
CONFERENCE ABSTRACT

Rural Stories of Getting Back Home: An integrated knowledge translation study of people's experiences of navigating access to healthcare from rural and remote communities in British Columbia, Canada

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Introduction: In British Columbia (BC), Canada, health systems centralization shifted services to population-dense cities within geo-politically defined geographies. Although intended to create structures to respond more efficiently to local needs, the result has been a reduction in rural and remote services. People living in rural and remote communities face disproportionate socioeconomic burdens related to navigating health care. With growing interest in providing care closer to home, rural communities face particular challenges. In BC's interior, one healthcare organization serves more than 100 rural and remote communities, including 54 First Nations communities, across 250,000 km². People travel vast distances, crossing multiple mountain passes through year-round intense weather to access care.

Methods/Theory: Our research question was: What are the experiences of patients, their families, and nursing care providers in transitions from a referral centre back to rural communities? This integrated knowledge translation study used narrative methods to document stories of people living in rural communities who were referred for care, but chose not to go. Our research team included patient and community voices, decision makers (i.e., administrative leaders), clinicians, students, and researchers—actively doing research with people who could affect change in response to the experiences of people living in rural communities.

Results: Findings highlighted the complexity of fragmentation within healthcare and transportation systems that interact with increasingly complex patient needs. Patients and families experienced emotional and financial hardship related to trying to get back home. Discharge planning and transportation coordination were frequently challenging for patients, their families, and their care providers—with limited participation of patients and families in the process overall.

Discussion: Embedded in the realities of living rurally and accessing healthcare are multiple assumptions. These assumptions occur at disparate governance points—from policy and decision-making domains outside the scope of the healthcare system to the daily practices of clinical and administrative staff involved in coordinating appointments, care, and transport. These assumptions can mask or entrench health and social inequities.

Conclusion: Rural communities face compounding inequities in navigating access to care, particularly in navigating transportation and getting back home. Using existing technology, improving the ways in which systems collaborate between urban and rural communities, and

supporting practical mechanisms for governance are essential pathways to ensuring centralized services do indeed serve the populations they are intended to serve.

Lessons Learned: We learned about the importance of supporting systems to know themselves, and validated the role research can play in facilitating this de-fragmentation process.

Limitations: Participants in our study felt compelled to share their experiences because they believed their story offered an important lesson to learn from—which means their stories illuminate opportunities for improving. People whose experiences were benign or unremarkable are unlikely to share their stories

Suggestions for Future Research: Our study validates others exploring rural health priorities and challenges in BC, as well as studies evolving nationally and internationally. Future research will build on established relationships with rural communities to foster evidence and equity-informed governance and rural engagement in decision making.