JUNE 2023

Emergency Department Closures in Northern, Rural and Remote Regions

Policy Guidance

Healthcare Excellence Canada

About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners to spread innovation, build capability, and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaboration with patients, caregivers and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence. Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement.

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Executive Summary

The sustainability and stability of emergency department (ED) services in northern, rural and remote areas in Canada has been an issue for health leaders and health system planners for several decades. Changing demographics, sub-optimally connected health system structures, rising costs of providing care and challenges maintaining the health workforce have contributed to intermittent and sometimes permanent closures of EDs in small communities.

On February 1, 2023, Healthcare Excellence Canada (HEC) convened a collaborative discussion to explore policy options for improving ED care and reducing closures in these communities.

Our objectives were to:

- incorporate multiple stakeholder perspectives
- validate key policy issues affecting the provision of urgent and emergency care
- review the policy context
- explore innovative approaches in policy and practice for providing care when EDs close

The report yielded three key messages about what northern, rural and remote communities need to prevent ED closures:

1. **A stable, experienced and sustainable workforce**

   Strategies to support communities in training, retaining and supporting their workforce can contribute to avoiding service disruptions.

2. **Connections to timely and appropriate care**

   Supporting local health resources to build capacity in primary and community services can reduce pressures on the ED and ensure more timely access to appropriate care.

3. **Health service design that reflects community voices and new models of care**

   A co-design process facilitating locally driven solutions and expanding access to culturally safe services will assist to meet the needs of northern, rural and remote populations.

We arrived at our key messages by examining policy issues under three categories:

1. **Health human resources**

   Ensuring an adequate supply of skilled workers is a challenge across the health sector and is especially challenging in smaller communities. Strategies for addressing health human resource issues are wide-ranging and include:

   - Optimizing scopes of practice by adjusting process and providing education, training and mentorship for healthcare professionals
   - Enabling more professionals to deliver care by building capacity in the workforce
   - Removing barriers to innovation
   - Working with professionals outside healthcare who can support healthcare workers
   - Recruiting and licensing more international graduates
   - Increasing the supply of health providers by reducing barriers and fostering interest
   - Retaining current staff, who understand local contexts
   - Recruiting from northern, rural and remote communities, as such workers may be more likely to stay in these communities

2. Accessibility of care

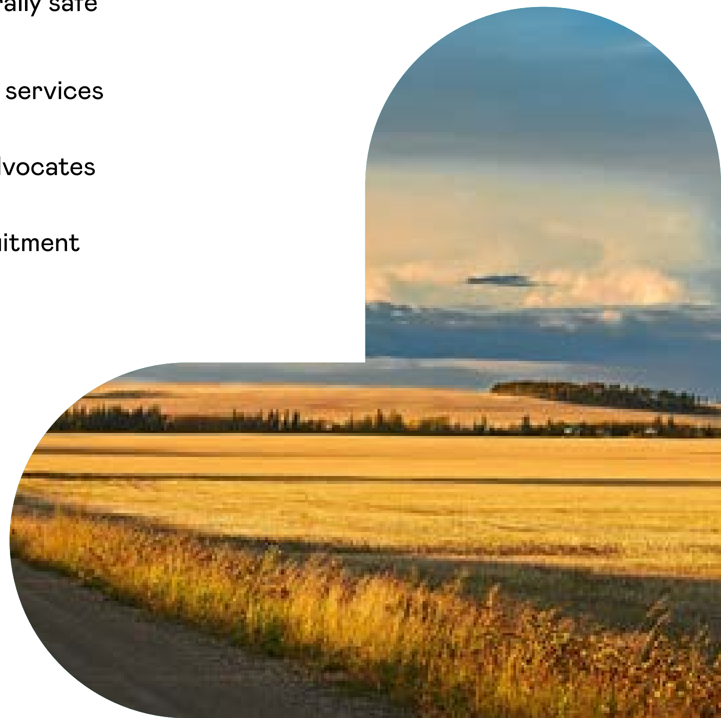
Rural, remote and northern communities experience overloaded EDs partly because it can be difficult for people to access care in the community when and where they need it. This reliance on EDs can cause major disruptions when EDs have to close. Potential solutions include:

- Using multi-disciplinary teams so that professionals with the highest scope of practice are reserved for the most urgent cases
- Bringing support closer to patients, which helps prevent transfers to EDs
- Increasing access to other care options, including videoconference assessment
- Leveraging virtual care supports in ways that are accessible via local broadband services and that address privacy concerns

3. Culturally safe and equitable care

Northern, rural and remote residents have unique needs, and well-rounded solutions are developed in close consultation with the communities that EDs serve. A path toward developing culturally safe and equitable care can include:

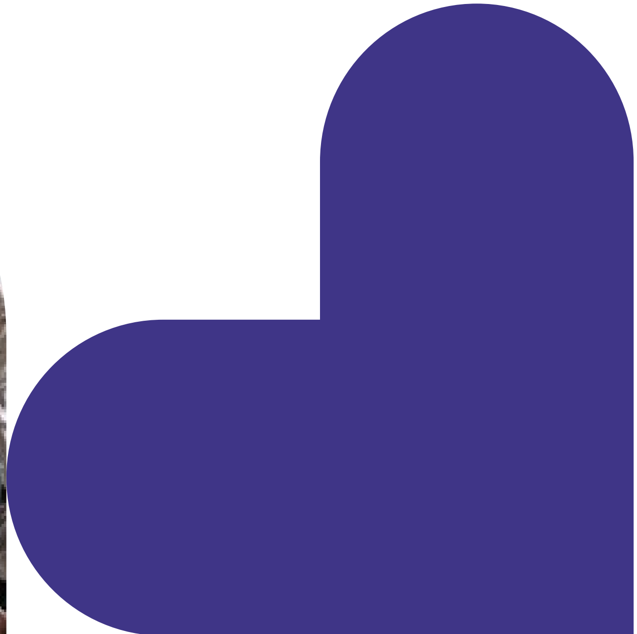
- Conducting a robust needs assessment to understand the services required
- Ensuring safe and equitable care, consulting community advocates throughout
- Providing culturally safe workplaces to improve staff recruitment and retention

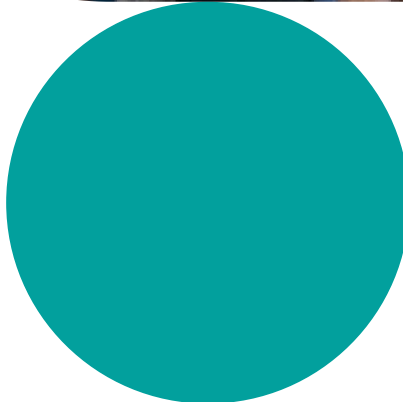


Conclusion

Smaller populations and smaller teams can make the sustainability of services more precarious, requiring creative solutions to optimize resources and support care needs. Solutions will require strategic investments, new roles and types of providers, close attention to the issue of recruiting international graduates and appropriate leveraging of technology.

Agile and adaptive leadership, in combination with an inclusive and partnered approach to innovation that focuses on the features and needs of communities, will assist in implementing effective and responsive policies and practices.





Background and objectives

On February 1, 2023, Healthcare Excellence Canada convened a collaborative discussion to explore, from a policy perspective, strategies and care delivery implications related to emergency department (ED) closures in northern, rural and remote communities. Participants attended from nine provinces and territories, with multiple perspectives represented, including patient partners, front-line providers, health leaders, regulatory bodies, national associations and policy-makers in government.

The objectives of this session were to do the following:

- Incorporate multiple stakeholder perspectives – patients, providers, health system leaders, policy-makers, regulatory associations and others.
- Validate key policy issues affecting the provision of safe and high-quality urgent and emergency care to northern, rural and remote communities in Canada using a systems-thinking approach.
- Review the policy context, including real and perceived policy barriers and enablers surrounding these key issues.
- Share, discover and explore emerging and innovative approaches – in both policy and practice – for providing safe and high-quality care when EDs have closed or are closing.

Participants were given the opportunity to validate key policy concerns impacting northern, rural and remote EDs, heard from innovators across the country and discussed which policy enablers and innovations might support the stability of ED services in communities or assist with mitigating care needs when an ED has closed. This report provides an overview of these discussions and highlights opportunities for responsive ways to deliver care to residents of northern, rural and remote communities.

Key messages

We heard that northern, rural and remote communities need three things:

1. **A stable, experienced and sustainable workforce**

   Securing and sustaining healthcare providers is a challenge experienced across all provinces and territories, and in centres large and small. In smaller teams and communities, this challenge can be even more pronounced: the loss of even one vital team member can contribute to temporary closures or disruptions in ED services.

   Strategies to support communities in training, retaining and supporting their workforce can contribute to avoiding service disruptions.

2. **Connections to timely and appropriate care**

   The closure of an ED in a northern, rural or remote community can be even more impactful due to the sometimes-limited services available in the community. For many, the ED serves not only as a locus of emergency services, but also as an access point to routine and primary care.

   Supporting local health resources to build capacity in primary and community services can reduce pressures on the ED and ensure more timely access to appropriate care for all those who reside in northern, rural and remote communities.

3. **Health service design that reflects community voices and new models of care**

   The needs of a community are not always reflected in the services and care options that exist. Policies and practices are needed that respond to population health needs in northern, rural and remote communities, and that promote and support partnership between health services and communities, patients and caregivers.

   Ideally, a co-design process facilitating locally driven solutions and expanding access to culturally safe services will assist to meet the needs of northern, rural and remote populations.

Policy guidance: Stakeholder action to stabilize ED services in northern, rural and remote communities

Historical and current health system challenges leading to ED closures in northern, rural and remote regions have had a cumulative effect on communities and those who organize, deliver and experience care. Opportunities exist to support communities and reduce not only the likelihood of future closures, but also the impact if closures do occur.

Policy and practice improvements and examples of innovations listed in the following sections are only a small sample of the innovations taking place in health delivery organizations in the provinces and territories. Some were highlighted by panelists and participants at the policy dialogue event; others are recent announcements related to ED stability efforts. Still others are illustrations of the strategies presented in this report. The guidance and innovations are grouped under the following categories:

- Health human resources
- Accessibility of care
- Culturally safe and equitable care

The purpose of this guidance and associated examples is to share that some jurisdictions have applied creative solutions to common issues. The purpose is also to generate further creativity in finding ways to deliver essential healthcare services to residents of northern, rural and remote areas.

Health Human Resources

Ensuring an adequate supply of skilled workers is a challenge across the health sector. This issue is more consequential in smaller communities due to smaller staffs and lack of flexibility to add additional capacity if absences or vacancies occur. Despite these challenges, opportunities exist to take action by recruiting, retaining and supporting staff to ensure an adequate supply of skilled workers.

Sometimes, strategies include addressing the need for more staff. Other times, strategies require maximizing the services that can be delivered by having staff work fully to their scope of practice, bringing new types of providers into teams to deliver services, and delivering services in novel ways.

These strategies are not specific solutions to addressing ED closures, but may assist in addressing health human resources as a whole, thereby supporting the stability of teams and ED services. Taking a rounded view of human resource strategies enables the examination of different policies and tactics, and their unintended consequences. For example, some communities have success recruiting new physicians to practice, but may have less success retaining them in the community. A cycle of recruitment-focused strategies may not be sufficient without examining other root causes and needs.

Optimize scopes of practice

The crisis in health human resources (HHR), magnified by the pandemic, has forced health systems to adapt and consider innovative staffing models and expanded scopes of practice to meet needs and deliver high-quality healthcare services.

One strategy – optimizing scopes of practice – entails adjusting processes (for example, care pathways, unit processes, handover protocols, etc.) as well as providing education, training and mentorship where possible to help healthcare professionals work to their full capabilities. As an example, Nunavut added paramedics to the complement of staff working in health centres. (Read an interview with Dr. Francois De Wet describing how it was done and what they learned.) Others have supported advanced certification/designation for registered nurses to meet needs of the community.

Enable more professionals to deliver care

Opportunities exist for another type of strategy: to expand the types of professionals delivering care – for example, paramedics, physician assistants, licensed practical nurses, pharmacists, etc. This maximizes the available workforce and the direct patient care that can be delivered.

Participants of the policy dialogue session noted the need to build and maintain the capacity of the current workforce rather than regularly rely on short-term or temporary staffing models in the face of ED closures. They noted that strong, team-based care models (either in person or virtual) support safe and high quality care.

Further, experienced care providers who are "generalists" are needed in northern, rural and remote contexts due to the variety of needs seen in those EDs. Nova Scotia as one example, has added physician assistants and nurse practitioners to ED teams. Those who have implemented similar approaches emphasized the need for clear roles, strong processes and constant communication among the individuals that make up a care team.

Alberta has amended mental health legislation to allow nurse practitioners to assess patients. Expanding the professions that can conduct patient assessments can improve many aspects of care and flow when an ED closes, including timeliness and accessibility of care.

Remove barriers to innovation

Differences among licensure across the provinces and territories affect various jurisdictions' ability to expand health professionals' scopes of practice. Some limit the privileges of health professionals – for example, who can assess, admit, treat and discharge patients – while others are nimbler in their approaches to healthcare provider roles in hospital settings.

Stakeholders, including policy-makers, health system leaders, unions and direct care staff, need to work together to remove the barriers that prevent innovations in scopes and care delivery models, while maintaining continuity of services and the delivery of safe, high-quality care.

Yukon has broadened the scope of nursing practice. This example can be found in the Putting People First report. Likewise, British Columbia's First Nations Health Authority covers costs for advanced training,

paid accommodation and expanded scope nursing practice opportunities for registered nurses joining teams in nursing stations and health centres.

Work with professionals outside healthcare to support healthcare workers

To ensure an adequate supply of HHR in northern, rural and remote communities, jurisdictions can take steps to reduce barriers to recruiting staff into key positions. It is critical to work with communities, organizations and other sectors of government beyond health to support healthcare providers and their families as they establish lives and careers in northern, rural and remote communities. This can include support to ensure suitable housing, as well as employment opportunities for the partners and family members of healthcare workers looking to relocate.

Additionally, supports to reduce isolation among health workers, including peer networks, access to specialist consultations, etc. can help to increase success in recruiting workers to these locations.

Finally, processes to help international medical graduates locate in smaller communities will require efforts to foster community integration as well as culturally safe workplaces. A 2015 report by the Rural Development Institute at the University of Brandon, Manitoba collected data from several provinces outlining key barriers to successful integration of newcomers to rural communities. Secondary to salaries and benefits, key supports such as childcare, schooling and orientation to local infrastructure and services are important considerations.

Recruit and license international graduates

The recruitment of international medical graduates can also be hampered by current licensing processes. Participants noted the need to make processes to recruit and certify internationally trained professionals more efficient to help alleviate pressures experienced in northern, rural and remote communities.

Provincial and territorial licensing requirements can be limiting to the process of recruiting more internationally trained health workers. Licensing varies across jurisdictions and there can be significant financial costs for workers seeking licensure in more than one jurisdiction. The College of Physicians and Surgeons of Alberta launched a five-year pilot program to streamline the Practice Readiness Assessment process for international medical graduates. The College of Registered Nurses of Alberta has also simplified the application process for internationally-educated nurses.

Some participants noted that national licensing could offer a more streamlined approach to establish greater mobility for healthcare professionals, offer greater job security and stability, and contribute to meeting surge capacity needs in a timely manner.

Increase the supply of health providers

Efforts are required to increase the supply of health workers that provide much-needed services in northern, rural and remote communities. This can be accomplished either by reducing barriers to the flow of workers from other jurisdictions or by fostering and supporting people's interest in pursuing health careers.

The Canadian Alliance of Physiotherapy Regulators signed a memorandum of understanding with 10 of its members in May 2017 to help facilitate cross-jurisdictional practice, allowing physiotherapists in one province to provide care to patients in another province. National and regional licensure continues to be discussed as a potential strategy for reducing barriers to the provision of patient care where and when needed. Here are further elaborations on this workforce mobility strategy:

- Canadian Medical Association
- The Atlantic Physician Register will support mobility of physicians licensed in any one of Newfoundland and Labrador, Nova Scotia, Prince Edward Island and New Brunswick.
- Canadian Association of Emergency Physicians
- Society of Rural Physicians of Canada

Other changes are underway across Canada to facilitate cross-jurisdictional practice of health care professionals. Recent developments include Ontario's proposal to allow health care workers registered or licensed in other Canadian provinces or territories to practice in Ontario before acquiring licensure there. And Nova Scotia passed *The Patient Access to Care Act* in early 2023 facilitating licensure of all 21 regulated health professionals in that province.

Strategies to increase the number of students choosing specialities, such as family medicine, paediatrics and other services in short supply in some northern, rural and remote areas, ideally start early and are encouraged in the training of all healthcare workers. A promising strategy is to encourage interest in healthcare careers among local youth, and support ways for them to receive education opportunities followed by mentorship and career progression back in their home communities. As an example of a training and placement service, Interior Health supports training and hiring for people beginning Health Care Assistant careers.

Retain current staff

Retention was identified as among most effective ways to ensure a stable supply of trained healthcare workers. Local staff understand the geographic, cultural, social and economic contexts they are working within, leading to a better understanding of what appropriate care is within their own communities.

The need to improve the safety and security of staff traveling across great distances or in remote areas was highlighted, as was the need to ensure greater pay equity for healthcare professionals working in northern, rural and remote communities. Agency staffing has become part of how services are delivered, resulting in differences in pay between health professionals providing the same vital services. This has led to intra-professional competition. To retain health professionals and acknowledge their important contributions to northern, rural and remote communities, fair and equitable pay is one of several benefits important to consider.

Additional retention incentives are important to people, including time to renew and recharge. Participants noted the need to engage with the current workforce to understand how they can be supported to stay in their current roles. As an example, Ontario has implemented an emergency department peer-to-peer program to provide mentorship, coaching and assistance to physicians in northern and rural hospitals. This support may contribute to a sustainable capacity to provide care and reduce burnout. The Alberta Medical Association's Physician Locum Services provides incentives for locum physicians to provide coverage and relief for physicians practicing in rural communities.

HEC, in partnership with the Canadian Institute for Health Information, identified promising practices for retention of the health workforce in northern, rural and remote communities. HEC recently conducted an analysis of recent health workforce reports that resulted in roundtable dialogues and a proposal for six retention objectives:

- Fostering physically safe work environments
- Enhancing sustainable staffing
- Building flexible work structures
- Providing equitable and appropriate compensation
- Ensuring supportive and inclusive workplaces
- Supporting career advancement

The purpose of this work was to leverage recommendations already available and move collectively towards action. HEC recognizes that to support and retain the current workforce, many stakeholders will need to be involved, using their respective levers and staying in close collaboration so each can share and learn from the others.

Recruit people from northern, rural and remote communities

In addition to supporting current staff to stay, recruiting individuals from northern, rural and remote communities into health careers was identified as another way to support a stable workforce. It was recommended that "locally grown" and supported healthcare providers would lead to a more sustainable workforce because individuals from northern, rural and remote communities understand local contexts and may be more likely to want to establish careers near their home communities. To do so, multi-sectoral collaboration among education, employment and health sectors at municipal, provincial/territorial and federal levels will be required.

There is a need to ensure clear opportunities and pathways for people straight from high school into the community as healthcare workers, matched with career supports, work-life balance and advancement opportunities. At present, a gap exists between the stated need to grow the health workforce, and practical means for people to do so. For communities that don't have a high school, attending elsewhere (often in a larger community) can make it more difficult to return.

Beyond considering the resources required to train as a healthcare worker (attending training away from home, costs of living away from home, etc.) youth also need to see the realm of the possible – role models, mentors and people from their community advancing careers in their community. Further, once recruitment is successful, building roots in a community outside of one's job role is key to balance, satisfaction and retention. For instance, Alberta's RESIDE program offers both community integration supports and financial incentives for family medicine practitioners interested in careers in rural centres.

Accessibility of Care

Accessibility of care in rural, remote and northern communities is a challenge beyond just the provision of emergency services. In addition to precarious ED services, some communities are also under-served in primary care, speciality care and community services such as home care. When primary and community care are limited, community members often need to access the ED for routine services that would be better provided in other settings if the services were available. This reliance on the ED can cause even greater disruptions when ED closures happen.

Use multi-disciplinary teams

One potential solution to deliver care in more appropriate settings is to use multi-disciplinary teams to leverage various types of expertise and reserve the professionals with the highest scope of practice for the most urgent cases. For example, Ontario's Renfrew County Virtual Triage and Assessment Centre (VTAC) offers remote consultation via family physicians, with paramedics supporting in-home care where needed.

Alberta's HealthLink service includes the Virtual MD program, where patients first triaged by registered nurses can virtually connect with a physician for certain cases requiring timely connection to medical advice. While multidisciplinary care increases the range of providers who can deliver care, health services upstream and downstream from the ED still need greater continuity. By focusing on the patient's or community's need, the design of care follows.

As an example of team-based care leading to appropriate care, patients referred to the Vancouver Spine Surgery Institute are first triaged by advance practice physiotherapists to determine the most appropriate care pathway. It is estimated that approximately 70 percent of patients referred do not ultimately require surgery after being assessed, but instead would benefit from other interventions.

Bring support close to patients

By virtue of being geographically distant from some necessary services, northern, rural and remote community members are often required to travel to other locations, sometimes at great cost, to access care. In addition to practical considerations such as ability to secure travel, costs of the travel and, potentially, accommodations, residents confront considerable navigational issues. Northern, rural and remote residents also can encounter multiple levels of government when seeking care. And when patients need to seek care outside their home province or territory, the lack of an integrated health record hampers continuity of care.

Bringing support closer to patients and providers can sometimes help prevent transfers or medical travel. Manitoba's Virtual Emergency Care and Transfer Resource Service (VECTRS), launched in Winnipeg, offers healthcare providers in northern, rural and some Winnipeg facilities improved access to specialist consultation for clinical advice and when coordinating the transfer of patients.

Increase access to other care options

Efforts to increase access to care options outside the ED is one strategy not only to take pressure off EDs, but also to minimize disruption if closures are required. As an example of increasing options for receiving care, the *Alberta Mental Health Act* has been amended to add nurse practitioners to the providers authorized to examine a patient and increases flexibility in the locations permitted to assess a patient. Allowing assessments at secure locations rather than designated facilities expand a patient's ability to connect with a healthcare provider closer to the patient's home. Additionally, allowing assessments via videoconference can eliminate the need for additional travel. These options to have care provided by different types of providers, or in different locations, can enhance service and be supportive when EDs close.

Increasing access to primary care and supporting greater use of community-based services can help meet local needs. Paramedicine and home-based medicine are showing great innovation in providing care to northern, rural and remote residents. As part of a multidisciplinary team, patients can receive care in their homes or in their communities, and do not always require emergency care.

The role of paramedics providing community care has shown promise in recent years, adding vital assessment and treatment services to communities – though a standardized approach for implementing the addition of this profession into non-traditional care settings requires further development. In addition, jurisdictional issues need to be resolved to facilitate timely and accessible care. This includes clarifying, for example, whether paramedics from a regional health authority can travel onto a reserve (federal jurisdiction) to treat patients. The potential to better serve patients

is spreading: Prince Edward Island, for example, has successfully incorporated paramedics into community-based care roles in a number of scenarios.

Changing the location of services outside traditional settings can also increase the capacity and in some cases appropriateness of services. For example, some provinces allow the delivery of mental health and substance use services outside of EDs, helping to increase capacity in the community and providing services that are more patient-centred. A Toronto initiative has created a stand-alone clinic for people with alcohol intoxication to be dropped off by paramedics (instead of accessing an ED). Care is taken over by harm-reduction workers, case workers and an on-call physician. Patients have a safe and supportive location to rest and recover while receiving health and social supports. This clinic has addressed the needs of this population, diverted patients from unnecessary ED visits and freed up paramedics to return to the community faster.

Leverage virtual care supports

The use of technology is another way to increase capacity for services in northern, rural and remote communities. Communities can leverage virtual supports for healthcare providers, such as peer-to-peer mentoring or consultations, triage services, etc. to optimize delivery of care and reduce demands. Additionally, community members can access services such as primary care, specialty care, etc. that might not otherwise be available to them in their local community.

However, virtual care is not a panacea and is best supported by investments in accessible and reliable broadband services. Continued efforts are also required to ensure that privacy legislation related to owning, accessing and sharing health information does not serve as a barrier to virtual care.

As a response to virtual care, in 2022, Canada's federal, provincial and territorial privacy commissioners and ombudspersons with responsibility for privacy oversight issued a joint resolution on digital health to propose simpler methods for working across provinces and territories.

The joint resolution states that the privacy commissioners and ombudspersons will work together on steps – including collaboration with governments, regulatory colleges, health sector and other relevant stakeholders – to provide privacy and security guidance as the health sector transitions toward modern, secure and interoperable digital alternatives for communicating personal health information. Privacy commissioners and ombudspersons will also provide privacy and security guidance to relevant stakeholders on how to fulfill their obligations and preserve public trust.

Most fundamentally, efforts are needed to ensure that virtual care services provided are high-quality and appropriate for the populations that live in rural, remote and northern locations, with cultural safety built into all virtual options.

In addition, when healthcare teams are already working at capacity, the introduction of new processes or technology requires thoughtful and thorough change-management approaches, training and support. A hybrid approach that combines virtual services and in-person care can help maximize community capacity and ensure the continued provision of appropriate services.

No matter what approach is taken to incorporate virtual care options, the focus is recommended to be on locally driven solutions, as urban models and approaches often are neither replicable nor relevant in northern, rural and remote communities. Efforts to create dialogue between community members and those who plan and deliver care can provide an opportunity to co-design options for care outside an ED, as well as learn the health needs of the community, which will enhance appropriate care (including primary care).

Culturally Safe and Equitable Care

The needs of residents living in northern, rural and remote communities are unique and require thorough consultation to support population health. The issues most commonly experienced in a community are not always reflected in its services and care options.

Policies for ED services, as well as services in the community, are best developed in partnership with patients, essential care partners and families from these communities. Special attention should be given to addressing disparities in access and health outcomes by engaging First Nations, Inuit and Métis partners to help health services meet their obligations under the Truth and Reconciliation Commission Calls to Action and the UN Declaration on the Rights of Indigenous Peoples.

Conduct a robust needs assessment

Community health service planning is ideally underpinned by a robust needs assessment process, including thoughtful collection of both quantitative and qualitative data to understand the services required and the most appropriate ways to deliver them. Policies are most likely to succeed and meet intended purposes when they are informed and designed by the communities using an iterative process.

Transparency and partnership can help clarify roles and scopes of influence – for example, that certain policy decisions need to be made by certain entities within the policy-making process. (In other words, regional policy-makers typically make decisions about where regional resources can be allocated). But decisions are best informed by hearing community needs and diverse voices in a co-design forum.

Ensure safe and equitable care

Consulting and engaging the community can help to increase the provision of equitable care. Historically, policies and practices have been designed with minimal thought for how they will affect diverse populations. Ensuring that underserved groups can receive adequate access and reducing harmful practices such as racism and discrimination are all critical to ensuring safe and equitable care.

We heard that to help improve the experience of First Nations, Inuit and Métis patients, the Government of Northwest Territories' Office of Client Experience has implemented Indigenous patient advocates and navigation supports. Furthering education and awareness of the historical contexts and inequities faced by First Nations, Inuit and Métis people is critical to providing safe and high-quality care. The Indigenous Health department at the British Columbia Provincial Health Services Authority administers the San'yas anti-racism Indigenous Cultural Safety Training Program. Core training modules are offered in British Columbia, Manitoba and Ontario. In Nova Scotia, Tajikeimɨk, the Mi'kmaw Health & Wellness organization, has partnered with IWK Health to develop a cultural safety curriculum for clinicians.

Provide a culturally safe workplace

Many First Nations, Inuit and Métis healthcare providers experience racism and discrimination in their workplaces. But a culturally safe workplace is foundational to recruiting and retaining staff. Training and education are important, along with safe mechanisms for reporting.

Building a culturally safe workplace begins by cultivating it during the education and career development process. The National Consortium for Indigenous Medical Education is transforming the future through action in its priority areas. As another example, Queen's University has launched a satellite campus in the James Bay and Hudson Bay areas to support a decolonized curriculum for local students pursuing health careers closer to home.

Conclusion

The unique circumstances and contexts of life in northern, rural and remote communities can create challenges for the delivery of healthcare. Despite these challenges, there are many dedicated and innovative leaders, providers and community members committed to finding ways to improve services to meet the needs of residents. Smaller populations and smaller teams can make the sustainability of services more precarious, requiring creative solutions to optimize resources and support care needs.

- Strategic investments to help local individuals enter healthcare careers was an approach that participants strongly recommended as an effective way to cultivate and retain a healthcare workforce.
- In certain circumstances, adding new roles and types of providers to teams can enhance care and deliver it in more appropriate settings.
- Simultaneously, addressing processes for assisting new graduates, internationally educated health professionals, and those seeking to practice in northern, rural and remote communities can assist to bolster teams.
- Leveraging technology to support delivery of care, when appropriate and feasible, can contribute to goals of sustainability and high-quality care.

As health systems across the provinces and territories incorporate adaptations and improvements emerging from the pandemic, there is opportunity in both policy and practice to catalyze creative and innovative approaches to the delivery of care.

During these times of continuing uncertainty and upheaval, health leaders are constantly facing new leadership challenges to ensure ongoing service delivery and innovation, and to create integrated systems that best serve patients, families, essential care partners and our health and care workforce.

Agile and adaptive leadership is required to move systemic change forward more quickly. Taking an inclusive and partnered approach to planning and designing health services with all involved will assist in implementing effective and responsive policies and practices. Maintaining focus on the features and needs of a community will lead to better outcomes and optimal use of the resources at hand.

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Appendix A: Historical context

The issue of emergency department (ED) closures is not new. Challenges in organizing and sustaining healthcare services in northern, rural and remote communities have existed for decades. What has worsened is the frequency and length of these closures, and that we are now seeing these challenges in larger centres, including major urban centres. Health system challenges related to ED closures can be broadly summarized as follows.

Capacity issues in the health system often reveal themselves in emergency departments. Capacity issues experienced within emergency departments serve as an early indicator of other challenges experienced across the health system. In northern, rural and remote regions of Canada, this might mean a shortage of community-based options, such as primary care, which brings patients into the ED who might otherwise be treated elsewhere if resources were available.

Even a decade ago, the Canadian Institute for Health Information (CIHI) found that one in five people who visited the ED could have had their condition treated in a family practice[1]. Nearly half of these visits were for upper respiratory infections such as colds, antibiotic therapies, sore throats, ear infections and care following surgery such as dressing changes and removal of stitches. Additionally, ED capacity can be stretched thin when there are too many inpatients elsewhere in a facility, preventing a flow of patients that need to be admitted from the ED.

ED imbalances can be viewed from a population health perspective as reflecting unmet need for services. At a population level, an increase in the burden of chronic disease has been observed due to an aging population, increases in obesity and other risk factors. Additionally, the burden of mental health concerns has increased significantly due to efforts to reduce the stigma associated with mental illness.

Many patients with these concerns end up in the ED due to a lack of access to primary care, culturally safe care or other necessary resources. Referencing pre-pandemic data from CIHI, one in three ED visits by older adults living in long-term care were for preventable or non-urgent issues where the patient did not need to be admitted[2]. Understanding the needs of a community, region or population — and serving them equitably — is key to improving health outcomes.

Lack of integration between healthcare services across the continuum. There is a need to work with communities to understand what kind of system design would work best for those living in northern, rural and remote communities, especially those facing ED closures. How can the system support the needs of the population and utilize the most appropriate resources for care? What are the unmet needs and what are the strategies that can be used to meet these needs?

Health human resources is an umbrella term that encompasses a significant number of complicated and connected issues[3]. ED nurses are more likely to experience aggressive behaviour from patients than nurses from other departments[4] — a situation made worse when there are long waits or challenges in accessing services. There is increasing and widespread recognition of burnout and moral distress in the health workforce.

The COVID-19 pandemic context

The COVID-19 pandemic exacerbated already-existing challenges in EDs, with effects particularly pronounced in northern, rural and remote communities.

Recruitment and retention challenges were even more marked in the face of higher volumes, higher acuity of cases, significant personal risk and moral distress and absences, which increased workloads and overtime — a negative cycle.

Concerns regarding the risk of virus transmission in health settings led many to delay care, leading to greater acuity once they made it to the ED. Patients also delayed routine care, such as childhood vaccination, cancer screenings, etc., potentially leading to worse outcomes and a greater burden of illness, some of it preventable. Further, the need to deploy providers to units treating patients with COVID-19 led to further access delays to non-emergent procedures, causing increased wait lists and sometimes poorer outcomes for patients. Issues of equity and population health became ever more pronounced.

The COVID-19 pandemic has served as a real-time test of the effectiveness of Canadian healthcare systems. It has highlighted areas where operational change and policy reform are critical, while also uncovering innovations and system resilience.

Legislative/regulatory context

In Canada, responsibility for the regulation of emergency healthcare is primarily within the jurisdiction of the provinces and territories. Canada's Constitution Act assigns responsibility for hospitals to the provinces and territories. Within provinces and territories, the federal government funds and operates some services directly in First Nations reserves and Inuit communities. In most provinces and territories, the ministry or department of health is responsible for health and care system planning, setting strategic policy directions and priorities, legislation, standards and guidelines, monitoring, accountability, compliance and the funding of services.

In a few instances, direct legislation in Canadian provinces and territories has guided the provision of emergency services or laid out guidance on what care should be provided when an ED experiences a closure. However, new elements of provincial and territorial law and regulations indirectly related to care provision may be needed to inform the planning for ED closures. The following elements provide a framework for considering how emergency services can be diverted and delivered safely:

- regulation
- licensure
- legislated restrictions on health care provider roles within hospitals
- location of emergency services
- oversight of closures by the minister or provincial health department
- health information privacy legislation
- privacy legislation and virtual care

Several jurisdictions have made legislative or regulatory amendments to create new options for types of providers that can deliver care, to allow care to be delivered in different ways or to create greater cohesiveness across provinces and territories for allowing care to be delivered more seamlessly. In other cases, organizations have created agreements or standard ways of working so that patients and residents benefit.

Healthcare Excellence Canada requested a scan of legislative and regulatory issues to provide background and inform the strategies presented in this report. The full version of the scan is available upon request. Please contact info@hec-esc.ca for more information on this policy guidance report or to request the full version of the legislative scan.

Endnotes

[1]Canadian Institute for Health Information. Sources of Potentially Avoidable Emergency Department Visits. https://secure.cihi.ca/free_products/ED_Report_ForWeb_EN_Final.pdf

[2]Canadian Institute for Health Information. Sources of Potentially Avoidable Emergency Department Visits. November 2014. https://secure.cihi.ca/free_products/ED_Report_ForWeb_EN_Final.pdf

[3]Canadian Medical Association. Physician Wellness: New 2021 National Physician Health Survey results – burnout and workload reductions. https://www.cma.ca/physician-wellness-hub/content/physician-health-survey-results-burnout-and-workload-reductions

[4]Stelnicki AM, Nicholas PR, Reichert C. Mental Disorder Symptoms Among Nurses in Canada. Canadian Federation of Nurses Unions. 2020. https://nursesunions.ca/wp-content/uploads/2020/06/OSI-REPORT_final.pdf