

NOSORH Rural General Surgery Committee Summary of Discussions, Recommendations & Tactics

(Submitted March 21, 2011; Approved by NOSORH Board of Directors July 20, 2011)

National Organization of State Offices of Rural Health

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I. Introduction

Over the past ten months, a work group of members of the National Organization of State Offices of Rural Health (NOSORH) has studied the future of rural general surgery and many of the implications for rural populations, communities and providers. Charles Dwyer, director of the Maine Office of Rural Health and Primary Care (MEORHPC) has chaired the work group; Jonathan Sprague of Rocky Coast Consulting has provided consulting support. The project was funded as a Partnership Champions Grant to the MEORHPC.

NOSORH and SORH interests have also been represented during the study in two national forums: a National Rural Health Association (NRHA) work group on rural general surgery and a developing national Rural General Surgery Coalition (RGSC).¹

This summary includes recommendations for NOSORH's participation in national dialogue and strategies; specific recommendations for state-level actions; and recommendations for continuation of a work group. Several suggested tactics are embodied in the recommendations; however, the work group has not developed specific tactics for each strategy, and the ones that are indicated as examples are not meant to be exclusive. Options are being clarified and need to be confirmed by NOSORH's Board of Directors, other relevant committees and other organizations.

II. Findings and Recommended NOSORH Position

The future of Rural General Surgery is a significant topic warranting involvement of NOSORH and of individual State Offices of Rural Health (SORHs) at the state and national levels. It remains an underappreciated issue with potentially profound negative implications.

While general surgery may not be provided in all rural hospitals, adequate access to services should be considered as a primary or fundamental healthcare need in rural areas, similar to access to primary medical care, obstetrical care and emergency medical/trauma services.

Workforce shortages, coupled with inadequate organization of existing resources, will significantly and negatively affect the health status of rural populations. Without intervention, access to surgical services will continue to decline. The loss of services will further compromise emergency department services and, in some locations, obstetrical care. In some cases, clinical and economic losses will threaten the quality and sustainability of primary medical care and other programs. Without adequate access to general surgery, the vitality of many rural hospitals and delivery systems will be threatened. Workforce development strategies alone will

¹ The building of the Coalition began with a meeting in June 2010, at which time Teryl Eisenger and Charles Dwyer represented NOSORH's and SORHs' interests. Discussions are continuing by conference calls. A summary of the June meeting's results has been circulated to workgroup members and can be made available to all SORH directors and FLEX Program coordinators. An updated summary of the RGSC discussions will be available in late March. Several points from the NOSORH discussions have been introduced to the RGSC discussions and will be reflected in the most recent summary.

be inadequate to address anticipated access barriers; delivery systems restructuring will be necessary in many circumstances.

NOSORH and SORHs can positively affect access, quality, cost and public policy related to rural general surgery by participating in national- and state-level discussions and by implementing collaboratively developed strategies. While accomplishing these ends, NOSORH and SORHs can also build visibility and cultivate new or expanded partnerships that can support other State Office initiatives.

III. Recommendations to Date

A. General Recommendations for NOSORH and SORHs

1. Continue to educate SORHs and their constituents regarding the importance of general surgery to rural communities. Promote the link between surgery and the stability of community health systems, including the interconnections with primary medical care.
2. Support and advocate that access to general surgery be universally recognized by Federal and State agencies, as well as all SORHs, as a “primary” or fundamental building block of sustainable rural health systems and as an essential complement to traditional “primary care” strategies.
3. Utilize NOSORH’s and SORHs’ strengths in facilitating multi-party discussions and convening stakeholders representing multiple facets of the issue.
4. Seek additional sources of funding to support a broader national collaborative and for NOSORH’s future involvement.
5. Work with partners to identify members of Congress with surgery-relevant backgrounds (including primary care). Engage all associated SORHs to educate these individuals regarding the importance of rural general surgery.

B. NOSORH National Level Initiatives

1. Continue to be engaged in the development and expansion of the national Rural General Surgery Coalition (RGSC).

Some possible tactics:

- *Participate in future meetings.*
- *Send a letter to all participating organizations offering NOSORH’s commitment to partnership.*

- *Share discussions and recommendations of the NOSORH Rural General Surgery Committee with the coalition and with the NRHA’s rural general surgery workgroup.*
- *Determine how NOSORH and SORHs, especially with those that are Primary Care Organizations (PCOs), can serve as a conduit with other partners to gain the support of primary care advocates in addressing rural general surgery.²*
- *Work with ORHP and other partners to promote the issue of rural general surgery more broadly within HRSA (e.g., Mary Wakefield, Marcia Brand and others).*

2. Include rural general surgery as a component of the NOSORH Policy Platform.
3. Work with ORHP, other organizations, and the RGSC to influence Congress to direct the National Health Service Corps to support general surgery as a “primary” or fundamental rural health service (not necessarily “primary care”). A demonstration project may be possible but past demonstration projects for pharmacists and chiropractors needed to be authorized by the Congress.

Some possible tactics:

- *Meet with legislative staffs of NRHA, the American College of Surgeons, the American Hospital Association and other organizations to develop and coordinate strategies.*
- *Contact and solicit support from members of the National Health Service Corps’ National Advisory Committee. Byron J. Crouse, MD³, currently chairs the committee; Mary Amundson⁴ is a committee member.*
- *Align SORH and NOSORH educational strategies with relevant members of Congress using state-specific information on the possible impacts of NHSC changes.*
- *Facilitate a SORH call on this topic and either facilitate or participate in a multi-organizational conference call or work group.*

4. Work with other partners to identify, create and advocate for strategies that will enhance incentives for medical schools and surgical residency programs to address rural general surgery and align loan forgiveness programs in support of recruitment and retention.

Educational Strategies:

² This is based on the June 2010 meeting’s findings and other discussions supporting the position that the “voice” of rural general surgeons is insufficient and the support of primary care physicians is necessary.

³Dr. Crouse, associate dean at the University of Wisconsin School of Medicine and Public Health, is responsible for the Wisconsin Office of Rural Health and the Wisconsin AHEC Program

⁴ Dr. Amundson, assistant professor in the Department of Family and Community Medicine at the University of North Dakota School of Medicine and Health Sciences, directs the Area Health Education Center and recruitment programs. She also serves on the Rural Recruitment & Retention Network’s (3RNet’s) Board of Directors.

- a) Admit more rural, place-committed students to medical schools and surgical residency programs.
- b) Selectively expand residency slots and funding for general surgical programs that commit to rural tracks which demonstrate results and reduce residency slots for programs that do not.
- c) Reallocate unused residency slots from other specialties to rural surgery specific residencies.
- d) Develop mentors (faculty and/or practicing rural general surgeons) who will address rural issues and encourage rural practice.
- e) Expand rural experiences during residency programs.
- f) Expand the skill set of surgeons training for rural practice to include greater depth of experience with rural-appropriate endoscopy, urology, gynecology, obstetrics and orthopedics.
- g) Work with SORHs to communicate rural interests to medical school curriculum committees and other appropriate contacts.

Loan and Scholarship Support Strategies:

- a) Pursue aforementioned NHSC strategies.
- b) In conjunction with other partners, advocate with HRSA for using any currently available flexibility that would enable the use of loan repayment funds to support rural general surgeons.
- c) Promote SORHs using state-funded loan repayment programs to support general surgery and inventory those states that are now making use of this practice and share results with all SORHs. (Include results in a “tool box” as addressed below.)
- d) Support the exploration of options for defining developing shortage area designations for general surgery.

Some possible tactics:

- *Encourage SORHs to include general surgery in their state-level discussions of workforce needs and to pool their findings in broader multi-SORH discussions.*
- *Facilitate discussion among SORHs regarding state-developed shortage area determinations⁵ (Include results in tool box.)*
- *Consider approaches for embodying state-level definitions in state statutes.*
- *Involve Charles Owens, director of the Georgia Office of Rural Health, to tap the experience he gained through participation in the current Joint Resolution process for refining current MUAs and HPSA designations.*

⁵ The Oregon Office of Rural Health is interested in exploring this point; the Nebraska office has developed criteria.

General Workforce Strategies:

- a) Work with HRSA and other partners to promote the issue of rural general surgery with the Center for National Healthcare Workforce Analysis and its director, Ed Salsberg.

Some possible tactics:

- *Work with the North Carolina Office of Rural Health and Commission member Tom Ricketts, PhD.⁶*
- *Encourage the Center for National Healthcare Workforce Analysis to include rural general surgery in its discussions and strategies. Identify all members of the Commission and establish contacts between members and their SORHs.*

- b) Advocate with Health Work Force Planning and Implementation Grantees to include rural general surgery in state workforce development strategies.

5. Encourage the National Advisory Committee on Rural Health and Human Services (NACRHHS) to include rural general surgery as a “primary” or fundamental rural service and to include a citation regarding the current and developing crisis in its 2011 “Report to the Secretary: Rural Health and Human Services Issues.”

Some possible tactics:

- *Identify all Committee members. Work with the relevant SORHs to educate and ask these members for their support. For example:
*Bob Pennell, director of the Florida SORH, has initiated conversations with Maggie Blackburn, chair of the Rural Primary Care Workforce Subcommittee.⁷
Graham Adams, CEO of the South Carolina Office of Rural Health, sits on the Rural Health Care Provider Integration Subcommittee.
Phyllis Fritsch, a CAH administrator from Wisconsin, is a Committee member.⁸**
- *Work with ORHP Associate Administrator Tom Morris and Dan Mareck, MD, ORHP’s current medical officer, on strategies for addressing this issue with the Committee.*
- *Offer a Webinar or in-person presentation to the Committee in conjunction with other coalition partners (e.g., NRHA and the American College of Surgeons (ACS)).*

⁶ Dr. Ricketts is a professor in the Department of Health Policy and Management at the University of North Carolina; deputy director for policy analysis at the Cecil G. Sheps Center for Health Services Research at UNC; and co-director of the American College of Surgeons’ Institute for Health Policy Research.

⁷ Dr. Blackburn is an assistant professor in the Department of Family Medicine and Rural Health in Florida State University’s College of Medicine and a constituent of the Florida Office of Rural Health.

⁸ Phyllis Fritsch’s hospital, Upland Hills, is participating in the rural surgery project with six other rural hospitals in Wisconsin; the Wisconsin Office of Rural Health; and, the Wisconsin Rural Healthcare Cooperative.

6. Link rural general surgery discussions to NOSORH’s and SORHs’ efforts to improve access to rural emergency services. Consider how the availability of general surgery influences the scope of services in rural hospital emergency rooms and the effects on out-of-area EMS transports and hospital emergency room trauma designations.
7. Coordinate educational efforts with the Center for Rural Health Works to address the importance of rural general surgery in creating and keeping rural jobs.⁹

C. State Level Initiatives

1. Support NOSORH’s national strategies with state-level stakeholders and, to whatever extent possible, members of states’ congressional delegations.
2. Promote rural general surgery as a service to be included in state rural health planning and state workforce development initiatives (specifically including shortage area designations for surgery).
3. Contact state chapters of ACS and meet with chapter representatives interested in rural surgery.
4. Bring together state multidisciplinary groups to discuss the importance of rural general surgery and consider developing state-level work groups that parallels the national RGSC.¹⁰
5. Identify state-specific stories of the impacts of general surgeons’ availability on rural people.
6. Assure that this topic is discussed by state FLEX/CAH groups and engage the state hospital associations.
7. Address how rural general surgery fits into developing primary care integration and medical home models (e.g., with PCAs, hospitals, FQHCs and related associations).
8. Establish contact with surgical residency programs, especially in states with rural general surgery residency programs, and solicit and support engagement in state and national discussions.
9. Promote inclusion of the topic in state rural health meetings and at state-level health planning meetings.
10. Provide multi-organizational sponsored/targeted state-level Webinars on the topic.
11. Using FLEX or other funding, develop-state level planning projects such as:
 - The Maine Office of Rural Health and Primary Care project involving fourteen hospitals and the Veterans Administration, or

⁹ Rural Health Works has recently developed a paper “The Economic Impact of a Rural General Surgeon and Model for Forecasting Need.”

¹⁰For example, ACS chapters; state hospital associations; primary care associations; CAHs and other rural hospitals; and representative primary care providers, including FQHCs, nurse anesthetists or anesthesiologists, EMS/trauma systems representatives and regional health systems.

- The Wisconsin Office of Rural Health’s collaboration with seven hospitals and the Rural Wisconsin Health Cooperative.
12. Include rural general surgery as an eligible service in state-level loan repayment programs and simultaneously advocate for inclusion in the national loan repayment programs.

D. Future Committee Initiatives

1. Report the findings and recommendations of the NOSORH Rural General Surgery Committee to NOSORH’s Flex Advisory Committee.
2. Report the findings to NOSORH’s Workforce Committee.
3. Conduct a NOSORH conference call with all SORHs to report findings.
4. If there is adequate interest before the all-SORH call, offer a “Rural General Surgery 101” Webinar for SORH directors, FLEX coordinators, and other SORH staff members as background. This call has been done recently for committee members to date and over a year ago with the NOSORH Workforce Committee.
5. Solicit additional survey feedback from those SORHs that have not responded to the Committee’s initial survey.
6. Summarize the feedback from steps 1-5.
7. Submit a “Call to Action” form to the NOSORH Policy Committee.
8. Re-commission a “standing” NOSORH workgroup made up of the existing members (who remain interested) and new representatives from other offices, to further develop and oversee the implementation of the possible initiatives and tactics. Divide actions steps among interested NOSORH sub-groups. Alternatively, topical work groups may be developed with other partners.
9. Discuss approaches for funding and project coordination.
10. Develop a tool kit for SORHs to support these initiatives and tactics. This tool kit might include the following, plus additional tools as developed:
 - a) A database of current and anticipated activities by state that includes lead contact information (to be maintained by NOSORH).
 - b) A list of those organizations that should be involved in multi-disciplinary state coalitions.
 - c) Sample letters, talking points, an introductory PowerPoint presentation, short issue-narratives, and/or data templates for communications as referenced above.
 - d) Suggested strategies for sponsoring Webinars.
 - e) A summary of state-funded loan repayment programs that support general surgery.
 - f) A summary of state-developed shortage area determinations.

11. Within NOSORH or in conjunction with other organizations (e.g., Rural Assistance Center, NRHA, ACS), develop a clearinghouse for information on rural general surgery that includes best practices for workforce development and systems restructuring.

Note: While the points outlined in this paper can guide SORH directors toward specific actions that can be undertaken at the SORH level, additional suggestions will evolve from ongoing conversations among the SORHs, NOSORH and other partners. NOSORH should coordinate updates.

IV. Comments and Suggestions

Comments and suggestions can be sent to Charles Dwyer (charles.dwyer@maine.gov) and Jonathan Sprague (JonathanSprague@RockyCoastConsulting.com).