

**Meeting with Stakeholders
Development of a Multistakeholder Framework of Rurality
September 13, 2002 -- Ottawa, Ontario**

HIGHLIGHTS

1. BACKGROUND AND INTRODUCTION

The Canadian Medical Association (CMA), along with its project partners – the Canadian Nurses Association (CNA), Canadian Pharmacists Association (CPhA) and the Society of Rural Physicians of Canada (SRPC) – convened this meeting with stakeholders in rural health to discuss the development of a multistakeholder framework of rurality. Peer-reviewed research funding for this 2-year initiative was received in 2001 from Health Canada's Rural and Remote Health Innovations Initiative.

Workforce issues for rural and remote healthcare providers, and issues relating to the delivery of, and access to, a full range of health services by individuals who live in these communities, are of concern to many groups. The framework reflects input from members of the community, nurses, pharmacists and physicians. Input has been sought via a national survey and through community focus groups in 8 different rural or remote locations across Canada. This input will be augmented by the framework's application and testing in 14 different rural or remote communities. The framework builds upon research carried out by the CMA in 1999 for which funding was received from Health Canada to develop a framework of rurality from the *medical* perspective.

The multistakeholder framework of rurality could be used for health human resource planning purposes and as a tool for recruiting health care providers to rural and remote communities. There may also be opportunities at a later date to merge the framework with separate data collected on health indicators in rural and remote communities. Ultimately, the framework would help to improve the health status of rural and remote populations.

2. MEETING PARTICIPANTS

A list of meeting participants is attached.

3. PROJECT OVERVIEW AND TIMELINES

The following main project components were described:

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|------|--------------------|---------------------------------------------------------------------------------------------------------|
| i. | Spring/Summer 2001 | Health Human Resources Planning: Report on Feedback to the 2001 International Environmental Scan |
| ii. | Fall 2001 | National Survey on Rural Health Practice in Canada: nurses (RNs, LPNs/RPNs), pharmacists and physicians |
| iii. | Spring/Summer 2002 | Rural Community Focus Groups |
| iv. | September 2002 | Meeting with Stakeholders in Rural Health |
| v. | October 2002 | Application and Evaluation of the Framework in Rural Communities |
| vi. | February 2003 | Final Report to Health Canada |

4. UPDATE ON PROJECT COMPONENTS

i. **Health Human Resources Planning: Report on Feedback to the 2001 International Environmental Scan**

A copy of the report was provided to meeting participants. It was explained that a questionnaire tool was used to seek input from governments, professional associations and others on a range of issues relating to health human resources, such as: the collection of demographic information, operational definitions of and distinctions between “rural” and “remote”, planning tools and policies. The survey was targeted to organizations within Canada, the United States, and abroad.

ii. **Survey on Rural Health Practice in Canada, 2001**

The *Survey* was sent to rural nurses (RNs, LPNs/RPNs), pharmacists and physicians. It was drafted by the project Steering Committee and received input from a number of health care professionals currently practicing in rural communities.

The *Survey* comprised the following components:

- *General*: This section included profession and community-related questions and sought input regarding plans to practice in the community in 2 years’ time.
- *Satisfaction with Rural Practice* (professionally and personally)
- *The Community in Which You Practice: Health Services Availability, Community Needs, Community Success in Retention and Recruitment*: Input regarding health services availability and community needs for a broad range of health care professionals (e.g., dentists, physiotherapists, social workers, and others) was sought. Feedback regarding the degree of community success in recruiting and retaining these broad range of providers was also requested.
- *Defining Rural/Remote* (from a health care perspective)
- *Collaborative/Team Care*: This section focussed on health care professionals’ involvement with a broad range of health care providers (e.g., nurses, pharmacists, physicians, paramedics, optometrists, occupational therapists and others.)
- *Telehealth Availability*
- *Personal Demographics*

The *Survey* was sent to 6244 (valid sample) rural health care professionals, specifically, nurses (RNs, LPNs/RPNs), pharmacists and physicians. An overall response rate of 47% was achieved, as follows:

- Physicians: 45%
- RNs/NPs: 72%
- LPNs: 52%
- Pharmacists: 40%

Feedback highlights from each of the professional groups surveyed were presented. This was followed by highlights of similarities and differences in feedback among all of the professional groups surveyed.

It was noted that survey feedback on factors that best define a community as rural or remote from a health care perspective, and which ultimately led to the development of the framework, would be discussed in more detail after lunch.

iii. Rural Community Focus Groups:

Highlights of feedback from focus group sessions convened with rural community members across the country were presented by Margaret McPhail of the Ipsos-Reid Corporation, which was commissioned to undertake the study.

Objectives

Specifically, the purpose of the focus groups was to:

- examine the views of community leaders (health professionals and community citizens) vis-à-vis the delivery of health care services in their community;
- ascertain what has or has not worked in the retention/recruitment of health care professionals; and
- determine what initiatives have or have not worked to improve the delivery of health care services in rural communities.

Communities and Focus Group Representation

Focus groups were convened in each of the following communities, which had been selected on the basis of various criteria (e.g., geographic barriers, language minority, rural or remoteness, predominantly Aboriginal population).

- Shawville, Quebec (pilot)
- O’Leary, Prince Edward Island
- Yellowknife, Northwest Territories
- Elkford, British Columbia
- Fort Qu’Appelle, Saskatchewan
- Lameque, New Brunswick
- Blanc Sablon, Quebec (2 focus groups, one in English and one in French)
- Moose Factory, Ontario

Each group included a range of health care professionals as well as other professionals (e.g., police, teachers) and members of the community.

Input to the Framework

In addition to discussion on the aforementioned points, members of the community who participated in the focus group sessions were asked to provide input to the factors within the framework. Specifically, each was requested to complete a form that listed all of the factors and identify whether each of the factors: i) accurately describes rural or remote communities in general; and ii) accurately describes their community. In addition, they were asked to designate the top 3 factors that they believed best define their rural or remote community, and any rural or remote community, from a health care perspective.

All of the factors identified by community focus group participants as describing either rural communities in general, or their community specifically, included all 10 of the factors within the draft framework.

In the case of best describing rural communities in general from a health care perspective, 3 out of 4 of the factors cited by respondents were among the top 4 mentioned factors already included within the draft framework of rurality, based on input from rural health care professionals.

The broader context of rural community development and a community's ability to attract and maintain a broad range of other professionals was also reflected in discussions. In addition, input regarding community needs and challenges in accessing health services and retaining and recruiting health care professionals was sought. Common themes that emerged from the focus group discussions were outlined in materials provided to meeting participants.

6. PRESENTATIONS ON RURAL HEALTH CARE

Several grassroots perspectives on rural community health care issues were provided, as follows:

The **community and patient/consumer perspective** on challenges in accessing health care in rural/remote communities was presented by Kurt Pristanksi, CEO of Glengarry Memorial Hospital. Emphasis was placed on those factors that emerged from feedback to the 2001 national survey and rural community focus groups; for example, challenges in accessing health services posed by travel distances, geography and unpredictable or unavailable public transportation. Other issues, such as lack of funding to operate CT scanners and MRIs, as well as a shortage of specialist physicians, were highlighted.

Challenges in recruiting and retaining physicians and nurses to serve First Nations communities were addressed by Rosemarie Ramsingh and Kathleen MacMillan of the **First Nations and Inuit Health Branch (FNIHB) of Health Canada**. Each

described the department's role in serving the approximately 706,000 First Nations population, half of whom live on reserves. The National Office of FNIHB provides program and policy guidance and works much like a provincial department of health. Currently, the program employs 12 medical officers, with a planned increase to 22 within the next year to meet needs. Nurses provide most of the professional services on reserve; approximately 700 nurses are employed directly by the FNIHB with an additional 700 employed by the bands who are managing their own health services. Physician recruitment strategies include offers for flexible

work environments, telehealth linkages and quality living and working conditions. Emphasis is also being placed on recruiting those of aboriginal ancestry and, in the case of nurses, a greater focus on retention.

Physician recruitment issues were addressed by Wanita MacIntyre, spouse of a rural physician and a former physician recruiter for Prince Edward Island. Challenges in recruiting physicians, from establishing first-point contact and pre-screening potential candidates, to coordinating licensure, credentialing and, in some cases, immigration, were reviewed from a personal perspective.

7. Development of the Multistakeholder Framework of Rurality and Determining the Rurality Index/Indices

The methodology for developing the framework, as well as the framework application and testing protocol, were described in detail. Meeting participants were referred to the handouts within their agenda package.

It was noted that, within the “Defining Rural/Remote” section of the *Survey*, respondents were asked to identify 5 factors from among a total of 16 that they believed to be the most important in defining a community as rural or remote from a healthcare perspective. This list of 16 factors within the *Survey* reflected input from a broad range of stakeholders. They also included a range of issues relevant to health care professionals, as well as access to service issues that would also be pertinent to persons living in rural communities.

The top 10 factors were compiled for each of the 3 professional groups (nurses, pharmacists and physicians), and for the groups overall, based on the total number of mentions they received from survey respondents. The 10 factors for the 3 groups combined were as follows:

1. Long distance to a secondary referral centre.
2. Barriers (geography/weather/roads) to timely access.
3. Insufficient health care providers.
4. Inability to provide services such as obstetrics , general surgery and anaesthesia.

5. Long distance to a tertiary referral centre.
6. High level of on-call responsibilities.
7. Difficulty in obtaining locums (temporary or casual professional staff).
8. Lack of equipment such as x-rays and laboratory services.
9. Limited or non-existent public transportation to health care services.
10. Sparsely populated catchment area.

A set of weights was assigned to each factor, for each professional group, based on the number of mentions it received. A range of measurements were then developed for each factor so that a community score could be determined for each. Each of these community scores would then be multiplied by the weightings given to the factors based on number of mentions received by each of the professional groups. The sum of these weighted scores would result in a rurality index for each of the professional groups.

Possible uses for the index were identified as: determining factors in the community that caused it to score high; facilitating comparisons with other communities; and facilitating comparisons to an established set of benchmarks.

Meeting participants were advised that they would have the opportunity next to apply the framework and determine rurality indices for 2 hypothetical communities. Forms and other materials to facilitate this process were included in participants' meeting packages. Their feedback would be sought regarding the appropriateness of the measurements for each of the factors and the overall process for determining the indices.

At this point in the meeting, discussion ensued regarding the development of the framework/index and its application. It was decided that the break out group sessions (wherein the framework would be applied and indices determined) would be suspended in favour of additional discussion. Highlights of comments and suggestions follow.

8. SUGGESTIONS AND COMMENTS

- It was suggested that the health care professionals' satisfaction levels from the *2001 Survey* be compared with urban health care professionals' and aboriginal health care workers' satisfaction ratings that may have been gathered from this survey or other sources.
- There was concern that the framework (or the factors within it):
 - reflects a traditional, medical model and do not incorporate collaborative or creative models of practice that may be in place; (e.g., "obstetrical services" does not sufficiently address midwifery);
 - do not reflect community perspective, including challenges in accessing health care services;
 - do not reflect the perspective of nurses.
- It was pointed out that the terms "framework" and "index of rurality" are not being used correctly.
- A national tool and standardization is needed to assess levels of community access to service.
- Provincial and regional analysis of data is needed.
- Community capacity-building factors need to also be assessed.
- A synthesis of findings and gaps in information would be useful.
- What is the research question? What is the purpose of the framework and who is supposed to use it?
- To compare the communities via the index, control factors are needed.
- A qualitative framework may be more useful.
- The survey results should be shared with Canadian communities and municipal representatives.
- Is the framework to address recruitment issues or health service delivery issues?
- The factors need to focus on positive elements rather than deficits.
- Other dimensions of "rural" need to be included in the framework.

The meeting adjourned at approximately 2:45 p.m. with thanks to all for their participation at the meeting.

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Participants

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| 1. Aboriginal Nurses Association of Canada | 11. Health Canada - First Nations and Inuit Health Branch |
| 2. Canadian Federation of Agriculture | 12. Health Canada – Office of Rural Health Population and Public Health Branch |
| 3. Canadian Healthcare Association | 13. Human Resources Development Canada - Office for Disability Issues |
| 4. Canadian Health Services Research Foundation | 14. Indian and Northern Affairs Canada |
| 5. Canadian Institutes of Health Research | 15. National Aboriginal Health Organization |
| 6. Canadian Medical Association | 16. Nursing Practice in Rural and Remote Canada Project |
| 7. Canadian Nurses Association | 17. Society of Rural Physicians of Canada |
| 8. Canadian Pharmacists Association | |
| 9. Canadian Rural Revitalization Foundation | |
| 10. Consortium for Rural Health Research/
Canadian Rural Health Research Society | |

Regrets

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|---------------------------------------------------------|----------------------------------------------------|
| 1. Advisory Committee on Health Human Resources | 8. Canadian Federation of Municipalities |
| 2. Agriculture and Agri-Food Canada (Rural Secretariat) | 9. Canadian Mental Health Association |
| 3. Canadian Agricultural Safety Association | 10. Community Health Nurses Association of Canada |
| 4. Canadian Association of Chiefs of Police | 11. Health Canada’s Ministerial Advisory Committee |
| 5. Canadian Association of Retired Persons | 12. Paramedic Association of Canada |
| 6. Canadian Chamber of Commerce | 13. Working Group on Health Human Resources |
| 7. Canadian Council on Social Development | |

Speakers

Ms. Wanita MacIntyre

Manager
Beachwood Professional Centre

Mr. Kurt Pristanski

Chief Executive Officer
Glengarry Memorial Hospital

Ms. Kathleen MacMillan

Executive Director, Office of Nursing Services
First Nations and Inuit Health Branch (Health Canada)

Dr. Rose Marie Ramsingh

Community Medicine Specialist, Office of
Community Medicine
First Nations and Inuit Health Branch (Health Canada)

Ms. Margaret McPhail

Senior Research Manager
Ipsos-Reid Corporation