Rural Surgery Tracks

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RTT Collaborative Annual Meeting
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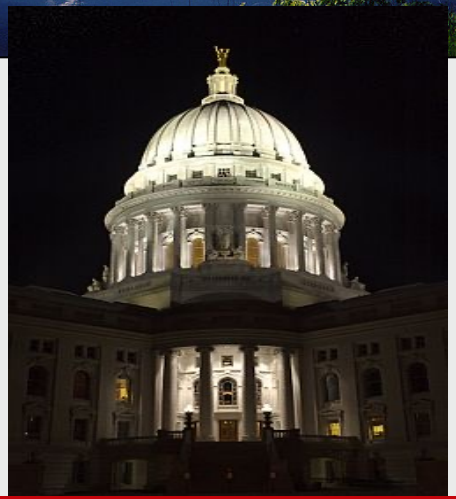
Disclosures

- We have no financial disclosures or conflicts of interest.

Outline

- Introduction to the UW General Surgery and OB/GYN Rural Training Tracks (7-10 mins)
- Small group discussions (5-10 mins)
- Large group reporting (5-10 mins)
- Summary and next steps (3-5 mins)

UW General Surgery and OB/GYN Rural Residency Tracks



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Rural health in crisis

Delivering Rural Babies: Maternity Care Shortages In Rural America

SHARE

Author: Jessica Seigel | Wednesday, Mar. 7, 2018

Rural Hospitals Are Closing – And Pregnant Women are Paying the Price

RURAL MATERNAL AND CHILD HEALTH

GIVING BIRTH IN RURAL AMERICA

ACCESS TO CARE IS VANISHING

More than **200 rural maternity wards closed** between 2004 and 2014, and the number has continued to rise. Today, 54% of rural counties are without hospital based obstetrics.

MATERNAL MORTALITY RISES

Maternal mortality rates are rising across the U.S., but are more drastic in rural areas without care. **Rural areas have higher rates of chronic conditions that make pregnancy challenging.**

DISTANCE IMPACTS OUTCOMES

Today, more than half of rural women in rural communities live more than the recommended 30 minutes from a hospital offering maternity services.

CREATING OPPORTUNITIES

The loss of maternity care in rural America is the result of multiple factors including: **workforce shortages, low birth volumes, and stingy Medicaid programs.** These are problems that **can be solved with Congressional action.**

Learn more at ruralhealthweb.org

NRHA

Maternal Health Care Is Disappearing in Rural America

Many women must travel an hour or longer to find a hospital where they can deliver their babies

By Dina Fine Maron on February 15, 2017

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Rural maternal health in crisis

- In recent decades there has been a dramatic decline in rural hospital obstetric care:
  - In 1980s, **50%** of rural counties had hospital maternity services
  - By 2000s, dropped to just **20%**

Rural health in crisis

When rural hospital obstetric services close:

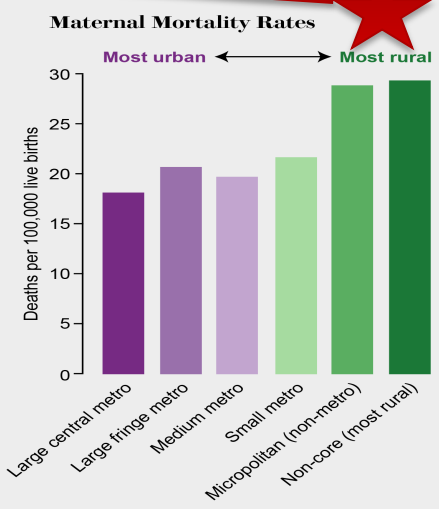
- Women must travel farther for prenatal healthcare
- Without adequate prenatal care babies have:
  - Increased rates of pre-term delivery, complications
  - 3 times higher chance for low birth rate
  - 5 times higher chance for death

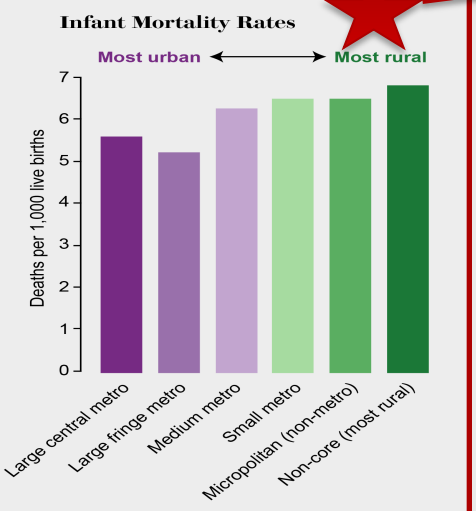
Rural maternal health in crisis

60% INCREASE

Maternal and Infant Mortality Rates Are Highest in Rural America

According to publicly available data from the U.S. Centers for Disease Control and Prevention analyzed by *Scientific American*, women living in rural areas of the U.S. have significantly higher chances of dying from causes related to pregnancy or childbirth compared with their city-dwelling counterparts. Likewise, babies are more likely to die before their first birthday if they live in rural locations. The graphs below reflect 2015 data.





20% INCREASE

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Rural maternal health in crisis

Our analysis of rural provider cost report data reveals that between 2011 and 2018, **134 rural hospitals – or 12 percent of all rural hospitals with OB services – ceased to provide OB services**[5]. Add to that an additional 18 facilities that have ceased operations altogether[6], meaning **152 rural communities have lost access to OB services**. This same analysis also shows that only **46 percent** of America's rural hospitals (1,011) **currently provide Labor & Delivery services**[7].

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13
ceased to provide OB services[5]. Add to that an additional 18 facilities that have

Across rural America, **3.8 million women** of reproductive age (ages 15-49) must cross county lines for labor and delivery services[12]. Of the 152 rural communities that lost OB services, **106 (70%) were the only hospital in their county providing maternity care**. These closures impacted nearly **450,000 women** of reproductive age, who are now without maternity care in their home counties[13].

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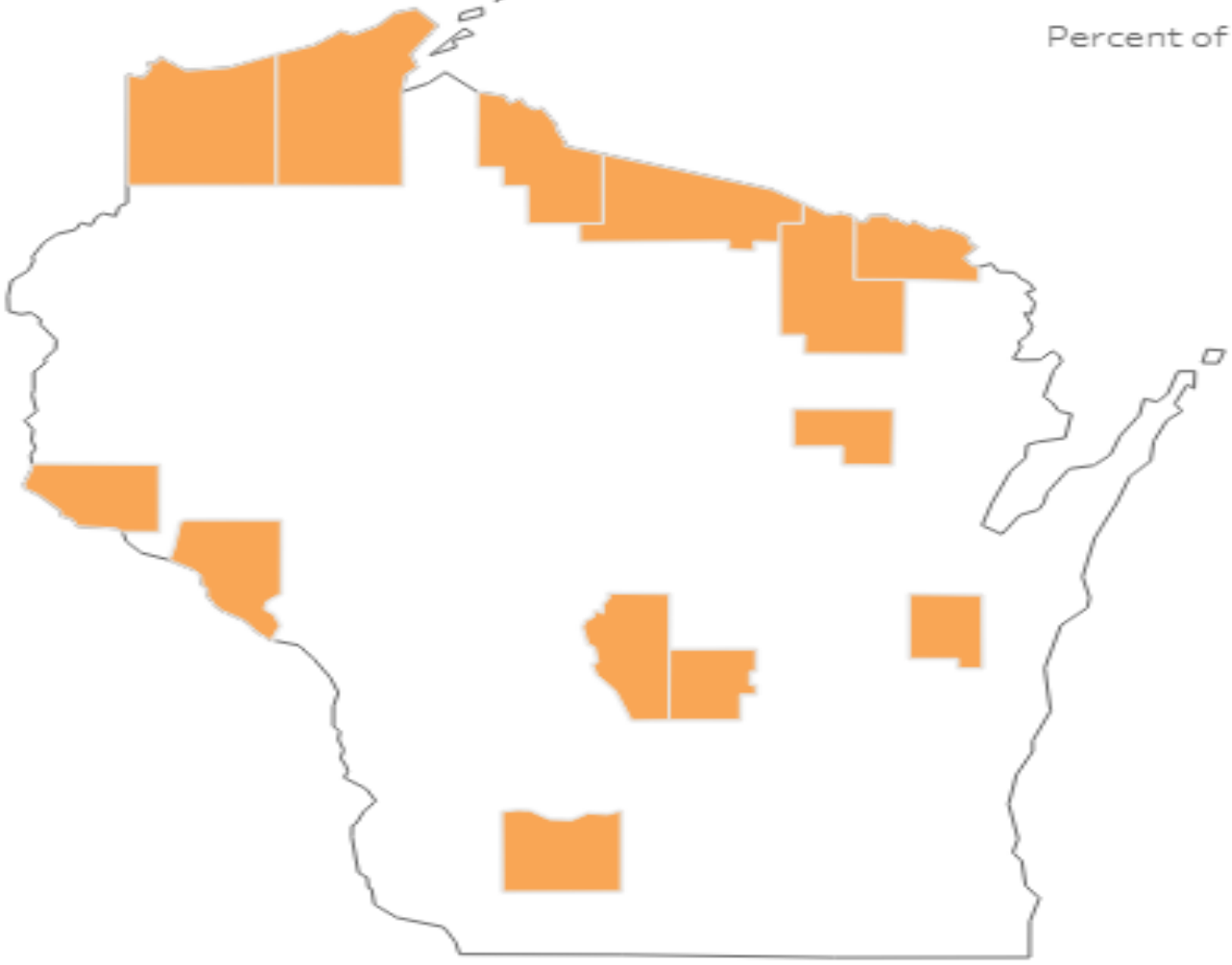
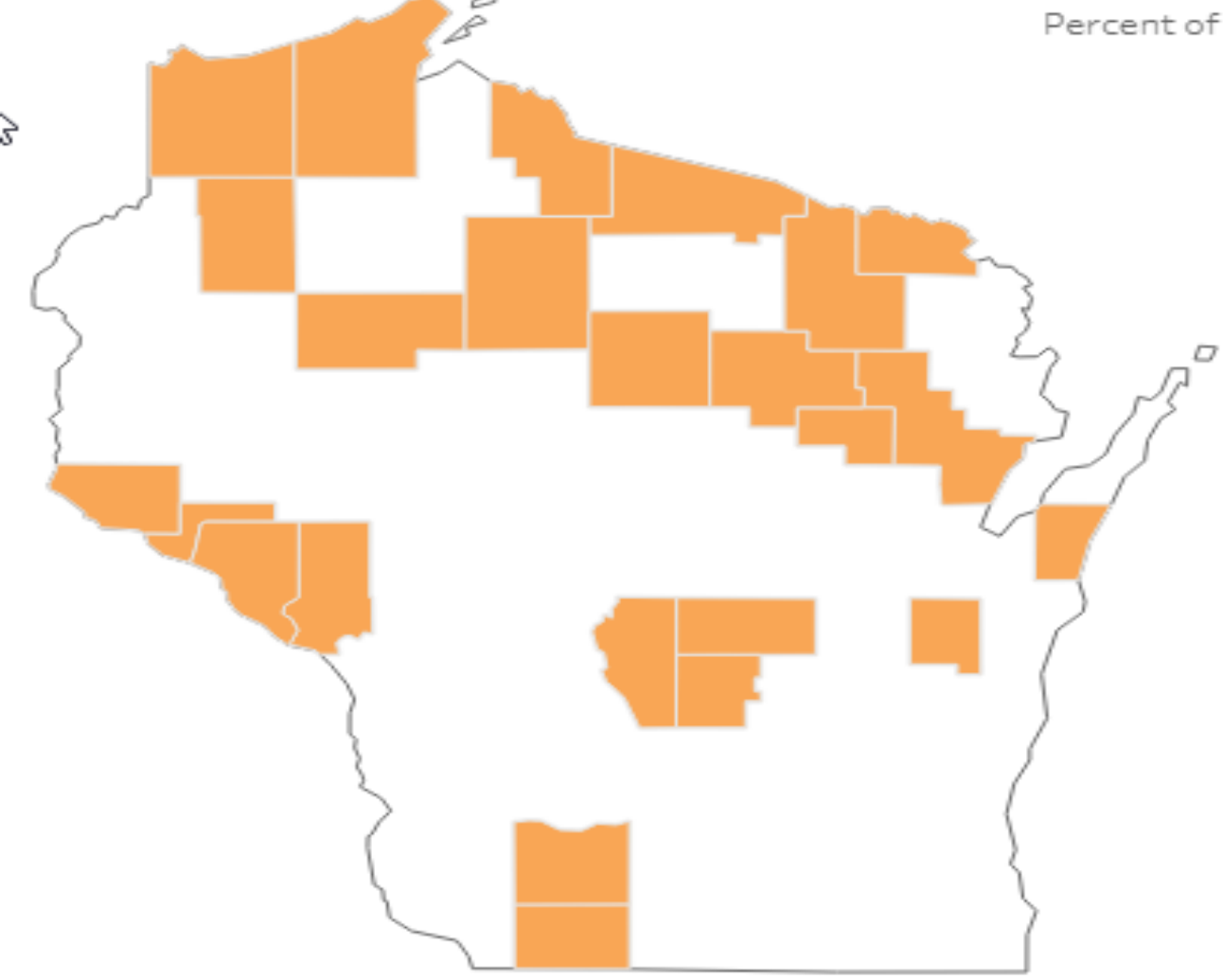


Percent of rural counties with NO facilities

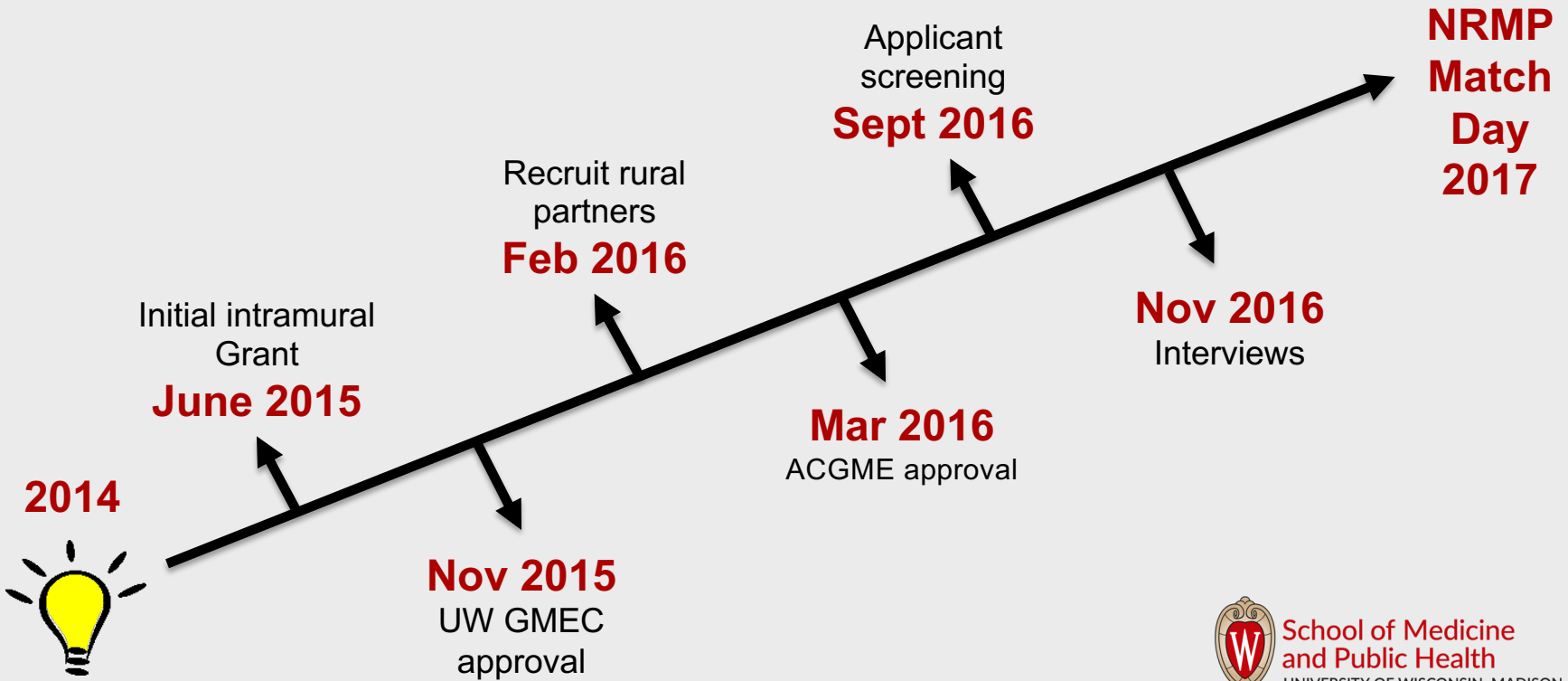
20%



Percent of rural counties with NO facilities

39%

Timeline for UW OB/GYN Rural Track



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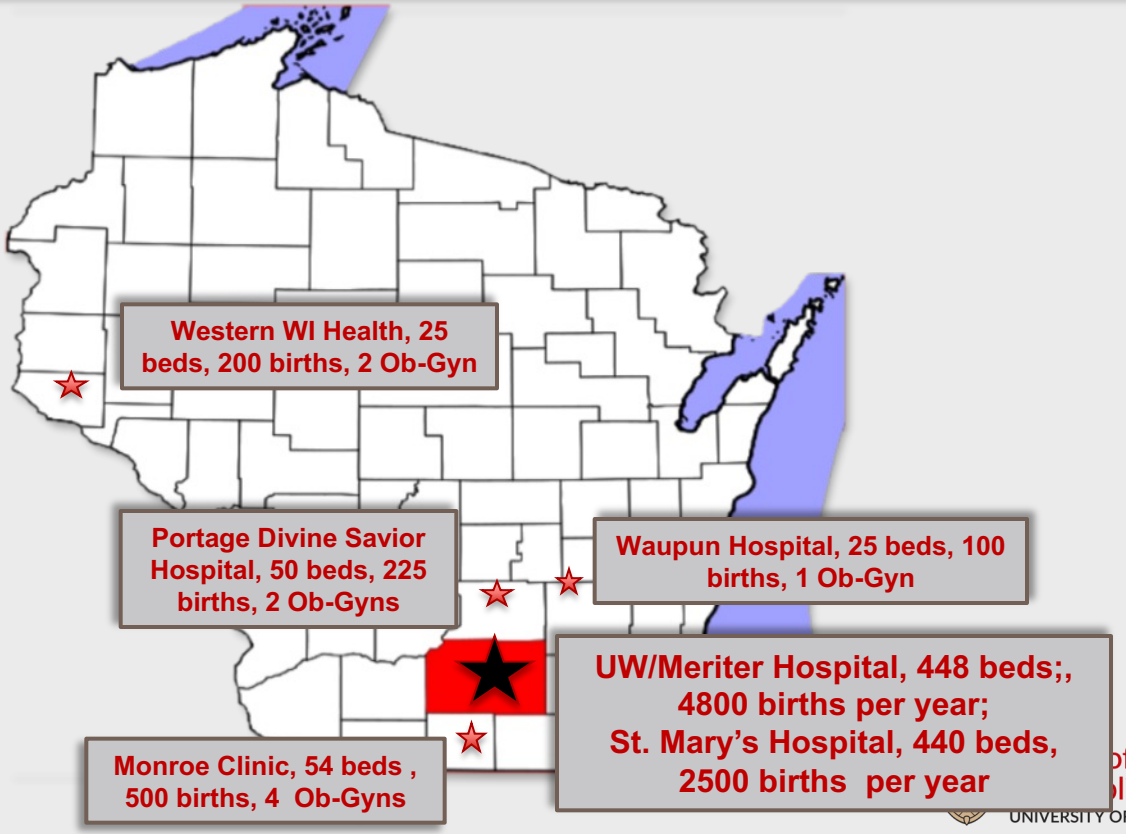
Current OB/GYN Partners



Scheduling

Major considerations in scheduling rural experience

- Rural resident's integration with home program
- Development of strong clinical skill set
- 80% of training at home program

Rural experience both varied, meaningful, & integrated

- Rural rotations during PGY 1,2,3 & 4 years
- 4 unique rural training sites

Scheduling

PGY1	OB	Gyn	OB	Clinics	OB	Gyn Onc	**Rural**
PGY2	MIGS	**Rural**	MFM	Gyn Onc	**Rural**	REI	Gyn
PGY3	**Rural**	Urogyn	OB	**Rural**	MFM	Elective	Gyn
PGY4	Gyn Onc	OB	**Rural**	Gyn	OB	**Rural**	Gyn

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Disappearing General Surgeon

- Number of general surgeons has declined by 7% since 2000
- Over 43% of general surgeons were over 55 in 2010
- 80% of all trainees in US general surgery residencies seek fellowship training upon graduation
  - Many subspecialty surgeons desire subspecialty practice in urban and suburban locations
- Critical shortage of surgeons willing to provide general surgical care to rural and underserved populations

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Surgery as an Economic Driver

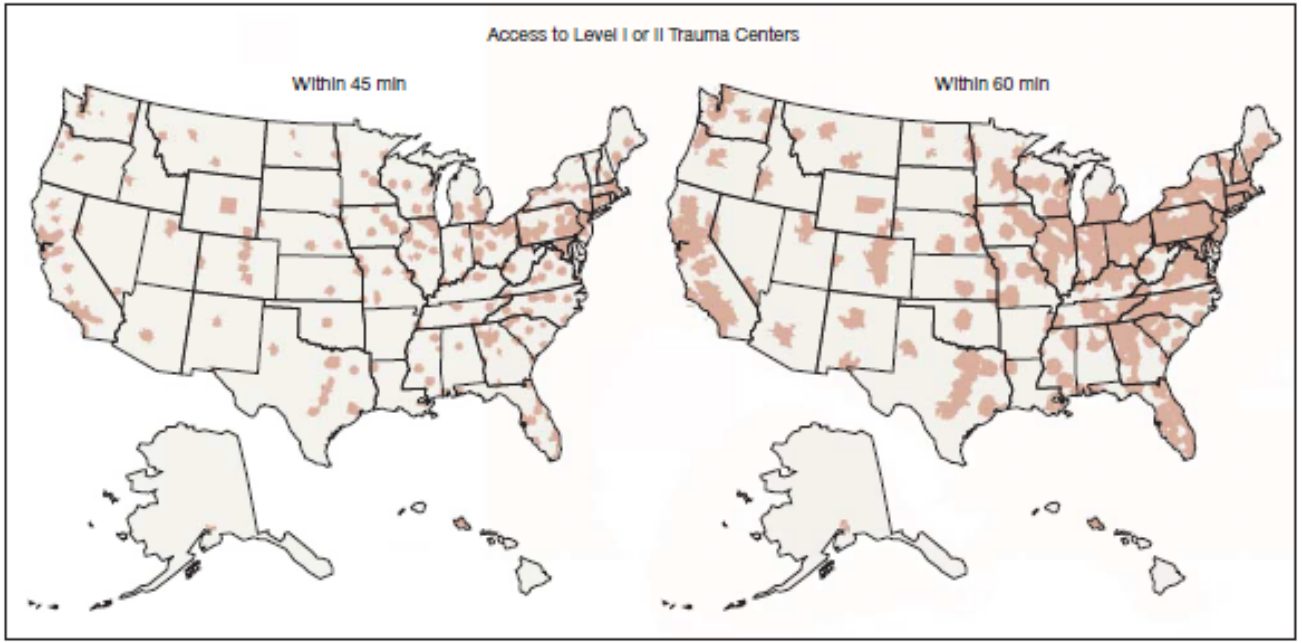
- Scarcity of general surgeons raises unique economic and public health concerns for community hospitals
- Survey of rural hospital administrators if lost surgical program:
  - 80% reduce services
  - 12% forced to close

Table 1. Population Percentages With Trauma Center Access by US Census Regions and States*

	Levels I and II Only, %		Levels I, II, and III, %	
	Within 45 min	Within 60 min	Within 45 min	Within 60 min
United States (total)	69.2	84.1	74.2	88.7
Northeast				
Connecticut	94.1	100.0	94.5	100.0
Maine	47.4	78.9	47.4	81.2
Massachusetts	83.6	96.8	85.3	97.1
New Hampshire	53.8	81.0	73.0	98.8
New Jersey	90.5	100.0	90.6	100.0
New York	87.7	96.8	87.7	96.8
Pennsylvania	88.5	99.3	89.2	99.3
Rhode Island	83.8	100.0	83.8	100.0
Vermont	30.3	66.6	31.3	76.3
Midwest				
Illinois	84.2	92.1	84.4	93.8
Indiana	48.2	90.3	48.2	90.5
Iowa	46.1	67.6	63.8	85.1
Kansas	48.5	62.3	49.2	64.5
Michigan	54.6	84.2	54.6	84.2
Minnesota	60.5	75.5	60.5	75.5
Missouri	65.3	79.4	73.0	89.3
North Dakota	50.5	54.5	53.5	57.6
Nebraska	23.4	74.4	59.6	76.9
Ohio	80.3	96.8	82.3	98.8
South Dakota	25.2	31.7	28.0	35.4
Wisconsin	55.3	82.9	55.4	83.6
South				
Alabama	24.9	47.5	24.9	47.7
Arkansas	1.7	6.1	1.7	14.8
Delaware	62.8	84.6	100.0	100.0
District of Columbia	100.0	100.0	100.0	100.0
Florida	78.4	93.9	78.4	93.9
Georgia	65.5	85.9	65.5	86.1
Kentucky	45.8	72.0	48.4	79.3
Louisiana	34.3	44.9	34.3	48.9
Maryland	87.5	96.7	95.9	100.0
Mississippi	36.9	60.5	54.8	76.7
North Carolina	51.1	80.6	56.0	81.8
Oklahoma	28.4	36.8	76.6	90.2
South Carolina	58.8	79.1	74.5	93.6
Tennessee	54.8	83.9	58.2	85.4
Texas	63.2	74.2	81.1	93.3
Virginia	71.5	90.2	75.3	92.1
West Virginia	39.1	62.1	58.5	78.9
West				
Alaska	42.3	51.7	42.3	51.7
Arizona	60.9	64.1	60.9	64.1
California	87.3	96.4	88.9	96.5
Colorado	80.9	87.3	87.8	92.9
Hawaii	71.8	71.8	71.8	71.8
Idaho	38.8	49.4	49.2	69.9
Montana	33.9	38.4	33.9	38.4
New Mexico	38.4	59.0	51.6	69.6
Nevada	86.5	93.7	86.5	93.7
Oregon	55.6	72.0	86.4	94.3
Utah	74.0	84.7	74.0	84.7
Washington	76.5	83.9	88.9	96.7
Wyoming	29.5	32.5	59.3	67.5

*By either ambulance or helicopter and including the trauma care resources of neighboring states.

Figure 1. Areas of the United States With Access to Level I or II Trauma Centers by Ambulance or Helicopter



Access to Trauma Centers in the United States. JAMA 2005;293:2626-2633

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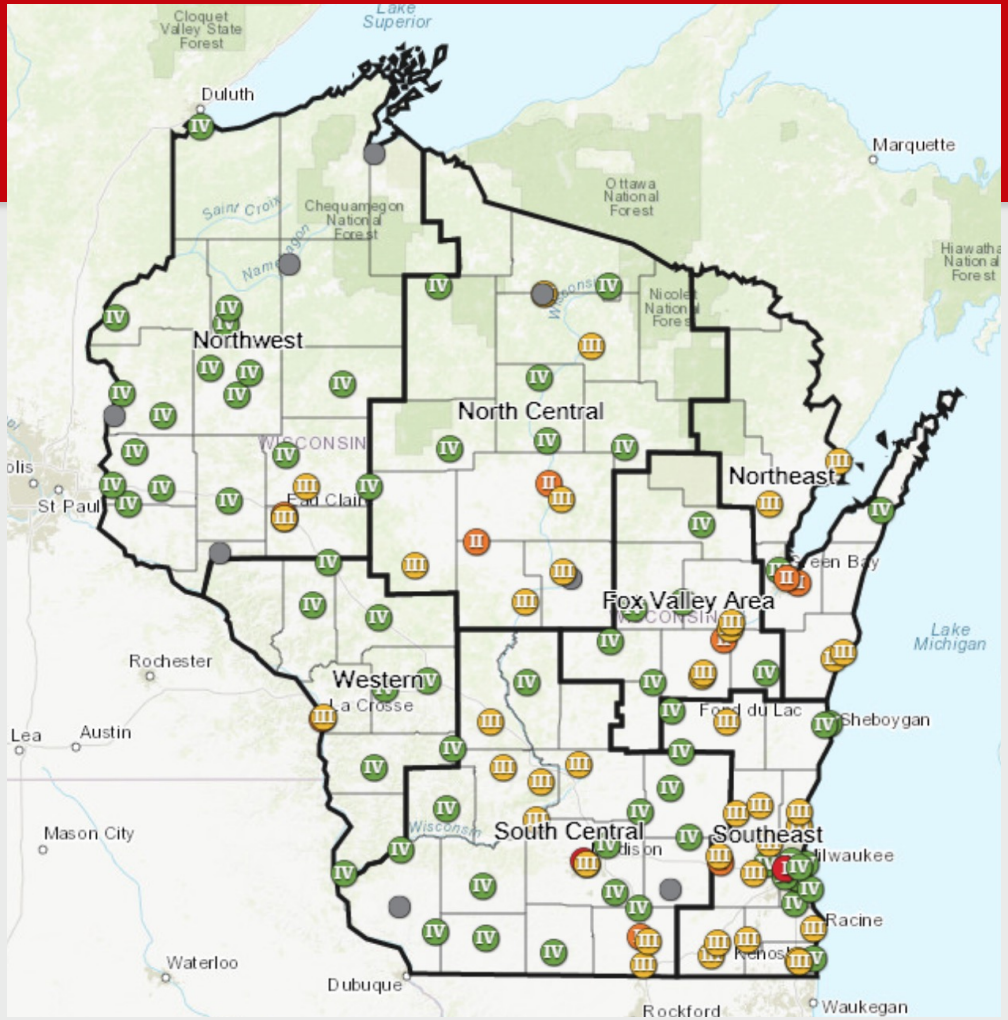

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Figure 2. Barriers to Traveling to a Distant Specialty Hospital

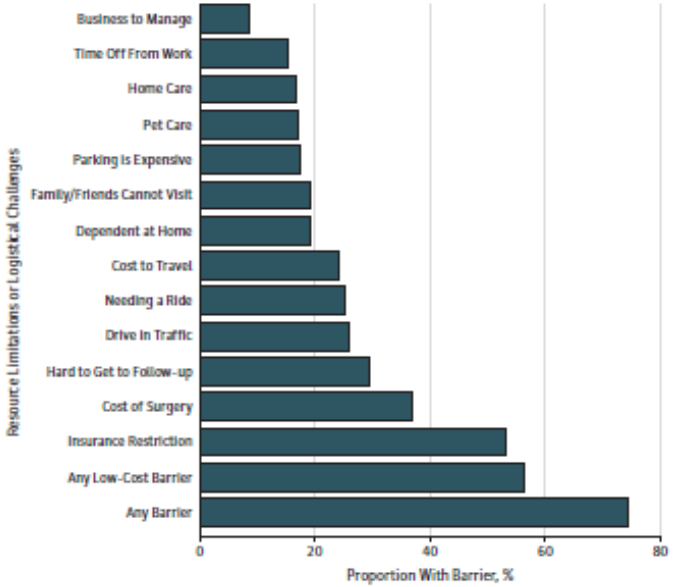
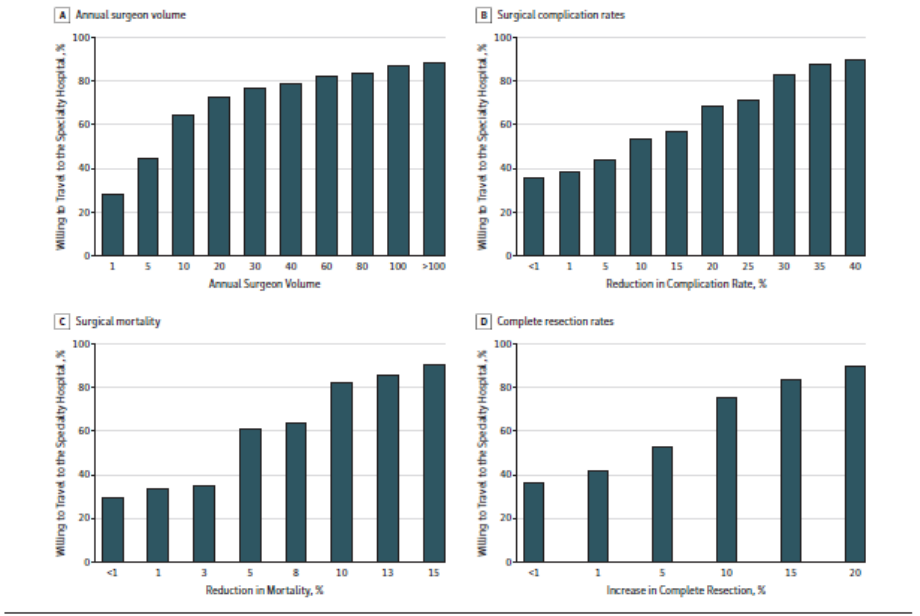


Figure 1. Thresholds to Travel



A separate graph is shown for 4 of the 6 quality and safety indicators. Each bar represents the total percentage of who would travel at any given threshold (and therefore includes respondents who indicated a specific threshold or any smaller margin).

Motivators, Barriers, and Facilitators to Traveling to the Safest Hospital in the US for Complex Cancer Surgery JAMA Network Open 2018;1(7):e184595

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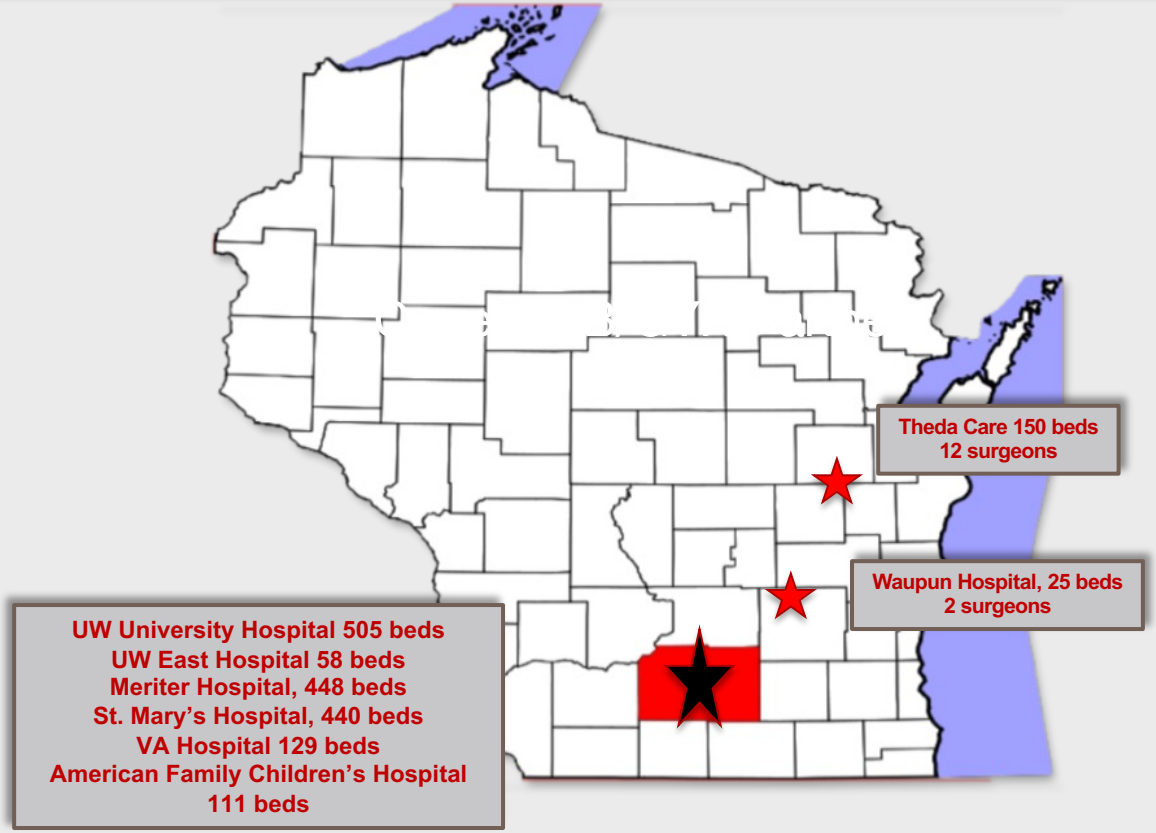
Current Surgical Partners



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Scheduling

- 80% of time in Madison integrated with academic track residents
- Rural experiences in PGY 2, 3, 4 year
- Participate in all didactics and conferences via Zoom

Scheduling

Clinical Block Schedule for Community General Surgery Resident												
PG1 (4 wk blocks)	Colo-rectal	Gen Surg (Meriter) x 2	Endocrine Surg	Surg Onc	Night Float x2	Vasc-ular	MIS	VA	Transplant		Thoracic	EGS
PG2 (6 wk blocks)	SICU/Trauma Days		SICU	Peds Surg	Burn	Trauma Nights	Gen Surg (Waupun)		Endoscopy		Gen Surg (Neenah)	
PG3 (7-8 wk blocks)	Colorectal		Surgical Oncology		Gen Surg (Neenah)		Vascular		Gen Surg (Waupun)		MIS/End ocrine	EGS
PG4 (7-8 wk blocks)	Gen Surg (Neenah)		Trauma Nights		Meriter (OB/Gyn)		Gen Surg (Waupun)		Throacic	Peds	Trauma Days	
PG5 (7-8 wk blocks)	Colorectal		Gen Surg (Meriter)		EGS		Gen Surg (VA)		MIS/Bariatric		Surg Onc	

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Curriculum

- Goal: independently perform “essential common” and “essential uncommon” procedures as delineated by SCORE
- Exposure outside of score:
  - OB/gyn including Cesarian
  - Additional endoscopy
  - Hand
  - Urology
- Apprenticeship model at rural sites

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Recruitment & retention

Challenges

- Lifestyle- limited activities and concern re schools
- Medical practice- longer hours, more on-call, less access to specialists, health of the population
- Competitive issues-payor mix

Successes

- Rural background 4X
- Exposure to rural health in training
- Self-actualization, sense of place and community engagement
- Spousal perspective

Lee DM, Nichols T. Int J Health Care Qual Assur. 2014;27(7):642-52

Challenges in Developing the Rural Track

1. Increasing resident complement for rural track
    a. Graduate Medical Education Committee (GMEC)
    b. Residency Review Committee (RRC)
2. Developing funding for the rural resident position
3. Recruiting rural training partners
4. Recruiting, screening, interviewing candidates
5. Scheduling rural rotations

Small Group Discussions

- What are your ideas of how to increase rural training with established Gen Surg or OB/GYN programs?
- How could we work to engage hospitals/communities in these efforts?
- What are your suggestions for advocacy?

Large Group Report Out

- What are your ideas of how to increase rural training with established Gen Surg or OB/GYN programs?
- How could we work to engage hospitals/communities in these efforts?
- What are your suggestions for advocacy?

Summary/Next Steps

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For more information…

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