Rural Emergency Medicine

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Background

- The WACHS ED medical workforce is a heterogeneous group, with a large IMG and significant short duration locum component.
- How do we ensure the best care is delivered consistently to our patients?
- Skills/ support/ equipment/processes

Background

- There is a tension between workforce provision and the measures we might put in place to ensure a standard of ED experience/competence.
- eg. Declining to credential potential locums based on ED experience/qualifications has implications for staffing.
- Deeming someone as unable to work independently has implications for CHI (Country Health Initiative) funding.

Background

- WACHS philosophy is to engage GP specialist trained doctors in service provision, supported by non GP specialists wherever possible.
- This applies to ED and across other specialities, most notably anaesthetics and obstetrics.
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- The Rural Generalist train has taken off.

Credentialing

- Required for every clinician
- Each clinician is discussed at a CASOP meeting.
- Credentialing for GP specialist doctors for disciplines where there are specialists is the tricky area.

GPAs

- NSACS (Non specialist anaesthetist credentialing summary)
- Covers:
- Qualifications
- Where the doctor intends to work
- Anaesthetic experience in last 12 months
- Upskilling done
- Scope of practice requested.

- This is signed off by Anaesthetic clinical lead or delegate.
- If not adequate, anaesthetic lead or delegate clinically assesses clinician on site or recommends further upskilling.
- Clinical lead also determines duration of credentialing based on above.

Credentialing by specialty

	GPA	GPO	GP-ED
Qualifications			
Recency of experience			
Upskilling			
Logbook			
Scope of practice			
Sign off			
Site			
Duration of credentialing			
Other requirements			

ED Credentialing

- No Credentialing form
- Credentialing criteria less standardised
- Currently based on any qualifications, ‘reasonable’ ED experience and certain CPD courses such as ALS1 or 2, REACT, trauma courses, APLS etc.
- No clinical lead/specialist reviews except in specific circumstances, generally post critical clinical incidents.

ED Credentialing

- It is my view and that of the EMLG that this should be significantly more robust.
- Why?
- Remote/Rural medicine – clinical isolation, spectrum of acuity, access to specialists, impact of critical incidents on the patient, community and the clinician.

- So how might we go about doing this?
- What comes next is a suggested approach for discussion.

There are basically 4 distinct groups to credential.

- Holders of advanced ED training (FACRRM, RACGP with ACEM diploma).
- GPs servicing their country town ED.
- IMGs
- Short term locums

Holders of advanced ED training. Potential approach

- 4 yearly credentialing.
- 4 yearly completion of specified/assessed courses (ALS2, APLS, EMT, REACT).
- Neonatal resus and obstetric upskilling courses and other CPD encouraged.
- Evidence of regular ED practice (logbook) during that period.

GPs servicing local ED. Potential approach

- 4 year credentialing
- Initial Clinical Review (see below)
- 4 yearly completion of specified/assessed courses and logbook completion as described above.

Clinical Review options

- Regional centre – 2 days
- or
- EM clinical lead / GP ED comes to GP
- or
- REACT course

- Pre-formatted core subject based assessment.

IMGs potential approach

- Credentialing requires 6 within last 12 months or 12 within last 24 ED experience with FACEM/DMO sign off, initial clinical review if no sign off available, completion of specified courses as above.

- 4 year credentialing requirements as for GPs servicing local hospital.

Short term locums potential approach

- Initial credentialing requires 6/12 or 12/24 ED experience with FACEM/DMO sign off, completion of specified courses as above.
- Initial clinical review within 3 months if no sign off available (applicable to locums working >3 months).
- ? Standardised review post locum
- 1 year credentialing.

The questions.

- How do we best utilise the Clinical Review?
- Will this model result in increased workforce pressure?
- How useful will a log book be in the ED setting?
- Is this approach workable /palatable?

Outcome of clinical review

- If satisfactory, no need to repeat unless concerns raised?
- If unsatisfactory, for a formal five day assessment in a regional centre.
- If remains unsatisfactory, not re-credentialed for ED until certain criteria are met.

Log Book

- Possibly ATS based.
- If low numbers of ATS 1 and 2, offered upskilling time in a regional or metro/outer metro centre or via ETS.
- ? Mandatory involvement of ETS for 1 and 2s

Maintenance of skills and support Mentoring

- Would a dedicated clinical support/mentoring model be useful for/ welcomed by long term rural GPs?
- Regionally based FACEM, DMO, GPED
- ? Command Centre supported.
- Fortnightly or adhoc post case hour catchup.

Workforce pressures

- Particular isolated small sites that struggle to get regular ED medical cover…
- Holiday/high activity periods where financial incentives have been required.
- The two edged sword of financial incentives for sites in staffing crisis.

What would help to attract locum ED staff beyond money?

- Simple things- pleasant accommodation, welcome pack
- Financial support for required CPD courses

- Is clinical isolation an issue?

- Would the clinical support model help?

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Evolving questions

- What is the role of command centre/ ETS and its expanding activities (just passed 100,000 cases, around 100 doctors, MH ETS)?
- Should ETS be a service provision strategy for difficult to staff sites?
- What supportive role could they have beyond clinical case management?

Role of Nurse Practitioners

- Dependant on size of medical centre
- Specific expertise and teaching
- Medical governance and scope of practice
- ? Where does the FTE sit (impact on nursing roster)
- Who should credential?

Equipment

- Perceived deficits in core equipment?

- Eg. NIV