JOINT POSITION PAPER ON RURAL SURGERY AND OPERATIVE DELIVERY

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Part 1 Background & Context

GENERALISM IN RURAL SURGICAL CARE

- Renewed interest in role of Generalist general surgeons, and Family Physicians with enhanced surgical skills (FPESS)
- Evidence pointing to effectiveness and cost savings
- Solution to attrition in rural surgical programs and closure in maternity care

LOCAL ACCESS TO SERVICES

- Evidence and consensus recommendation: Women should be able to deliver as close to home as possible
- Lack of local intra-pardum obstetric service forces women to travel and leads to worse outcomes
- Important to community, offers economic and social benefits

SCOPE & RESPONSIBILITIES

- Attract colleagues in sufficient numbers to maintain full service local health care
- Offer broad set of skills and additional competencies across range of functions and/or specialties well suited for low volume environments
- Rural practitioners have a wider scope (range of procedures) than urban counterparts
- General surgeons provide back-up services
- Historically, generalists met needs of rural communities
- Ontario and Eastern Canada: Rural surgical services performed by generalists
- Western Canada: general surgeons supported by 150 FPESS

SUSTAINABILITY

- We need caesarean delivery capacity locally
- Without local or nearby surgical services it is difficult to sustain local operative delivery and maternity care
- Low volume of procedures, staffing and continuous coverage issues, recruitment of stable supply of professional staff needed
- Stand-alone local operative delivery programs largely unsuccessful due to infra structural issues listed

SAFETY

- **Holistic Perspective:** Patient travel risks, social costs of separation from family and community, financial implications
- No evidence to suggest that basic maternal surgical care, including caesarean section, is less safe when provided by GP proceduralists with ESS than when provided by specialist obstetrician

Part 2 Network Model of Rural Surgical Services

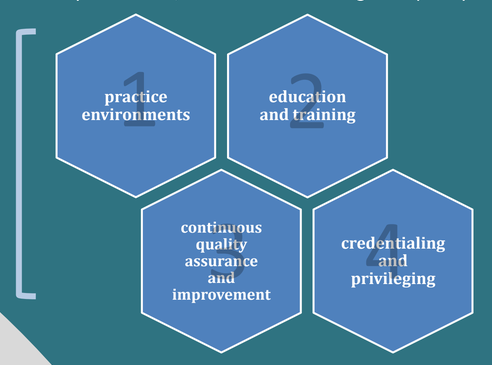
CHARACTERISTICS OF A NETWORK MODEL

- Formal – defined structure
- Highly integrated across geography where referral centres function collaboratively with the local rural surgical program
- Form the platform for both continuing professional development and continuous quality-improvement activities.

UNDERLYING PRINCIPLES

1. Support of rural services by referral and regional centres in building professional capacity and confidence, competence and currency in practice
2. Functional and formal referral patterns spokes to hub to highest-level regional metropolitan specialist and subspecialist services, according to risk or need
3. Effective and efficient mechanisms of patient transport for acute and sub-acute cases
4. Integrated referral, which includes documented discharge, with awareness of rural site capacity, improved through both relationship-building and formal asset mapping
5. Educational programs undertaken with referral hospitals at both a site- and system-level, linked to monitoring and quality improvement

4 PRIORITY AREAS



BENEFITS

- Increased capacity for surgical care
- Optimized clinical activity through improved access and utilization by rural populations
- Preventive, upstream and recovery services as close to home as possible
- Appropriate and efficient care: avoiding involvement of higher levels of care
- Formal integration of surgical care
- Providers lessens the probability of
- Gaps in continuity in health care transitions

Enhanced Recovery after Surgery (ERAS) Pathway

- Multimodal perioperative care pathway designed to achieve early recovery for patients undergoing major surgery
- Reducing physiologic stress caused by surgical procedures and promote rapid recovery
- Studies show: altering traditionally perioperative care lead to shorter stay by 2 days and an almost 50% reduction in postoperative complications
- Patient-centered care and continuity of care through interprofessional collaboration

RECOMMENDATIONS

Network Model

1. Network models of integrated rural surgical services be established and maintained by all key professions in rural Canada
   - Optimal health human resources solution to meet the surgical needs of rural resident
2. Referral specialists and rural FPESS providers should work together
3. Each patient should receive surgical care as close to home as possible by a provider and in a setting best suited to their anticipated needs
4. Patient diagnosis, the complexity of the procedure, the patient comorbidities, the skill sets of the local and itinerant providers, and the resources of the local environment, including infrastructural capacity
5. Built on platforms of efficient, effective and safe transport
6. Patient travelling for surgery: integrate their local program into the preparation for, and the recovery from, their surgery

Credentialing

1. Make the principles of team competency and patient safety foundational
2. Create population catchment areas around each individual facility and each network of facilities such that outcomes of both can be tracked
3. Embed a formal quality improvement process in the network (e.g., National Surgery Quality Improvement Program of the American College of Surgeons [ACS NSQIP] and MOREOB)
4. Provide timely feedback on risk-adjusted outcomes

Practice Environment

1. Integrate rural and regional surgical and operative delivery programs
   i. Defined catchment area
   ii. Across regional geography
   iii. Into the same departments that are inclusive of the rural specialists and the FPESS surgeons
2. Structure rural surgical programs around a range of procedure options, based on provider and institutional capacity, as well as population needs
3. Plan decisions regarding local surgical services to include the financial and social costs, health care outcomes, and risks of not providing the service
4. Consider all decisions on surgical, maternity and endoscopic care within the framework of safety and holistic risk – risks and costs of patient travel, timeliness, operative safety, family separation, non-delivery of service and avoidance of presentation
5. All recommendations apply equally to the provision of endoscopic services for rural Canadians

Continuous Quality Improvement Program

1. All of the applicants' education and training, accumulated practice experience, measurement and examination of risk-adjusted outcomes and participation in both professional development and continuous quality improvement
2. Appropriateness of the procedure within the local human resources environment
3. Access to high-quality procedural care as close to home as possible, across the regional network
4. Linkages to the sustainability of other services, including local maternity care programs
5. Regional planning infrastructure for the individual procedure, the associated clinical services and the linkages to other clinical services

Education & Training

1. Core, competency-based curriculum, reflective of the required skill set of FPESS providers, in recognized programs for training, evaluation and certification
1. Also reflective of the required skill set of operative delivery
2. Develop pathways for the training, evaluation and certification of added competencies across disciplines for rural general surgeons
3. Also added competencies across disciplines, for rural OB–GYNs, with particular attention to the strategic role they play in rural surgical care.

Each rural surgeon, whether specialist or generalist, should be nested within a supportive community of practice. A Supportive community of practice, includes rural surgeons – both specialists and generalists, colleagues, mentors, teachers, referral and patient transfer receivers, and the support professionals and staff pertinent to surgical and obstetric care.

There is a renewed interest in role of Generalist general surgeons, and Family Physicians with enhanced surgical skills (FPESS) with evidence pointing to its effectiveness and cost savings. Generalists are a solution to attrition in rural surgical programs and closure in maternity care.

Core principles

- Network model positions surgical care as a regional rather than institutional phenomenon
- Small operating rooms are an extension of core referral hospital programs
- Care programs provided through well-integrated and balanced surgical team (outreach surgeons and local surgical providers)
- Surgical procedures provided in the closest operative facility to the patients' residence
- Respects the complexity of the procedure, the risk status of the patient, and the availability of surgical providers with procedural competency

1 Practice Environment

- Colleagues and organizations linked and interdependent through:
  - Professional and Personal relationships
  - Training Pathways
  - Referral Pathways
  - Distant and local collaboration
- Members within easy and immediate communication
- Engage together in continuing professional development, quality enhancement and advocacy
- Patient centered culture and considerate of community
- Rural surgical programs nested within regional programs
- Supported by regional staff who are available for consultation
- Learning occurs in a continuous, seamless model
- Program assessment must consider risk of isolation (intrinsic health and social risks) as well as quality and safety

2 Education and Training

- Entry level and continuing professional development
- Participation of the generalist specialist surgeons and FPESS providers key for educational program to reflect realities of rural practice and needs of communities
- Emphasis on generalist workforce for rural health care and Doctors trained/credentialed in surgical services

3 Continuous Quality Improvement Program

- **Iterative process**
  - ensure safe and effective care through documenting, reporting and examining risk-adjusted surgical outcomes
- Measure outcomes based on risk identification and management (continuous quality improvement)
  - Example: Managing Obstetric Risk Efficiently (MORE)
    - built on a platform of team competence and a culture of patient safety
- How to measure Quality Improvement?
  - Tracking and examining the outcomes of population catchment areas surrounding a facility
  - Outcomes: within reasonable 1 hour travel time, regardless of where care is received
  - Quality-of-care framework
    - providers and hospitals provide feedback on performance for the catchment area
    - Benchmark against other communities with similar service levels

4 Credentials and Privileging

- Verifiable evidence of training to perform given procedure
- Documentation of training, relevant evaluation, reference letters attesting to training and skills, and reports from mentors or practice assessments (where relevant)
- Single level of care, regardless of specialist performing procedure
- Mentorship and privileging to avoid vulnerability during transition period

SUMMARY

Endorsed by:

The College of Family Physicians of Canada (CFPC)
The Society of Obstetricians and Gynaecologists of Canada (SOGC)
The Canadian Association of General Surgeons (CAGS)
The Society of Rural Physicians of Canada (SRPC)