

Summary of March 1, 2014
Forum on Sustainability of Rural Maternity Services

Starting early in 2012, BC's Ministry of Health initiated province-wide key-stakeholder consultations to establish a set of consensus-derived action items for a provincial primary maternity care agenda. The move came from recognition of signs of system instability, particularly in rural settings where over 20 small maternity services have closed in the past 10 years. This concern resulted in the provincial Primary Maternity Care Action Plan document. Although larger systemic problems exist—such as disparate funding models providing disincentives to inter-professional practice, recruitment and retention of health professionals in rural areas, educational support for entry and maintenance, etc. —and demand a longer horizon to resolve, collaborating partners identified a series of short term (12-18 month) action items resulting from the issues identified that could affect immediate change. One such issue concerns meeting the perinatal surgical needs (cesarean section) of rural women. Issue 13 in the plan notes:

Rural maternity services show system stresses early and are particularly vulnerable to shifts in provider supply or availability for intra-partum care. Several consultations have pointed to the importance of sustained availability of C-section capacity in preserving the small maternity services. The availability of general practitioners with C-section (and general surgery) skills or anaesthesia skills could play a significant role outside of urban areas. There are tensions within the medical community that make it difficult to develop a concrete next step with regard particularly to GP Surgery but also GP Anaesthesia.

Perinatal Services BC was asked to begin the consultation to explore multi-stakeholder participation in developing potential responses to this ongoing issue. On Saturday, March 1, 2014, a group was convened to explore the complexity of the situation and identify some opportunities for action. A full report of the proceedings of the day will be developed and distributed in the coming weeks.

Although this issue has been discussed and written about extensively for the last two decades, sustainable solutions have not been developed or implemented here in the Province. Bringing those responsible for surgical care in BC together with those leading maternity care provided an opportunity to openly discuss the intersection of these programs. A brief history of the situation was presented by Dr. Stu Iglesias. A literature review of centralized and regionalized maternity services in rural settings is currently being completed and was referenced during the day but will be used more extensively in future work. It is clear that there are many valuable lessons to be learned from the experience of other jurisdictions in addressing this almost universal problem.

The themes of work required for any movement forward were:

- Policy development
- Relationship building
 - Communication/networks
- Service Planning

- Strategic HHR planning, including recruitment and education
- Quality assurance and improvement including defining metrics and risk
- Rural impact assessment

Below is a summary of the four focus action areas that arose from this first meeting:

1. Those in attendance recognized the need to support quality assurance and improvement but collectively agreed that the current process being considered for privileging various physician groups does not take into account the unique situations in rural and remote communities. A letter of concern will be written and endorsed by those representing the many stakeholder groups and will be forwarded to leadership for the privileging project.
2. Strategic human resource planning was identified as another key area of foundational work. This included examining the education needed to support enhanced surgical skills for physicians, nursing in rural communities, expanded scope of midwifery, and others. There was agreement that educational experience within rural settings was essential as well as ongoing education of individual professionals and teams to maintain skills. This will need to be built into a network of care. This is not a new idea but one that continues to be brought forward each and every time care in rural communities is discussed.
3. Networks was the third key focus area. This was meant to include networks of clinical care as well as administrative networks required to 'cross-pollinate' the planning work of many groups. For instance, surgical planning and maternity planning interface at the need for cesarean section, and planning must include both groups. A first step was to develop documents that outline which groups are involved and who is responsible for which parts of the system.
4. The final focus area was the Pilot Projects proposal by the Joint Standing Committee (JSC) for rural care. The group made the suggestion that an advisory group be developed with membership comprising of some of the members present on March 1 and potentially others to assist the JSC in developing criteria for the pilots. They would also be interested in being included in reviewing a one-pager submission by the potential communities prior to the JSC making a final decision.

The key success of the day was the development of shared vision and goals by groups that had not previously worked together. Beginning the development of relationships and the establishment of joint commitment was a good first step. A follow-up meeting will be scheduled for late April 2014.

Follow-Up Meeting for Rural Maternity/Surgical Services

June 14, 2014

Kim Williams, Provincial Executive Director, Perinatal Services BC opened the meeting with a summary of the March 1 meeting. An update on the four key action items was provided, as follows:

1. Physician Privileging Project

Correspondence between the working group and the Ministry of Health included a letter and working paper signed by members representing various organizations outlining the concerns regarding currency” as a measure of competency. Dr. Slater advised the group that a large amount of work had been completed to date and that ongoing engagement with providers will be conducted to provide clarity regarding processes. He advised the group that volumes (numbers of procedures) were intended to initiate a conversation between providers and health authority administration and are not intended as a disqualifier to practice. He also indicated that ‘lifetime’ numbers may be considered along with annual numbers. There is no intent to close services in rural communities. Further discussions regarding this project are ongoing.

2. Strategic Human Resource Planning

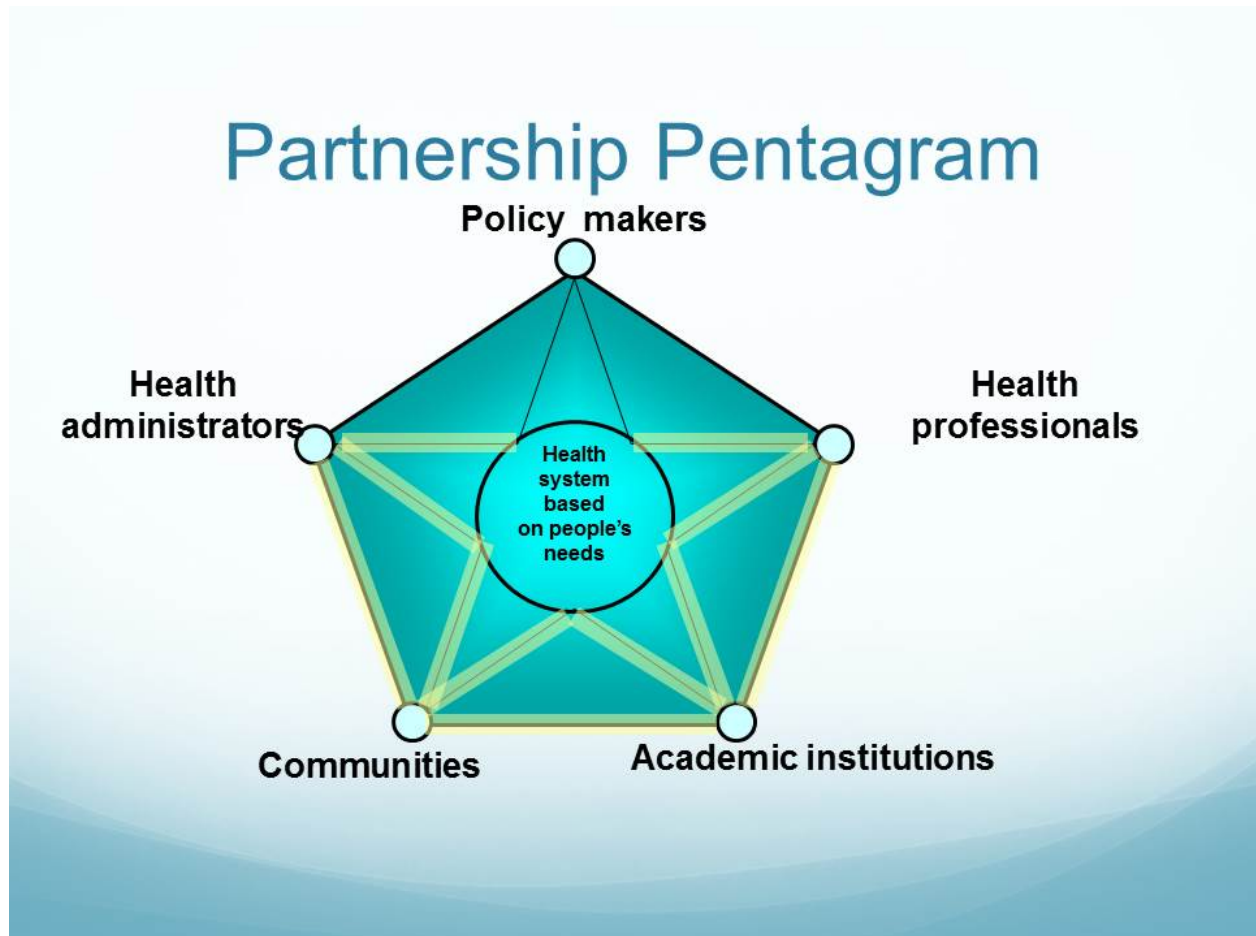
Dr. Bob Woollard provided an update from the Society of Rural Physicians of Canada Conference, which was held in Banff, Alberta on March 27-29, 2014. There was a strong interest in a national strategy. A working group has been very active in developing such an action plan since 2012 and the meeting confirmed a “four pillar” Strategy for action:

- 1) development of a national core curriculum for teaching and evaluating enhanced surgical skills (*third draft in circulation, intended for completion this fall*);
- 2) joint position paper collectively written by SOGC, SRPC, CFPC with the potential for CMA input in support of a ESS program/education/support (*initial DRAFT developed at Banff with top leadership of each organization present, now in 5th draft and for completion this Fall*);
- 3) Special Interest Focused Practice (SIFP) section *established* by College of Family Physicians of Canada by CFPC Board to provide a “home” for recognition, development and support of SIFP practitioners and related quality enhancement activities;
- 4) Working with regulatory and credentialing bodies to deal with privileging and portability issues (*currently developing pilot strategies in Alberta and Saskatchewan and hope to move forward in BC once current issues are ironed out*)

This very active process is gathering feedback from GPs with ESS, general surgeons, OB/GYNs, and anesthesiologists to move work forward by integrating feedback and developing evaluation as a pilot project.

Dr. Woollard also presented a model of collaboration called Pentagram Partnerships, which shows the relationships and partnerships that must be developed and strengthened in order to sustain and

improve the current health system. This model provides a framework for this group to use going forward with planning for sustainment of rural and remote maternity/surgical services. The essential “web” of relationships illustrated by the diagram has proven valuable in many approaches to health system development in both high and low resource situations.



3. Networks

PSBC is developing a network map outlining how the work of the various agencies and organizations intersects. Participants were asked to add information to existing ‘circles,’ so that it could be incorporated into that already received. What is evident in compiling information was that many groups are working hard on resolving rural maternity/surgical issues and just need to be connected to others. Facilitating such connections by providing venues and processes for ongoing communication across the Province and between the “pentagram partners” offers the surest pathway to building a sustainable service for rural women, babies and families. There is much goodwill but, as history shows us, *good intentions are not enough* and unintended consequences can undermine hoped-for outcomes. Bringing those networks together with the best evidence and experience of other jurisdictions will convert this very difficult task into a *feasible* one.

4. Pilot Projects

Dr. Granger Avery provided an overview of rural communities which have closed services in the last years, are at risk of closing (22), and in crisis (14). The JSC will grant one-time funding of \$500,000 for a two-year pilot project that will support the development of plans for maintaining patient care that is integrated and cross-provider. Health authorities will be asked to submit up to three proposals, and a JSC selection committee will determine successful applications in September. The development of the selection process for such pilots and the pentagram partners animating them will provide significant joint trust and experience upon which the network/collaboration can build.

Centre for Rural Health Research

Jude Kornelsen from the Applied Policy Research Unit provided an overview of the in-depth literature review and report, which was commissioned by MoH and PSBC. The research question was “Can we meet the perinatal surgical needs of rural women more effectively through an optimally centralized or optimally decentralized model of care?” Sub themes included: safety and quality; cost and cost effectiveness; satisfaction of key stakeholders including women, providers, and system administrators; and sustainability.

The report showed that GPs with ESS can safely and effectively deliver perinatal surgical care in low-volume settings. One of the biggest challenges to support operative delivery is the recruitment, training, and retention of providers from various disciplines (including administration/management) supported in working together. The report included the following summative recommendations based on the research and applied to the BC health planning context:

1. Care should be provided as close to home as is organizationally feasible. “Close to home” must be defined and operationalized with service targets for all communities.
2. The extent of population need for perinatal surgical services should define the organizational feasibility for local care, regional care, and subspecialized care.
3. Population need should be defined by the numbers of births in the population served, the characteristics of the births (complexity, risk), and community/regional geography.
4. Population catchments should be established for local community, regional referral, and subspecialized care, and population outcomes should be linked with the responsible services.
5. The service, whether local, regional or subspecialized, should be resourced by integrated teams of practitioners working to the full extent of their skill set, be they generalists with enhanced skills, specialists, or subspecialists.
6. These integrated networks of surgical care should be established between referral services and smaller community services which would include outreach surgical support to the smaller centres.

7. Measurement of outcomes should be grounded in utilization patterns starting with normative goals for the catchment population and compared to similar populations.
8. Perinatal surgical system management should support innovative service evolution identified through outcome monitoring and leading to ‘scaling up’ where appropriate.

There was excellent discussion regarding the recommendations. General consensus among the group was that the recommendations provided a framework in which much more specific and context specific actions can be planned by the partners..

The full report, *Optimal Perinatal Surgical Services for Rural Women: A Realist Review*, can be accessed online at: http://centreforruralhealthresearch.files.wordpress.com/2014/06/optimal-perinatal-surgical-services-for-rural-women_a-realist-review2.pdf.

Moving Forward

The “*virtual birthing/surgical suite*” has been used as a way to conceptualize maternity care provided to women in rural and remote areas across the province. Although many sites are small and have small numbers of births, collectively, these communities make up a large percentage of births in the province and could be seen more along the lines of various wards in a hospital “umbrella” that sees themselves as sharing overall responsibility for flexible and responsive practices that respond to ever changing needs. Doing this on a community by community basis risks continued attrition as “wards” close for a variety of reasons—most of which are temporary but the result is permanent closure.. This could include planning for and staffing (including mentorship and education) within a network model rather than localized and separate for each community. Having said that, it is clear that the context of each community must be able to be taken into account and planned for. Experience with a “cookie cutter” model that seeks to impose rigid “standards” has failed and will continue to fail to preserve or enhance the current services. There is every reason to believe that the current services are both safe and appreciated. But their existences are under threat for a number of reasons and it will take vigorous, collective and thoughtful action to ensure that we change those reasons to a more positive mutual commitment to rural women, babies, families and communities.

There is consensus that the culture is shifting and recognition that rural maternity and surgical services cannot be totally separate from urban services with regard to planning, education, and ongoing support. However, it is clear that there are a number of features and challenges in specifically *rural* obstetrical and surgical services that require two things:

1. A collective approach that unites and takes mutual responsibility for the identified “virtual birthing/surgical suite” represented by existing and needed services to rural maternity care close to home and,

2. A system of support and quality maintenance which promotes Provincial standards and outcomes by being flexible and responsive to the unique features of each rural community (“when you have seen one rural community you have seen one rural community”)

This is a challenging balance to achieve but it is clear from experience and evidence from elsewhere and the reality of rural service closures here in BC that attempts at simple application of general rules are likely to continue to be clumsy and counterproductive.

Following two full days of stakeholder engagement, consultation, review of the literature, and current work by provincial and national organizations, *it is apparent that to sustain the maternity services in rural BC, there must be a commitment to both stabilize and enhance overall surgical services in these communities.*

Work currently underway provides a strong foundation for moving forward and should be leveraged where possible. This list (identified in a paper to the JSC) includes:

- [Setting Priorities for the BC Health System](#), Ministry of Health (February 2014);
- Joint Standing Committee’s long standing focus on evaluation to measure outcomes;
- UBC’s long standing and evolving commitment to relevant educational innovations that impact on rural health practice and practitioners;
- UBC Faculty of Medicine’s current exploration of a broadly based Advisory Committee on Rural and Remote Health Issues;
- Current proposal by the JSC to provide endowment and infrastructure funding for academic position and academic focus on rural issues at UBC;
- Centre for Rural Health Research’s growing expertise, working in conjunction with key stakeholders to establish and reaffirm such specific research and evaluation priorities as outcomes of low vs. high volume surgical services, inter-professional models of care, and telehealth distribution of specialist services;
- Creation and evolution of the First Nations Health Authority;
- The national initiative in developing a strategy for training and credentialing ESS practitioners as outlined above and the evolving recognition that it is equally important to focus on enhanced skill nurses and other needed rural professionals.
- The gathering movement towards the social accountability of medical schools as expressed in the *Global Consensus for the Social Accountability of Medical Schools* and the commitment of both UBC and the Association of Faculties of Medicine of Canada expressed in *Future of Medical Education in Canada* initiatives; and
- The increasing interest of granting agencies and others in knowledge translation and policy relevant research.

*This, properly connected should provide a solid basis for optimism while underscoring the urgency of taking collaborative action **now**.*

Action Items

The following are action items and areas where further work was needed:

1. Align work with Ministry of Health's report *Setting Priorities for the BC Health System*, which speaks to patient-centred care, access to specialists, and care in rural areas of BC.2. Continue to work towards obtaining greater participation from the Surgical Advisory Council members as it has been agreed that this is fundamentally a surgical issue that impacts maternity care.
2. Jude Kornelsen to revise recommendations from the literature review.
3. Centre for Rural Health Research to work with PSBC to update the Rural Birth Index.
4. PSBC and Centre for Rural Health Research to work to integrate Rural Birth Index with the Tiers of Service planning.
5. Identify clear pathway and incentives for training rural medical practitioners.
6. Engage the sectors of the 'partnership pentagram' in the process to ensure the most effective planning and the most rapid translation of that planning into practical action. This will include activities and connections at various scales from the local through Regional to Provincial and National.

Next Meeting

The next meeting will be planned for late September and will focus on defining and prioritizing the "next steps of action" to be taken.