The Delivery of Home Care Services in Rural and Remote Communities in Canada

Identifying Service Gaps and Examining Innovative Practice

NOVEMBER 2006

Canadian Home Care Association
canadienne de soins et services à domicile
The National Voice of Home Care

About the Canadian Home Care Association

The Canadian Home Care Association (CHCA) is a not-for-profit membership association dedicated to ensuring the availability of accessible, responsive home care and community supports to enable people to stay in their homes with safety, dignity and quality of life. Members of the Association include organizations and individuals from publicly funded home care programs, not-for-profit and proprietary service agencies, consumers, researchers, educators and others with an interest in home care. Through the support of the Association members who share a commitment to excellence, knowledge transfer and continuous improvement, CHCA serves as the national voice of home care and the access point for information and knowledge for home care across Canada.

For more information, visit our website at www.cdnhomecare.ca

www.cdnhomecare.ca

Table of Contents

The Canadian Home Care Association would like to gratefully acknowledge the funding from Health Canada which enabled the execution and completion of this project on Rural and Remote Home Care. The views expressed herein do not necessarily represent the views of Health Canada.

Acknowledgements

The Canadian Home Care Association (CHCA) is a national, not-for-profit organization that represents over 600 organizations and individuals from the publicly funded Home Care programs, not-for-profit and proprietary service agencies, consumers, researchers, educators, and others with an interest in Home Care.

Through ongoing dialogue and publications the CHCA acts as a united voice and access point for information and knowledge for home care across Canada. The CHCA advocates on behalf of its member- ship for high quality home care that is part of the continuum of care within an integrated health care system.

In support of one the CHCA's strategic initiatives, Home Care in Rural and Remote Communities in Canada, this document was written to provide information and recommendations for public policy and health care decision-makers.

I wish to acknowledge Susan Donaldson who led the research and development of this discussion paper. The CHCA Board of Directors and a number of Provincial/Territorial representatives provided their time and expertise in reviewing this document.

It is our intention that this publication will serve as a basis for discussion about the delivery of home care services in rural and remote communities in Canada. Furthermore, it is our hope that these discussions will lead to the continued development and implementation of strategies to support these communities and home care programs to enable them to maintain their best practices and explore new ways to provide services.

Nadine Henningsen
Executive Director
Canadian Home Care Association
November 2006

Executive Summary

According to Statistics Canada (2001), rural Canadians make up about 20% of the employed Canadian workforce and 31.4% of the total population. In addition, approximately 98% of the nation's geographic territory is classified as 'rural'.

Given the predominance of rural and remote regions across Canada it is important for health care to be maintained in these areas. Individuals who reside in rural and remote communities often have less favourable health determinant status i.e., low level of formal education, low income. Since populations in rural communities tend to be older on average, the in-migration of older people into rural areas will increase the stresses on the local health care system. In addition, hospital closures, amalgamations, and government funding cuts are adding to the challenges for rural and remote areas to meet the health care needs of their citizens.

In accordance with the Canada Health Act, all Canadians will have accessibility to health care as one of the five principles. This is often very challenging and sometimes non-existent in many rural and remote communities and affects not only an individual's right to access necessary health care, but also their quality of life.

A review of both peer reviewed and grey literature available relating to rural and remote home care, a survey sent to key informants from each province and territory and a detailed interview with key informants from three jurisdictions (British Columbia, Ontario and Nunavut) was conducted to obtain the re- quired information.

This project was undertaken to:

- Identify and illustrate innovative home care delivery practices or policy in rural and remote communities in Canada—within acute, chronic and palliative/end-of-life care—in at least three provinces/territories.
- Identify and illustrate best practices in rural and remote home care policies and/or practices including telehealth and other technology applications.
- Explore innovative approaches to home care case management, discharge planning, community resource allocation and support for the informal/family caregiver in rural and remote communities.
- Identify gaps in home care service delivery in rural and remote communities and illustrate ongoing barriers resulting from service gaps.
- Determine vulnerable populations (e.g. seniors living alone, children, family caregivers, clients diagnosed with mental illness) that are affected by gaps and/or limitations in service delivery and examine the consequences of not meeting these needs of rural and remote communities.

"Approximately 98% of the nation's geographic territory is classified as 'rural'. "

At the onset of the project it was clear that the respondent jurisdictions did not use a common definition for rural and remote. However, the responses enabled the project team to identify two overarching themes that emerged from the definitions that are currently used:

RURAL
Small populations and low population densities and/or a relatively large distance from major urban centres.

REMOTE
Geographically isolated (difficult to access, a distance from a main route) with small populations.

Maintaining an understanding of the broad definition of remote and rural (as described above) is important when discussing the challenges and gaps that jurisdictions are facing in the provision of home care services, as home care programs must work collaboratively with other community services, physicians, facilities (acute care and long term care), specialty programs and family caregivers to be effective.

The main challenge for all jurisdictions was lack of health human resources; including doctors, nurses, nurse practitioners, and home support workers as well as the limited number of informal/family care- givers in rural and remote communities. This challenge is exacerbated by a net out-migration of young individuals from rural and remote communities, a lack of support systems and local resources, limited transportation, and the requirements to travel long distances and hours to see very few clients.

This challenge has a domino affect on other system capacities. Availability of community resources is limited by lack of human resources, appropriate utilization of the health care system is impacted, and the client and family caregiver are often required to make difficult life-altering choices that require moving from their communities and the splitting up of their family unit. All these have a huge impact on the vulnerable populations of the frail elderly, seniors and individuals living with chronic diseases, individuals with mental illness or dementia and people requiring palliative/end of life care and their families.

Home care programs providing services to rural and remote regions of Canada have developed innovative solutions to address their unique challenges. In response to this overwhelming challenge, home care leaders in rural and remote communities have developed and implemented a number of innovative programs that include:

- Leveraging partnerships to optimize local resources and build required capacity.
- Utilizing case management as a strategy for systems integration to maximize community resources and access resources outside the community.
- Empowering the client and family caregivers to promote independence and provide guidance and the appropriate use of scarce resources.
- Using technology to train, provide service, support family caregivers, decrease isolation and build health care teams.

While these innovations are positively impacting client and families in a number of communities, this project has just begun to bring forth some of the wealth of innovations and best practices taking place in home care delivery in rural and remote areas of Canada. Our challenge is twofold:

We must continue to support these communities and home care programs to enable them to maintain their best practices and explore new ways to provide services. This support should include both financial support and linkages with other programs that are experiencing similar challenges and have developed unique solutions.

We must share the experience and learning that is currently taking place in rural and remote communities with home care stakeholders across Canada so they too can benefit from the grass roots knowledge and programs that have been developed to service this unique population.

To meet these challenges, the Canadian Home Care Association (CHCA) recommends the following:

- Provide targeted funding for rural and remote home care programs to develop and implement best practices that support primary health care and the development of partnerships to optimize resources and build support networks for human resources.
- Support (through funding and resources) innovative approaches to human resource challenges including the use of technology for training and education, provision of remote visits, support for the informal caregiver and specialty support for the health care professions (remote wound care programs, etc).
- Promote research on informal/family caregiver needs and coping strategies in rural and remote communities to determine the necessary supports required to reduce caregiver burnout and empower clients/family.
- Share rural and remote experiences and best practices across Canada by highlighting the findings of this report at the 2006 CHCA Home Care conference in a roundtable to gain input into the findings and stimulate new ideas in the delivery of rural and remote home care services.
- Fund a study that will build upon this preliminary report and conduct an in-depth review of the program and service innovations that are currently underway (detailed implementation strategies, lessons learned, outcomes, etc) in rural and remote home care programs.

We must act swiftly on these recommendations to support the excellent initiatives that are currently taking place in rural and remote communities and build upon the momentum to ensure all Canadians have access to high quality health care services wherever they choose to live.

Introduction

The demand for effective and efficient home care is a challenge facing the Canadian health care sys- tem, in large part due to the growth of our aging population, the advances in technology and the eco- nomic realities of institutional (hospital) care. Additionally, provincial and territorial governments have clearly signaled a shift in policy focus from provision of care in an acute care setting to provision of care "closer to home". This shift toward community based services presents a number of challenges to home care policy planners, administrators and service providers.

The challenges of providing effective home care are most notable in rural and remote areas. Compared to urban areas, rural areas tend to have less access to health care re- sources and very limited community supports. Often, the delivery of complex home care services requires an interdisciplinary team approach and working over long distances presents unique challenges for teamwork and communication.

There are varying definitions for both Rural and Remote across the country and this adds to the challenge of comparing across jurisdictions.

The challenges of providing effective home care are most notable in rural and remote areas.

Methodology

The goal of this project was to further our understanding of the complexity of rural health care policy as it relates to home care services in Canada. The project team set out to obtain qualitative information on home care services for rural and remote communities pertaining to unmet needs and service gaps, innovations, best practices and the resultant impact on vulnerable populations.

Approach

The following provides a summary of the overall approach to the project:

- A review of both peer reviewed and grey literature was carried out to determine the extent of literature available relating to rural and remote home care. While the available literature was sparse, it was clear from the review that there is little agreement on the definition of Rural and Remote and that in many instances it is based on a local understanding of the term rather than a written definition.
- Much of the peer reviewed literature was discipline specific to either nurses or physicians, although there were a number of articles that related to women in rural communities and access to services in rural communities. A link was made with Primary Care renewal. A number of presentations and reports were also reviewed as they addressed the informal caregiver and research in health in Rural and Northern areas.
- A stakeholder survey was developed using the information identified in the literature review and the experience of the team. In addition to a broad range of information, the survey also included questions that would enable the team to understand the definitions used by the various jurisdictions. The

draft survey was sent to a sub-committee comprised of board members of the CHCA for review and minor modifications were incorporated. (Reference Appendix A for a copy of the survey.)

- The CHCA board members were asked to identify key informants from their province/territory to whom the survey was sent. The survey was distributed electronically to all identified key informants with instructions for completion within the designated time. When responses were not received a follow-up email was sent. This often resulted in additional surveys forwarded to other stakeholder as they were designated the most appropriate individual. The proximity to the Christmas period added a timing concern.
- Inclusion criteria were developed to facilitate the selection of the 3 jurisdictions that underwent a more in-depth interview by the project manager. Interview protocol was developed, vetted and used for each key stakeholder interview for the 3 jurisdictions. (Reference Appendix B for Inclusion Criteria and Interview Tool.)
- Interviews were conducted with the 3 jurisdictions (British Columbia, Ontario and Nunavut) and a written summary of the responses was completed and reviewed by each key informant for their respective region. Data gathered from the initial surveys was also incorporated into the document to provide a broader understanding of gaps, innovations, best practices and vulnerable populations.
- On completion of the draft the team reviewed the report and sent it to the project sponsor (Health Canada) and the CHCA representatives for review and feedback.

Research Findings

Thirteen provinces/territories were surveyed. Nine responses were received. These were from: British Columbia, Manitoba, Ontario, PEI, Nova Scotia, Newfoundland & Labrador, Nunavut, the North West Territories and Yukon. Although findings from all respondents are included in this report, the analysis focuses on the three jurisdictions that underwent a detailed review through a key informant interview - Ontario, British Columbia and Nunavut.

Detailed Jurisdiction Reponses to Definitions

DEFINITION	ONTARIO	BRITISH COLUMBIA	NUNAVUT
RURAL	The percentage of individuals living in enumeration areas with less than 150 individuals per square kilometers.	Outside of the regional centre/largest city.	No formal definition. General understanding that area without a big city is rural.
REMOTE	No specific definition.	More than 30 minutes drive from the town and off the highway.	Only air access available
ACUTE HOME CARE	Address the client's need for short term education, care or support as a result of illnesses, disability or injuries. A clearly identified and predicable outcome or recovery and the length of service are anticipated to be approximately 60 days.	Expectation of cure or recovery and full independence from nursing services.	A range of services available to people in follow up to diagnosis, treatment and/or intervention for a temporary period.
CHRONIC HOME CARE	Maintain the client's independence by preventing/ minimizing the premature decline in health and/or functional status. A chronic but stable self care deficit that requires ongoing need for assistance with activities of daily life. Length of service is not time limited.	Expectation of lifelong management to maintain best possible outcomes and prevent exacerbations.	A range of services provided to clients who can be maintained at home with ongoing home care services and family assistance.
PALLIATIVE CARE/END OF LIFE	Alleviate distressing symptoms to achieve the best quality of life by providing complex support in the last stages of their illness. A health condition which is not responsive to curative treatment and who are dying. Length of service is usually less than 6 months.	Focus on care not cure, diagnosis of a terminal illness/condition.	Active, compassionate care offered to a person with a progressive, life threatening illness that does not respond to curative treatment. Provides family support, prevention, assessment and treatment of pain and other distressing symptoms, and integrates the psychological, social, cultural and spiritual.
BEST PRACTICE	Documented strategies and tactics employed by highly admired organizations/agencies in the delivery of goods, products and services as captured through global benchmarking with peak national excellence awards organizations and leading edge research.	Evidence backed practice that is workable within our processes and resources.	A practice is identified based on a group consensus.

Areas of Interest

Innovation

Respondents were asked to identify innovative approaches that have been adopted in the provision of home care and support of the informal caregiver. Responses from the broad response group (9 jurisdictions - British Columbia, Manitoba, Ontario, PEI, Nova Scotia, Newfoundland & Labrador, Nunavut, the North West Territories and Yukon) identified the following:

- A large number (5/9) of jurisdictions identified a focus on programs and initiatives to assist Palliative/ End of Life clients and caregivers.
- The use of specialists (i.e., wound care, respiratory therapist), specialized case management and caregiver support being a certified profession were identified by various jurisdictions.
- Innovative service delivery methods including out-patient clinics, cluster care and Family Health Teams and the provision of education/monitoring for specific populations in Primary Health Centres and/ or promotional material in hospitals, clinics, and doctor offices.

Best Practice

Research and evidence based practices that have been implemented in the various regions were identified through the survey responses, and included:

- Use of teleconferencing and video conferencing technologies (Telehospice, Telehomecare, Telehealth).
- Introduction of electronic Case Management Tools.
- Partnerships with hospitals and practitioners.
- Activities to increase public awareness and implement educational initiatives.

Gaps

Three (3) key areas emerged from the general survey responses from the nine (9) jurisdictions that described current gaps in home care service delivery. These included:

- Health Human Resources – lack of doctors, nurses, practitioners, and home support personnel was the most frequent gap identified.
- A need to address rural and remote specific issues such as caregiver travel conditions, lack of public transportation, ability to access an area (e.g., air), and limited home services.
- Limited local resources (e.g. Long Term Care beds) resulting in unnecessary use of acute facilities.

While equally important, the following gaps were not consistently identified by the respondents:

- Not enough Adult Day Programs provided.
- Home support services are either not available or are limited.
- Financial support required for some to acquire equipment, enter programs, or specialized housing.
- Not all areas have availability to new technological tools (i.e., Case Management Tools).
- Transportation for clients is often an issue.
- Lack of family supports.
- Inability for client or informal caregiver to properly perform clinical protocols (e.g. wound care).
- No standards or consistent policies in place for hours of service.

Vulnerable Populations

Respondents were asked to identify vulnerable populations that are affected by the gaps and/or limitations in service delivery. The following 4 population groups were identified the most frequently by the provinces/territories:

- 67% of regions identified elderly living alone (including frail elderly) and chronically ill clients without family supports as a population group that is especially vulnerable given the challenges in service provision as described above.
- Mental health and disabled clients were identified by 6 of the 9 jurisdictions as a vulnerable population group.
- The need for enhanced or 24/7 services for palliative and brain-injured clients given the challenges of distance and human resources was specifically identified by 55% (5/9) of jurisdictions.
- Caregivers (both Formal and Informal) were also identified by the majority of regions.

Additional populations that were identified by the jurisdictions include:

- Individuals living in very rural and/or remote areas that have limited or no local services.
- Children and Youth.
- Low income families and individuals.
- First Nations off reserve.

Impact and Consequences

Given the challenges of providing home care services in rural and remote locations, and the resultant vulnerable population groups, respondents identified in their opinions the consequences of not meeting these population needs in rural and remote communities.

The major consequence was the clients' inability to live in a safe environment which results in relocation of residents to urban areas resulting in emotional, physical and financial challenges to the client and affected family who must manage the impact of not living life fully in their community.

Inadequate resources in rural and remote locations also results in increased cost to the health care system as palliative or mental health clients must seek care in acute care or residential facilities which is often more costly than the provision of care in the home and community setting.

The third major consequence of the current gaps in service delivery is caregiver burnout which is experienced by both the formal and informal caregiver.

Detailed Findings from Three Regions

Areas of Interest

Based on the inclusion criteria, three jurisdictions were identified to gather more detailed information on the 5 key areas (innovation, best practices, gaps, vulnerable populations and consequences) through key informant interviews. The following is a summary of the responses from Ontario, British Columbia and Nunavut.

FINDINGS AREA OF INTEREST

INNOVATION

ONTARIO	BRITISH COLUMBIA	NUNAVUT
Service Delivery Approaches Hospital replacement strategies: - Additional/dedicated case management. - Enhanced involvement with hospital discharge planning process. - Shared nurse clinical specialists/ nurse practitioners with LTC homes. - Increased support strategies with at-home or LTC homes with dialysis modalities. - LTC homes provide beds to postacute hospital patients who still require convalescent care before returning home. - Care pathways to facilitate early hospital discharge and deferrable emergency visits. **Palliative/End of Life Care** - Pronouncement of death in the home protocols. **Specialty/Caregivers** - Wound care frameworks and standardized wound care protocols. - Identifying with hospitals casemix-group patient populations which can be transferred to home care. - Specialized case management services. - Respite programs for caregivers.	**Service Delivery Approaches** - Use of ambulatory clinics. - Cluster Care in seniors' apartments/ residences. - Provision of resource lists for services not provided by home care. **Palliative/End of Life Care** - Palliative equipment arranged through community hospice services, providing introduction to the service. - No charge Palliative Home Support. - Inclusion of Hospice Volunteer sector in palliative planning, and support for same (phones, use of office space). **Specialty/Caregivers** - Use of a wound care specialist nurse for the region. - Primary Health Centres providing: education/monitoring for: CHF, pain, cardiac, diabetes, respiratory, renal. - Caregiver Support as a recognized position, providing education and support to caregivers and staff.	**Service Delivery Approaches** - Telehealth for visual access for elders to see friends and relatives in other communities. - Telehealth to follow up with southern specialists for ongoing. - Telehealth used to provide in service on equipment from southern suppliers and referral sites. **Specialty/Caregivers** - Seniors - Elders' groups and drop ins – to provide socialization, stimulation, physical activity to elders; to provide respite for caregivers; to assess elder's in group setting; to provide nutrition. - Geriatrics in Nunavut program– consultations by physician in elder's homes. **Child/Youth** - Regional innovation: first three baby visits done by home care nurse in client's home – to assess the environment as well as baby and caregivers. - Regional innovation: Child life specialist from southern center brought into community to deal with end of life issues when a child had a terminal illness; this specialist services are continued to be accessed via telephone and when clients are in southern site.

FINDINGS AREA OF INTEREST

BEST PRACTICE

ONTARIO

Partnerships
- Creating integrated primary care network involving home care, hospital, public health and physicians with funding from the Rural Health Initiative Fund of Health Canada
- Close involvement and leadership with development of new Family Health Teams, advocating for unique local client needs related to rural demographics and/or health determinants
- Partnering with nurse practitioners in rural nursing stations for better service delivery

Case Management
- Preventing hospitalization of high risk elderly by implementing Resource Integration for Seniors in the Community (RISC) – an intensive case management program for high risk elderly

Telehealth/Technology
- One CCAC has partnered with North Network (Telemedicine) to provide speech-language therapy via telehomecare to outlying communities as part of the CCAC School Health Support Services program
- One CCAC ran a pilot project on telehomecare targeting frail elderly and medically complex but stable senior and adult populations

Education/Client Empowerment
- Public awareness campaign across districts about in-home care and in particular, using examples of 'hospital avoidance' situations

BRITISH COLUMBIA

Partnerships
- Use of Community Respiratory Therapist as part of prevention of ventilator-acquired-pneumonia.
- Monitoring of CHF clients via BC nurses line with local community nurses as back up

Case Management
- Inter RAI-HC tools for case management

Telehealth/Technology
- Will be receiving Pixelaire telehealth tools in 2006
- All areas now using the Meditech registration record; will expand to e-health record in Phase 2.

Other
- Certification process for Central Line Care.

NUNAVUT

Partnerships
- Virtual Hospice
- Partnerships with southern referral sites
- Partnering with Pallium the text: A caregiver's guide: a handbook about end of life care translated into Inukitut and Inuinnaqtun.

Telehealth/Technology
- Pallium Teleconferences
- Telehealth services

FINDINGS AREA OF INTEREST

GAPS

ONTARIO

Human Resources
- Informal survey indicated that family physicians leave/retire from rural areas more so than urban.
- Medical specialists usually have to be accessed outside of rural CCAC area.
- Difficulty attracting/recruiting allied health professionals.
- Shortage of nurses and personal support workers.
- Lack of family support as seniors retire to rural areas and leave family units behind (Rural area children move to urban settings when grown).

Rural/Remote Location
- Long distances to travel to local hospitals.
- Geographic challenges (distance, weather, terrain) for staff to access clients.
- Lack of cell phone access; many clients with rotary phones.

Resources
- Lack of assisted living services for elderly and disabled.
- Large geographic catchment areas limit opportunities to find economies of scale.
- LTC homes have higher than provincial average of 'light care' clients and of these residents, many are physically disabled.
  Presents a system challenge compounded by lack of 'light care' alternatives.

BRITISH COLUMBIA

Human Resources
- Not always adequate numbers of staff.
- Lack of nursing specialty services.

Rural/Remote Location
- Ability to provide service to remote areas.

Resources
- Ability of some clients to provide their own specialized wound care products according to policy.
- Ability to provide 24/7 services to palliative or complex clients – resource issue.
- Occasional waitlists for equipment.
- Few resources for brain-injured clients – 24/7 supervision.
- Palliative referrals not always timely.

NUNAVUT

Human Resources
- Infrequent rehab visits.
- Need for ongoing training for home care staff especially support staff.
- Inconsistent staffing of home care nurses across territory.

Rural/Remote Location
- Access and communication is often a big challenge.

Resources
- Inconsistency amongst regions in the hours of care that can be supported.
- Home & community care program becoming overwhelmed with services offered – continuing care bed requirement high so hours of care are being increased to keep clients in their own community.
- Hours of service not defined for homemaking and personal care services.
- Standards, policies and procedures are current in development.

FINDINGS AREA OF INTEREST

VULNERABLE POPULATION

ONTARIO	BRITISH COLUMBIA	NUNAVUT
- Seniors living alone/lacking informal supports. - Frail, vulnerable elderly. - Disabled - Clients with mental illness/dementia. - Family caregivers of clients with complex/chronic illnesses. - Very rural/remote clients. - Clients with meager incomes/low education. - Clients who are dying and require palliative/End of Life care. - First Nations clients who may live on or off the reserve.	- Frail elderly - Disabled - Clients with Mental Health issues. - Population with low IQ but not low enough to be eligible for program support.	- Seniors living alone - Family caregivers - Clients diagnosed with mental illness. - Children and Youth - Palliative/end of life clients and families – need more hours of care.

FINDINGS AREA OF INTEREST

CONSEQUENCES

ONTARIO	BRITISH COLUMBIA	NUNAVUT
Safety/Limited Client Choice - Inability of clients to retain independence in self care at home. - Increased susceptibility to feelings of isolation with associated mental health concerns. **Resource Utilization/Cost Implications** - Unnecessary use of hospital services. **Human Resources Burnout** - Increased probability of iatrogenesis when primary care providers and processes not available on a consistent basis.	**Resource Utilization/Cost Implications** - Palliative or complex care client is unable to stay in the home – costly hospital stay. - Clients awaiting a residential bed are admitted to acute. **Human Resources Burnout:** - Time spent on specialized care planning for clients in remote areas – regular visits are not an option.	**Safety/Limited Client Choice** - Not being able to meet the needs of Nunavummiut through home care services may mean transferring tat person out of their community to another facility within Nunavut or may mean placing Nunavummiut south of 60. **Human Resources Burnout** - Increased stress on client, family and caregivers both home care and back up care providers.

Discussion

Early in the study, it became apparent that the varying definitions of rural and remote provided by the Provinces and Territories indicated that there are numerous ways for a community to be designated as 'rural' and "remote".

Statistics Canada defines:

- Rural as "A community (generally a municipality in the west and a township in the east) is defined as "rural" if its population density is less than 150 people per square kilometre", and
- Remote as "A region, or census division, is defined as "rural and remote" if more than 50% of its population lives in rural communities"

The Canadian Association of Emergency Physicians defines:

- Rural as "Any area where health care is dispensed by general practitioners or non-physician providers and where immediate specialist support is limited or not immediately available", and
- Remote as "Rural communities about 80-400 km or about one to four hours transport in good weather from a major regional hospital. (Defined as Isolated when >400KM or 4hrs +)".

As seen from the examples above and the responses obtained from the nine Provincial/ Territorial jurisdictions, two overarching themes emerged from the definitions:

- Rural = small populations and low population densities and/or a relatively large distance from major urban centres.
- Remote = geographically isolated (difficult to access, a distance from a main route) with small populations.

In advancing this project and gathering the necessary information to identify challenges, gaps, innova- tions and best practices in rural and remote home care in three jurisdictions across Canada, it was de- cided that each province/territory would provide their current working description of rural and remote and this would set the context for the subsequent discussion of challenges and innovation solutions.

Maintaining an understanding of the broad definition of remote and rural (as described above) is important when discussing the challenges and gaps that jurisdictions are facing in the provision of home care services, as home care programs must work collaboratively with other community services, physicians, facilities (acute care and long term care), and specialty programs and family caregivers to be effective.

"numerous ways for a community to be designated as 'rural' and 'remote'"

According to the Canadian Home Care Association's Portraits of Home Care 2003, the top four challenges facing home care service providers and administrators are:

- **Increasing Costs & Limited Funding:** Home care costs continue to escalate due to increased demand, rising consumer expectations, increased client acuity, increasing human resource costs, and growing demand for technology and equipment.
- **Inconsistent Access to Core Services:** Increasing demand, geographic dispersion and lack of consistency in the scope of services within regions across the country affects access to home care services.
- **Shortage of Human Resources, Recruitment and Retention:** Shortages of health and social care professionals are a major issue in every province. Shortages exacerbate waiting lists for services and often compromise the quality of care since overburdened providers have insufficient time to visit or follow established treatment protocol.
- **Inefficient Systems to Support Accountability and Reporting:** Lack of well defined information and reporting standards and limited data collection capabilities and supporting information technology, diminish the home care sector's ability to evaluate, compare and plan for future needs and services.

This scan of rural and remote home care programs, asked provincial and territorial home care stakeholders to identify gaps (or challenges) in home care service delivery and illustrate ongoing barriers resulting from service gaps. While similar to the challenges identified by all home care stakeholders (above), rural and remote programs had unique issues that result from geographic isolation, limited population and scarce resources found in these locations. The following are three (3) key challenge areas that emerged through the survey and discussions with key informants:

Lack of Health Human Resources

All jurisdictions indicated a lack of doctors, nurses, nurse practitioners, and home support workers as well as the limited number of informal caregivers in rural and remote communities. This observation is sup- ported by the Canadian Home Care Human Resources Study (2002) that identified "perceived shortages of home care workers in Canada, particularly in rural, isolated areas". The health human resource challenge is exacerbated by the lack of support systems and local resources in rural and remote locations to prevent early burnout of both the informal and formal caregiver.

The solution to this challenge is more complex than simply implementing recruitment programs for health professionals. Canada's rural communities are seeing a trend in their becoming retirement communities. Additionally the younger populations are leaving the rural and remote communities for career development and job opportunities in urban settings. This phenomenon affects the accessibility of formal caregivers and informal caregivers who are often without the benefit of local family support systems.

Geographic and Infrastructure Challenges

Many jurisdictions indicated a continuous challenge with caregiver travel conditions, lack of public transportation, ability to access an area (e.g., air), and limited health care resources. Transportation to doctors, hospitals, clinics, hospice and other respite care facilities is a barrier that continues to plague rural and remote communities.

The Home Care Human Resource Sector Study (2002) identified, "in rural and remote communities, home care providers are challenged with limited transportation and the associated costs of traveling long distances and hours to see very few clients".

This challenge affects the accessibility of home care services as air travel and long distance travel are often prohibited by cost containment, weather, and caregiver availability. The resultant effect is the informal support networks of family and friends are re- lied upon more heavily or the client must be transferred to a more accessible location away from the community.

Limited local resources

While home care programs across Canada have identified the challenge of inconsistent access to core services, rural and remote home care programs experience this gap with greater frequency and impact. The challenge of ensuring access to specialty services in remote locations or the availability of long term care beds within a rural community is one that is faced on a daily basis. When community based services or solutions are not available, client must be moved to more expensive acute care facilities and can act as a potential "bed blocker" which affects waitlists and results in increased costs to the health care system. Availability of 24/7 respite care continues to be an issue in some areas. This is particularly of concern for palliative/end-of-life clients.

Impact on Vulnerable Populations

While the gaps and/or limitations in service delivery in rural and remote areas have direct consequences of not meeting the needs of many unique populations, there are a number of key populations that emerge across all locations (urban, rural and remote) continually as being vulnerable. These are the frail elderly, seniors living alone, clients with mental illness or dementia and palliative/end of life clients and families. Historically, it has been easier to address the needs of these populations in an urban setting where resources (system and human resource) are more plentiful and geographic challenges are limited. What are the consequences of not meeting the needs of these vulnerable populations for the rural and remote communities?

First and foremost is the tendency for premature admission to hospital and likely for a longer period of time. This then puts a financial and resource strain on the hospital and emergency services. It also affects the clients frame of mind as it is likely that they will need to leave their community setting and, depending on the nature of their ailment, may mean a permanent relocation to address continuing episodes of illness and/or subsequent treatment. This then escalates to the need for caregivers to make adjustments in their lives.

Another factor that needs to be taken into consideration is that of caregiver quality of life. In rural and remote areas respite programs are not as available as in urban locations. This leads to caregivers, particularly informal care providers, feeling isolated, exhausted and suffering from burn-out.

Innovation and Best Practices

Innovation is key in the delivery of home care in rural and remote communities because of the many facets that delivery entails in this area. The following must be taken into consideration: demographics, distance from urban centres, road conditions, weather, availability of family physicians and/or specialists, availability of alternative transport (e.g., air), availability of physicians/surgeons/nurses acquainted with the latest procedures and of course the economic and educational status of the residents.

Technology

In all three regions (British Columbia, Ontario and Nunavut) the innovative use of technology by way of telehealth, telehomecare, telemedicine and even telehospice was evident and highlighted throughout the responses. Telehealth and other technology based options are being taken advantage of. An example is the use of digital camera or video pictures to take photos of wounds or skin rashes and then these are electronically forwarded for consultation. Hospice accessibility is often an issue. A possible way of overcoming this is the "virtual hospice" accessed through a web portal. An example of use of this technology is www.pallium.ca. In September of 2004 a video "Living with Hope" was launched with the goal of fostering hope among palliative care patients and their caregivers. The video can be viewed from the above cited website. Also, The Caregivers Guide to End of Life Care has been translated into languages such as territories.

Although the use of telehealth and other technology applications are being used in rural and remote areas we need to be cognizant of the need to do more. We must also remind ourselves that individu- als in rural and remote areas often do not have the technological platforms required to host modern uses. Training and education programs must be made available to assist users to take full advantage of these technical provisions.

Specialists

British Columbia's Interior Health Regions (4) have adopted the concept of having a Nurse Wound Care Specialist at each of the Regions to provide training twice a year in each community and are generally available for consultation by phone and/or visit in both the hospitals and community. No Vacuum - assisted closure (VAC) thera- pies (a trademarked Negative Pressure Wound Therapy Device) can be used without their approval.

The Symptom Response Kit is a northern Ontario innovative initiative. A locked kit contains the medication which has been dispensed to the client. The nurse, when access to the medication is required, calls the physician who gives the required instructions to access the locked box and administer the medication.

"individuals in rural and remote areas often do not have the technological platforms required to host modern uses"

Nunavut has introduced a process where two doctors, on a regular basis, fly into communities to do full Geriatric assessments. Another innovative approach to home care is following the discharge from hospital of mother and baby. Three home care visits are made and then the fourth visit is made by the Health Centre in order to address the immunization needs.

Case Management & System Integration

All three jurisdictions are exploring innovative approaches to home care case management to use this function as a strategy for systems integration and optimizing community resources and support systems for the informal/family caregiver in rural and remote communities. The use of standardized assessment tools and reporting systems also supports the effectiveness of the case management function in determining client needs, allocating resources and planning future community programs.

Ontario: Community Care Access Centres in Ontario have implemented the Resident Assessment Instrument for Home Care (RAI-HC) province-wide. They are also involved with the implementation of management information systems, reporting standards and automation.

Nunavut: The Nunavut Home Care Program has been enhanced by the First Nations and Inuit Home and Community Care Initiative (FNICCI) that was designed to establish a complete range of home care services, which reflect the health and social needs of the citizens.

British Columbia: British Columbia's Home and Community Care Program, which provides a continuum of supportive health care services from community care to residential care, has focused on the development of their Independent Living and Assistive Living programs. They are also developing a comprehensive strategy for better end-of-life care.

Partnerships

The use of Partnerships has enabled some regions to establish Best Practices. Ontario's "NorthNet- work" is a good example of the use of communications and information technologies to assist in the delivery of clinical care, education and health-related administrative services.

Specific to the Cochrane District CCAC, partnership with North Network enabled the provision of Speech Language Pathology in Moosenee. Within the last school year it has been possible to provide this service to over 20 children through video conference. The initial assessment is carried out face-to- face in Moosenee (which does not have road access) and subsequent weekly visits are carried out via the telehealth access.

Recommendations

Home care programs providing services to rural and remote regions of Canada have developed innovative solutions to address their unique challenges. The number one challenge of lack of human re- sources (both formal and Informal caregivers) has a domino affect on other system capacities.

Availability of community resources is limited by lack of human resources, appropriate utilization of the health care system is impacted, and the client and family caregiver are often required to make difficult life-altering choices that require moving from their communities of splitting up their family unit. In response to this overwhelming challenge, home care leaders in rural and remote communities have developed and implemented a number of innovative programs that include:

- Leveraging partnerships to optimize local resources and build required capacity.
- Utilizing case management as a strategy for systems integration to maximize community resources and access resources outside the community.
- Empowering the client and family caregivers to promote independence and provide guidance and the appropriate use of scarce resources.
- Using technology to train, provide service, support family caregivers, decrease isolation and build health care teams.

While these innovations are positively impacting client and families in a number of communities, this project has just begun to bring forth some of the wealth of innovations and best practices taking place in home care delivery in rural and remote areas of Canada. Our challenge is twofold:

We must continue to support these communities and home care programs to enable them to maintain their best practices and explore new ways to provide services. This support should include both financial support and linkages with other programs that are experiencing similar challenges and have developed unique solutions.

We must share the experience and learning that is currently taking place in rural and remote communities with home care stakeholders across Canada so they to can benefit from the grass roots knowledge and programs that have been developed to serve this unique population.

"Share the experience and learning that is currently taking place in rural and remote communities with home care stakeholders across Canada"

To meet these challenges, the CHCA recommends the following:

- Provide targeted funding for rural and remote home care programs to develop and implement best practices that support primary health care and the development of partnerships to optimize resources and build support networks for human resources.
- Support (through funding and resources) innovative approaches to human resource challenges including the use of technology for training and education, provision of remote visits, support for the informal caregiver and specialty support for the health care professions (remote wound care programs, etc).
- Promote research on informal/family caregiver needs and coping strategies in rural and remote communities to determine the necessary supports required to reduce caregiver burnout and empower clients/family.
- Share rural and remote experiences and best practices across Canada by highlighting the findings of this report at the 2006 CHCA Home Care conference in a roundtable to gain input into the findings and stimulate new ideas in the delivery of rural and remote home care services.
- Fund a study that will build upon this preliminary report and conduct an in-depth review of the program and service innovations that are currently underway (detailed implementation strategies, lessons learned, outcomes, etc) in rural and remote home care programs.

Appendices

Appendix A – Rural and Remote Survey

Rural and Remote Home Care Questionnaire

LOCATION

Please identify the Province, Territory or specific Region in which you provide Home Care

CONTACT PERSON

Name: ..... Title: .....

Phone number: ..... Email address: .....

DEFINITIONS

Please Provide the definition used in your jurisdiction for:

- Rural
- Remote
- Acute Home Care
- Chronic Home Care
- Palliative Care/End of Life
- Care Best Practice

INNOVATION

List any innovative approaches you have adopted in the provision of Home Care and support of the caregiver

BEST PRACTICE

List any Best Practices you have in rural and remote Home Care including Telehealth and other technology applications

GAPS

Identify any gaps in home care service delivery.

VULNERABLE POPULATIONS

Which vulnerable populations (e.g. seniors living alone, family caregivers, clients diagnosed with mental illness) are affected by gaps and/or limitations in service delivery?

CONSEQUENCES

What are the consequences of not meeting these needs in rural and remote communities?

Appendix B – Inclusion Criteria and Interview Protocol

Criteria for follow up with Three Provinces and or Territories

As a follow up to the cross Canada survey that CHCA has conducted as a part of the project follow up

- Informant willing to participate
- Informant has completed survey
- There is a significant percentage of Rural and or Remote Home Care
- provided within the jurisdiction

Interview Protocol

INTRODUCTION

Thank you for agreeing to be interviewed as a part of the project looking at the Delivery of Home Care Services in Rural and Remote Communities in Canada. As you know the intent is to identify Service Gaps and Examine Innovative Practice.

The questionnaire that was completed for ---------- (Province/territory)

by ----------(Name) identified an number of areas that I would like to find out more about.

A number of Innovations were listed, I wonder if you would tell me about

List at least 3 points for each jurisdiction, check for any similar projects

Several Best Practices were listed in the response please tell me more about

List 3 Best Practices for each Jurisdiction

There are some consistent gaps identified across the country tell me more about Seniors lacking informal supports

Family Care Givers

Clients with Mental Illness

Palliative Care clients

There are consequences of not meeting needs in Rural and Remote areas.

What impact does this have on?:

-Hospital use

-Long term Care facilities

-Quality of life of clients and caregivers

Please will you forward any documentation that you have which you are able to provide that can be shared with Health Canada and other Provinces and Territories. We hope that this will be the beginning of a meaningful exchange of experience as well as Best Practice.

Thank you for your valuable input

Appendix C – Provincial/Territorial Contacts

British Columbia: Karen Ritchie, Interior Health Region (East Kootenay Region of B.C)

NAME/TITLE: *Karen Ritchie, Clinical Practice Consultant*
PHONE NUMBER: *250- 420-2247*
EMAIL ADDRESS: *karen.ritchie@interiorhealth.ca*

Manitoba: Antoinette Zloty, Government of Manitoba

NAME/TITLE: *Antoinette Zloty, Consultant* PHONE NUMBER: *204-788-6634*
EMAIL ADDRESS: *azloty@gov.mb.ca*

Ontario: Tina Sakr, Natalie Diduch (Questionnaire), Home Care and Community Support Branch, MOHLTC Sharon Marsden (interview)

NAME/TITLES: *Tina Sakr/Natalie Diduch, Program Consultants*
PHONE NUMBER: *Tina: 416-314-1146 Natalie: 416-314-1197*
EMAIL ADDRESS: *tina.sakr@moh.gov.on.ca, natalie.diduch@moh.gov.on.ca*

Nova Scotia: Susan Weagle, Director, Standards & Policy Development

NAME/TITLE: *Susan Weagle, Director, Standards & Policy Development* PHONE NUMBER: *902-424-5129*
EMAIL ADDRESS: *weaglesj@gov.ns.ca*

PEI: Mary Sullivan, Provincial Coordinator Home Care

NAME/TITLE: *Mary K Sullivan, Provincial Coordinator Home Care*
PHONE NUMBER: *902-888-8005*
EMAIL ADDRESS: *mksullivan@ihis.org*

Newfoundland and Labrador: Debbie Morris, Regional Consultant, Department of Health and Community Services

NAME/TITLE: *Debbie Morris, Regional Consultant* PHONE NUMBER: *709-753-1699*
EMAIL ADDRESS: *debbiemorris@gov.nl.ca*

Nunavut: Gogi Greeley, Territorial Home & Community Care Coordinator

NAME/TITLE: *Gogi Greeley, Territorial Home & Community Care Coordinator*
PHONE NUMBER: *867-979-5839*
EMAIL ADDRESS: *ggreeley@gov.nu.ca*

Yukon: Liris Smith, Manager of Community Care

NAME/TITLE: *Liris Smith, Manager of Community Care*
PHONE NUMBER: *867-667-3607*
EMAIL ADDRESS: *liris.smith@gov.yk.ca*

North West Territories: Ialeen Jones, Health and Social Services

NAME/TITLE: *Ialeen Jones, Senior Nursing Consultant, Home Care Phone: 867-920-8746*
EMAIL ADDRESS: *Ialeen_jones@gov.nt.ca*

To find out more other initiatives we invite you to contact us at the Canadian Home Care Association 613.569.1585 or visit our web-site at: www.cdnhomecare.ca