Real-Time Virtual Support quick-reply pathways

Physicians working together to deliver equitable team-based care in rural BC.

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This article has been peer reviewed.

Background

Residents of rural, remote, and Indigenous communities in British Columbia face significant disparities in accessing quality health care services and professional supports. These well-documented disparities are particularly pronounced in Indigenous communities, where a history of inequitable and underprioritized access to health care resources has been observed.[1] In response to these challenges, the Real-Time Virtual Support (RTVS) program launched its quick-reply pathways starting in 2020 (during the pandemic) to provide a pan-provincial roster of specialist services.[2,3] The quick-reply pathways provide timely, video-enabled access to specialty expertise for health care providers, such as on-the-ground family physicians working on the front lines of rural, remote, and Indigenous communities.

RTVS quick-reply pathways are part of a larger network of rural video-enabled clinical supports, which also include emergency medicine (RUDi), maternity (MaBAL), and pediatric (CHARLiE) expertise. All providers strive to create a psychologically safe and supportive culture for clinicians to seek advice and exchange ideas. The "call a friend" culture of RTVS has made it easier for rural providers to reach out and advocate for patients who may need specialist care. Lowering barriers to access specialist support through the RTVS network can have significant positive influences on patient care and professional support.

Sample case

Here we explore a case that highlights the impact quick-reply pathways can have for patients and providers in rural, remote, and Indigenous communities.

A 66-year-old male presented to the emergency room in Fort Nelson, which is 800 km from the nearest tertiary care hospital. The patient told his family physician that he had been experiencing headaches, confusion, general unwellness, and a rash for 3 months.

Upon examination, the patient had a red, scaly, pruritic rash over his torso and limbs. There were no focal neurological deficits observed. Pertinent investigations

revealed positive SSA and SSB antibodies, hypocomplementemia, a decline in hemoglobin levels from 120 to 80 over 5 months, and an increase in creatinine levels from 69 to 110 over the past year, along with hematuria and proteinuria. At a previous visit, a skin biopsy had been performed, revealing vacuolar interface dermatitis consistent with a connective tissue disease–associated rash. As well, 1 month prior, the patient had been hospitalized at a different facility for cognitive decline so severe he couldn't speak or eat. During that admission, he was found to have diffuse symmetric white matter lesions involving the temporal lobes and sparing the corpus callosum on MRI. He improved with three doses of 1000 mg IV methylprednisolone but left hospital before further therapeutics could be initiated.

At this point, there was concern that the patient had neuropsychiatric lupus. Due to the complexity of the patient's case, his family physician sought assistance from RTVS quick-reply specialists. Over several days, guided by his family physician, the patient interacted with the RTVS dermatologist, rheumatologist, hematologist, and neurologist. After ruling out alternative autoimmune, infectious, and malignant diagnoses, a diagnosis of neuropsychiatric lupus was confirmed. The patient is now receiving definitive care and is on the path to recovery. He is free of headaches with no neurocognitive symptoms, but he does not recall the events of the previous 3 months.

For rural physicians, encountering patients with rare, multisystem diseases can be challenging, and the lack of support managing these patients can be frustrating. The virtual physicians on the other end of the Zoom or telephone call are committed to be friendly, culturally safe, compassionate, and dedicated to providing assistance wherever needed. According to this patient's family physician: "The help I received undoubtedly saved the patient from imminent decline. It was timely and effective. It was a real mountain of support for me, and in turn for the patient."

Conclusions

Access to specialists should not require years-long waits and marathon journeys on the part of rural patients. Specialists are distributed inequitably in British Columbia and tend to work in urban centres. It is incumbent upon us as physicians to devise innovative programs to address the gaps in care that arise from this uneven distribution of specialists. The RTVS program aspires to provide quality care to rural areas that have been historically underserviced. Because of RTVS, rural clinicians no longer need to feel isolated, managing challenging medical conditions they have never seen. As this case demonstrates, advice is only a Zoom call away.

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Additional information

RTVS quick-reply pathways are supported by the Rural Coordination Centre of British Columbia (RCCbc) and receive approximately 153 calls per month. Family physician compensation for accessing the pathways varies depending on the physician's payment model. Specialists bill specialist advice codes or telehealth consultation codes for their interactions, depending on the nature of the encounter.

How to get involved

Rural family physicians can access the RTVS quick-reply pathways through the directory of their RCCbc Zoom account. Specialists interested in becoming involved can contact the corresponding author, Dr Ohata, at brent.ohata@ubc.ca.

To find out more and connect with RTVS, visit https://rccbc.ca/initiatives/rtvs/getting-started. ■

Competing interests

Drs Ohata, Yee, Kitson, Johnston, and Pawlovich, and Ms Connop Price all hold positions with the RTVS program.

References

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