VIPER and Supporting LTC / In-patient Care

VER 5.0

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# Version

1. Version 1.0 – May 2, 2025
2. Version 2.0 – May 3, 2025
3. Version 3.0 – May 5, 2025
4. Version 4.0 – May 8, 2025
5. Version 5.0 – May 15, 2025

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# Terminology

1. VIPER – Virtual Physician for Emergency Room.
2. VIBEX – Virtual Physician for Basic and Episodic Care
3. ViPP – Virtual Physician Program. An umbrella term including VIPER and VIBEX
4. LTC – Long term care. Patients who permanently reside in the hospital or a facility on hospital grounds.
5. INP – In-patients. Specifically, patients admitted to hospital with the intention of a short stay to recover from discrete illness.

# Problem Description

The VIPER program was created with the single objective of keeping rural emergency departments open (e.g. avoid ER disruptions). One of the fortuitous second order effects was allowing local physician to achieve better work-life balance by using virtual care to reduce the number of days / nights on call. However, it was made clear from inception that the VIPER program was not designed to support LTC or INP. The ‘New Viper Site Checklist’ document clearly states:

*“The VIPER physicians ONLY cover the emergency department. They do not (at this time) cover any admitted patients, in-patients, or long-term care beds at your site”.*

The exclusion of LTC and INP was made at the outset for a few reasons. Most notably because such patients require ongoing longitudinal care and not the episodic care that is the hallmark of emergency medicine. The operational requirements needed to support patients who are admitted for weeks (or in the case of LTC possibly years) differs markedly from the typical VIPER scenario of keeping an emergency room open for an 8-hour shift.

Physicians in local communities have communicated a desire to revise this assumption and have asked VIPER assume care for LTC and INP. The reasons vary but can be summarized as follows

(a) if they continue to be responsible for LTC and INP they do not achieve a true break from work and as such continue to suffer from work-life imbalances

(b) being on-call for LTC and INP requires immediate communication with nursing staff and (as per legislation) the ability to attend in person within 30 minutes to the facility which further restricts travel and recreational plans.

# Problem Scope

There are several ways to scope the problem of virtual care and LTC/INP and the following four categories have been identified. The scenario entitled ‘longitudinal care’ is the focus of this document.

1. Acute decompensation – There are instances where LTC / INP have an acute medical emergency or decompensate significantly from baseline. Historically these patients would have been moved from LTC / INP to the local ER for further management. What constitutes an ‘emergency’ or clinically significant decompensation remains ill defined. However, this is a situation where virtual care might have some roll to play.
2. Longitudinal Care – communities served by the virtual physician program have repeatedly requested that virtual care be used to takeover as MRP for LTC / INP. This is contrary to the current model where the VIPER program is MRP for the emergency room and a local physician remains MRP for LTC / INP. The rationale for this request is that local physicians do not get a ‘true break’ if they continue to be on-call for a subset of patients. This scenario is within the scope of this document.
3. Absent MRP – Regrettably there are instance where local physicians have simply left town or failed to provide a call schedule. By default, leaving LTC / INP the responsibility of the virtual physician. This has been done without any process in-place and without prior agreement. This case represents a failure of professionalism. As such it will be addressed by physician leadership and is not under the scope of this document

# Comparing LTC / INP vs. ER

Visiting any large acute care hospital quickly demonstrates the fundamental difference between emergency patients and admitted patients. Emergency physicians are replaced every 8-12 hours and responsible for finding a final diagnosis and disposition for all patients under their care. While physicians responsible for admitted patients (e.g. General Internal Medicine) work for 1-2 weeks at a time and accept large numbers of patients in handover (often 10-20 preexisting patients), they will subsequently pass many patients on to the next physician.

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|  | **Emergency Patients** | **INP / LTC** |
| Typical Length of Stay | 2-10 hours | INP – 3-4 daysLTC – Several years  |
| Need for a long-term therapeutic relationship with the patient | None | INP – preferable but not neededLTC - Critical. Since many ‘live’ at the hospital they are well known to their providers  |
| Handover between physicians | Minimal / avoided | Regularly handed over between physicians as they provide care during their week of service  |
| Duration of physician shifts | 8-12 hours | 7-14 days  |
| Value of a detailed prior history and active medical issues | Valuable but not impossible to overcome this deficit | Critical. Patients are often older, suffer from cognitive impairment, are unable to provide a history and have numerous active medical issues.  |
| Need for a complete (and up to date) patient chart | Variable | Critical. Given the older and higher risk population and active issues and plans list is key to care |
| Documented Code Status | Variable utility | Critical. Again, an older population with poor health and a high risk to decline.  |
| Patient charts | Stored digitally in e.h.r under the viper program | Often no digital record. Stored completely on paper with no online access.  |

# Proposed Solutions

Internal discussions have led to range of possible solutions for virtual support of LTC / INP. The solutions vary in their approach and efficacy. Yet a common thread is that almost all solutions would require net new funding and the addition of staff.

# Plan A – Use Existing MD Resources

It is important to recognize that HealthLine 811 does not have additional resources to act as a catch-all solution for other program needs. However, the physicians raising these concerns are uniquely positioned to be part of the solution. By collaborating to form an after-hours and weekend coverage model, they can address their shared challenges while continuing to support the LTC and INP areas they already serve.

HealthLine 811 is prepared to provide startup and ongoing support to enable this physician-led initiative, including:

* Medical leadership to support program development,
* Physician onboarding and training in the required technology,
* Ongoing office administrative support,
* Access to and customization of the technology platform.

Under this model, physicians would self-organize and independently operate the program. It is a cost-effective solution that does not require additional resources and has the potential to significantly reduce on-call burdens—particularly with strong participation. Importantly, it ensures care continues to be provided, to some degree, by rural physicians who are already familiar with the patients and communities they serve.

This approach empowers physicians to drive a sustainable, locally responsive solution rather than relying on external fixes. It is more cost effective and long term prospectives of success will be much higher.

# Plan B – Use Existing NP Resources

Alternatively, the above Plan A could also operate Plan B using existing Integrated Rural NP positions in the same manner should that be more desirable. On June 7, 204 the Government of Saskatchewan issues a [news release](https://www.saskatchewan.ca/government/news-and-media/2024/june/07/rural-and-remote-communities-set-to-benefit-from-27-new-nurse-practitioner-positions#:~:text=Twenty%2Dseven%20new%20permanent%20NP,primary%20care%20in%20underserved%20areas) entitled ‘Rural and Remote Communities Set to Benefit From 27 New Nurse Practitioner Positions’ (see [Appendix A](#_Appendix_A_–)). Specifically, the document states ‘Twenty-seven new permanent NP positions in rural and remote areas are now available with applications being accepted until June 10, 2024. The province announced funding of $4.5 million in this year's budget for the positions”. Many of these communities are the same communities utilitzing VIPER making this a unique opportunity sourced from within the community.

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| **Description** | Use the NP’s hired as part of this 202 Rural & Remote NP initiative to provided LTC and INP care in these small communities  |
| **Costing** | Minimal as cost paid for as part of the $4.5 million noted in the news release |
| **Timeline to Execution** | NP’s from the 25 communities involved in this program would be onboarded to use the virtual call center, video, documentation tools at HL811 and then be ready to serve these same communities  |
| **Advantages** | Staff already hired and paid for (?verify). Staff already working in these communities.  |
| **Disadvantages** | No knowledge or visibility into this workforce or its current workload.  |
| **Probability of success** | TBD |

# Plan C – Use Healthline NP Resources

Healthline has recently secured NP positions to support several initiatives as directed by the Ministry including provincial clinical networks, chronic disease management through provincial primary care initiatives like home health monitoring, early covid therapeutics and relief for the VIBEX service. At present these positions continue to be under active recruitment with no success to date. Currently positions have been posted 3 times with no applications received. Use of NPs in this manner would require Provincial SUN support and once fully resourced will not provide night support. Additional funding would be required.

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| **Description** | Use NP’s hired into Healthline to support Vibex and take on LTC and INP work  |
| **Costing** | Already in the budget |
| **Timeline to Execution** | TBD.  |
| **Advantages** | Natural synergy between NP’s at Healthline and VIBEX / VIPER programs also at Healthline.  |
| **Disadvantages** | * There are > 800 NP positions open inside the SHA and the appeal of this part time / casual rule is limited
* The NP’s would not work nights. This is a critical limitation because much of the LTC / INP coverage is needed at night.
 |
| **Probability of success** | Very Low  |

# Plan D – Use VIBEX Physicians

Supporting LTC and low acuity in-patients is something many general practitioners are already comfortable with. In both urban and rural communities GPs provide most support for LTC. Should an LTC patient become acutely unwell they could be transferred to the local ER (often in the same building / short distance away) for management by VIPER. Important to note that average wait time for public callers is 30 minutes. Demand already exceeds current resource levels. Do not currently operate at night.

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| **Description** | Add shifts to the existing VIBEX stream dedicated to LTC support. Anticipated that most demand would be at night.  |
| **Costing** | Extra VIBEX night shift $584,000 in physician time (8 hours / day \* 365 days) |
| **Timeline to Execution** | Would be < 60 days  |
| **Advantages** | Natural synergy between VIBEX / VIPER programs also at Healthline. Existing pool of physicians already doing this work |
| **Disadvantages** | New cost of adding night physician hours on VIBEX  |
| **Probability of success** | Medium  |

# Plan E – Use VIPER Physicians

Using VIPER as the backup to support LTC / INP has already become the default option. There is historical precedent at many sites that one physician is responsible for LTC / INP and should patients become “too sick” they are transferred to the local ER for further treatment. This model may work when physicians are on-site for a variety of reasons; access to the paper chart with all information, often the same local ER physicians do LTC / INP shifts and are familiar with long stay patients, a tacit understanding of what “too sick” means. In the virtual world there is no agreed definition of “too sick”, some sites have simply stopped staffing anyone to be on-call for LTC and all issues go to VIPER in contravention of our VIPER checklist agreement.

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| **Description** | Add a dedicated VIPER shift to deal all the LTC patients.  |
| **Costing** | Extra VIPER night shift $838,000 in physician time (8 hours / day \* 365 days) |
| **Timeline to Execution** | Would be ~ 90 days  |
| **Advantages** | This work is already falling to the VIPER physicians  |
| **Disadvantages** | The number of LTC / INP on a given day / night shift can be highly variable depending on the sites we take on. Some sites may have no LTC / INP while other can have upwards of 20 patients.  |
| **Probability of success** | Unknown  |

# Critical Roadblocks

Regardless of the solution chosen there are critical roadblocks to providing virtual LTC and INP that impact all plans. The proposals above address potential staffing issues but do not address the physical plant, equipment, software and informational workflow upon which all virtual care rests.

# Roadblock – Paper charts

Safe virtual care relies on a complete understanding of the patient’s health history. All the Virtual Physician Programs rely heavily on the common provincial electronic health record to glean this information. However, many patients (specifically those from remote and rural) have provincial health records that are completely devoid of information. Having lived, and received care, lifelong in smaller centers all their health information is locked in paper charts.

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| **Description** | Patient information locked in paper charts |
| **Solution** | Sites wanting virtual support for LTC and INP would have to (a) create a clinical summary for all LTC patients capturing their health history to date and (b) moving forward switch to electronic charting to allow seamless information flow between in-person care and virtual care. Analogous to how the VIBEX and VIPER programs chart everything in the Regina instance of SCM. |

# Roadblock – Handovers

Consider what happens on a general internal medicine / in-patient ward. At the end of the week the departing physician typically ‘hands over’ the patients remaining on the ward to the newly arriving physician who is working for the next 1-2 weeks. The format varies but at a minimum every patient’s chief diagnosis and active issues and plans are reviewed. This ensures care is continued without interruption.

If there are minimal patients on the ward with a few isolated issues this handover process can take as little as a few minutes. As the number and complexity of patients increases so to does the time required to handover. A busy internal medicine ward might require a 1–2-hour handover but given this should only happen once every few weeks the impact is diminished.

Conversely consider what needs to happen in the virtual context. We would take over different numbers of patients and different sites every single night. This requires each site participate in nightly handover and the corollary is we must repeat the handover in the am when patients return to the care of the local MD.

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| **Description** | Handover between in-person and virtual care providers.  |
| **Solution** | There are commercial electronic handover tools that facilitate efficient handover. Unfortunately, almost all rely on electronic medical charting as a prerequisite.  |

# Roadblocks – Longitudinal Care

As explained above most acute care in-patients or LTC patients are cared for by single physician for weeks at a time. Unlike the emergency department there is often a large amount of information and numerous active issues for each patient that practitioners must become familiar with. The significant upfront cost of ‘becoming familiar' with a list of admitted patients is offset by the fact that this cognitive burden is infrequent and the time invested yields better patient outcomes over the course of the week(s). In the virtual care model, we should consider how closely to emulate this real-world process. While there is more work for the virtual physician programs to take over for a group of LTC and/or INP for week(s) at a time it may, paradoxically, be less work than switching care between providers every 8-12 hours.

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| **Description** | Paradoxically it may be more efficient in the long-term to take care of a group of LTC / INP for week(s) at a time instead of handover q8-12 hours |
| **Solution** | Considering a scheduling system for sites wanting support for LTC / INP that is different from the VIPER schedule where physicians change every 8 hours.  |

# Recommendation

## HealthLine 811 – Supporting System Solutions

HealthLine 811 is not immune to the health human resource challenges being experienced across the Saskatchewan Health Authority. While we remain committed to supporting the system, we cannot be positioned as the sole solution to these challenges when we ourselves are navigating resource limitations.

It is essential that we shift the focus—from HealthLine 811 providing the solution, to being a support partner that enables teams, programs, and disciplines to develop and implement their own models. Our goal is to share our experience and expertise, helping others establish similar services that are sustainable and tailored to their needs.

HealthLine 811 is fundamentally a support service. We are currently engaged in multiple priority initiatives, service lines, and roadmap commitments. We will continue to provide guidance, training, and office administrative support to capacity. We have received an increasing number of requests, we want to flag that we may require support in communicating back to some areas and their SLT leaders that, due to current demands, their requests cannot be supported at this time. We will prioritize our efforts based on the direction and guidance of this leadership and appreciate continued understanding as we work to manage our capacity responsibly.

# Comments from Reviewers

## Anonymous Review #1

### LTC Coverage

LTC charts are notoriously inaccurate and often not up to date. Understanding what’s happening with a patient typically involves digging through nursing notes, as physician documentation is frequently absent. In many facilities, GPs document LTC visits in their own EMRs—if they document at all—and VIBEX or VIPER would not have access to those charts. Fortunately, nurses usually know the patients better than the physicians, which is a key asset.

Most overnight calls are simple—e.g., “Martha is more confused, can I get a UA?”—but some are much more complex, such as “Bill, who is a full lift and has advanced dementia, is unresponsive and is full code,” which could necessitate a family conference about goals of care.

Given these realities, I believe a dedicated night VIBEX shift (with NPs covering daytime hours) would be the most effective approach. Night shifts would likely need to run from 5:00 p.m. to 9:00 a.m. to allow for morning handover to on-site physicians (who's shifts start at 8:00am).

### Inpatient Coverage

Inpatient handovers in rural settings are often poorly done and tend to occur only when a locum is present. Local doctors just call each other if clarification is needed and often nursing has a pretty good handle on these patients.

Unfortunately, direct handovers between local and virtual physicians may be impractical given the number of sites (potentially 20+) being covered. This is tricky as CPSS is very clear that in order for there to be a transfer of care, a Dr to Dr handover must happen.

A more feasible solution would be a standardized "handover form" completed by the on-site physician and attached to the front of the patient’s chart. This form would include key details like code status, allergies, active issues, and the current care plan. It should also include the handing-over physician's number in case the receiving physician actually needs clarification. Nursing staff could then forward this to the virtual physician during consultation. Gravelbourg currently does this for handover...I'll see if I can get a copy of their form. If memory serves, I believe their form does require an actual Dr to Dr discussion--but this discussion is almost never done.

As with LTC, I think we'd need 16-hour night coverage (5:00 p.m. to 9:00 a.m.) to facilitate proper handover of any consulted patients in the morning. Also, if VIBEX or VIPER is to cover inpatients, I believe patients should have to consent to remain in a facility without an on-site physician overnight.

### Summary Recommendation

LTC night coverage: VIBEX line from 5:00 p.m. to 8:00 or 9:00 a.m.

Acute care night coverage: VIPER night shift from 5:00 p.m. to 8:00 or 9:00 a.m. (as these sites are likely already on VIPER and managed by the same nurses who run the ED's).

# Appendix A – Government of Saskatchewan Nurse Practitioner News Release

From this [link](https://www.saskatchewan.ca/government/news-and-media/2024/june/07/rural-and-remote-communities-set-to-benefit-from-27-new-nurse-practitioner-positions#:~:text=Twenty%2Dseven%20new%20permanent%20NP,primary%20care%20in%20underserved%20areas)

Rural and Remote Communities Set to Benefit From 27 New Nurse Practitioner Positions

Released on June 7, 2024

The Government of Saskatchewan has exceeded its commitment of adding 25 new Nurse Practitioner (NP) positions. Twenty-seven new permanent NP positions in rural and remote areas are now available with applications being accepted until June 10, 2024. The province announced funding of $4.5 million in this year's budget for the positions which are designed to increase access to primary care in underserved areas.

"Nurse Practitioners play a vital role in the Saskatchewan health care system, and adding positions in rural and remote areas will help residents find the care they need closer to home," Mental Health and Addictions, Seniors and Rural and Remote Health Minister Tim McLeod said. "We look forward to seeing more Nurse Practitioners providing quality care in Saskatchewan communities."

NPs are registered nurses with additional training to support a higher scope of practice, and working within a primary care team, can provide many of the same services as family physicians, including;

* advanced assessments, diagnosis, and treatment of acute and chronic illness;
* ordering diagnostic tests;
* admitting and discharging patients;
* prescribing medications; and
* performing medical procedures and providing referrals to specialist services.

"The Saskatchewan Association of Nurse Practitioners is pleased to see the creation of 27 new positions for Nurse Practitioners across the province," Saskatchewan Association of Nurse Practitioners (SANP) President Elect Michelle O'Keefe said. "These positions will assist with the stabilization of primary health care services in these communities whilst creating employment opportunities for NPs who may have been previously underutilized."

The Ministry of Health worked in collaboration with the Saskatchewan Health Authority and SANP to prioritize communities that require additional NP services.

"We support the integration of more Nurse Practitioners into primary health care teams across Saskatchewan, working alongside physicians and other health care professionals to deliver high quality care," Saskatchewan Health Authority Vice-President for Integrated Northern Health and Chief Nursing Officer Andrew McLetchie said. "We remain committed to enhancing access to health care for all residents of the province and stabilizing services in rural and remote communities to achieve our vision to improve the health and wellbeing of everyone, every day."

Communities that can expect NP services as part of this initiative include:

1. Fort Qu'Appelle/Balcarres
2. Indian Head
3. Yorkton
4. Esterhazy
5. Preeceville/Kamsack/Canora
6. Estevan
7. Lanigan
8. Melville
9. Weyburn
10. Kelvington
11. Lestock/Raymore
12. Hudson Bay
13. Cumberland House
14. Nipawin/Aborfield/Carrot River
15. Lakeland Area - Christopher Lake, Paddockwood
16. Biggar
17. Wilkie
18. Meadow Lake/Goodsoil/Loon Lake
19. Lloydminster
20. Herbert
21. North Battleford
22. Outlook
23. Turtleford/Edam/St. Walburg
24. Maple Creek
25. Prince Albert

The 27 additional positions will enhance and expand the use of NPs and enable health care teams to see more patients. There are currently 360 licensed NPs in the province.