “asset” as it guarantees the end-users to be connected to a resourceful emergency physician in a timely matter. This serves as a genuine “backup” when doctors in the local community cannot be contacted. End-users indicate consistently that RTVS is improving their comfort in providing care and has positively affected patient outcomes. One nurse described the experience of using RUDi as a “dream come true, to be able to have a resource that is actually always available. And it doesn’t put more strain on local resources.”

## RTVS Challenges

The technology and connectivity available in their workspace are highlighted across interviews to be a challenge in workflow in emergency cases. There is a dissatisfaction with the technology used in the program. First, end-users indicate patients having very expensive or lack Wi-Fi to access FNVDoD, reflecting inequities in BC that persist today. Second, nurses indicate that the telehealth cart is inefficient, inconvenient, and require doctors to call in but they cannot dial out. Third, there are instances where nurses indicate it is difficult to use a phone on the wall or open their computer and connect via Zoom. Fourth, connections (landline to Zoom) have disconnected part-way through RUDi calls for a code case.

There is also a demand for more effective document sharing (e.g. signatures, forms, photos of patient, etc.). Emailing is indicated to be very inefficient in emergency cases. This challenge poses a risk to lowering the quality of care.

## Case Highlights

Across interviews, end-users emphasize the variety of cases which RTVS has supported them in their capacity as a healthcare provider. We have selected three cases that highlight the impact the service has made in patients’ care.

**Case 1: Post-Partum Intervention**

*During a memorable RUDi case, nurse KL handled a young mother with post-partum infection. The mother had just arrived back from Terrace and felt unwell. Through RUDi, KL called a doctor quickly after her initial assessment and provided patient vitals. The RUDi VP "took this seriously" and trusted KL's assessment. Together, KL and the RUDi VP quickly determined a course of action and recommended that the patient go to the regional hospital. KL heard back from the patient's family that the patient was admitted to hospital and treated over the next several days.*

**Case 2: Pain Control for Sciatica**

*Nurse LE determined patient needed an interim pain control (not with a controlled substance) but needed a prescription order. The RUDi VP walked through the assessment to make sure they did not miss anything. Together they determined the patient was suffering from sciatica. The RUDi VP asked detailed questions that the nurse would never get from an emergency doctor and the RUDi VP provided more time for the nurse. In the end, the RUDi VP agreed with nurse's initial assessment and the patient received care (order for medication) at the time, who then went to their family physician later on. RUDi provided emergency care but also primary care – something that was never given by regional emergency hospital doctors.*

**Case 3: Opioid Withdrawal Management**

*Nurse DL managed a special case with a patient experiencing opioid withdrawals. DL wanted to start him on suboxone treatment, which is not something seen very often in DL's community. She initially spoke with the regional physician, who was uncomfortable starting this treatment. DL then reached out to a RUDi physician, who understood where DL was coming from and quickly started an opioid withdrawal pathway. She called the RUDi VP, asked for FNHA treatment pathway, physician provided her with the contact and emailed the pathway. The technology enabled rapid agreement and support by RTVS.*

## Tracking collaboration within and among RTVS pathways

As mentioned above and also emphasized in our earlier F90D report, interprofessional collaboration remains a crucial element of RTVS. We have continued to observe in Q2 that VPs within each pathway regularly share cases, clinical knowledge, and resources amongst themselves, with the regular Community of Practice meetings being a good focal point. Further, we also see that VPs often reach out to their colleagues working on other RTVS pathways; for example, FNVDoD providers connecting to RUDi for support, or RUDi VPs contacting ROSe for assistance during more urgent cases. VPs also readily access other clinical supports and resources during cases, such as Poison Control, pharmacists, and the Patient Transport Network.

Together, these examples of interprofessional collaboration continue to showcase how RTVS is advancing a culture change within BC and our healthcare system and helping new and vulnerable providers adopt a call a friend mentality in their practice.

Collaboration of health providers and others to develop, implement, sustain, and grow RTVS is exemplified by teamwork and team based care that occurs to provide these services. Virtual physicians, nurses, virtual medical office assistants, and myriad technicians, experts and personnel spanning the partnership “pentagram plus” work together to provide service, and advance health equity. The following table outlines the types of activities and relationship building resultant from the RTVS collaboration.

Clinical Practice	Practical Matters	Educational and Evaluative	Relational (Kinship)
<ul style="list-style-type: none"> <li>• Sharing clinical information like guidelines and best practices</li> <li>• Education and mentorship, reciprocal learning and perspective-taking</li> <li>• Sharing what was learned during a case or encounter</li> </ul>	<ul style="list-style-type: none"> <li>• Just in time training and resources</li> <li>• Updates on processes and changes in procedures</li> <li>• Admin matters such as sharing schedules, getting help to swap a shift</li> <li>• Problem-solving (e.g., tech issues)</li> </ul>	<ul style="list-style-type: none"> <li>• Providing feedback and assessment</li> <li>• Arranging educational and simulation sessions</li> <li>• Mentorship and mutual learning, knowledge sharing</li> <li>• Sharing educational resources, guidelines, good practices</li> </ul>	<ul style="list-style-type: none"> <li>• Sharing stories, encouragement, humour, friendship</li> <li>• Getting to know each other and what others are doing</li> <li>• Celebrating personal and professional milestones</li> </ul>

## What’s next for RTVS evaluation?

Ongoing and upcoming activities through March 31, 2021, for the RTVS evaluation include: Interviews with virtual physicians and others delivering RTVS via the pathways; end-user feedback survey and interviews including residents, new-to-practice physicians, and other “vulnerable” practitioners; administrative data linkages (MSP, ED visits, transport) to triangulate findings and for health economics analysis; and development of monthly dashboards to regularly showcase RTVS findings/utilization and for iterative improvement.

RTVS leaders and evaluation advisory members have provided input on the further development of the RTVS benefits realization framework (see Appendix). The table below summarizes the current and ongoing data collection.

	Peer-to-Peer Pathways	Patient-Facing Pathways	Notes
<b>Pathway Utilization</b>	<ul style="list-style-type: none"> <li>VP end of shift surveys (all)</li> </ul>	<ul style="list-style-type: none"> <li>HEiDi KDR/encounters</li> <li>FNVDoD - request</li> </ul>	Dashboards MOIS
<b>Patient reported experience and outcomes</b>	<ul style="list-style-type: none"> <li>Patient feedback (via VP report)</li> <li>Case vignettes</li> </ul>	<ul style="list-style-type: none"> <li>HEiDi post-call survey</li> <li>FNVDoD post-encounter survey</li> </ul>	
<b>End-user experience</b>	<ul style="list-style-type: none"> <li>End-user interviews (Nursing Stations, Residents, Locums, community providers, etc.)</li> <li>Post-call end-user feedback survey</li> </ul>	<ul style="list-style-type: none"> <li>Case vignettes</li> <li>Patient stories</li> </ul>	
<b>Provider experience</b>	<ul style="list-style-type: none"> <li>VP Interviews (all pathways)</li> <li>MoA interviews</li> <li>Nursing interviews</li> <li>Documentation of collaborative learning (formal, informal), education/credits acquired (SIMS, Pocus, residency training, IMGs)</li> </ul>		
<b>Needs Assessment and Environmental Assessment</b>	<ul style="list-style-type: none"> <li>Needs assessment survey (collaboration w/ CPD)</li> <li>Virtual care surveys</li> <li>Provincial Evaluation Committee</li> <li>Community Context - Digital divide – connectivity, infrastructure, and equity</li> </ul>		
<b>Outcomes (administrative data)</b>	<ul style="list-style-type: none"> <li>Transfers out of community</li> <li>HCP engagement in communities</li> </ul>	<ul style="list-style-type: none"> <li>ED and UPCC utilization (triangulate with pathway utilization)</li> </ul>	Linkage PHN Ethics; DAR
<b>Process/ Collective Impact and Collaboration Analysis</b>	<ul style="list-style-type: none"> <li>Network analysis survey – VPs and community end-users interconnections (includes clinical practice, education/learning, students supported, etc.)</li> <li>Documentation analysis (CoPs, minutes, collaboration tools, etc.)</li> <li>Program administrative data (contracts, costs of equipment, personnel, etc.)</li> <li>Documentation of cultural competency training</li> <li>Documentation of collaborative learning (formal, informal), education/credits acquired</li> <li>Interviews and focus groups with personnel in partner organizations</li> </ul>		
<b>Stakeholder Analysis</b>	<ul style="list-style-type: none"> <li>F90D interviews – stakeholders, policy makers</li> <li>Remuneration survey - VPs</li> <li>Focus groups interviews recommendations (final report)</li> </ul>		

At the time of filing this interim report, we are now eight months into our evaluation of RTVS and the different pathways. In this short time, we have seen tremendous development and uptake of these virtual health services, underpinned by strong partnerships and advancing healthcare equity for BC patients. Soon, we will reach the one-year mark for RTVS, at which time we will produce a summative report designed to capture the many and myriad impacts of RTVS and how the different pathways have achieved their objectives. To reach that point, our evaluation team and partners will continue with our current evaluation activities, as well as incorporating new methods to wholly realize our goals and thus reflect the full value of RTVS.

## Appendix: Benefits Realization Plan

Cross-reference with relevant evaluation framework(s):

- Quadruple Aim (4A): population health outcomes (HO); patient experience of care (PtE); HCP experience of care (PrE); cost factors [C]
- Social Accountability (SA): relevance [R], quality (Q), equity [E], cost-effectiveness (C)
- BCPSQC Quality Matrix (BCQ): respect [Re], safety (S), accessibility (Acc), appropriateness (App), effectiveness (EFT), equity [E], efficiency [Effic]

Theme/Aim	Benefit	Outcome	Measure	Data Source	Access	X-Ref
Safety Net	<b>Are patients able to access timely, appropriate care virtually, regardless of where they reside in BC?</b>	Unattached patients are able to access timely care virtually		MOIS/KDR (retrieve patient PHNs to link to admin data)	HA Decision Support > MOH > PopDataBC	4A: PtE; HO
		Patients are able to access necessary care virtually, even with closures/limited service in community	Number of ED/UPCC visits averted	MSP	Lists of VPs on each pathway	SA: R, E
		Rural/remote patients can access appropriate care virtually from home, thereby reducing need to travel outside their community	Number of patients able to be treated in community (or number of out-of-community visits averted)	PTN/BC EHS /BC Trauma Registry	Anonymous surveys sent to patients post-call	BCQ: S, Acc, App; Eq; Effic
		Improved patient safety and outcomes	Number of virtual encounters	NACRS/DAD		
		Indigenous patients are able to access culturally safe care virtually		Patient/provider surveys/interviews		

Theme/Aim	Benefit	Outcome	Measure	Data Source	Access	X-Ref
<b>Funnel</b>	<b>Are patients directed to the most appropriate healthcare service?</b>	Patients re-directed to another type of health service more appropriate for their care needs	Number of patients re-directed to another level of care	MSP	HA Decision Support > MOH > PopDataBC	4A: HO; PtE; PrE
	<b>Are patients directed to a primary care network (or other team-based care) for longitudinal, patient-centred care?</b>	Patients connected to team-based care  Indigenous patients are provided with longitudinal, culturally safe care  Improved care coordination; cross-pathway collaboration	Number of unattached patients attached to primary care network or family provider  Use of eHealth tools (MOIS)	NACRS/DAD  Patient surveys/interviews  MOIS		SA: Q, R, E, CE  BCQ: S, Acc, App; Eq; Effic
<b>Fire Department</b>	<b>Does RTVS positively impact rural/remote providers and communities through its diverse functions?</b>	Rural/remote providers' sense of professional isolation is improved  Rural/remote providers' clinical confidence is improved  Increased use of technology at point-of-care	Number of rural/remote providers that contact RTVS for clinical support  Number of rural/remote providers that access RTVS for simulations  Number of rural/remote providers that access RTVS for other educational support	Provider surveys/interviews  Community surveys (UBC CPD needs assessment)  UBC CPD	HA Decision Support > MOH > PopDataBC  Lists of VPs on each pathway	4A: HO; PtE; PrE; C  SA: Q, R, E, C
	<b>Does RTVS build capacity for rural/remote healthcare providers?</b>	Rural/remote communities are appropriately supported and able to access traditionally urban-based expertise	Number of new communities that contact RTVS  CPD credits given	Communication tools (Zoom, Slack)		BCQ: S, Acc, App; Eq; Effic

Theme/Aim	Benefit	Outcome	Measure	Data Source	Access	X-Ref
<b>Cost-Effectiveness / Cost Factors</b>	<b>Does RTVS positively impact healthcare utilization, thereby minimizing costs to the health system?</b>	<p>Decreased ED/UPCC utilization</p> <p>Increased primary care utilization</p> <p>Decreased patient transports</p> <p>Costs of implementing RTVS pathways</p> <p>Decreased out-of-pocket costs to patients</p>	<p>Number of out of community patient visits appropriately averted</p> <p>Number of patient transports averted</p> <p>Number of ED/UPCC visits diverted to lower level of care</p> <p>Number of rural/remote providers completing locums</p>	<p>MSP</p> <p>NACRS/DAD</p> <p>PTN/BC EHS</p> <p>Internal admin data (e.g., VP wages)</p> <p>Patient surveys/interviews</p>	<p>HA Decision Support &gt; MOH &gt; PopDataBC</p> <p>Lists of VPs on each pathway</p>	<p>4A:C</p> <p>SA: C</p> <p>BCQ: Effic</p>
<b>Recruitment and Retention</b>	<b>Does RTVS improve the recruitment and retention of rural healthcare providers?</b>	<p>Reduced professional isolation</p> <p>Improved QoL, clinical confidence, healthcare team satisfaction</p> <p>More providers doing rural locums/placements</p>	<p>Number of new medical grads/IMGs doing locums (or repeating placements)</p> <p>Number of HCPs leaving their positions (ahead of term)</p> <p>Number of HCP positions filled/empty</p> <p>Accreditation; CPD credits given</p>	<p>Provider surveys</p> <p>PRA-BC/RCCBC</p> <p>UBC CPD</p>	<p>Lists of VPs on each pathway</p> <p>HA/Hospital personnel data? Annual reports</p>	<p>4A: PrE</p> <p>SA: Q, R, E,</p> <p>BCQ: Acc, App; Eq; Effic</p>

Theme/Aim	Benefit	Outcome	Measure	Data Source	Access	X-Ref
<b>Sustainability and Partnerships</b>	<b>Is RTVS sustainable in the long-term and entrenched in the wider health system?</b>  <b>How do partnerships and collaboration strengthen RTVS?</b>	Existing RTVS pathways receive funding to continue	Number of RTVS pathways launched			
		New RTVS pathways are developed to address existing care needs	Utilization of each RTVS pathway (see above)			
		Existing RTVS stakeholders are engaged throughout service implementation	Cross-pathway collaboration (connections of one pathway to another)	Internal admin data (see above)		
		New partners/organizations join RTVS working groups to bring additional expertise	Number of partners and stakeholders engaged in RTVS	Communication tools (Zoom, Slack)	Lists of stakeholders/partners	4A: PrE; C SA: R, E
		Development of RTVS governance model	Number of RTVS working groups and committees	Stakeholder interviews/surveys		BCQ: App, Effic, E
		Dissemination of RTVS services/findings to external stakeholders and communities	Number of governance documents generated	Network analysis survey		
			Number of presentations/articles generated			