Rural Coordination Centre of BC
Enhancing Rural Health Through Education

2010 Conference Proceedings
Rural Emergency Continuum Of Care

Kelowna, BC • June 18-20, 2010

Society of Rural Physicians of Canada
Société de la Médecine Rurale du Canada

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Rural Emergency Continuum of Care
2010 Conference Proceedings

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Conference Overview

The Rural Emergency Continuum of Care Conference was held June 18-20, 2010 in Kelowna, BC. The conference provided an opportunity for accessible, accredited and multidisciplinary professional education for rural physicians, nurses, first responders and paramedics.

> ***"an opportunity for accessible, accredited and multidisciplinary professional education..."***

Attendees

Over 270 people participated in the conference, including 211 attendees and 62 presenters. In keeping with the interprofessional focus of the conference, participants included paramedics, nurses, residents, students and physicians.

Friday, June 18, 2010

The Joys & Challenges of Rural Practice

Friday's policy discussions provided a forum for dialogue between a wide variety of health care providers, administrators and academics. The day opened with an introduction by Dr. Granger Avery of the "Continuum of Care" for patients with emergency medical conditions in the rural areas of BC. Highlighted were the complexity and the interdependency of each stage – and the consequent frailty of the entire system.

> ***"...a forum for dialogue between a wide variety of health care providers, administrators and academics."***

Minister of Health Services, Kevin Falcon

The keynote speaker, Minister of Health Services Kevin Falcon, focused on the need for an integrated approach to rural health care delivery. Minister Falcon also highlighted the gains to be made in primary care and health promotion province-wide. This was followed by a panel discussion, a Town Hall Meeting and a series of discussion tables.

Opening address: Minister of Health Services, Kevin Falcon

Key points:

- Use health care funding creatively to achieve goals. We need an integrated approach, involving all stakeholders to achieve long term solutions and to deliver appropriate rural care.
- Summary of programs – benefit programs, rural locum program, GPAC, GPSC, FP4BC.
- Increasing number of doctors trained in BC and strengthening support for nurses, LPNs, NPs, paramedics.
- Increased role for paramedics– enhance their training and use their services in hospitals.
- Prevention: inject element of personal responsibility into the system.
- Boost primary care.

"We need an integrated approach, involving all stakeholders to achieve long term solutions and to deliver appropriate rural care."

Q *Question from audience:* Why are cuts being made to primary care in small communities?

Answer: The demand is unlimited in health care. The only way the system knows to control cost is to ration care - by reducing elective procedures, and laying off nurses. We have to stop measuring the system by what we are putting into it financially. We need to make fundamental shifts. The fact is we do not have on-demand health care. The system works by saying – if you have emergency needs – these are dealt with well. But then we ration elective procedures.

Three parts to the solution:

- Innovation – we have to innovate within the system. Currently there is no correlation between spending and outcomes. We are seeing dramatic results with new patient-focused funding initiatives in trials on the lower mainland. Facilities are being rewarded for doing things well.
- Prevention, primary care – GPSC, BCMA – delivering services in a way that makes sense for patients.
- Health promotion piece.

If we integrate all three we start to have sustainability in the system.

Panel Discussions

Rural Emergency Continuum of Care

Moderator: Dr. C. Stuart Johnston

Panelists:
Dr. Mike Ertel, Emergency Physician, Kelowna
Dr. David Butcher, VP Medicine, Northern Health
Dr. John Soles, Family Physician, Clearwater
Dr. Steve Wheeler, Medical Director and Air Transport Advisor to the B.C. Ambulance Service's Air Ambulance Program
Ms. Marie Root, Director, BC Bedline
Ms. Cathi Mounsteven, RN, Clearwater

Discussions highlighted the challenges faced from the point of view of providers along the continuum of care, and emphasized the importance of understanding others' perspectives.

Key points included:

- Technology as a road to improving rural medical care. Challenging transport terrain – by road and air.
- Emphasizing the rural ER during training: providing ER coverage is a vital part of rural practice.
- Experienced work force reaching retirement age (particularly nurses).

Left to right: Dr. Stuart Johnston, Dr. Mike Ertel, Dr. Steve Wheeler, Dr. David Butcher, Ms. Marie Root, Dr. John Soles, Ms. Cathi Mounsteven

Town Hall Meeting

Moderator: Dr. C. Stuart Johnston

Q *Question:* What are the long term plans for the CCT/Paramedic from the perspective of the BC Air Ambulance Program?

Answered by: Dr. Steve Wheeler

Critical care transport programs have been developed in house over the years. The critical care teams in the province are based mainly with the air program. Vancouver, Kelowna and Prince George are where these programs are. The central question is location: Where do you put the paramedics? In the center they are in or coming from? How do you maintain a level of competency with the paramedics? Do you train paramedics to learn the medics and the system? We need a ground-based system that is complimentary to the air system. There is a trial in Trail right now.

Q *Question:* Is there a better way to get a person on the line at BC Bedline immediately?

Answered by: Ms. Marie Root

Our systems is to go through a 1-800 number. The only other option is direct lines. We have tried that before. Prioritizing is difficult with people sneaking in a priority 2 when it isn't. Bedline looks at call flows on a yearly basis. We have tried a number of routes and are always looking for better options. This is the best option at this time.

Q *Question:* How can we move forward with the implementation of appropriate IT to facilitate virtual care? In non-critical cases physicians need help, support, answers – and can't get it – and so the reflex is to transfer. Providing the support would lessen the transfers.

> ***"We need a ground-based system that is complimentary to the air system."***

Answered by: Dr. David Butcher

Rural BC is ready to implement but virtual medicine is lagging. We are significantly behind where we should be for using IT. There are huge infrastructure challenges – bandwidth in some areas is not enough. We need to leverage Telus to build fibre optic cables to small communities. The basic infrastructure needs to be built before we can put clinical applications in place.

But we need more than technology to make this successful – we need a network of care providers working together. There are gains to be made in terms of using the telephone in real time, to manage patients based on information transfer rather than patient transfer. An example is with acute psychiatric consultations. Gains can be made by better using infrastructure that is available now.

Interprofessional team training was a key component of the first CARE course. Here, a nurse, paramedic and two rural physicians are learning a multidisciplinary approach to emergency care.

Question by Cathi Mounsteven: A question for Dr. Blair Stanley, can you briefly discuss your thoughts on the value of working with Nurse Practitioners.

Answered by: Dr. Blair Stanley

In Trail, working with Nurse Practitioners in both clinic and ER settings has been collaborative and invaluable. The NP was an ICU nurse previously and this helps with making the ER shifts work well. In the clinic, working with an NP allows for a wide scope of practice, and a team approach to work. This approach is especially valuable with chronic disease management.

Question: It seems that nurses are taught not to take responsibility / liability. For physicians, being on call 1:2 and 1:3 is not workable without triage. More remote communities are losing experienced ambulance / nursing staff / technicians. What is your understanding of these issues?

Answered by: Ms. Cathi Mounsteven

That can be challenging. The Health Professions Act has changed things now, and that changes the scope. New nurses have no confidence. Older nurses pay attention to intuition. They can do triage – using an algorithm. Not really sure what the answer is.
Physicians trust some nurses more than others to do things, based on the nurses' experience. Retention is a big issue. Seasoned nurses can mentor the new nurses.

Answered by: Dr. Granger Avery

We just finished the first CARE course yesterday, where we had an interprofessional team at each station. That is a good example of how we can work together. The objective is to take this course to every rural emergency department in the province every three years.

Answer:
A lot of the rural sites have one of something (surgeon etc.) There is just not a depth of human resources, and when someone leaves town the whole system implodes. Having the opportunity to participate in a larger practice environment rather than just the small community is helpful. As is providing networks to pick up other skills or ongoing training.
Locum support is vital.

The challenges with a volunteer ambulance service, with basic stipend and training, is that it is difficult to maintain a core group, and for them to maintain their skills. It's time to look for models where the ambulance attendant can also work in the health facility in the community to cover some gaps in the facility, while making a reasonable salary. It's a question of relying on networks, rather than individuals.

Question: Why do the HAs not have a mechanism to prevent communities in crisis?

> ***"Partnership between the physicians and Health Authorities - that is one of the factors of success."***

Answer:
Burn out factor in many communities is the ER. This has a huge impact on rural areas. Being proactive both in reacting when a community is in crisis, but also in identifying communities that have a crisis coming up.

The model of expecting private practitioners to set up businesses and to take on the risk of being a small business and take on the HA expectation of training is not working. The sustainability model is very different than 25 years ago.

Partnership between the physicians and HAs - that is one of the factors of success. The tools at our disposal to move a community along the continuum are not well developed. The models have changed: private practice vs. health authority etc.

If there is a community that has access (driving distance) to another ER then that is one point. If the emergency room closes in a community that has no access – that is a whole other point. Suggestions to bring in teams to support communities in crisis.

Discussion Tables

Equity of Rural Programs Throughout BC

This group focused on academia and rural clinical ER practice.

Moderator: Dr. Granger Avery

What's working?

- Strengths of having learners.
- Learners having a positive experience in the community return to practice. Since 5 to 9 doctors previously trained there.
- Vitality / Energizing. Good anti-depressant. Helps me through the "Darker Days."
- Expose students to the richness of practice in rural settings and the uniqueness of practice.
- Community gets engaged and creates a supportive environment for learners. Very, very important.
- Revitalizes me and keeps me current / fresh / engaged in medicine.
- At first I was afraid of WHAT I didn't know. Once I had learners it became a partnership (learning).
- Teaching appeals to a higher calling. We serve our community. They expect us to help young people. We also have a strong desire to share what we have together.
- ER Rotations for residents from PG/Kelowna have been excellent.
- Office recognition as a clinical teaching site.

What needs improvement?

- Watch for preceptor burnout.
- Loss of efficiency – re: the office /ER.
- Loss of income.
- Support for clinical preceptors (benefits, funding, feedback, teaching improvements).

Action steps for improvement?

- Preceptor support: FD Group like Cabin Fever (U of C), Arbutus Blooms (Kelowna).
- Technology – same internet access as students, up to date.
- Feedback as teachers, funding to be better.
- Some funding – not sure how much.
- Some sites wish to get involved but no one is approaching them despite their having space, hospital, ambulatory care.

Integrating Ongoing Emergency Training and Teaching

Moderator: Dr. Rebecca Lindley

What's working?

- Residents, students…give them confidence and competence.
- Rural emphasis.
- IRP*bc*.

What needs improvement?

- Continuing to develop courses tailored to rural teams.
- Mentoring.
- Individually tailored ongoing education (individual person, or individual community).
- No more silo education.
- Flattening of hierarchy in emergency settings – build team emphasis in emergency and non-emergency, cross inter-professional work.
- Communication skills.
- Multi-disciplinary problem solving.

Action steps for improvement?

- Course coming to the communities (skills drills, care reviews, team building).
- Education coming out to communities.
- More debriefing with teams after situations in everyday life – local infrastructure.
- Value and respect.
- Change rhetoric regarding interprofessional staff – experiential learning.
- Rural teams teaching rural teams.

> ***"Joint decision-making and policy development with clinicians."***

Conflict Resolution – Between Health Authorities and Providers of Emergency Care

Moderator: Dr. David Butcher

What's working?

- Strong community leadership (local).
- Joint decision-making and policy development with clinicians.
- Targeted funding.

What needs improvement?

- Comparisons – someone else is worse off than you are.
- Negotiated agreement – BCMA to MOHS and lack of flexibility around.
- Unilateral decision making.

Action steps for improvement?

- Development of HR plans for physicians and contribution for succession planning, recruitment etc.
- Clear description of where we are and where we need to go from an overall system perspective.
- Needs to be a well laid out responsive note for local issues to be brought up the chain.

Integration of Rural and Regional Emergency Services

Moderator: Dr. Mike Ertel

What's working?

- Protocols (stroke, STEMI, NSTEMI, Sepsis).
- ALS teams when available (communication).
- Technology.
- Standardization/Simulation.

What needs improvement?

- More CT availability.
- Better and more reliable data.
- Improved/shared education between healthcare professionals (funded).

Action steps for improvement?

- Improved CT availability and skill set for rural paramedics.
- Required number of PAs / NPs.
- Improved data/required reliability of data/sharing of data.
- Streamlining Bedline calls.
- Improved technology.

More support for programs such as IRPbc and CARE was identified as an action step.

> ***"Expanding roles and scopes of practice for ambulance attendants..."***

Interprofessional Team Building of the Emergency Team

Moderator: Dr. Blair Stanley and Ms. Cathi Mounsteven, RN

What's working?

- Ambulance attendant – long shift (7 days a week) – expanding roles/scopes of practice, training program (IV endorsed) (Powell River).
- Nurse Practitioner – ER call shifts (Fraser Lake).
- Nurse managed care.
- IRP*bc*.

What needs improvement?

- Utilizing all staff to their maximum abilities and expanding scopes.
- Breaking down myths/territorial barriers.

Action steps for improvement?

- Market ERA [emergency room attendant] idea – could work in other communities like Grand Forks.
- Funding for NPs – NPAC working on a provincial plan for funding.
- Support IRB*bc* and CARE and RCC*bc*. NP placements placed with residents.

Strange Bedfellows – Integrating the Academic and Clinical Provision of Rural Emergency Care

Moderator: Dr. Allan Jones

What's working?

- Rural incentive programs (MOCAP).
- Student exposures to rural practice.
- Lifestyle opportunities are great.

Laura Motley IRPbc Student (Nursing), Kathy Copeman-Stewart IRPbc Program Manager, Jenna Dedels IRPbc Student (Nursing)

> ***"Improve rural student exposures and improve IRPbc local coordination."***

What needs improvement?

- Need to increase rural plans – recruitment and retention.
- Support for rural residents and student accommodations.
- Rural locum program needs augmentation of locums, requirements and workload.

Action steps for improvement?

- Improve rural student exposures (nurses & others).
- Improve IRP*bc* local coordination.
- HAs take over community offices.
- Improve feedback process and parameters of RGRCP.
- Survey needs and requirements.

Discussion Groups

Overlapping Scopes & the Health Professions Act

Moderators: Eileen MacDonald & Linda Sawchenko

How do we embrace the overlapping scopes of practice to ensure sustainable rural health care services? It is a very complex process with no cookie cutter easy answers. It is important to have a strong understanding of the Health Professions Act, Regulations, Professional Standards, limits and conditions. From there, we can build on individual health care provider competence to create interprofessional competencies. It starts with a culture of collaboration, and patient-centered care, and builds from there.

> ***"It starts with a culture of collaboration, and patient-centered care, and builds from there."***

GP Anaesthesia and the Virtual Birthing Suite

Moderators: Dr. Louis Prinsloo and Dr. Bob Woollard

Discussion of a broad range of issues and concerns faced by rural GPAs and Health Authorities, including: evaluation; training; certification and revalidation; locum support and the nascent on-line BC GPA network. The Virtual Birthing suite highlights issues faced by GPAs across the province and looks at GPAs involved in maternity care as a microcosm of rural GPA work in general. When all of the births in the province are tallied, the second largest "birthing suite" in BC is the combined total of births in those rural hospitals serviced only by GPAs.

First Responders, Paramedics & Health Authority Integration

GP Surgery

Moderator: Dr. Nadine Caron

Saturday, June 19, 2010

Saturday's conference events opened with a panel discussion on emergency transport in rural areas. Panelists represented a broad spectrum of viewpoints – from health authority administration to rural emergency room physicians to members of critical care transport teams. The balance of the day featured a variety of hands-on sessions, discussion groups and seminars, all focused on the unique perspective of rural health care practitioners.

"...focused on the unique perspective of rural health care practitioners."

Friday ended with a Wine and Cheese reception, hosted by RCCbc, just one of the social events that made the rural conference so popular.

Transport Discussion

Moderator: Dr. Trina Larsen Soles

Panelists:
Dr. Greg Powell
Dr. Nick Balfour
Mr. Brent Hobbs
Ms. Olive Powell
Mr. Randy MacLeod

Discussion focused on:

- Inconsistencies in system.
- Better understanding of transport issues is needed.
- Quicker access to aircraft is an issue in many areas.
- Critical care nursing course only available in the US until recently.
- Labour relations issues faced by critical transport team leads to delays (two unions).

Continuing Medical Education

The RECC Conference provided a broad range of rural-relevant training and education. These included interactive talks and workshops, a chance to share stories and experiences and opportunities for hands-on learning. The interactive nature of the CME learning was integral to the success of the conference and the active engagement of participants and presenters alike. Over 60 speakers and presenters became actively engaged in the conference, and shared their knowledge and experience with participants.

> ***"The interactive nature of the CME learning was integral to the success of the conference..."***

Lectures, interactive discussions and workshops covered a wide variety of topics, all with a rural focus. Everything was covered: from eyes to abdomens to airways to limbs and everything in between. Workshops on suturing, ultrasound and sedation, interactive discussions of shock, antibiotics in the ER and vitamin D deficiency and lectures on sepsis, hot stroke and anaphylaxis were just a few of the over 50 CME options available to participants.

The RECC was accredited for 21.5 MainPro M1 Credits. Pre- and post-workshop courses included the CARE course, AIME, ACLS-EP and SHOCK Course.

Sharing stories and expertise between rural practitioners was a vital part of the conference.

Social Events

A conference of rural health professionals provides a rare chance for old and new friends and colleagues to come together and share the joys and challenges of their work, and lives in rural areas. This aspect of the program is part of what makes the rural conference such a popular one. The social aspects are not sidelines, but, rather, are a crucial component that brings all the other elements together, and makes participation so worthwhile. Participants were encouraged to bring the whole family, and child care and spousal registration were provided as part of the conference.

The 2010 RECC Conference featured a Wine and Cheese Welcome Reception and a Red and White Dinner Gala hosted by RCC*bc*, as well as a bike tour of the Kettle Valley.

Social events are an essential element of a successful rural conference.

> ***"...a rare chance for old and new friends and colleagues to come together..."***

Conclusion

The Rural Emergency Continuum of Care Conference provided an opportunity for open discussion, and professional development for rural health care providers from across the province.

Participants were able to appreciate the work of others in the system of emergency care. There seemed, at the end of the day, to be a general willingness to work closely together with others in the system for the betterment of patient care.

For selected conference materials, and information on the 2011 RECC and RCC*bc* projects and initiatives, please visit **www.rccbc.ca** or contact us at **info@rccbc.ca.**