HOW TO WIN FRIENDS AND INFLUENCE HEALTH PLANNING: LESSONS FROM THE EDGES OF COLLABORATIVE HEALTH SERVICES RESEARCH

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Objectives

- To consider a case-study of a research-embedded political process of policy development;
- To review the strategic interplay of research evidence with the political environment; and
- To extract lessons learned from this opportunistic research-to-policy engagement.
- I am a health services researcher with a particular passion for moving ‘evidence’ into policy and decision-making;

- I do primary research through the Centre for Rural Health Research (DFP, UBC), focusing on model and outcomes of and satisfaction with models of rural health care;

- I started the Applied Policy Research Unit (APRU) in 2013 to create a formalized structure to synthesize relevant research evidence (peer-reviewed and grey literature) in a way that may aid evidence-based policy and decision-making;

- I have an abiding interest in evaluating strength of evidence and its applicability to the local setting.
Re-considering evidence

- The output of primary research is rigorous evidence, which sheds light on a phenomenon under consideration;
  - Pioneered by Archie Cochrane, who advocated for Randomized Controlled Trials as the highest form of evidence

- The hierarchy of evidence is reproduced through systematic reviews of published research evidence;

- In the era of ‘evidenced based medicine’, health services research is at risk of normatively valuing scientific evidence (easily measurable) at the cost of alternative forms of knowledge (not easily measurable);

- This will be at the cost of pluralism – the acceptance of multiple points of view and experiences – that fulsomely represents reality.
### Costs of Having Services VS Costs of Not Having Services

<table>
<thead>
<tr>
<th>Manifest Costs</th>
<th>Intangible Costs</th>
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<tbody>
<tr>
<td>Capital costs (operating room costs, equipment)</td>
<td>Costs of separation (from community and family)</td>
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<tr>
<td>Annual operating costs (supplies, costs of cleaning and sterilization of equipment)</td>
<td>Loss of cultural mandate to birth on traditional territory</td>
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<tr>
<td>Emergency travel expenses</td>
<td>Cost of increased stress due to separation</td>
</tr>
<tr>
<td>Equipment maintenance</td>
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**System costs gathered through administrative data**

**Gathered through interviews with key stakeholders**
HEALTH IMPROVEMENT
- Reproductive Health
- Healthy Development
- Healthy Communities
- Healthy Living
- Mental Health Promotion
- Food Security

DISEASE, DISABILITY, & INJURY PREVENTION
- Chronic Disease Prevention
- Prevention of Unintentional Injury
- Prevention of Violence, Abuse & Neglect
- Prevention of Problematic Substance Use
- Communicable Disease Prevention & Control
- Dental Health
- Prevention of Disabilities

ENVIRONMENTAL HEALTH
- Water Quality
- Air Quality
- Food Safety
- Community Environments

HEALTH EMERGENCY MANAGEMENT
- Prevention and Mitigation
- Preparedness
- Response and Recovery
Conceptual Framing of the Issue at Hand:

<table>
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<th>Health Service Delivery Problem:</th>
<th>Closure of rural maternity and surgical services</th>
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<tr>
<td>Evidence Needed:</td>
<td>Best practices for sustaining rural health care</td>
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<tr>
<td>Policy:</td>
<td>Provincial (MoH); Health Authority</td>
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<td>Influencing factors:</td>
<td>Professional associations Individual practitioners</td>
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The Closure of Rural Surgical and Maternity Services

- Precipitous closure of services in BC starting in 2000;
- Due to challenges recruiting and retaining care providers, increasing risk intolerance within the context of sub-specialization
- Poorer maternal/newborn outcomes (Grzybowski et al 2009; Grzybowski 2014);
- Negative psycho-social consequences (Kornelsen and Grzybowski 2006);
- Negative cultural consequences (Kornelsen et al 2011);
- Destabilizes existing primary care services;
- Difficult to recruit and retain care providers;
- No conclusive evidence regarding costs savings (Kornelsen & McCartney 2013).
Building the evidence

Maternal-Newborn Outcomes

Provider Outcomes

Patient Satisfaction
Evidence $\rightarrow$ KT
Impasse

1. Timing
2. Lack of systems framing of the problem
3. Lack of awareness of the larger political landscape
Impasse

1. Timing
2. Lack of system framing of the problem
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1. Timing
2. Lack of system framing of the problem
3. Lack of awareness of the larger political landscape
Neglected the role of surgical services in maternity services

Operative Delivery

Rural Surgical Services

Maternity Care

the Intersection
1. Timing

2. Lack of systems framing of the problem

3. Lack of awareness of the larger political landscape
Family Physicians with Enhanced Surgical Skills

- GPs with additional training in procedural care
- 60 communities in Western Canada and North
- Populations of 5000-15000
- Large enough for a small volume surgical program: too small for a GS group
Training

- Formal accredited programs (Prince Albert; historically Grande Prairie Alta)
- Standardized curriculum
- Evaluation - oral and written, internal and external
- No accredited program in any other jurisdiction
Proceedings from the Invitational Meeting on Rural Surgical Services
Co-Chairs: Dr Stuart Iglesias and Dr Nadine Caron

June 22-23, 2007
Hyatt Regency Hotel
Vancouver, British Columbia

Edited by the Centre for Rural Health Research
Early work: the experience of FPESS

“The Training and Practice Experience of GP’s with Enhanced Surgical Skills” (Kornelsen, Caron, Iglesias, Humber and Grzybowski)

Thematic findings suggested the importance of establishing positive inter-professional relationships: demanded addressing inter-professional challenges at a macro (system) and micro (personal) level.
Rich description of (mostly negative) experiences with specialists:

*And the chief of Surgery made it very clear my first week there that it was his intention to make me quit the year and that as far as he was concerned, family docs should never be in an operating room, and that we weren’t smart enough to be in an operating room.* (Participant 20, 35-39)

- Overwhelming experience of specialists’ negative attitudes towards GPESS

Two ‘take home’ messages:

1) Interprofessional relationships based on trust and respect were key to success of a GPESS program;

2) We heard what GPESS thought specialists’ attitudes were: we did not hear from specialists themselves.
“The Outcomes of Perinatal Surgical Services in Rural BC: A Population-Based Study”

- A review of perinatal data for singleton births 2000 – 2007 by stratified population catchment

- Found that catchments served by GPESS (9,174 births) compared favorably to those attended by Obstetricians.

Rural surgical service delivery

As researchers and physicians working in surgical service delivery in British Columbia, we would like to share some of the highlights of an Invi Rural Surgical Serv 2007, Vancouver, BC Centre for Rural Health goal was to share educational initiatives: holders in rural surgery Attendees included the BC Health Authority’s Association (BCMA), British Columbia, (C) general practitioners! The BC Reproduction

Podium: Doctors Speak Out
La parole aux médecins

Professional isolation in small rural areas

Policy Briefs
Issues in Rural Maternity Care

CENTRE FOR RURAL HEALTH RESEARCH

Optimal Perinatal Surgical Services for Rural Women

Background

“Rural maternity services show system stresses early and are particularly vulnerable to shifts in provider supply or availability for rural communities. General practitioners with Enhanced Surgical Skills (GPES) have included concerns over privileging, credentialing, education, and regulation, even in sustain birth of rural communities.

Tensions regarding the role General Practitioners in rural B.C. are in crisis. Since 2000, 21 maternity centres have closed and more are considered unstable. The preference of women in...
2011: Taking Stock

- +++ evidence (local and internationally): very little uptake
- Unabated closure of rural services (minimal policy uptake)
Political Landscape

- General Surgeons (CAGS)
- Obstetricians (SOGC)
- Rural GPs (SRPC)
- Royal College of Physicians and Surgeons (RCPSC)
- College of Family Physicians of Canada
- Local Hospital Administrators
- GPESS
- MoH
- Health Service Delivery Areas
- Health Authorities
- MoH
- Obstetricians (SOGC)
- Health Authorities
“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 (or 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.”
‘Optimal Perinatal Surgical Services for Rural Women: A Realist Review’

Commissioned by the Ministry of Health and Perinatal Services BC to answer the question:

*Can we meet the perinatal surgical needs of rural women more effectively through an optimally centralized or optimally decentralized model of care?*
Key Findings

- There is no existing clinical, case study, or qualitative evidence that basic maternal surgical care, including caesarean section, is less safe when provided by GP proceduralists with enhanced surgical skills than when provided by specialist obstetricians; …

- Lack of any local maternity services is associated with worsened birth outcomes, with both the risk that women present to underprepared health service units, and distance to care affecting outcomes.
Policy Moment #2: Provincial Policy Papers

- ‘Delivering a Patient-Centered, High Performing and Sustainable Health System in BC: A Call to Build Consensus and Take Action’

- ‘Primary and Community Care in BC: A Strategic Policy Framework’

- ‘Future Directions for Surgical Services in British Columbia’

- ‘Rural Health Services in BC: A Policy Framework to Provide a System of Quality Care’
In Parallel…

Primary Research: ‘What are the perceptions and experiences of Specialist Surgeons and OB/GYNs towards GPs with Enhanced Surgical Skills?’
‘What are the perceptions and experiences of Specialist Surgeons and OB/GYNs towards GPs with Enhanced Surgical Skills?’
Consolidating the evidence-base

- Quality BC data
- Supported consistently by international data
- Shifting policy environment
- Increasing support
Joint position paper on rural surgery and operative delivery

Our professional organizations have prepared this paper as part of an integrated, multidisciplinary plan to ensure the availability of well-trained practitioner teams to sustain safe, effective and high-quality rural surgical and operative delivery services. Without these robust local (or nearby) surgical services, sustaining rural maternity care is much more difficult. This paper describes the “network model” as a health human resources solution to meet the surgical needs, including operative delivery, of rural residents; outlines necessary policy directions for achieving this solution; and poses a series of enabling recommendations.

Nos organisations professionnelles ont préparé cet article dans le cadre d’un plan multidisciplinaire intégré visant à assurer la disponibilité d’équipes soignantes bien
National Working Group on ESS

- Maintaining and Expanding Quality Rural Surgical/Obstetrical Services
  - Joint Position Paper
  - Development of a National Curriculum
  - CFPC Communities of Practice
  - Work on Quality Assurance and Privileging
National Working Group on ESS

Maintaining and Expanding Quality Rural Surgical/Obstetrical Services

Joint Position Paper

Development of a National Curriculum

CFPC Communities of Practice

Work on Quality Assurance and Privileging
Policy Network Analysis

- PNA is a study of the linkages and interdependencies between actors in and influences of the policy making process

- Networks describe forms of government policy making:
  - **Interest intermediation**: networks analyzed the identify the most important actors
  - **Inter-organizational analysis**: aims to understand the interdependency in decision-making between political/administrative/professional structures
  - **Governance**: study of the general patterns of policy making (power-sharing between government and private interests)
Convened a key-stakeholder symposium → Did primary qualitative research → Did a population-based study of outcomes based on models of care → Intensified KT efforts

POLICY MOMENT #2: MoH Policy Papers

POLICY MOMENT #1 BC Primary Maternity Care plan

Key stakeholder funding for more primary research

Evidence gap identified: completed systematic realist review

Consolidation of evidence in the Joint Position Paper

Formation of National Working Group (need for evidence)
Reflections

- KT (iKT) is not the technical implementation of research evidence targeted at decision-makers: it is part of an expansive, non-linear social process.

- Policy is political!
  - Non-neutrality of evidence → policy as social production (non-linear and difficult to predict)

- Bi-directional influence between research and policy

- “Policy change is the result of diverse, non-linear negotiations among multiple actors operating within a policy network” (Kelly Murphy and Patrick Fafard)

- Importance of understanding the development of policy from within an expansive social process (i.e., Network Analysis framework)