VERRa: Frequently Asked Questions

What does VERRa stand for?

VERRa stands for Virtual Emergency Room Rural assistance.

What does VERRa do?

The VERRa program is the newest pathway in the Real-Time Virtual Support (RTVS) service and has taken over what was previously called the RUDi_MRP program. VERRa is a group of BC Emergency Physician and administrators who are passionate about helping clinicians in rural Emergency Departments (EDs) by providing virtual physician coverage to a rural ED that would otherwise potentially go on diversion or close.

The RTVS Program has so many lines, can you please clarify them and how VERRa fits in?

The RTVS program is indeed rapidly growing and on the peer-to-peer side we have:

- RUDi – 24/7 Emergency Physician on call, with double coverage on weekdays.
- CHARLiE - 24/7 Pediatrician on call, for rural areas.
- MABaL - 24/7 GP-OB on call, for rural areas.
- ROCCi - Internist on call for rural areas, starting in late fall 2024.
- RUDI_MRP – For the past 3+ years this was the name for our service that provided a virtual physician dedicated to a single community ED to take first call for their nurses and helped keep the ER open while a local physician got some well needed rest. This line has been retired and replaced with VERRa.
- VERRa – New for fall of 2024, this line aims to double the capacity of the previous RUDI_MRP line and trial some new processes to improve its ability to serve rural BC EDs.

Want to learn more? See rccbc.ca/initiatives/rtvs/

What community EDs does VERRA cover?

Currently, VERRa is dedicated to Rural Subsidiary Agreement (RSA) A communities with seven or less physicians. These are the same sites covered by the BC Rural Locum Program.
Want to learn more about RSA communities, check it out here:
https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/rrp_points.pdf

Dr Brydon Blacklaws
September 2024

Is VERRa always one virtual doc for one community?

The RUDI_MRP Program did operate this way. The VERRa program is looking at being able to combine two rural sites (like Fort Nelson and Tumbler Ridge) per virtual doc if needed, but will remain with the one virtual doctor per larger rural ED (like Port McNeill).

What happens when a very sick patient presents and a virtual physician is not able to manage the patient?

This definitely happens, and that is why we always have had an in-community physician on back-up to come in. The community physician is at home and can be at the hospital in <15mins, which is standard for many rural ERs at night anyway. The community doctor, the VERRa doctor, local nurses and RTVS administration do a virtual huddle at the beginning of each shift.

Why isn't VERRa involved with larger rural EDs like Prince Rupert and Williams Lake?

VERRa would like to get to the point of having a large enough team to lean into these larger rural EDs, because we know they need help too. The virtual physician + RN model works really well in smaller rural EDs and doesn't work nearly as well in busier EDs – we have tried. We believe the recipe for success in larger rural EDs is for a virtual physician to be paired with another non-emerg physician colleague + a local RN, to help facilitate essentially a virtual buddy-shift model. The VERRa program does plan to lean in on this work in the near future.

How many shifts does the VERRa team cover, and how many could it cover?

In July 2024, the VERRa team covered 27 night shifts for rural EDs facing diversion. Going forward, we plan to have VERRa available 7 nights a week and for summer 2025, we hope to have capacity for >1 shift per night.

How does privileging work for the VERRa Docs?

Currently each VERRa doctor has to get privileged in each health authority where shifts are requested, which is currently: Northern Health, Interior Health, VCH, and VIHA. After that, each doc also needs privileges at each site we cover. This process is a burden and the RCCbc, and other groups, continues to advocate for a provincial license for ED docs, including virtual ones.

How do VERRa docs communicate with the local nurses and document their assessments?

Calls are done over Zoom and phone. Notes are generated on the RTVS version of MOIS EMR, and then faxed to the local site. Currently the VERRa doctors have Care Connect and access local

EMR info via the nurse on the ground. We have piloted versions of the VERRa doctor practicing within a site's local EMR, but at this point that workflow is not ready for launch given the multitude of isolated EMRs that exist across the multiple health authorities we work in.

Who are the VERRa doctors?

The VERRa group currently has ~15 doctors, all of whom live and practice emergency medicine in BC. Most VERRa docs have 10+ years of ED experience and have held senior leadership positions in various aspects of health care across BC and Canada.

Is VERRa a for-profit group?

VERRa is absolutely not for profit. The RTVS program is funded by the Ministry of Health (MOH) and the Joint Standing Committee on Rural Affairs (JSC). It is a partnership between the Rural Coordination Centre of BC (RCCbc), MOH, First Nations Health Authority, UBC, Northern Health, and multiple other partners. The admin team and physician leads of the RTVS Program are paid sessional by the RCCbc for their hard work.

Does VERRa cover rural EDs during the day?

At this point we do not. We have tried this multiple times, but when the patient volume gets too high the virtual physician + RN team struggles to keep up and it has not been a great experience across the board. We are currently going to stick with overnight coverage only, and can consider virtual buddy-shifts with larger rural sites for daytime work in the future.

Does VERRa proactively wrap itself around at-risk rural ERs, or is it a 'crisis coverage' only program?

VERRa wants to build a team large enough so that it can have meaningful impact during the predictable times of staffing shortage – summer, flu-season, Spring Break, Christmas etc. The only way for VERRa to be able to staff the multiple requests that come every summer is to have a predictable volume of work all year long to maintain a staff of 20-30 physicians. Instead of going from crisis to crisis, the VERRa program would prefer to work with the health authorities and identify sites that are at risk of staffing shortage, and offer to do 1-2 nights / week for a year at a time. We believe this can significantly decrease overnight call burden on rural docs, while also increasing a rural community's ability to recruit and retain doctors who would be covering the ED.

How does VERRa support primary care?

VERRa supports primary care by ensuring that rural physicians aren't obligated to spend all night at the hospital when they have primary care patients to attend to during the day. In a rural community, daytime clinic coverage can get cancelled if the rural physician has been at the hospital all night.

If a site doesn't need VERRa coverage because they found a locum or a new hire, can they drop the VERRa coverage?

Absolutely they can. We have had many communities need brief stabilization and then hire enough docs to not need virtual help at night any more. In these cases, the VERRa program will happily bow out.

How much does VERRa cost a community that requests it?

There is no cost to a community ED or requesting health authority for a VERRa shift. The MOH and Northern Health have provided the contract for VERRa, currently for one shift, seven nights a week, for two years. We recommend that the local ED uses some of its funds to pay the community doctor to be on back-up.

Do you see the VERRa program growing much bigger than 1-2 shifts/night?

I see the model of virtual coverage at night in rural EDs as being a model that can have huge benefit for rural docs who are often stuck with a 1:2 or 1:3 overnight call schedule that is unsustainably difficult. I suspect more and more rural EDs will look at a virtual overnight model, even if it has a start time of midnight, as this could at least protect the local docs sleep from say midnight – 0700, only waking them up for clinical presentations that absolutely require them.

Who is the team running the VERRa Program?

The VERRa program is run through the RTVS Program, which is a project of the RCCbc.
The physician leads for VERRa are Dr Brydon Blacklaws (Powell River) and Dr Caroline Walker (Masset). The project coordinator from RCCbc is Taryn Ridsdale and our engagement and system lead consultant is Dave Harris.

Want to read more about VERRa's impact?

Journal article: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10770790/
Chetwynd case study: https://rccbc.ca/story/rudi-mrp-program-brings-support/
VERRA launch story: https://rccbc.ca/story/verra-to-bolster-rural-hospitals-facing-diversion/