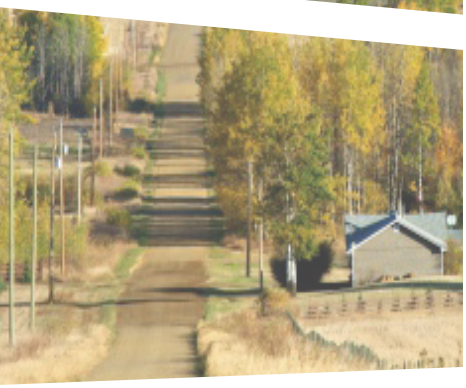

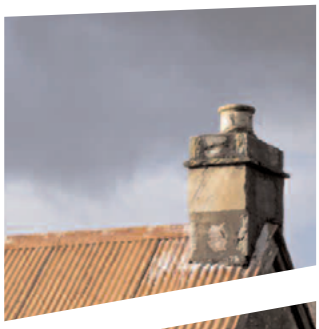

Delivering Home Care in Rural, Remote and Northern Regions of Canada

A Scan of Options

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

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Executive Summary

The demand for effective and efficient home care is a challenge facing the Canadian health system, in large part due to the growth of our aging population, the advances in technology and the economic realities of hospital care. Since the early 1990's home care programs have evolved and grown in response to changes in the acute care sector (bed closures, increase in ambulatory care clinics, and day surgery) and limitations in the long term care sector (waiting lists for beds, limited availability). Through this evolution, home care has emerged as an essential element of the health care system. As provincial, territorial and the federal government (federally funded programs for First Nations and Inuit, Veterans Affairs) shift their policy focus from provision of care in an acute care setting to provision of care "closer to home", it is critical that home care policy planners and administrators understand the challenges of providing this care in rural an remote settings.

Research shows that the health care delivery system in rural and remote areas is significantly less than that which is offered in urban settings. According to a 2006 scan of rural and remote home care programs, undertaken by the Canadian Home Care Association (CHCA), the main challenges all programs face is a lack of health human resources, lack of support systems and local resources, limited transportation, and the requirements to travel long distances and hours to see very few clients. In response to the challenges of delivering health care in rural and remote settings, new and emerging delivery approaches are showing promise of better serving these communities. The need to gain an in-depth understanding of the challenges and innovative approaches to health care in rural and remote settings was the basis for this initiative. This project explored home care services in three distinct communities across Canada in order to gain a comprehensive understanding of the challenges and solutions from a client perspective, a provider perspective and a system perspective. The project attempted to address the question of how a rural and remote setting influences the implementation of home care policy and direction. The findings will be used to inform public policy development and enable sharing of leading and successful practices. A total of six days of community visits in the three locations – Northern Lights Health Region in Alberta, North Simoce Muskoka Community Care Access Centre in Ontario and the Eastern Health Authority in Newfoundland & Labrador – were undertaken in order to gather an in-depth understanding of the challenges and approaches to home care delivery. The CHCA is grateful to the three sites for their willingness to share and for organizing meaningful visits which included time with frontline staff and clients.

Defining Rural and Remote

The notion of rural and remote is not only an issue of quantification (distance and population). Remoteness can be defined by the individual's connectedness to a social support network of any kind, and to the health care system, both in terms of access and contact. Time and effort to access or provide care are key elements of the rural and remote context. It is therefore possible to have the same set of challenges of being remote in a large urban centre. From the isolation perspective, individuals who are economically disadvantaged or in a minority group experience many of the same issues described by those with geographic barriers to health care. Communities of interest, whether rural or urban, are defined by a common bond (e.g. feeling of attachment) or entity (e.g. farming, church, or cultural group). Where present, these groups can be a source of support for individuals living in rural and remote settings.

Key Findings

The findings from the three sites suggest that health care delivery in rural and remote settings is achieved through a mix of:

- client resiliency;
- provider creativity and initiative; and
- system flexibility.

The major challenges for clients are the absence of family supports in the rural setting and the distance to accessing care; for providers, the recruitment and retention of staff; and for the system the need to deliver cost-effective and efficient health care services.

Client Resiliency

The foundational premise of health care delivery is that clients want to remain in their homes for as long as possible. Clients recognize that their decisions to live in rural or remote settings impact the nature and approach of their health care services; however they believe that their rights regarding health care should be equitable to those in urban settings. Clients are pragmatic and accept the limitations associated with where they live, but challenge providers to develop innovative approaches and policymakers to advance policy in order to achieve a greater balance between the rural and urban settings. There is a heavy reliance on family and community to support the delivery of health care. In rural and remote communities, out of necessity, the paid staff may be a family member who also assumes the informal caregiving role. The burden placed on these individuals can become excessive and impact their family relationships.

Provider Creativity and Initiative

The limited health human resource supply is a reality across the health care system. With few exceptions those in home care experience a lower rate of compensation when compared to their institutionally based colleagues. Compounding the discrepancy for those providing care in rural and remote settings are issues of risk and cost related to travel; issues of loneliness and safety; and challenges to clinical skill and knowledge development. Pairing staff and working closely with community based volunteers are effective means for proving to addressing safety concerns. Health care systems need to introduce strategies to respond to compensation and career development of those working outside of the centralized services within the urban settings.

Staff supply, in many cases, dictates the amount of service that can be provided. Clients and their families are expected to cope and do. It is not known however, whether outcomes are compromised; or if in fact, the urban context is too supportive creating an excessive level of dependency on the system. The paradigm of home care service delivery in rural and remote settings being inadequate when compared to the urban setting may need to be shifted so that the city benchmarks its service levels to the rural reality.

System Flexibility

Technology is described as an enabler for access to health care in rural and remote settings and an important means for more effectively and efficiently serving the broadly dispersed population. However, technological capacity is also a limiting factor to accessing health care for some communities. The inability to utilize cellular communications and establish electronic linkages for telehealth or telemonitoring further disenfranchises those in rural and remote settings escalating the level of isolation and inability to access care. Of note is the fact that there are densely populated geographic locations within Canada proximal to urban settings that have limited cellular and electronic linkage. The potential of technology to enabling access to care, care delivery and provider support is significant and accordingly, rural and remote settings of care need to become the priority for investment.

This project examined the home care delivery experience in three very different, albeit rural and remote settings in Canada. Staff and clients opened their doors and spoke frankly about their efforts to secure quality health care. This final report serves to share the experiential data from the site visits and provide analysis and recommendations drawing on the knowledge and expertise within the CHCA. The approach taken is to comment on findings from the system, provider and client perspectives and provide insights that can be helpful to informing public policy.

Introduction

Background

The demand for effective and efficient home care is a challenge facing the Canadian health system, in large part due to the growth of our aging population, the advances in technology and the economic realities of hospital care. Since the early 1990's home care programs have evolved and grown in response to changes in the acute care sector (bed closures, increase in ambulatory care clinics, and day surgery) and limitations in the long term care sector (waiting lists for beds, limited availability). Through this evolution, home care has emerged as an essential element of the health care system.

The Canada Health Act recognizes home care as an element in the category of "extended health services", and, as such, it is not an insured health service to which the principles of the Act apply. Currently nine provinces have legislation related to public home care through various acts and policies. Other provinces and territories have orders-in-council or guidelines that direct the delivery of their home care services. Despite this lack of legislative framework, all 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. Based on a review conducted by the Canadian Home Care Association (CHCA) in 2006, 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. 35% of Canadians expressed dissatisfaction with access to home and community care in 2003.[1]
- **Shortage of Human Resources:** 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.

While these four factors reflect pan-Canadian challenges, they are compounded in rural and remote settings. Residents living in rural and remote communities tend to have poorer health and socio-economic status and face barriers accessing health services.[2] Research has shown that those living in rural settings have poorer health outcomes. Life expectancy is estimated at four to five years less than the Canadian average.[3]

The recent focus on provincial/territorial home care programs through the Health Accords, and specifically the 2004 Accord where agreements regarding the provision of short-term acute home care, short-term acute community mental health home care and provision of end-of-life care were made, has resulted in increased efforts by governments across the country to ensure that home care services are provided universally to Canadians. However, realizing

this commitment in rural and remote communities across Canada is challenging and currently, the home care needs of Canadians in rural, remote and northern areas of Canada are not well addressed.[4] Research shows that the health care delivery system in rural and remote areas is significantly less than that which is offered in urban settings. According to a 2006 scan of rural and remote home care programs, undertaken by the CHCA, the main challenge all programs face is lack of health human resources; including doctors, nurses, nurse practitioners, and home support workers as well as the limited number of informal / family caregivers in rural and remote communities. This challenge is compounded 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.

With the outward migration of younger people from rural/remote areas and inward migration of the elderly[5,6]; lean budgets in health and social services driving centralization of health care delivery; the transfer of caregiving responsibilities to family, friends and community; as well as the growing pressures of an aging population, most rural and remote communities across Canada struggle to provide health and community services.[7] This situation has a domino affect on other system capacities. For example, the availability of community resources is limited by a lack of human resources; individuals use the most available health resource, often the hospital emergency department and so appropriate utilization of the health care system is impacted. Ultimately, the client and family caregiver are required to make difficult life-altering choices that require moving from their communities and the splitting up of their family unit. All these factors have a huge impact on the most vulnerable - the frail elderly, those living with chronic diseases, individuals with mental illness or dementia, and/or individuals requiring palliative / end-of-life care and their families.

While there is no single definition for the rural and remote context (there are at least six alternate definitions of rural available)[8], 95 to 99.8 percent of Canada's land mass is considered "rural" and communities with less than 10,000 residents account for 22.2 percent of the population… 6.4 million Canadians.[9,10] The senior population within rural areas represents almost 23 percent of this population.[11] Given these statistics, the magnitude of the health care issues is significant and it remains important and challenging to ensure that health care is maintained at a level comparable to those in urban areas. Geography does matter when considering the health of Canadians living in rural and remote areas of Canada.

In the face of the challenges to deliver health care in rural and remote settings, new and emerging health care delivery approaches are showing promise of better serving these communities. The need to understand the challenges and innovative approaches to health care in rural and remote settings in order to inform public policy development and enable sharing of leading and successful practices was the basis for this initiative. This report is intended to provide information about possible options on how to address the issue of home care service access to Canadians living in rural, remote and northern regions. The report explores the application of provincial home care policies and directions and how they are impacted by the unique challenges of rural and remote locations and the limitations in access to health care services that are generally expected in urban settings. It is important to understand how home care policies are implemented and how the consequences, in terms of accessibility and quality, of not meeting the home care needs of those living in rural, remote and northern regions has potential implications for the broader health care system.

Specifically the project objectives were to provide:

- a comprehensive description of three rural, remote and/or northern health care programs along with a thorough analysis of the program components conducted from three perspectives (1) the health care system (2) the service provider (3) the client
- information on possible options to address the issue of health care service access to those living in rural, remote and/or northern areas
- the CHCA and Health Canada with useful policy relevant information and serve as a foundation for policy options development
- support for knowledge transfer of new ideas and approaches amongst jurisdictions faced with similar challenges of rural and remote service delivery.

Approach

In order to obtain a deeper understanding of home care delivery in rural jurisdictions that rarely comes across through telephone interviews, site visits were made to three home care programs providing service to rural and remote communities. The definition of rural and remote was, for the purpose of site selection for this project, interpreted to be *communities with less than 10,000 residents and to be greater than one hour by car from a large urban centre.* Determination of the jurisdictions to visit was made in collaboration with the CHCA advisory committee and staff from Health Canada. The priority was to have representation from diverse regions in Canada; and to work with home care programs that provide a full complement of home care services in order to depict ideas and approaches that would be relevant to the broadest home care applications. The sites were assessed according to the criteria listed below. While there was no formal ranking system established for the criteria, the sites were tested to ensure that the final three locations were diverse and reflected a range within each criterion.

- Population density – rural and/or remote community as defined by Statistics Canada
- Respondent to 2005/06 analysis funded by Health Canada[12]
- Size of home care program (funding and number of clients)
- Population profile
  - Average age of population
  - Percentage of seniors
  - Population dependency ratio
- Economic status of the community
- Availability of program staff for interview and on-site analysis (essential)
- Recent and/or current initiatives with specific demonstrable outcomes
- Initiatives that employ technology; human resources; system integration
- The priority afforded to home care and aging in place

The definition of rural and remote was, for the purpose of site selection for this project, interpreted to be communities with less than 10,000 residents and to be greater than one hour by car from a large urban centre.

Introductory letters to the home care Chief Executive Officer of the identified sites were sent and follow-up telephone discussions about the nature of the work were conducted. A site visit protocol and interview guide were sent to assist the programs in planning for the visit. Several locations were approached and all were enthusiastic about the project; however workload and scheduling issues precluded many from participating. It therefore took longer than originally anticipated to schedule the site visits.

A qualitative analysis using in-person interviewing with open-ended questions was conducted with providers, including administrative staff and frontline providers, and clients in the three sites. The visits to the home care programs were two to three days in duration and provided the opportunity for extended dialogue and observation, enhancing the quality of the findings. Summaries of the experience, observations and home care program components specifically designed to address those living in isolated communities were documented and checked for accuracy by the key contacts in the sites. (A listing of contacts is available at Appendix A)

The experience, observations and strategies employed by the sites were shared at an interactive workshop held during the CHCA 2007 Home Care Summit in December 2007. Participants in the workshop offered their insights and recommendations through a facilitated dialogue on the issues relating to home care in rural and remote settings from across the country. The information captured in the proceedings of the workshop has been used to enhance the information within this report.

Throughout the initiative, the CHCA Board of Directors served in an advisory capacity for the project to provide direction, examine the analysis and develop recommendations.

This final report serves to share the experiential data from the site visits and provide analysis and recommendations drawing on the knowledge and expertise within the CHCA. The approach taken is to comment on findings from the system, provider and client perspectives and provide insights that can be helpful to informing public policy.

Site Selection General Statistics

The description of the three sites on next page reflects the findings using the identified criteria mentioned above. The sites represent a mix of west, east and central Canada and mix of geographical elements. The sites have different population issues and reflect a range within the financial indicators. All sites deliver home care services under their respective provincial regulations and directions and were able to accommodate site visits. Below is a summary of the site elements by selection criteria.

	NORTHERN LIGHTS HEALTH REGION, ALBERTA	NORTH SIMCOE MUSKOKA CCAC, ONTARIO	EASTERN HEALTH AUTHORITY, NEWFOUNDLAND LABRADOR
CRITERIA	REGION		
	WESTERN CANADA	CENTRAL CANADA	EASTERN CANADA
POPULATION CHARACTERISTICS	Population growth - temporary & permanent inward migration	Variety of population challenges: - largest province - greatest population growth - CCAC neighbours Toronto – largest city in Canada - Shifts in pop'n in CCAC region due to tourism	Declining population: - temporary & permanent - outward migration
GEOGRAPHIC FEATURES	- Landlocked ~ 56 degrees latitude - 192,509 sq km	- Mix of islands, land ~ 45 degrees latitude - 9,200 sq km	- Impact of Island ~48 degrees latitude - 21,000 sq km
ECONOMIC STATUS – POPULATION IN PRIVATE HOUSEHOLDS – INCIDENCE OF LOW INCOME[13]	- 12.6%	- 16.9% (Muskoka-Nipissing and Parry Sound DHC)	- 22.7%
RESPONDENT (PROVINCE) TO 2005/06 ANALYSIS[14]	No	Yes	Yes
HEALTH-CARE (PROVINCE) 2005 EXPENDITURE / CAPITA[15]	$4,819.99	$4,595.23	$4,400.54
HOME CARE SERVICES[16]	- Nursing - Home Support - Therapy - 3% of Region's total health expenditures which were $107.8 million (2006-07)	- Nursing - Home Support - Therapy	- Nursing - Home Support - Therapy
SIZE OF HOME CARE PROGRAM	- ~$3.2M - 26,615 hours of service[17]	- 627,000 hours of personal support service - 329,000 visits[18]	- 172,616 visits[19]
HOME CARE (PROVINCE) EXPENDITURE / CAPITA[20]	- $82.00 (2005-06) - Includes home care services only & does not reflect other community based services	- $124.96 (2006-07)	- $185.00 (2006-07) - Includes home support only
RECENT AND/OR CURRENT INITIATIVES WITH SPECIFIC DEMONSTRABLE OUTCOMES	Telemonitoring	To be determined	To be determined
AGING AT HOME	- Provincial Aging in Place Strategy[21]	- Provincial Aging at Home Strategy announced[22]	- Clarenville & Port Hope Simpson participating in research on supports for aging pop in rural & remote[23] areas
INITIATIVES THAT EMPLOY TECHNOLOGY; HUMAN RESOURCES; SYSTEM INTEGRATION	Yes	Yes	Yes
AVAILABILITY OF PROGRAM STAFF FOR INTERVIEW AND ON-SITE ANALYSIS (ESSENTIAL)	Staff available	Staff available	Staff available

Summary of Findings & Analysis

Definition of Rural and Remote

There is no universally accepted definition for rural, remote and northern since these spatial concepts cannot be sufficiently defined to reflect the unique and dynamic nature of the various regions and communities across Canada.

Rural geography and demographics (e.g., economies, societies and cultures) vary considerably across the country and within regions. This project was undertaken using the definitions established by the CHCA in its earlier work; that is that rural settings are those with "small populations and low population densities and/or a relatively large distance from major urban centres" and remote settings are those "geographically isolated (difficult to access, a distance from a main route) with small populations".[24] However, those in the sites visited for this project portrayed the rural and remote context as 'relative' and reflecting degrees of isolation. The findings of this project suggest that rural and remote is not only an issue of quantification (distance and population).

Remoteness can be defined by the individual's connectedness to a social support network of any kind, and to the health care system, both in terms of access and contact. Time and effort to access or provide care are key elements of the rural and remote context. It is therefore possible to have the same set of challenges of being remote in a large urban centre. Overall, health care delivery in rural and remote settings appears to be achieved through a mix of client resiliency; provider creativity and initiative; and system flexibility. It is through the perspective of client, provider and system that this report is written. The major challenges for clients is the absence of family supports in the rural setting and the distance to care; for providers is recruitment and retention of staff; and for the system the need to deliver cost-effective and efficient health care services. Cost-effectiveness and efficiency have been long-standing health system drivers; however escalating health human resource shortages coupled with the aging population and the projected associated health needs have resulted in the centralization of health services. These challenges are fundamental to the issues of home care delivery in rural and remote settings.

Toronto—A Remote Community in Canada's Largest City

The Toronto Central Community Care Access Centre delivers home care services to individuals who reside in a "rural and remote setting". Canada's largest city has an island which is home to a small number of residents and is accessible only by ferry. While only a 20 minute ferry ride, there are weather circumstances that preclude travel and compromise the islanders' access to care. There are no vehicles on the island and so travel around the island is limited.

As in other jurisdictions, providing services daily is a challenge and more frequently almost impossible. Coordination of the delivery of supplies and equipment is challenging. The home care team relies on volunteers to oversee immediate client care concerns; and is currently fortunate to have a part-time nurse who works in the city volunteer to support those in need in the community.

As in the three sites described in this report, there are no specific service metrics related to service on the island. The leadership team knows intuitively that there are variances to typical urban metrics in order to provide care to residents in this remote setting.

Client Perspective on Rural and Remote Home Care: "Limited Access to Services"

Travel and Transportation

Living in a rural setting means that access to care is more difficult. There is greater distance to travel for hospital, physician and/or specialist care and additional costs to bear for those whose costs are not covered through other programs – such as more time off work and loss of pay; greater transportation related costs; additional out-of-pocket expenses for meals and often overnight accommodation as the travel cannot be completed in one day. If transported by ambulance, the hospital closest to home might be bypassed because of a number of system issues such as physician admitting privileges, the nature of services available, emergency and/or in patient bed capacity. The inability to receive care at the closest hospital translates to increased effort and cost for the client and their family in order to access health care.

Research has shown that individuals living in rural and remote settings have lower income and so the issue of cost is significant.[25] A family caregiver expressed frustration at having no option but to use an ambulance in order to get the client to appropriate care and having to pay for those ambulance costs because of being employed. If living in the urban centre, access to care would be easier and if on social assistance, the cost would be absorbed by the province. Access is influenced by transportation and community infrastructure that supports transportation. A rural allowance for clients on home care services in order to subsidize travel costs (as is the case for First Nations Inuit clients through Non-Insured Health Benefits) related to accessing health care would help to balance the cost barriers to care.

Lack of Available Services

Clients' use of emergency services for primary care is greater in rural than urban settings.[26] This is in part due to the absence of other primary care services and / or home care services. The increased utilization may be the only option and care must therefore be taken when evaluating system effectiveness in order to determine the root cause of utilization. The establishment of some forms of 'primary response teams' for individuals living in rural/remote settings so they can avoid emergency/ acute care utilization might address some of the challenges with accessing care and appropriate system use.

Long term care services are also often a great distance from the client's home community. Individuals reported that clients may remain in the community longer than appropriate or than would be the experience if in an urban setting, because of the travel burden that would be placed on the family once placement is made. "…there is a level of tolerance for seniors who experience dementia as they age…as the closest Alzheimer unit is two hours away…" However, conversely, some clients are admitted to long-term care facilities prematurely; if there was more frequent and accessible care and support in their rural/remote home community they would be able to stay at home.

Limitations on Service Delivery

Clients do not receive home care services with the same frequency and intensity as in the urban setting. This is because of the distances between clients with the limited availability of staff make it impossible to undertake as many home visits in a day as in the urban setting. Additionally, access to clients in rural and remote settings can be restricted as a result of weather. Access to island communities can be limited for example until water is completely frozen or thawed; power outages, fallen trees, flooding and snow can result in clients being isolated for days. Family members must be willing to provide care on their own and/or rely on telephone support for guidance of health care concerns. The implementation of technology solutions to enable remote monitoring would help to ensure timely intervention in response to changes in clinical status.

Where medication and supplies costs are not absorbed by the home care program (Alberta and Newfoundland & Labrador), this cost further challenges clients when accessing home care. Some clients admitted that they make choices about which medications and/or medical appointments to make. Possible solutions to this challenge may include the establishment of a compensation program to ensure access to drugs, supplies and equipment for short-term treatment (up to thirty days) initiated in hospital and continued in the community.

Reliance on Increasingly Limited Family Caregivers

It is generally believed that there is a culture of caring in rural settings. However, there was mixed feedback about the extent to which individuals in rural and remote settings can count on their community for care support. The outward migration of the younger population in search of jobs has significantly impacted the balance provided to communities by young adults whose presence enhance safety (the police may not be readily accessible), who support children's activities and who provide general assistance through volunteer organizations. Clients typically rely on family to provide care; a situation that may necessitate time off work and for some returning from out of province for a period of time.

A Pragmatic Approach

The clients that were interviewed for this project value the rural life style. They recognize though that where they choose to live affects their ability to access care. They appeared to be quite pragmatic about their circumstances and grateful for the efforts of health care staff that travel to provide them with care in their communities and/or homes. They accept that they cannot often know when their health care provider will arrive. Some communities manage without service for months at a time and many cope with no more than once a week visits from the home care team. Clients therefore must be willing to manage their own care. Notwithstanding the pragmatism and patience that clients demonstrated, many individuals expressed the opinion that more should be done to compensate them for the challenges they experience in accessing health care. Strengthening the community is vital to the delivery of home care in rural and remote settings. Expanding and developing community capacity to support individuals to remain at home for as long as possible requires cross-ministerial initiatives to promote neighbourhood caring and outreach; and includes transportation, justice, volunteerism and education strategies to enhance awareness about the needs of the vulnerable.

Provider Perspective on Rural and Remote Home Care: "Limited Human Resources"

Approaches to Service Delivery

Delivering health care in rural settings is challenging and more labour intensive primarily because clients are so dispersed and there is an absence of a critical client population. A concentration of clients allows for efficiency, skill development and the honing of expertise within the staff. Centralization of the health care system responds to the need for efficiency and maximization of a limited human resource pool. However, the human resource strategy outside of the urban setting must be driven by staff empowerment and flexibility. Making the most of a visit with a client is essential. Furthermore, the system needs to recognize the value of technology to support 'virtual visits', be it by telephone or computer; reserving the resources for in-person visits to those with greatest need. The outcomes being realized through the telehomecare monitoring in the Northern Lights Region is exciting and promising. Expediting the implementation of telehomecare would bridge the gaps in home care service created as a result of staffing shortages and access challenges related to geography.

Skills, Training and Expertise

Developing and maintaining expertise for various skills is difficult and as a result some acute care services typically found in the urban setting, such as home based intravenous therapy, are not available. The issue relates to having enough need in order to apply the skill and having the opportunity to provide the training, which typically must be received in the urban centre. Choosing to send staff for education and training means that they are not available for client service further compromising client access to care – a vicious cycle. Technology based continuing education and skills development programs for staff are potential solutions that would help staff with their continuous learning needs; and would help to ensure consistency from acute care to home.

Home care staff require broad general health care knowledge, excellent assessment and problem solving skills, a fearlessness of the unknown and unpredictable and the ability and confidence to function independently. In many situations staff know that there will not be a health provider back to see a client for a week, and so they are compelled to make tough decisions about whether individuals are safe to stay at home or should be sent "into town" where they might be turned around and sent home again.

Expectations regarding the ability of home care programs to deliver intravenous therapy are not realized in rural and remote settings. There are issues of staff skill development relating to the initiation of intravenous lines; and without access to physician/emergency support, first dose intravenous medication cannot be safely administered. In addition, intravenous medications cannot be administered where special preparation within a pharmacy that would not typically be available in community pharmacies (such as use of a laminar flow hood) is required; or where the timing between medication preparation and delivery may be time sensitive and the client's location is not close.

The human resource strategy outside of the urban setting must be driven by staff empowerment and flexibility. Making the most of a visit with a client is essential.

Collaboration and Integration

Collaboration amongst the health team was observed to be more limited than expected. Staff declared that this is in part due to the turnover rate and/or shortages of staff. Providers are just too busy and struggle to find time to work together to develop care strategies. While provincial mandates and policy directions reinforce collaboration there are a number of inherent challenges in the system that inhibits successful models. Physician compensation, communication systems, high turnover and limitations on available time to build partnerships are key challenges that are experienced by all rural and remote sites. In some communities, physicians particularly rotate in for a few weeks or months and when they are replaced the plan of care and nature of communication between the health care providers often changes.

An emphasis on building strong partnerships to support proactive and integrated care was a particular priority in Ontario as evidenced in their efforts to initiate linkages between home care case mangers and family physicians and their practices.

All jurisdictions recognize the development of partnerships, collaboration and effective integration of care at the frontline are essential to support the delivery of home care, however rural and remote challenges often impede the implementation of this policy direction. These initiatives need to be supported by a wireless infrastructure and/or satellite supported communication devices to enable better collaboration amongst providers and provide enhanced safety for providers. Within the home care team, isolation amongst frontline home care providers is of concern to employers who identified the lack of contact with colleagues as one of the main reasons for staff turnover.

Limitations on Time and Managing Expectations

Time specific service cannot generally be delivered because of issues of travel, weather, and coordination of the delivery of supplies and equipment. For some clients, the efforts required for coordinating delivery of supplies means that 24 hours, or more, of notice for home care referrals is required. Members of the health care team who do not understand this reality sometimes establish unrealistic expectations for families and become frustrated by delays that are inherent to health care delivery in rural and remote communities. The dispersion of clients means that more staff are required to serve the population and in the face of the health human resource shortage, the ability to provide more than weekday service during normal 'business hours' is limited. This is in sharp contrast to urban settings where home care staff is expected to deliver services as needed (including more than once per day) seven days per week.

With a limited number of local health care providers to whom clients can be referred, case managers spend a greater amount of time coordinating care. A referral to the urban center often requires that the case manager arrange for the client's travel and accommodation logistics. A change in appointment time by the referral setting can be hugely complex for people traveling from the rural setting.

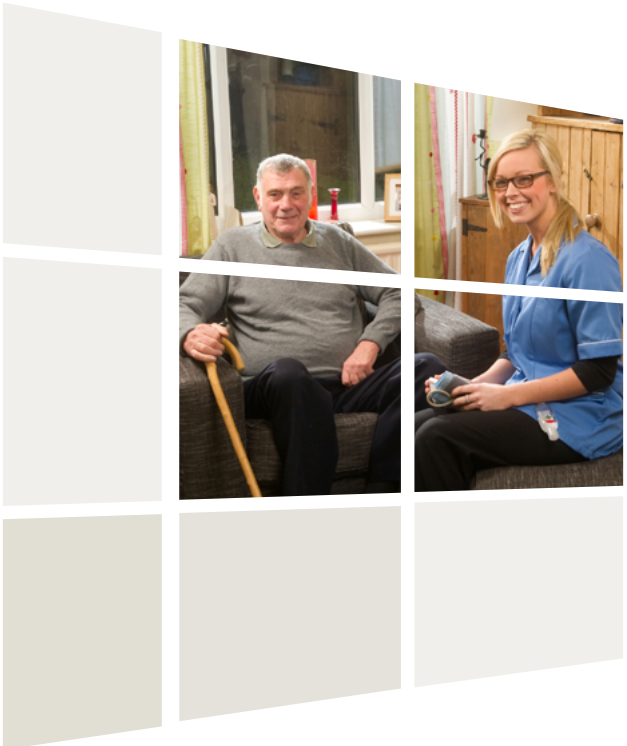
Staff Safety

Staff safety is a significant issue to delivering care in rural and remote settings. A road washout or severe snow storm may mean that staff is stranded for hours if not longer. Issues within client homes are sometimes of greater threat in isolated areas. Specific tools essential to assisting staff include cell phones, satellite phones, emergency kitbags and appropriate transportation. Depending on the season, staff use boats, skidoos,

four-wheel drive vehicles and in some situations air transportation. Policies and home care policies and procedures provide guidelines for staff who work alone. The three sites reported that they will double up staff if there are safety concerns. The second person may be a nurse, member of the care team, or police. Another approach used is to require that clients receive their care in a clinic within one of the home care satellite offices.

Staff Profile

Providing home care services in rural and remote settings appeals to a certain type of person. Compensation is typically less than in the institutional sector[27]; and so the motivation for staff is often intrinsic. Staff describe the attraction to this work as being multifaceted – "autonomy", "diversity", "respect for clients and from clients" and "flexibility in practice" are some of the words used. Addressing the compensation disparity within home care and across health sectors would serve to reinforce the importance of home care services to the health care system.



System Perspective on Rural and Remote Home Care

Responsiveness & Evaluation

Across the country, the shortage of staff and cost pressures within the health system has necessitated centralization of care in order to effectively respond to the demands for health care. Health regions have consolidated and many services have centralized. While practical and efficient for the 80 percent of the population that lives in urban centres, there remains a need to respond to those residing in rural and remote settings where it is difficult to achieve economies of scale or efficiencies.

There are no rural and remote metrics at the regional, provincial or national level for funding and evaluating care. This situation ignores the increasing challenge of responding to the health care needs of Canadians residing in the vast rural and remote geography. The needs of those in rural and remote settings impact all aspects of the health system. Utilization of hospitals, for example, may be for primary care due to an absence of physicians. Length of stay within acute care facilities can be positively impacted by the ability to provide care close to home; however, where services such as complex intravenous therapy cannot be provided in rural and remote settings, clients remain in hospital increasing length of stay statistics. A mechanism that ensures within planning, funding and execution of home care services that there is recognition of the rural / remote context is necessary to enable effective planning. It was suggested that the RAI–HC be modified to capture rural and remote specific indicators.

System Efficiency and Cost Constraints

Those tasked with delivering care in rural and remote settings express the importance of continually justifying the expense of care delivery; and explaining the system utilization patterns that individuals are required to make. For example, the shortages of health human resources, particularly the absence of family physicians, means that clients whose needs cannot be met by the home care team seek care in the emergency department. When their needs are not of an emergent nature, clients may wait for hours for service and may feel guilty for accessing care in this way.

Within home care, administrators report that they consider the rural context when reviewing performance indicators, but that consideration is intuitive. Home care leaders know that staff workload needs to reflect the additional travel that is necessary; but none apply a formula or additional funding for services provided in rural and remote communities.

Clinical integration is greater in rural and remote settings and staff often fulfills multiple roles. A nurse may, for example, fulfill home care and public health responsibilities. Nurses were also observed to be responsible for a wide variety of tasks including general clinic maintenance, clerical duties and nursing care. While there is much emphasis on leveraging and maximizing capacity in health care, the reality in rural and remote settings is often that the individual must be prepared to do whatever is required.

It was noted that the opportunity for staff participation in non-clinical organizational work, such as safety, quality improvement committees, was believed to be decreased in many situations as a result of the challenges (distance, impact to client care) to bringing staff into the office.

Equitable Services

The amount of services offered to individuals within rural and remote settings is generally acknowledged to be less than in the urban context. The three sites all confirmed that daily visits are impossible and many clients and communities manage with limited direct support from the home care team. The amount of service is essentially defined by the resources and yet many clients do well with their service level. Staff provided many examples where clients who relocated to the rural setting (for vacation with family for example) were initially shocked by the reduced levels of home care service available but found that they could cope on their own. They experienced increased independence and confidence in their ability to manage their health concerns.

Issues of health service equity are challenging as funding, training and resources are not available to provide comparable levels of service in the rural and remote communities as in the urban settings. Provision of the full scope of home and community care services outside of urban centres is challenging.

A Flexible Approach

Adapting to the real and daily challenges of delivering home care services in rural and remote areas requires a system flexibility that is not generally incorporated into provincial policy approaches. There is a necessity to learn from each other and to be able to benchmark and share each other's accomplishments and lessons learned. Home care leaders at all three sites expressed an interest in the development of a vehicle for stakeholders to share information, and promising practices about the types and approaches to service delivery. The implementation of information technology to support communication and front-line service delivery and the ability to track and trend clinical outcomes and service delivery effectiveness will inform funding and planning within these challenging home care settings.

Conclusion

Canada is the second largest country by size in the world. Approximately 80 percent of the population within Canada lives in urban centres and not surprisingly, health care policy is centred on the urban context. Urban based policies and practices however, do not always translate to the rural and remote setting—a notion without standard definition.

This project provided an opportunity to examine home care service delivery outside of the typical urban setting and in traditional rural and remote areas. While there was significant variation in the three regions their issues were very similar. The variation resulted from different policy initiatives and priority focuses as well as unique community and geographical challenge. The similarities reflected the common challenges of addressing limited human resources, lack of community resources and increased burden on family caregivers. The solutions relate to a mix of client resiliency; provider creativity and initiative; and system flexibility.

Clients need appropriate access to the health care system; but shortages of health personnel, inflexible and under-resourced health care systems and overall depopulation in rural and remote communities challenge the system's ability to respond.

Providers need to be safe, valued and supported to provide quality service to those placed in their care. Again staff shortages across the system, increasing client demands, lack of appropriate resources and limited collaboration across the health care system challenge the health care system's ability to respond.

The characteristics required of staff practicing in rural and remote settings are similar to those of home care staff in all settings. They include – flexibility, creativity, caring, ability to cope with uncertainty, and ability to practice independently. The unique component of these characteristics in rural and remote environments is independence and the about to work in an environment with limited availability of support staff and access to resources. Home care staff are truly on their own.

Health care delivery to those in rural and remote regions of Canada requires a balancing of issues – increasing demand and decreasing resources; centralization of care around urban centres and the need for a presence in the rural and remote aspects of the country. This need to balance is a reality in every health care jurisdiction in the country as the rural and remote context applies to a certain extent in every community.

The solutions relate to a mix of client resiliency; provider creativity and initiative; and system flexibility.

Appendix A - Endnotes

1 Health Care in Canada Survey 2003

2 CIHI, 2006

3 Health Canada (2001)

4 Health Canada (2001) Roundtable on Rural Home Care Research Needs

5 Keating et al (2004)

6 McCracken et al (2005)

7 Hanlon and Halseth (2005)

8 duPlessis et al (2002)

9 Health Canada (2001)

10 Applying OECD definitions, the population living in rural settings increases to 38 percent - duPlessis et al (2002)

11 Turcotte & Schellenberg (2007)

12 CHCA (2006)

13 Statistics Canada (1996)

14 CHCA (2006) p25

15 CIHI (2007) retrieved from http://www.icis.ca/cihiweb/dispPage.jsp?cw_page=media_07dec2005_e#nhex

16 Ibid

17 Northern lights Health Region Annual Report

18 North Simcoe Muskoka Integrated Health Service Plan

19 Eastern Regional Health Authority Annual Performance Report 2006-0

20 CIHI (2007)

21 CHCA (2008)

22 Retrieved from http://www.homecareontario.ca/public/docs/news/2007/august/agingathome_nr_18_20070828.pdf

23 Manitoba (2007)

24 CHCA (2006)

25 CIHI (2006)

26 Haggerty, J. et al (2007)

27 Canadian Home Care Human Resources Study (2003)

Appendix B - Key Contacts

Northern Lights Health Region, Alberta – Phone: 780 791-6251

- Eileen McCracken, Head Nurse, Home Care, East Side
- Cathy Porter, Manager, Home Care, West Side
- Darline Reid – Director of Community Services
- Heather Munroe – Home Care Nurse
- Karen Benwell – Home Care Nurse
- Cheryl Jebbink – Telehome Care Team Lead
- Rest of the team present at luncheon and in foot care clinic
- Clients

Eastern Health Authority, Newfoundland Labrador – Phone: 709 759-3365

- Betty Reid-White, Director of Integrated Health Services, Community Health, Rural Avalon
- Pat Coish Snow, Chief Operating Officer Peninsulas
- Mona Romaine Elliot, Director of Integrated Services, Community, Peninsulas
- Fay Matthews, Chief Operating Officer, Rural Avalon
- Doris Lewis, Renee Dobbin, Wendy Maloney, and Kelli Spearns, Home Care Managers
- Natalie Morgan, Rhonda O'Driscoll, Eleanor King, Cindy Smith, Clinical Nurse Coordinators
- Jo-Ann Sooley, Continuing Care Nurse, Heart's Delight
- Gail Warford, Shag Rock Manor
- Clients

North SimcoeMuskoka CCAC, Ontario - Phone:705 726-0039

- Jane Rieger, Case Manager
- Kathleen Powell, Community Case Manager
- Terry Smith, Case Manager, Senior Continuing Care Program
- Karen Taillefor, Senior Director of Client Services
- Tevor Clark, Senior Director Corporate Services
- Clients

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