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# The Canadian Association of Emergency Physicians & The Society of Rural Physicians of Canada

## Press Release: Rural Emergency Departments & COVID19

**FOR IMMEDIATE RELEASE**

**Ottawa, ON: March 21, 2020**

Canada's rural population, which includes many Indigenous communities, requires equitable access and care close to their homes. Infrastructure, human resources, geography and weather impact rural medical outcomes. During the COVID-19 pandemic, it is crucial that urban and rural referral sites support each other and act as a unified system of emergency care. It is critical that Canada's rural Emergency Departments (EDs) remain open and staffed. It is of national interest to avoid unnecessary rural patient transfers to urban and tertiary care centres already at full capacity. Similarly, robust repatriation of patients back to their rural origin will optimize tertiary care capacity. Some rural regional hospitals have ICUs, in-situ ventilator capability, and a core generalist specialty service but require specific attention and support.

Rural Canadian resources are ill equipped for the pandemic. Rural EDs are much smaller and have limited human health resources making it difficult to mitigate staff illness, self-isolation/quarantine requirements and burn-out. The staffing models and service impacts are also different. Full scope rural family practice generalists cover multiple community roles simultaneously. In addition to ED coverage they provide office practice, inpatient and long-term care, maternity and obstetrics, OR assisting, chemotherapy, remote clinic oversight, Indigenous population outreach and transfer medicine to name a few.

Rural Canadian hospitals are now struggling with supply chains of basic medications (MDI, antibiotics, sedation agents), testing supplies and Personal Protective Equipment. Coupled with more prolonged testing turnaround times and fewer resources for managing and educating staff, there needs to be increased attention to rural access to care during the COVID19 pandemic.

**Recommendations**:

1. **National licencing/credentialing:** establishment of emergency pan-Canadian licensure of health care workers. Create a standardized national system for rapid / dynamic intra-provincial and cross-provincial regulatory licensing. Improving provincial health authority credentialing and privileging for multiple jurisdictions (rural to urban, urban to rural).

2. **Utilize new grads**: mandate that recently graduating MDs with provisional licenses (because of delayed formal certification exams) can do locums, be assigned billing numbers and sign employment contracts.

3. **Increased Funding and coverage:** Federal and provincial funding mandated to respond immediately to increase number of temporary rural positions. The majority of rural EDs are staffed with single physician coverage.

4. **Create Rapid Rural Relief Teams:** creation and deployment of centralized provincial teams that include MDs, core generalist specialties, RNs and Respiratory Therapists**.**

5. **Improved PPE supply:** Urgently increase the supply of personal protective equipment to every rural ED to protect the rural health workforce.

6. **Increased testing supplies/facilities:** Rural regional laboratories need to be accredited and equipped to do testing. Improved access to federal testing facilities is required. Rural hospitals are experiencing unacceptable turnaround times of up to 7 days due to transport times and backlog. Additionally, an urgent supply of COVID testing supplies dedicated to the rural health workforce would enable rapid return to work.

7. **Established patient transfer agreements:** Regional and tertiary care centres must work collaboratively with rural EDs to allow the seamless transfer of critical patients. Agreements and contingency plans should be in place to support understaffed and under-equipped rural EDs. This includes patient transfer and repatriation.

8. **Improved medevac resources:** Air and ground medevac resources (particularly for remote Indigenous populations) must be increased. Financial and logistical support is required. Medevac systems should also be mandated to help distribute and collect testing samples. This could improve testing turnaround times.

9. **Virtual support:** For medevac delays, a virtual critical care support resource should be accessible and utilized optimally by rural health care providers.

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