FITTING A ROUND PEG INTO A SQUARE HOLE: EXPLORING ISSUES, CHALLENGES, AND STRATEGIES FOR SOLUTIONS IN RURAL HOME CARE SETTINGS

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ABSTRACT

While home care has received much attention lately, little research to date has drawn on the experiences of rural multidisciplinary teams providing in-home care. Home care is typically studied in urban areas, with the tendency to expand urban practices to rural settings, often with problematic results. This paper presents findings regarding unique rural multidisciplinary home care issues, challenges, and strategies for solutions. Five focus group interviews were held with each of three rural multidisciplinary home care provider groups (n=19) in southwest Ontario, Canada. Findings revealed practice issues related to time, distance, communication, recruitment and retention, as well as system issues regarding poor understanding and scheduling of rural practice by administrators and urban employers. Study findings indicate that rural home care requires enhanced understanding and changes to policies and practices to provide efficient and effective care to rural residents. Best practice guidelines for home care in rural areas are urgently needed.

INTRODUCTION

Health care providers such as nurses and personal support workers contribute vital human and professional resources for rural home care (Forbes & Janzen, 2004). Few studies to date have drawn on the experiences of rural multidisciplinary teams that provide home care. Furthermore, home care is typically studied in urban areas, with the tendency to expand urban practices to rural settings, often with problematic results. This paper presents findings regarding unique rural multidisciplinary home care issues, challenges, and strategies for solutions that emerged from a study in southwest Ontario, Canada. Five focus group interviews, held with each of three rural multidisciplinary home care provider groups that included nurses, personal support workers, and others, highlighted issues, challenges, and strategies for solutions in providing rural home care.

Rural is defined as living "outside of commuting zones of urban centres with 10,000 or more population" (duPlessis, Beshiri, Bollman, & Clemenson, 2002, p. 1).

BACKGROUND

Rural home care providers offer vital support and care to rural residents. These providers are essential in assisting clients who return home from urban care facilities. While there have been many changes in health care delivery in Canada in recent years, three emerging trends (population aging, home care as the fastest growing sector of health service delivery, and empowering partnership models of care) support the need to critically investigate the provision of home care in rural settings.

The unprecedented aging of populations world-wide (Robinson, Novelli, Pearson, Norris, 2007; World Health Organization [WHO], 2004) creates significant opportunities and challenges for health service delivery in both urban and rural settings. It is predicted that by 2025 (in less than 20 years) Canada will be in the top 10 countries world-wide having the highest proportion of seniors (WHO). The majority of these seniors will live in the community. By 2011, in 3 short years, the leading edge of the "baby boomers" (individuals born 1946-1965) will reach the age of 65, with the full impact of the "baby boom" (when all "boomers" fall between the ages of 65 and 85) hitting Canada in 2031 (Wister, 2005). It is well recognized that there are many shortcomings in research related to aging, particularly regarding contextual factors (community, social environmental) that influence health and health service utilization home care needs of older individuals living in rural settings (Arbuthnot, Dawson, & Hansen-Ketchum, 2007; Clark & Leipert, 2007).

It is projected that by 2021 one in four seniors will live in a rural setting (Health Canada, 2002). In addition, rural home care providers provide care to other groups, such as individuals of all ages recovering from surgeries, with chronic conditions, and/or undergoing treatments for cancer and other conditions. In many small rural communities, the visit from the home care provider is the only access to care that rural clients have (Leipert & Reutter, 1998). Distance, weather, lack of access to or ability to drive or finance transportation, and being ill or in recovery can severely compromise rural residents' access to care outside their immediate community. Thus rural home care providers are essential to the health of many rural residents.

In Canada, home care has been the fastest growing sector of health care for more than two decades (Anderson, 2006; Canadian Home Care Association [CHCA], 2004). Public expenditures have grown at almost 20% per annum, double other health spending (Coyte, 2003). Restructuring of hospital, social, and mental health services, technological advancements, escalating acuity of medical care, and an aging population have increased the volume and complexity of services required. The demand for home care has continued to exceed resources (Forbes et al., 2003), despite the care management approach. Consequently, case managers (who ration and coordinate in-home services, matching scarce resources to professionally-assessed client needs rather than providing client-driven holistic care) have been forced to deal with caseloads of as many as 120 clients, far in excess of what is recommended (Shapiro, 1995). Similarly, service provider agencies have been confronted with increasing service demands at a time when recruitment and retention of adequate staffing to meet these demands has become a key problem.

In addition, empowering partnerships of care have become a focus as a way to promote quality in-home service delivery. Accordingly, several Ontario home care programs have adopted the flexible-client-driven care approach (McWilliam et al., 2003), which includes optimizing potential to effectively contribute to care by building on the strengths of each provider, drawing out the knowledge, skills and abilities each has to contribute through care partnerships that are often challenged by the geographic spread and isolated nature of work in this health care sector. This approach is supported by Canadian health services and case management leaders (Salfi & Joshi, 2003), theorists (Hackstaff, Davis & Katz, 2004; Hagerty & Patusky, 2003; Rose, 1992), leaders in the field of chronic care management (Bodenheimer, Wagner & Grumbach, 2002; Wagner et al., 2001), and by recent evidence (Aronson, 2003; Chang, Li & Liu, 2004; Hibbard, 2003; Nunez, Armbuster, Phillips & Gale, 2003). The evidence to date suggests that improved client satisfaction (Gagnon, Schein, McVey & Bergeron, 1999) and health outcomes (Chang, Li & Liu, 2004; Hibbard, 2003) may be obtained when health care consumers are engaged as partners in care (Forbes et al., under review).

Nonetheless, in spite of the need and importance of home care providers, rural home care providers experience significant challenges. Rural in-home providers, for example, must travel over extensive distances to reach clients. As well, in-home providers must be well prepared generalists so that they can address a variety of client needs (Lee & Winters, 2006; Leipert & Reutter, 1998). In addition, rural care providers are often under-resourced in terms of personnel, time, and equipment, recruitment and retention of health care personnel in rural settings is often problematic (Romanow, 2002), and resources are allocated based on the population served, which in rural areas is quite low, and on urban- standardized resources and client needs which differ substantially from rural locations (Romanow, 2002; Sutherns et al., 2004). These issues challenge the provision of effective and efficient home care in rural settings.

METHOD

Study Context

The study was undertaken in southwestern Ontario, Canada, a 22,000 square kilometer area with a population of just under one million people (McWilliam et al., under review). Approximately half of this population resides in cities of 30,000 to 360,000 largely focused on light to heavy manufacturing and white collar industry. The remainder of the population resides either in small bedroom communities or in relative isolation across expansive rural areas. The province of Ontario has the highest number of rural residents in Canada (Turner & Gutmanis, 2005). Southwest Ontario consists of varied rural contexts and diverse health and socioeconomic needs and resources and includes agricultural, recreational, and retirement communities (Turner & Gutmanis, 2005), and Aboriginal, Mennonite, and other cultural groups.

At the time of this study, southwestern Ontario was served by six home care programs, each comprised of a government-mandated in-home service brokerage agency providing service access and case management, and multiple service provider agencies supplying the in-home nursing, therapy, social work, and personal support services contracted for clients by the brokerage agency. On average, the six home care programs

together served approximately 16,000 clients at any one point in time. As approximately half of in-home clients served had longer term chronic care needs, these home care programs serve about 50,000 people annually. To meet client needs, the programs deployed the appropriate mix of services through a total of 1470 full time equivalent providers (200 managers, 390 nurses, 840 personal support workers, 35 therapists, 5 social workers) (McWilliam et al., under review).

Sample and Recruitment

After ethical approval was received from the University of Western Ontario Research Ethics Board, formal home care providers were recruited in southwest Ontario. Thirty-three formal care providers responded to recruitment efforts and were included in the study. This paper addresses findings from 19 participants from three rural sites who provided information relevant to rural home care. The 19 members in these three groups included seven nurses, six personal support workers, three case managers, two occupational therapists, and a team assistant (See Table 1). The average time in home care varied from one to 20 years; nine participants worked full time and ten worked part time; participants had baccalaureate, diploma, and certificate education. All participants were female, and the mean ages in the three groups were 46, 47, and 49 years.

Table 1
Participant Demographics

	Group One	Group Two	Group Three	Totals
Occupations				
Nurses	4	2	1	7
Personal Support Workers	2	2	2	6
Case Managers	0	2	1	3
Occupational Therapists	1	1	0	2
Team Assistants	1	0	0	1
Totals	8	7	4	19
Employment Status				
Full Time	3	5	1	9
Part Time	5	2	3	10
Education				
Baccalaureate	2	3	1	6
Diploma	5	3	1	9
Certificate	1	2	1	4
Mean Ages in Years	46	47	49	

Data Collection

Data were collected using focus group methods for building and stimulating ideas and discussion (Morgan & Krueger, 1998). Participants in the three groups completed five 2-hour researcher-facilitated sessions to identify self-developed, self-directed strategies to promote empowering partnering. These strategies were based on the principles of flexible client driven care (McWilliam et al., 2003), which, in summary, suggests that care should be client-centered and built on the client's strengths; flexibly respond to client's choices and abilities for partnering in their everyday care management; include partnering amongst all care providers, clients, and agencies; and foster empowerment by sharing and building on the knowledge, abilities, and potential of all involved. The researchers thus worked with the study participants as partners as they facilitated participants' exploration of service delivery in the rural context. To facilitate discussion and building of ideas, each group was facilitated by the same researcher for all five sessions. Group sessions were audio-taped to facilitate data capture and analysis.

Data Analysis

Individual and team interpretive analyses using an editing analysis approach (Miller & Crabtree, 1992) were completed, with the analysis team initially coding key phrases and themes that emerged from the data, and subsequently comparing and contrasting coded data to clarify the interrelationships of concepts and themes. Ultimately an edited set of key themes and sub-themes of issues, challenges, and strategies for solutions was developed. Rigor was attended to by conducting primary analysis by a minimum of two researchers to identify preliminary conceptualizations, and conceptualizations were brought back to the research team as a whole for consideration (Kuzel & Like, 1991). These strategies assisted with the development and refining of conceptualizations that accurately reflect data presented by study participants.

FINDINGS

Analysis revealed practice and system issues for rural home care providers, and strategies and recommendations to address rural practice and system issues. (See Table 2)

Practice Issues

Practice issues related primarily to time, distance, communication, and recruitment and retention of staff. Regarding time, several participants noted that demanding workloads required them to be vigilant about being on time to meet client needs and the challenges this presents in rural settings. As one participant noted, "I have to keep in mind on Tuesdays I have certain people I have to do first thing in the morning because they go to day care…and then I have to…[care for] her [another client], and then I still have to be [at] the other [client's home] by 9 o'clock because she's diabetic". Because of extensive distances that often existed between clients, staying on time for visits was a challenge. In addition, providers needed to schedule care to accommodate rural seasonal demands, as this participant explained, "I've run into problems with the

Table 2
Study Themes

Practice Issues	System Issues	Recommendations
Time required to reach clients; seasonal requirements for timing of visits	Lack of understanding of rural practice by urban supervisors and dispatchers	Reorganization of care provision to accommodate geography
Distances between clients and between clients and providers; driving demands in rural areas	Inappropriate scheduling of care providers in relation to client locations	Enhanced communication strategies to improve understanding about rural care issues
Communication effectiveness issues		
Recruitment and Retention issues related to travel, driving, and remuneration		

rural community with it being planting season…. [A farmer] wanted me to come at 6 am because it's not going to rain today and he's planting…I'm willing to do that but [because of my workload and distances to clients I can't do this every day]…trying to find a happy medium has certainly been a challenge".

Distance was a concern for several reasons. Driving long distances was daunting, especially in winter when roads and visibility could be compromised. A participant noted, "A lot of the girls [care providers] live out in the country, and there's winter driving, you know. Some of the girls don't have a four-wheel drive…if I call the office and say I can't get there, I literally mean it".

Participants also noted the added expenses of driving to provide care in the rural context and the need to have a driver's license, "[Providers in the city] don't need a car…they can hop a bus [to see clients]". In addition, participants repeatedly noted that reimbursement for distances driven to see clients was inadequate and inconsistent among homecare agencies, "The only thing you get now is kilometers and not that well paid…with the price of gas…at over a dollar a litre"; and, "They [employers] are saying 15 minutes is allotted for driving from one client to the other…I'm going, 'Well that's stupid because it takes you 25 minutes'. So I [won't] get paid [what I should]". Another participant stated, "Working in the country now, I have a huge issue with the driving. We're not paid to drive from A to B. The other day, I was asked to drive to [a location] to see a client and I said, 'I'm not driving [there]'. They don't pay me enough to drive my car, they don't pay me my time to drive there". A fourth participant noted, "They had me going out to the very end of [region]…I put over 300 kilometres on my van…. I say if it's [the visit] not here, here, or here, I'm not going there because I can't subsidize my car to do this job….sometimes we have to do that [subsidize their own costs of providing rural in-home care]".

The challenge of effective communication among rural care providers and between rural care providers and their managers and dispatch personnel was also noted. Face-to-face communication was highly prized, even if it was not always readily

available, as this participant indicated, "Voicemail doesn't cut it. I can't get the message [details] I need from voicemail all the time". Another participant noted that she could "not even get to talk to [colleagues] with voicemail". Communication was viewed as important to help rural providers schedule their workdays, work better as a team, and establish with clients flexible partnering care.

Recruitment and retention of staff was a major issue in the rural context that hindered the provision of consistent care and the development of effective flexible client-driven care strategies. Participants noted that the "biggest problem that we are facing is [a shortage of] nursing and personal support worker [staff]". Some participants believed that part of the reason that staff did not apply for or stay with community agencies that provide care in rural areas was due to excessive travel. Such travel was hard on personal vehicles ("We're…wearing and tearing our vehicles [out]") and interfered with the amount of time the care provider could dedicate to clients. The demands of having to complete clients' care, no matter where clients lived or how long it took to reach them, were additional reasons for poor recruitment and retention for rural community home care. Participants remarked, "Most people once they've got their personal support worker [education]…go work in a nursing home because they're getting three, four, five dollars an hour more than we are [in community care], and it's an eight-hour shift, they're not driving all over…They're going one place and they're done and go home". Other participants remarked, "It's hard when you've only got 10 minutes [with the client] because you drove for 50 [minutes] and the visit time is clicking on and you know at the end of the day, you're going to be measured for whether you got the task done, not whether the [client] felt good"; and "You don't want to be still working when the sun goes down [due to driving demands]". Another participant summarized the effects of providing care in rural community settings when she stated, "[Home care providers] work five months and they're outta [home care]. Well you can see why, if they're driving all over the country for one client and then across the country to the next one, [and] not getting paid much". These comments reveal both the commitment of providers and the challenges to providing care in rural settings.

In summary, time, distance, communication, and recruitment and retention of staff emerged as significant issues that affected providers' ability to engage in home care services in rural contexts. Without sufficient staff who were familiar with initiatives, and who felt valued, able, and supported to contribute, the development and implementation of familiar as well as new practice initiatives were challenging.

System Issues

System issues included a lack of understanding of rural practice by urban supervisors and dispatchers, and inappropriate scheduling of care providers in relation to client locations. Lack of understanding by urban supervisors and dispatchers of rural practice issues, especially rural distance, was a common theme, as comments by several participants reveal, "They can't fathom [rural travel time] because they can get anywhere in the city in ten [minutes]"; "City folk don't really understand rural….We had a boss in our office who was going to meet one of our [rural] case managers and she thought she'd be there in eight minutes. She hadn't a clue…It's at least 40 [minutes away]". Other participants noted, "They can't…visualize…Once they're outside the city, they say

'Where is that?'…They call me for a map because they wouldn't have a clue how to find [a rural location] themselves"; and "If you look at a road map, [the distance from rural location 1 to rural location 2 looks] like only two city blocks on the map, but it's [rural's] big"; and "Rural is very different from the city".

Lack of understanding of rural practice issues such as distance contributed to inappropriate scheduling of care providers in relation to client locations. Participants noted that they were sometimes assigned clients who didn't live in their practice locations. A participant noted, "We have case managers in the [urban] hospital who do the assessing and send clients home [for] service, and they send us clients who don't even live in our county, that's how much [little] they understand". In addition, inappropriate expectations for when care could be provided resulted when rural was not understood, "The dispatchers say, 'Well, it's only this far on the map. Can you be there in 10 minutes?'…I'm like…it's an hour's drive…they don't understand". As a result, care providers may be overwhelmed with too many widely geographically dispersed clients to visit in a day, and they are challenged to provide adequate care in the limited time they have available when they do arrive at the client's home. As has been noted, this leads to frustration on the part of the care provider and the client and contributes to recruitment and retention issues.

Inappropriate scheduling of care providers in relation to client locations also occurred as a result of home health agencies' policies and methods of procuring clients. In Ontario, home care is paid for by the provincial government which, in turn, allocates funding to community care access centres that contract services from private for-profit and non-profit agencies that submit the lowest estimate for the costs of care provision in specific counties (Armstrong, 2007). Participants noted that this process often resulted in care providers being employed by agencies with geographically overlapping care responsibilities. This procedure was problematic, as the assignment of clients to care providers based on the agency's county responsibility, rather than the location of their provider in relation to the location of the clients, resulted in care providers being "all over the place, wasting time", "inefficiency", and "a dog's breakfast" approach to care. Care providers found themselves driving to clients in rural communities where a care provider from another agency already lived. Thus, providers were driving long distances to far off clients, when they could be providing care to clients in or near their own communities which would result in more time available to spend with clients, more clients seen in a day, and less wear and tear on care providers and their vehicles. A participant noted, "I had clients say to me in [a location], 'Well, my neighbor's got the [provider who lives] across the street. Why are you here?' And I'm like, 'I don't know, she could come here and that would be good for her, and I could go and do something else [closer to where I live] and save on gas mileage and everything else'". Another participant agreed, "If [a care provider] is just down the road, she could do twice as many [visits if she could visit there] rather than driving forty minutes in between every visit".

Almost every participant remarked on the frustration of having to provide care using an urban-based model that didn't fit rural needs and resources. The following quotes illustrate participant perspectives regarding rural care situations: "There are structural barriers to having empowering relationships with [rural] clients because we're driving all over the place, wasting time, not getting paid [sufficiently], and we're frustrated…we [need to] study the impediments to effective home care [in rural areas]";

"Currently we're trying to retrofit an urban [care] phenomenon onto a rural environment and so we run into all of the issues that come with that". "They don't understand how to make it work [in the rural context]" was a common statement and sentiment.

Participants sometimes felt that, as one participant explained, "They're [employers] not unaware of [our situation]. They might not realize or understand exactly what happens out here but I'm sure they know because I keep sending those 'unable to serve' reports". Lack of employer attention to rural practice issues led to a sense of frustration and despair on the part of some participants, as revealed by these comments: "The farther you are from the grassroots, the [more the] weeds get in the way"; "But is it [change] going to happen?"; and "I think we've gone as far as we can if they're not going to listen to us". These comments indicate significant implications for quality of care and recruitment and retention of providers in rural settings.

Strategies and Recommendations

Strategies for solutions and recommendations to address practice and system issues focused primarily on reorganization of care provision to accommodate geography and enhanced communication strategies to improve understanding about rural care issues. A participant summarized the solutions, "It has to be geographic if you want it to work in the county".

Reorganization of scheduling of care provision to accommodate geography was addressed in several ways. Participants recommended that rather than "one, two, three [agencies] in a town…there should be one agency for each town or [area]"; to "divide the county into quadrants and have agencies within a particular quadrant"; and to "bid on rural visits differently than urban visits because of the [higher] costs involved [in providing rural care]". These recommendations would help formal care providers avoid time and distance issues involved in traveling to clients in a community where another agency already provides care, as a participant noted, "Why have somebody from [Agency A] go there [when] somebody from [Agency B already] goes there?" In addition, scheduling that takes into account geography would, participants felt, facilitate recruitment and retention, as care providers would not have to be "driving around" and would thus feel more fulfilled as they would have more time to provide care. Participants explained, "They're not going to be on the road traveling as much"…. "[Providers] could do even more [due to] time with each client…. It could be so much nicer", "And the person providing the care, when they get to the door, the patient will realize they're really happy to be there".

In order to highlight to themselves and to others, such as managers, policy-makers, urban employers, and dispatchers, distances traveled and locations of formal health care providers and the agencies they represented, participants recommended a mapping exercise as one strategy for enhancing flexible client-driven care in the rural context. On a map that illustrated the counties served, participants recommended that each care provider place a colored pin on the town or rural location where they had clients. Pin colors would represent the agency for which the care provider worked, for example Agency A would be red, Agency B would be blue, etc. Thus, the map would convey in color where agencies overlapped, where gaps in care existed, and where changes could be made so that agencies could provide more efficient service delivery that

required less travel and time, thereby allowing more time for flexible client-driven care. As a participant explained, "You can see the overlap and you know, you're driving down my street and I'm driving down your street". Participants felt that this mapping exercise could result in agency recognition of the need to reorganize care so that it was 'closer to home', which would result in more time with clients and more clients visited in a timely manner. Participants commented, "It does show…with the dots [pins on the map] how stupid the system is set up", and "Our next step would be to see how much closer we can bring each worker [to her/his clients] instead of…driving all over the country".

Participants believed that trying to "retrofit" urban care provision policies in rural areas was not appropriate and did not work. Participants also sensed an undervaluing of rural care, "No agency still yet wants to take the [rural] county when the dollars are in the city [where the majority of clients are]". A suggestion was made to create "a rural home visiting agency [that] would get the entire contract [for patients in rural areas] and get more money for visits because the costs are higher in terms of transportation and time". A recommendation was also made to attract nurses and other care providers who "are more interested in rural nursing and [accepting of] the vagaries of rural nursing", such as distance and location, "so that you have a better match between the client [and the care provider]".

Better pay and benefits for rural care providers was also recommended, "They'd probably get people [health care providers] out there if they paid them what they're worth…better benefits, full-time".… "They could look at isolation pay". In addition, parity in salary among the various agencies would facilitate staff retention, as this comment reveals, "Make it [salary] uniform…so that you don't have nurses quitting [Agency A] to work for [Agency B] because they're going to pay more…If it was uniform and standardized, it would be way better". In essence, participants believed that rural care requires not only parity with urban providers but additional incentives and supports to adequately provide care in rural settings and to support the additional costs and commitments that rural care requires. Adequate reimbursement for travel expenses and wear and tear on vehicles when providing care and salaries that compensated providers for not only the number of clients seen but also for the miles traveled and the overtime providers sometimes needed to commit to rural care were two examples of supports that would help attract and retain providers in rural settings.

Recommendations for enhanced communication strategies to improve care included more face-to-face meetings to supplement telephone and email communication across distances ("The case managers and nurse[s] [used to] have a get together round table discussion, maybe a lunch, [to discuss patient care] but they don't do it anymore…they miss it") and in-person case conferences ("We used to present case reviews to give a real picture of the situation…they were great eye-openers because it's real, [not] airy fairy"). Working in multidisciplinary teams was recommended as a way to sustain care provision with a small staff and large patient commitments in rural settings, as these participants noted, "The very fortunate part of our job is we've got a small team in our office and we work as a team…if we didn't, we'd all have drowned as individuals. But somehow we keep each other afloat. There's been times when [the care provider] is far behind and says 'Book [this many clients] that day', and I'll say 'No,…it's not good for you'"; and "Out here…we have a team and we get together and talk about how we're handling things…if a client load's too much". The focus group

format facilitated the sharing of strategies such as these so that they could be considered, and perhaps adopted, by various disciplines and agencies.

Other suggestions included the need to learn from and develop best practices for the provision of community care. A participant stated, " It's too bad there aren't best practices that we're aware of for this kind of [care]…There's probably in every country where there's home nursing, nurses in cars visiting people [who] are probably doing it more or less efficiently. But I don't know what the best practice stuff says about it".

Although participants hoped that these and other recommendations could be implemented, a sense of distrust persisted based on the fact that most policies and decisions were made in urban settings, "I just hope that however [solutions] are presented, that they [those who make decisions about policies and practices] get it. I'm not sure they're going to because they don't live or work in the county, they don't understand, and those are the people making the decisions". In addition, some participants noted urban reluctance to understand or accommodate rural locations, "When we suggested to them [urban employees] to come to [our rural] office for a meeting for a change, all of a sudden it's like, 'Oh, God, I've got to drive all the way there'". To develop understanding about the rural context and rural practice, and in addition to the mapping exercise described above, participants suggested, "It would be good if they could just follow us around for a whole day and see what we do…how far spread we are… and how thinly spread we are…with two people working in it [the rural community]".

In addition, participants believed it was important to be collectively assertive, "We need to stand up as a group…If we would stand up as a group, I think we could make change. If we just say, 'We're not working today. Until you fix the gas price, we will not be driving our vehicles', something would happen"; and "It's easier to marginalize individuals and [one or two] agencies…If everybody's saying that we're all over the place and wasting time, it's harder for government to disregard the inefficiency, right?"

DISCUSSION

Findings of the study reveal several important aspects of rural home care practice and system issues and valuable recommendations for improvement. Rural home care providers and clients experience significant challenges that make present practice problematic and that affect the adoption of new approaches such as flexible client-driven care.

Valuing and Supporting Rural Practitioners and Rural Home Care Needs

The importance of valuing, including, and listening to rural practitioners was clearly evidenced in this study. Practitioners in rural contexts live close to the care experience and, as such, have important and relevant 'on the ground' experiences and strategies for practice and system refinements. Participant comments indicate their interest and ability to be involved in practice and policy discussions. For effective rural home care practice and planning, practitioners must be included in local, regional, provincial, and agency planning meetings.

Participant distrust and frustration regarding the need for, yet the lack of change merit particular attention. Change that effectively moves rural home care practice forward must be done, and seen to be done, if practitioner confidence and trust are to be restored. Change may not be easy, however. Recent restructuring of the home care system in Ontario has resulted in a process whereby private for profit and non-profit agencies bid for care contracts, with the lowest bid usually awarded the contract for care (Armstrong, 2007). Determination of care provision in this way can result in even more under-resourcing of care in rural settings, which typically are more costly due to sparse populations and extensive distances.

Advancing Rural Home Care

Flexible client-driven care, while a very valuable approach for home care in rural settings, will require additional system supports if rural home care providers are able to learn about and implement them. Given rural practice demands and recruitment and retention issues, provider attendance at educational and implementation meetings will be challenged. For example, in this study participants who were not funded to attend sessions and participants for whom no alternative care providers were available found it difficult or impossible to attend sessions. Thus, financial support and recruitment and retention issues must be attended to so that providers can have the time to attend and be involved in initiatives that advance rural home care.

Other initiatives that can help advance rural home care could include the strategies of telemonitoring and home care co-ops. Telemonitoring devices may assist rural providers and clients to monitor vital signs, assess drug administration, and instruct regarding other health care regimens and needs from a distance (Anderson, 2006). Anderson (2006) notes that this use of technology can help care providers to assist rural clients between visits and to see, assess, and educate more patients in one day than was possible in a week of home visits in a rural area. Home care cooperatives, which are used largely in home care settings in Quebec to provide care to mostly elderly clients in their homes, provide a variety of services and resources to rural clients and have been found to generally perform well in rural settings (Anderson, 2006; Girard, 2005). Community-based health care models, such as home care co-ops, have also been demonstrated to provide care at substantially less cost per capita (Armstrong, 2007) mainly because of lower hospital utilization rates (Anderson, 2006). These two strategies, telemonitoring and home care cooperatives, may thus be ways forward in the future in assisting rural home care providers and rural clients to provide and access care. Further development, implementation, and evaluation of these methods in rural settings are required to demonstrate and refine their effectiveness.

Participants in this study identified mapping as a way to identify and illustrate practice locations, needs, and resources. Geographic information system (GIS) mapping, the pairing of databases of information with advanced mapping capabilities, is being used by senior and community groups in the United States and Australia to assist with planning and allocation of health-related resources (Anderson, 2006). For example, GIS mapping can assist in showing where clients live and thus where resources are needed, to identify isolated clients, and to visually see the distances and spatial relationships between services and between services and clients. Thus, mapping may be another way to

highlight the needs and resource issues of rural providers and clients, and assist in effectively and efficiently planning the delivery home care resources to meet rural needs.

Participants recommended best practice guidelines for rural home care. This highlights an important opportunity for research to identify these practices and for education among rural health care providers to share practices that work. Appropriate knowledge translation and exchange activities are required to share interventions/approaches that have been shown to be effective in meeting the needs of rural home care clients and rural care providers. As well, research is needed to further examine best practices using a rural lens. The study of rural health care and the identification of best practices for rural care by nurses and others in Canada have only recently begun (Andrews et al., 2005; Bushy and Leipert, 2005; Hartley, 2005; Leipert and Smith, in press; MacLeod et al., 2004). These studies and participant issues and recommendations expressed in this study indicate that the important work of identifying and supporting best practices is a vital way forward in strengthening rural home care.

Finally, advocacy is clearly needed for change at the agency and provincial level so that policies can be adjusted to more effectively provide home care to rural residents. Rural home care practitioners who have relevant practice experience and who know how things work – or not - should be active participants in advocacy and policy discussions so that effective systemic change occur. For example, rural home care providers must be included on agency boards and governmental health decision-making committees. However, because advocacy may not be an activity with which practitioners are familiar or comfortable, education and support for their involvement should be provided. This may present challenges due to the large number of agencies that employ home care practitioners, the small numbers of practitioners in some agencies, and agency interest in economics of care versus staff development. An agency external to employing agencies, for example professional associations such as the Canadian Home Care Association, the Ontario Home Care Association, and the Registered Nurses Association of Ontario, may be best able to support rural home care provider advocacy needs and initiatives.

The findings of this investigation were limited by inconsistent attendance at the focus group meetings used to elicit understanding of the issues, challenges, and strategies for providing home care in rural settings. Limited reimbursement for provider participants and limited availability of replacement staff to enable provider participation meant that providers attended whenever they could. Sporadic attendance perhaps impeded optimal discussion to elicit the in-depth data sought. Nonetheless, rich data were revealed, and issues and strategies important for effective rural home care were identified and can serve as the basis for additional investigation.

CONCLUSIONS

Best practice guidelines for home care in rural areas are urgently needed. Rural home care provider interest and participation in this study, in spite of overwhelming workloads and often on their days off from work, indicate that rural providers are committed to quality care. Findings from this research regarding system and rural practice issues and strategies indicate that rural home care practice would benefit from additional participatory action research with rural home care providers. Understanding of rural home care could be enriched by interviews with care recipients and the families and

neighbors who care for them, and by individual interviews of home care providers. Exploration of sensitive practice and system issues could then be more fully explored in a confidential manner. Research that explores rural care provision by discipline/position (eg. nurses, personal support workers, case managers, etc.) would also provide a deeper understanding of discipline and position-specific needs and solutions. Committed financial and personnel support by agencies is vital to research participation by overworked rural care providers. Additional research would help to acquire vital information, such as best practices for rural home care, that support the provision of effective and efficient home care in the under-resourced, yet growing, rural care environment.

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