Why COVID-19 could be a boon for rural patient transfers

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The COVID-19 pandemic has led to an escalated need to transfer patients for intensive care, even between provinces. Pre-existing barriers to transfer such as licensing requirements and policies prohibiting air transport across provincial boundaries have fallen.[1] This unprecedented flexibility must be leveraged to address long-standing issues for rural patients requiring transfer. Crisis brings opportunity.

This is an equity issue for the Canadian health care system. It disproportionately affects Indigenous remote communities and is one element of systemic racism within our health care system.

This issue is also a health workforce issue. Barriers to timely and safe patient transfer are a source of stress and burnout for rural physicians. For some, they contribute to a decision to leave rural practice.

What practical strategies will work to improve rural patient transfers? The first is to implement 'no refusal' policies. When I call to transfer a patient, either I know what I'm doing, in which case my transfer request should be accepted, or I do not know what I'm doing, in which case my transfer request should also be accepted!

Air transport of patients is expensive. In 2018, patient transfers in the Northwest Territories (NWT) cost about $20000 per occurrence, numbering about 100–120 transfers per month. Triaging transfer requests for reasons of putative cost containment can lead to barriers to care for patients and frustration for physicians and nurses in rural and remote communities. In 2018, a 'no refusal' policy was implemented for transfers within the NWT to the regional hospital in Yellowknife following some outcomes for patients which contributed to staff burnout and attrition. The number of medivacs did not increase, and an added benefit was the reduction of stress for emergency room physicians who no longer felt the need to be cost gatekeepers for the health care system.[2]

Second, tertiary care centres must implement formal agreements between referring and accepting regional, provincial and territorial health care institutions. The maitre d' of a fine restaurant pays attention to the ambience, the menu and the quality of the experience while not worrying about all those who cannot get a reservation at their highly acclaimed establishment—the reputation of the first-class business is accolade enough for the maitre d'. Hospitals which focus only on the quality of care

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within their walls without taking responsibility for their catchment area are arguably in a similar situation, the obvious difference being that these institutions have a social accountability that a fine dining establishment does not.

Rural patient transfers constitute a two-way journey. Health sciences centres, under pressure for beds and personnel, need to return stable patients to their home communities in a timely way. Formal policies between referring and receiving centres, rather than a reliance on collegial relationships alone, can make a difference in the ease of arrangements for patient movement between facilities.

Lack of understanding of the context of care and resource limitations in referring communities also contributes to transfers being declined.[3] Unfortunately, refused transfers are difficult to track. According to recent media reports, Alberta can report the number of surgical procedures cancelled due to COVID. However, despite an interjurisdictional transfer agreement between NWT and Alberta, no data can be produced regarding how many patient transfers from NWT to Alberta for non-urgent surgeries have been deferred due to COVID-19.[4] As a third strategy, we must collectively use data to evaluate, improve and reduce the need for patient transfers. We can create measurable benchmarks to promote continuous quality improvement, perhaps using Accreditation Canada's required organisation practices as a lever. What we measure matters.

What else can be done? Proper policies and infrastructure are crucial for timely transfers and appropriate consultations between rural health facilities and tertiary hospitals. For example, trauma patients must be transferred to the nearest trauma centre, even if this means crossing a provincial boundary—unusual in the past, and now necessary during COVID times.

We can leverage the use of virtual care technologies to support more care close to home. Enhanced broadband capacity is essential for advancements in technology that can support point-of-care, urgent and real-time consultations between locally based health care practitioners and regional specialists. Lack of local diagnostic services has recently been shown to be a major reason for interfacility transfers and delayed care. As an example, this has led to an argument in support of improving local access to computed tomography scanners.[5] Let's improve access to diagnostic technology in rural hospitals.

The Society of Rural Physicians of Canada and the College of Family Physicians of Canada, along with other partners, have issued a Call to Action on rural patient transfers.[6] These transfers will continue to be a necessity in Canada long after the headlines about COVID-19 intensive care unit aeromedical transport have disappeared. Only concerted collaborative action will make a difference to ensure equitable access to health care for rural and Indigenous communities. If we can do it for COVID-19 patients, our rural patients deserve no less.

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