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Continuing Care in Northern Alberta: Capacity and Collaboration

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Abstract

As rural communities face aging, population decline, and the withdrawal of public services, the provision of care in rural and northern areas becomes increasingly complex, draws from multiple and often over-lapping stakeholders and organizations, and often functions differently than in more urban or ex-urban areas. Drawing from a series of continuing care capacity workshops held in Northern Alberta, this paper presents a roadmap of both continuing care in the region, as well as a refined model for how capacity can be built, maintained and developed for continuing care practitioners and organizations. Based on five broad research questions, we demonstrate not only the differentiation between rural, Aboriginal and northern communities in terms of continuing care, but also the need to acknowledge that the factors driving the functional success of the provision of continuing care can also become weaknesses.

Keywords: rural; northern; capacity; care; networks

1.0 Introduction

In 2014, 54% or more of the world's population was living in urban areas, and over 80% of North Americans were living in urban spaces (United Nations [UN], 2015). However, this population shift is not equally distributed across all demographic sectors and, as a result, may be more pronounced and have greater implications in rural communities. For example, while Canada is experiencing an aging population (the number of Canadians aged 85 and older increased by 19.4% between 2011 and 2016, almost four times the rate of the population as a whole [Statistics Canada,

2017]), rural populations in general have been older than their urban counterparts for several years (Dandy & Bollman, 2008). Similarly, Canada's rural population is aging faster than the urban, meaning that the percentage of older rural citizens is increasing faster than the percentage of older urban citizens. This is caused, in part, by the broader demographic movement of younger Canadians, particularly those with secondary education, to larger centres for education and employment (Strommen & Sanders, 2017). Finally, as a counterpart to the "rural brain drain" of younger, skilled adults, approximately 16% of rural communities in Canada are aging due to the in-migration of seniors (Artz, 2003).

These seniors typically come from smaller surrounding agricultural communities that no longer provide the resources required or desired by older rural citizens (this pattern is not new—see for example Hodge, 1993). In turn, a major and well-documented population dynamic, supported by 'Aging in Place' policies, sees a long-growing segment of rural populations that require access to health care, housing, home supports, recreation, transportation, as well as innovative solutions to the design, delivery, and maintenance of those same services.

As a result of the growing policy and academic awareness of these pressures on rural populations in Canada, there has been a need for attention to the combination of well-being and demographic changes in these areas. This is particularly true for communities that are situated at a slightly greater distance from the larger urban areas, such as Toronto, Edmonton, Saskatoon or St. John's. In Canada, the continued focus on the social determinants of health by public health practitioners and policy has raised awareness of how health and well-being extend beyond questions of disease to issues of place, social status, income, race, and gender (Raphael, 2016). This has direct implications for the provision of health services in rural communities, and particularly for continuing care (CC), which includes both health and accommodation services for individuals with chronic care demands.

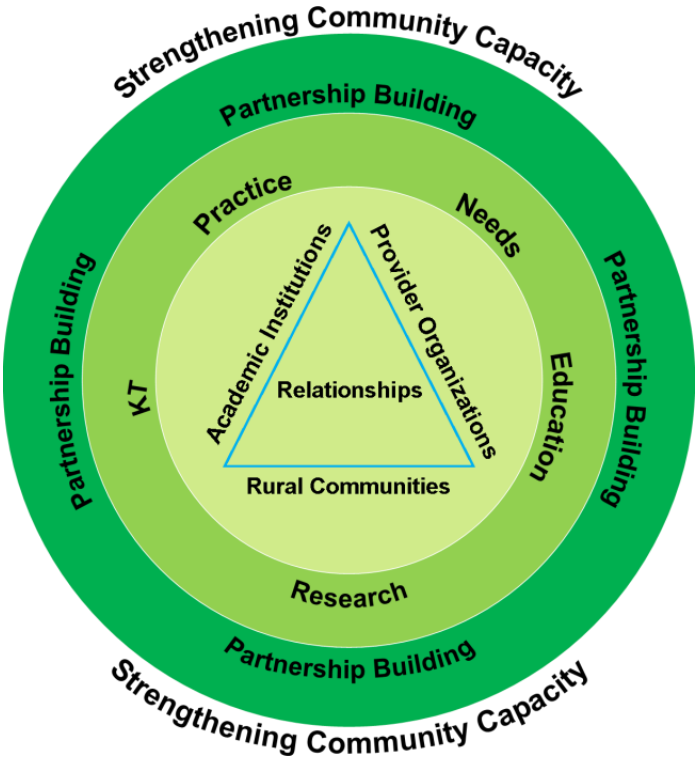
Continuing care in rural and remote communities in Canada is often characterized by a scarcity of formal services and resources, leading to a disproportionate reliance on informal supports. The sustainability of these informal providers, including family, friends, neighbours, volunteer-based programs and social services, is increasingly under question as issues of affordability and infrastructure are brought forward in the literature. At the same time, the impetus for partnerships, a collaboration between formal and informal providers, and evaluation and recognition of the diversity of rural communities, all point to the need for a functional as well as structural understanding of rural CC.

As rural communities are commonly framed from a deficit or negative standpoint, we want to challenge this framing by recognizing: (1) the assets and resources that do exist; (2), the functionality that is already present; and (3) the capacity in place to make decisions, and act upon and implement changes based on those decisions. In turn, the broader impetus and model (see Figure 1) for the events leading to this article was to begin from an assumption of capacity, and to then let the specific practices, relationships, and histories of different rural places within Alberta inform the meaning of capacity, whom it engaged (either as individuals or as organizations) and how it might be further developed or supported. This more place-based approach to both the organization and practice of care is particularly suited to rural areas, where the mixture of formal and informal caregiving and often close intersections with other care and support organizations present a much more adaptive model of CC.

Drawing from a series of workshops held in Northern Alberta, this paper seeks to answer five core questions in regards to rural CC:

1. How are rural residents receiving continuing care?
2. Who in the health workforce is providing the continuing care?
3. What are the gaps? What is working?
4. How can the post-secondary institutions (PSIs) best address the gaps?
5. What research (into continuing care) could support best practices in the area?

Figure 1. Original Community Capacity Model.



Source: ACSRC & ICCER ©.

The pressures faced by rural communities have sparked innovative and sometimes long-standing collaborations between various organizations and institutions. In Alberta, one such opportunity was provided by the creation of the Rural Alberta Development Fund, and the subsequent creation and funding of the Alberta Rural Development Network (ARDN). This network was the first of its kind to include all 21 publicly funded PSIs in Alberta and was implemented to encourage inter-organizational and inter-institutional collaboration for rural communities. The ARDN supported a wide range of research, knowledge exchange, networking, and event-based projects between 2009 and 2015. In early 2010, the Alberta Centre for Sustainable Rural Communities (ACSRC) and the Institute for Continuing Care Education and Research (ICCER), both housed at the University of Alberta, agreed to begin exploring the rural dimensions of CC in Alberta through a series of ARDN-funded consultations to be held in rural Northern Albertan communities.

This paper outlines the combined results of the workshops and the questions above. It also aims to position these results with the academic and grey literature focused on Canadian CC. Specifically, the differentiation between formal and informal caregiving, availability of infrastructure and services, and the different costs of CC identified in the literature were reflected in the workshops. However, the literature tends to emphasize urban-based care and neglects the importance of place, and rurality specifically (Brassolotto, Haney, Hallström, & Scott, forthcoming 2018). Also overlooked are the complexity and variability of how CC is defined, how it exists and functions within different settings and the resulting importance of tools such as policy design (Bobrow & Dryzek, 1987) to inform the practice and analyses of rural CC.

Building from this adaptive, place-based view of capacity building (see for example Beckley, Martz, Nadeau, Wall, & Reimer, 2008; Kulig, Edge, & Joyce, 2008; Swanson & Bhadwal, 2009), we aim to examine the themes identified in the workshops through a higher-level, policy design approach that addresses the variation, similarities and contexts of these different caregiving settings (Hallström, Ashton, Bollman, Gibson, & Johnson, 2015). This approach allows us to see CC in a way that crosses sectoral or ministerial divisions and strategies by placing the themes within the policy design categories of the locally articulated, explicitly rural values, audience and contexts shaping CC in Northern Alberta (Bobrow & Dryzek, 1987; Hallström et al., 2015).

2.0 Continuing Care in Alberta

Although the majority of individuals in CC are seniors, it is important to remember that CC is not just about older adults; it also includes non-seniors with disabilities who require health care and personal care services on an ongoing basis. Within the home living and supportive living sectors, 31% of clients are younger than 65 years of age (Alberta Health Services [AHS], Provincial Continuing Care, Community, Seniors, Addictions, & Mental Health, personal communication). In long-term care, approximately 9% of residents are under the age of 65 (Alberta Health, Continuing Care Branch, 2017).

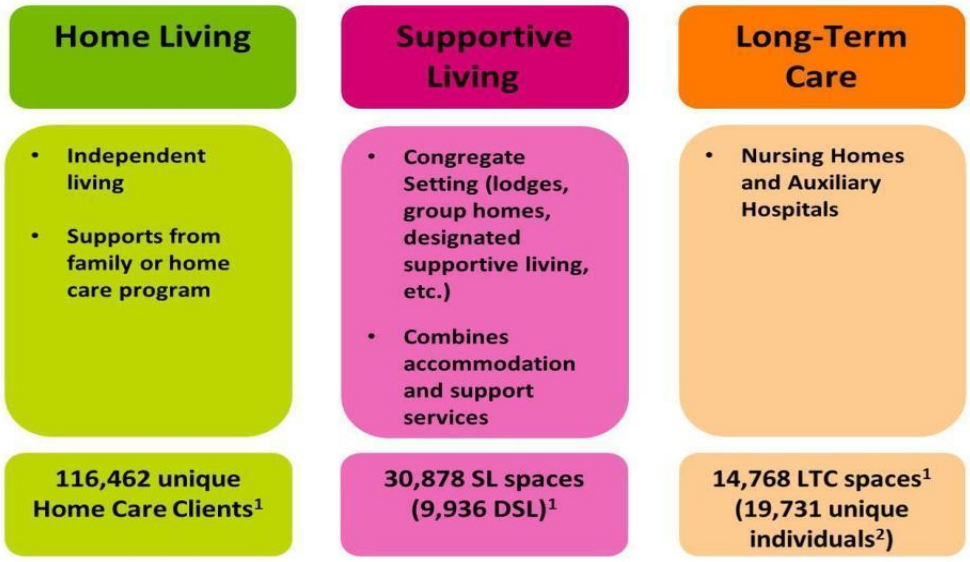
Both the number and the percentage of seniors in the population are increasing. In 2016, there were over 505,000 seniors in Alberta, representing 12% of the population (Alberta Government, 2017). This number is expected to grow to over one million in the year 2035, and seniors as a percentage of the population will increase during this same period (Alberta Government, 2017). As the population ages, there will be a greater need for CC services in both urban and rural spaces.

Continuing care in Alberta is defined as a continuum of care that provides people with health, personal care, and accommodation services to support them in maintaining as much independence and quality of life as possible. There are three streams of CC in Alberta: home living, supportive living, and facility-based living (long-term care). These streams are shown in Figure 2.

Home living is (by population) the largest stream of CC, and is for individuals who are able to live independently and require only basic home care and personal supports. As care needs become more complex, or as a result of a shift in health status, individuals may transition to a supportive living environment, which includes congregate living situations, or long-term care. There are four levels of supportive living, depending on the amount of personal and health care support an individual

requires, and care can be implemented through variety of infrastructural and service models. Finally, long-term care is congregate living for people who have complex, unpredictable medical needs who require a high level of personal and health supports.

Figure 2. Alberta's Continuing Care System.



Note: [1]AHS, 2016; [2]Alberta Health; Continuing Care Branch, 2017.

There are different types of CC providers across the province who deliver care within the three streams: public, private for-profit, and private not-for-profit, as well as the various supports available for home or health support, including Family and Community Support Services (FCSS) and Meals on Wheels. These are also complemented by conventional health care services, such as public health, physicians, community care, and hospital/emergency care. With the diversity in programs and access between health zones across the province, it is no wonder that individuals can find CC structures difficult to navigate.

3.0 Continuing Care in Rural Canada

Continuing care is a significant component of the health care landscape for rural communities in Canada. Given the demographic, fiscal and service trajectories that are well-known in such communities, it is also an increasingly challenging landscape for both citizens and providers to navigate and is often characterized from a deficit or needs-based perspective. As the brief literature review demonstrates, much of the scholarly (and policy) attention has been focused on the nature of care provision and the barriers to care.

3.1 Formal Care

The literature suggests that formal services are perceived as insufficient in many rural and remote communities (Dal Bello-Haas, Cammer, Morgan, Stewart, & Kosteniuk, 2014; Health Council of Canada, 2013; Keating, Swindle, & Fletcher, 2011; Morgan, Semchuk, Stewart, & D'Arcy, 2002; Nelson & Stover Gingerich, 2010; Rozanova, Dosman, & de Jong Gierveld, 2008; Skinner et al., 2008). One factor in the absence of formal services is the lack of human resources (Averill, 2012; Chappell, Schroeder,

& Gibbens, 2008; Dal Bello-Haas et al., 2014; Gallagher, Menec, & Keefe, 2006; Kelley, Sellick, & Linkewich, 2003; Nelson & Stover Gingerich, 2010; Special Senate Committee on Aging, 2009). Studies note the "outmigration of youth" (Clark & Leipert, 2007, p. 14) from rural areas as a problem that often leads to insufficient staffing (Keating et al., 2011; Skinner et al., 2008). Without doctors and health professionals to deliver needed services, they cannot exist (Clark & Leipert, 2007). The issue of staff recruitment and retention is another example of this (Goins, Williams, Carter, Spencer, & Solovieva, 2005; Health Council of Canada, 2013; Keating et al., 2011; Novek & Menec, 2014; Skinner et al., 2008). Working in a rural CC setting does not appeal to many health care workers due to the distant location. This is especially prevalent in "remote and isolated" Aboriginal communities (Health Canada, 2011, p. 28). Health care workers are also turned off by the lack of professional development and training opportunities in rural and remote areas (Dal Bello-Haas et al., 2014; Goins, Gainor, Pollard, & Spencer, 2003; Keating et al., 2011; Kelley et al., 2003; Morgan et al., 2002).

The use of technology, such as telemedicine, may improve access to formal health services and supports without the need for travel (Clark & Leipert, 2007; Dang, Gomez-Orozco, van Zuilen, & Levis, 2018; Gallagher et al., 2006; Keating et al., 2011; Nelson & Stover Gingerich, 2010; Special Senate Committee on Aging, 2009). Telemedicine may also improve the "cultural safety" of care, which is especially significant for Aboriginal communities (Health Council of Canada, 2013, p. 9). While technology has shown to be extremely useful for many remote communities, it is important to note that the necessary technological supports and internet connectivity is not always present in these areas (Clark & Leipert, 2007; Health Council of Canada, 2013; Keating et al., 2011; Special Senate Committee on Aging, 2009). Further, not all older persons know how to use a computer (Clark & Leipert, 2007).

3.2 Informal Care

Informal and volunteer services are a large part of service delivery in rural and remote settings (Averill, 2012; Dal Bello-Haas et al., 2014; Di Gregorio, Ferguson, & Wiersma, 2015; Keating et al., 2011; Novek & Menec, 2014; Rozanova et al., 2008; Skinner et al., 2008). Adults in remote Canadian communities "provide more help to family members, friends, and neighbours" compared to those in urban centres (Rozanova et al., 2008, p. 78); however, many of the volunteers in these communities are seniors themselves (Gallagher et al., 2006; Keating et al., 2011; Skinner et al., 2008; Special Senate Committee on Aging, 2009; Strommen & Sanders, 2017). As younger generations move away from rural communities, what is left is the old caring for the old (Rozanova et al., 2008; Special Senate Committee on Aging, 2009). Voluntary services that rely on older generations to provide support cannot be sustained (Rozanova et al., 2008) and may lead to burnout if formal supports are not in place (Chappell et al., 2008; Gallagher et al., 2006; Skinner et al., 2008). The reliance on the notion of strong informal ties in rural communities as a justification for the absence of formal services will put too much weight on informal caregivers (Keating et al., 2011) and further complicate existing challenges (Skinner et al., 2008).

3.3 Privacy Concerns

Privacy is another issue specific to rural culture that impacts delivery of care. In many remote communities "everyone knows everyone" (Sims-Gould & Martin-Matthews, 2008, p. 47) and some residents may avoid formal health services because they fear a lack of confidentiality about their state of health (Chappell et al., 2008; Morgan et al., 2002). For some, a personal relationship may be the reason residents prefer to receive care in their area (Kelley et al., 2003) as providers may know each individual's attitudes and preferences related to care (Di Gregorio et al., 2015). Close relationships can pose an issue for staff working in these settings as well (Dal Bello-Haas et al., 2014; Jervis-Tracey et al., 2016). As Sims-Gould and Martin-Matthews (2008) indicate, it can be difficult for health care workers to separate their "professional and personal boundaries" (p. 47) when caring for someone with whom they have a personal relationship. For many, though, the desire to provide the best quality of care to those in their community stems from this close connection.

3.4 Affordability

The affordability of formal health services poses an issue for rural and remote seniors to stay in their community (Bacsu et al., 2012). Compared to those living in urban settings, rural residents tend to be socioeconomically disadvantaged (Clark & Leipert, 2007; Scharf & Bartlam, 2008). This is, in part, due to lower incomes earned throughout their lives in rural settings (Nelson & Stover Gingerich, 2010; Scharf & Bartlam, 2008). This may hinder their ability to access certain formal supports as older adults (Scharf & Bartlam, 2008). For example, the absence of reimbursement for residents or their caregivers for travel and accommodations when accessing out-of-town services is a major financial barrier (Bacsu et al., 2012; Chappell et al., 2008; Gallagher et al., 2006; Keating et al., 2011; Novek & Menec, 2014; Ryser & Halseth, 2012; Special Senate Committee on Aging, 2009). Affordable housing options are missing in many remote communities (Novek & Menec, 2014) and the high cost of home maintenance and repairs (Keating et al., 2011; Strommen & Sanders, 2017), in addition to home care costs (Gallagher et al., 2006; Special Senate Committee on Aging, 2009), can be a deterrent for those who would prefer to remain at home (Bacsu et al., 2012; Morgan et al., 2002). Where financial assistance does exist, many residents are unaware of how to access it (Ryser & Halseth, 2012).

3.5 Infrastructure

There are often not enough housing options available across the continuum of care in rural areas either (Averill, 2012; Bacsu et al., 2012; Gallagher et al., 2006; Novek & Menec, 2014; Special Senate Committee on Aging, 2009; Strommen & Sanders, 2017). Frequently residents go to long-term care or acute care hospitals following a change in their health, regardless of the level of care they may require (Keating et al., 2011; Skinner et al., 2008). This is due to the shortage of alternative levels of care in rural communities, such as supportive or assisted living, as well as home care options (Averill, 2012; Gallagher et al., 2006; Goins et al., 2005; Skinner et al., 2008). Most residents prefer to remain in their own home for as long as possible, however, in rural communities, a shortage of home care staff (Nelson & Stover Gingerich, 2010) makes aging in place less likely. At times, the shortage of housing options or staff to provide care leaves residents in hospitals or inappropriate care settings for extended periods (Keating et al., 2011). It may also force them to relocate

to urban centres where their needed level of care is more accessible (Di Gregorio et al., 2015; Sims-Gould & Martin-Matthews, 2008; Strommen & Sanders, 2017), preventing older persons from living the remainder of their lives in their desired community (Gallagher et al., 2006; Novek & Menec, 2014).

Affordable housing options are a significant barrier for Aboriginal populations. The majority of Aboriginal seniors cannot access the level of CC or supports they require within their community (Dal Bello-Haas et al., 2014; Novek & Menec, 2014), and must leave to access services that are not culturally sensitive (Health Council of Canada, 2013; Special Senate Committee on Aging, 2009). Although there are programs that exist, such as the First Nations and Inuit Home and Community Care program, funding is not perceived as sufficient and varies between regions (Health Council of Canada, 2013). As Aboriginal populations experience health concerns, such as chronic disease, at a higher rate and a younger age than the rest of the Canadian population, their need for home care assistance and alternative levels of care is emphasized (Health Canada, 2011; Keating et al., 2011).

The opportunity for collaboration between formal and informal service providers, the users of these services, and PSIs appears to be rare in most rural and remote regions. The involvement of various stakeholders within these communities and nearby not only ensures that real needs are identified, but also increases community capacity to address them (Chappell et al., 2008). Without this type of collaboration, little change can be made (Jensen & Royeen, 2002).

4.0 Methods

We began planning for our first community consultations in 2010 and held our first in 2011. At that time a number of important documents related to CC and seniors health had been released that influenced people's interest and willingness to participate in the consultation process (*A Profile of Alberta Seniors* [Alberta Government, 2010]; *Moving Continuing Care Centres Forward: A Concept Paper* [Alberta Health, 2012]; *Rising Tide: The Impact of Dementia on Canadian Society* [Alzheimer Society of Canada, 2010]).

The original purpose for holding the community consultations was to help develop community capacity to address issues related to CC. “Community capacity building refers to the identification, strengthening and linking of your community's tangible resources, such as schools, businesses and local service groups, and intangible resources such as community spirit” (Ontario Healthy Communities Coalition, n.d.). We wanted to introduce the concept and highlight two elements of capacity: the capacity to self-determine, and the capacity to implement decisions that are made. In order to support these discussions, we developed and presented a framework at each of the workshops, which started with the recognition and need for both formal and informal relationships between rural communities, CC providers, and PSIs to be developed (see Figure 1). This model served as a catalyst for discussion and communication within the workshops but was not a primary objective or goal of the workshops. Rather, it provided a starting point for discussions and a point of reference for the core questions being asked.

Following the formal release of *Continuing Care Strategy: Aging in the Right Place* (Alberta Government) in December of 2008, the policy emphasis in Alberta has been on providing CC to individuals regardless of where they live. This raised a number of core questions for rural CC, and the PSIs providing training and resources in Northern Alberta:

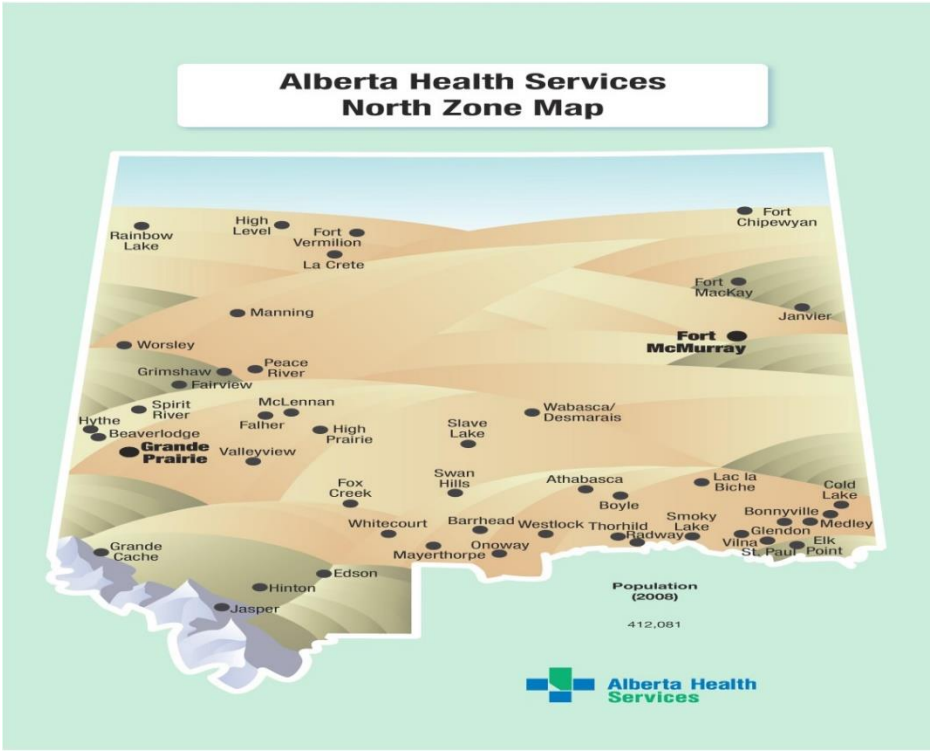
- How are the residents receiving continuing care?
- Who in the health workforce is providing the continuing care?
- What are the gaps? What is working?
- How can the PSIs best address the gaps?
- What research (into continuing care) could support best practices in the area?

Based on these questions, the ACSRC and ICCER conducted a series of workshops for seven different communities with local CC service providers, community organizations, and PSIs. These events were held between 2010 and 2016 and utilized a global café format. This involved grouping participants at small round tables to discuss the questions above, as well as provided an opportunity to identify as a larger group what and how CC needs were not being met locally, and whether issues could be addressed by PSIs through training and education programs for students and/or practitioners, and through research. These workshops, therefore, were largely unique as they not only brought different stakeholders together than would usually be the case, but also sought to engage local PSIs (including Keyano College in Fort McMurray, Grande Prairie Regional College, and NorQuest College in Edmonton) in finding opportunities for enhanced educational programming, research, collaboration, and capacity building. These goals were consistent with the mandates of both the ACSRC and ICCER, as well as the broader principles of community engagement, evidence-based decision-making and practice, the social determinants of health, and integrated public policy and programming, all of which contribute to the sustainability, resilience, and quality of life in rural Albertan communities.

Consultation events were held in Northern Alberta, in an area that corresponded roughly with the AHS North Zone (as depicted in Figure 3). According to the Canadian Community Health Survey 2014, the North Zone population was 491,793 (as cited in AHS, 2016, p. 41). Of these, 44,920 were over 65 years of age (as cited in AHS, 2016, p. 41). Notes for each event were captured as part of the global café format and were then used to create a report for each community and workshop. These summaries were then distributed back to the participants from each community as a resource for the local CC network.

Following the final workshop in 2016, we began assessing these reports as a collective, rather than as stand-alone documents. While each workshop and subsequent report utilized the same format and questions (see above), the goal of this analysis was to identify consistent themes and responses across the workshops in order to: (1) identify gaps and similarities within the policy, peer-reviewed and grey literatures; (2) provide a more regional level of analysis to complement the community-specific results identified; and (3) position the themes within a policy-making (i.e. potentially programmatic) construct rather than SWOT or deficit-based framework for analysis.

Figure 3. AHS North Zone Map.



Source: AHS, 2016.

4.1 Results from Workshops

Working from the reports generated by each workshop (available at http://iccer.ca/ccne.html), a research team of three individuals assessed the answers provided in each of the workshops and determined areas of consistency and overlap. The intention behind this approach was to determine the broad commonalities across rural, Northern Albertan communities, rather than to identify community-specific issues or assets, which was done within the workshops themselves. These common responses are:

How are the residents receiving CC? Common Responses:

- There is a combination of funded CC services and community-based supports within rural communities that are considered to constitute 'continuing care' in these areas.
- The boundaries/limitations of the services offered by social programs vary between communities; there is no consistency between them.
- The patchwork of formal CC facilities/home care in these areas leads to reliance on informal/volunteer-based programs for rural residents.
- Social programs often act as a bridge between the individual and formal CC services.
- Various health centres take on aspects of seniors care due to gaps in CC services in rural and remote communities (i.e., pharmacies, Primary Care Networks).

- The experience of receiving CC for First Nations, Métis, and Inuit populations in rural Alberta differs from non-Indigenous populations, in part due to jurisdictional issues.

Who in the health workforce is providing the CC? Common Responses:

- There is a broad definition of 'health' when considering who in the health workforce provides CC in rural and remote Albertan communities. This definition, therefore, expands the concept of the workforce to include:
    - the traditional health care providers (i.e., RNs, LPNs, physicians, specialists);
    - informal caregivers (i.e., family, friends, neighbours); and
    - staff/volunteers from program-based services (i.e., FCSS, Meals on Wheels).

What are the gaps? What is working? Common Responses:

- There is no singular 'system' or model of CC in rural Alberta—rather it is a variable, inconsistent blend of formal/institutional/home care and informal/home supports/ad hoc actions, connections, and programs that are potentially vulnerable with no resilience or redundancy.
- Despite the above mentioned comment, functionality can be quite high in some regions, but may largely be driven by informal/volunteer and supports rather than CC itself.
- There is a notable contrast between individual and systemic dynamics—not much attention is given to the necessary spaces between individual, person-centred care and the broader policy/institutional functions of CC.
- Distance remains a commonly identified issue, but also one that permits programming/interventions relatively easily (via technology, volunteers, etc.).

How can the PSIs best address the gaps? Common Responses:

- There was an immediate emphasis and recognition on the need for health/health care focused education and research in areas such as nursing, health care aide training, nutrition, financial literacy, etc.
- More innovative models of education were also identified as necessary and potentially best facilitated through PSIs. These included activities such as social learning, volunteer recruitment and engagement, and program development.
- In contrast to teaching or research, PSIs could also be engaged in service:
    - Engagement of faculty as volunteers/experts/supports;
    - Innovation in terms of: (1) brokerage; (2) network development (+/-); and (3) 'value-added' institutional presence (public good).

What research into CC could support best practices in the area? Common Responses:

- What are the most effective ways to identify, articulate and teach a rural 'lens' for CC in rural Alberta (whether for conventional or non-credit instruction, advocacy, policy, and inter-organizational collaboration)?
- What are the most effective ways for PSIs to undertake brokerage and network development for rural CC?
- What are innovative and effective methods for recruiting, retaining and building the capacity of the rural CC workforce?
- In addition to technical capacity, how can PSIs support 'soft-skills' for practitioners, including advocacy, empathy, cultural competencies (for Indigenous, elderly and agricultural communities in particular), and collaboration?

4.2 Discussion: Bringing Policy Design to Rural CC

Drawing from the results noted above, we place our findings into a high-level framework for rural CC in Northern Alberta using the concept of policy design as an approach to inform the "pursuit of valued outcomes through activities sensitive to the context of time and place" (Bobrow & Dryzek, 1987, p. 19). This overarching perspective seeks to sit above the 'languages' of public policy and hinges upon three elements: context, audience, and values. Our synthesis and conclusions are intended more to be "catalysts that shape the character and content of policy debate" (Bobrow & Dryzek, 1987, p. 21) rather than singular answers to how rural CC should work. Given the diversity of rural communities, this approach avoids the trap of 'one-size-fits-all' and instead provides a mechanism for comparison as well as a means to inform the selection of place-specific policy and delivery tools.

Continuing Care in Rural Alberta—The Context: The CC context for rural communities in Alberta is largely one of cooperative, blended models of care delivery with primary, acute and continuing care sometimes provided in the same place. That said, there is no pre-defined or singular model for rural CC, rather the delivery of care draws from the available resources within each community. These may extend beyond conventional models of health care provision and may even go outside local support services (e.g., FCSS in Alberta) to include the larger volunteer sector working within that region. While some levels of care (such as long-term care) naturally involve highly institutionalized settings, in many cases a variety of support organizations have evolved to take on both formal and informal roles in the delivery of care. It is important to note that while these individuals and organizations may work towards the same goal of providing CC, the identity, mandates, and functionality of these agents may vary from one community to the next.

The absence of a uniform system or model of CC in rural communities implies that (1) capacity building must take into account the network of formal/informal and institutionalized/ad hoc care providers; (2) care provision is not necessarily replicable or replicated between communities. Therefore, an organization may provide one portion of services or resources in one area, and a completely different body of services (or not at all) in another; and (3) models of capacity and capacity building require some level of adaptability that permits alignment with provincial policies and goals (where applicable) as well as the flexibility to

build on the histories, relationships, and practices already in place within the community.

Continuing Care in Rural Alberta—The Audience: There is a broad range of individuals and organizations engaged within the context of rural CC. The breadth of stakeholders was also reflected across the different workshops. It is important to distinguish, whether for policy, practice, or planning, between the levels of care, and providers and recipients of care. The levels of care cut across the three streams of CC, and include community/municipal/regional and provincial resources and programs. Care providers, whether formal or informal, cross all levels of care. Therefore, not only is the patient or client base going to vary between communities, but the breadth and diversity of CC functionality, and the individuals and organizations involved, is also a recurring factor.

The complexity and diversity of those involved in rural CC is made evident through a number of the themes noted above. For example, individual versus systems-level differences can lead to under-recognition of the provider and the importance of the delivery spaces found between micro (individual) and macro (health care) levels. As in many rural areas, the provider workforce is a highly diverse combination of conventional/formal health care workers generated by both local and provincial initiatives and structures, as well as informal caregivers and support services, that may not have a mandate clearly directed towards CC. Similarly, the jurisdictional 'setting' for Indigenous populations, including First Nations, Inuit, and Métis, has created a different experience for the delivery and receipt of CC within those communities.

Continuing Care in Rural Alberta—The Values: Three core values emerged throughout the workshops we conducted: collaboration, functionality, and continuity of care. While rural areas undoubtedly face significant challenges in terms of financial, human, and service provision (see literature review above), the reality of rural CC is commonly one of problem-solving, inter-organizational cooperation and collaboration. In this environment, adaptation and flexibility are necessary to respond to a frequently changing health system in terms of policy, fiscal, and labour supply. In order to continue to provide care, this system requires organizations to maintain long-standing relationships, attend to well-developed practices of place-based programming, and to be responsive at the individual and organizational level in ways that can enable care outside of typical organizational parameters.

While this adaptability is often understood as a positive, it can also pose a threat to organizational stability and service delivery if faced with changes in staffing, budgets, or operations. Even small shifts in resources can create communication gaps. Services, such as telehealth facilities, can disappear due to loss of knowledgeable staff. Delivery mechanisms that have been functioning for years can experience shocks that require innovative responses by the formal and informal care and support communities.

5.0 Conclusion: A Network Development Model for Rural Continuing Care Research, Education, and Service in Alberta

The issues regarding access to and experiences with CC services faced by residents living in rural and remote communities differ from their urban counterparts. These issues tend to be categorized broadly by geography, service deficiency, financial

constraints, and rural values. From a health systems standpoint, there are four critical areas that characterize the delivery of CC in rural Canada: (1) formal versus informal providers; (2) the importance of housing (both more generally, and specifically in terms of supportive living and long-term care environments); (3) financial considerations for both care providers and recipients; and (4) the importance of communication between different support and provider organizations.

While the traditional challenges of distance and density for rural communities mean that costs for providers are often higher, these factors also provide compounding issues. For example, the distance to some rural communities can be a deterrent for health care workers as they may take on the costs of traveling between client homes, including gas, as well as the risks related to extreme weather and road conditions (Goins et al., 2005; Keating et al., 2011; Sims-Gould & Martin-Matthews, 2008; Skinner et al., 2008). Similarly, the costs of providing and maintaining facilities, and care itself, can present challenges.

A common factor in the perceived scarcity of formal supports and resulting issues is a lack of awareness of the existing services within these communities (Bacsu et al., 2012; Chappell et al., 2008; Di Gregorio et al., 2015; Gallagher et al., 2006; Goins et al., 2005; Keating et al., 2011; Morgan et al., 2002; Ryser & Halseth, 2012; Skinner et al., 2008). Improved communication of the available and accessible services can help support service utilization in rural and remote areas. The collaboration between multiple service providers and members of the community may increase the knowledge of what services are available in a particular area (Chappell et al., 2008; Ryser & Halseth, 2012) and clarify the gaps that need further improvement (Gallagher et al., 2006; Nelson & Stover Gingerich, 2010; Special Senate Committee on Aging, 2009). Local service providers, both formal and informal, and the users of these services require "face-to-face communication" (Jensen & Royeen, 2002, p. 120) to address these issues as part of an adaptive network of rural CC.

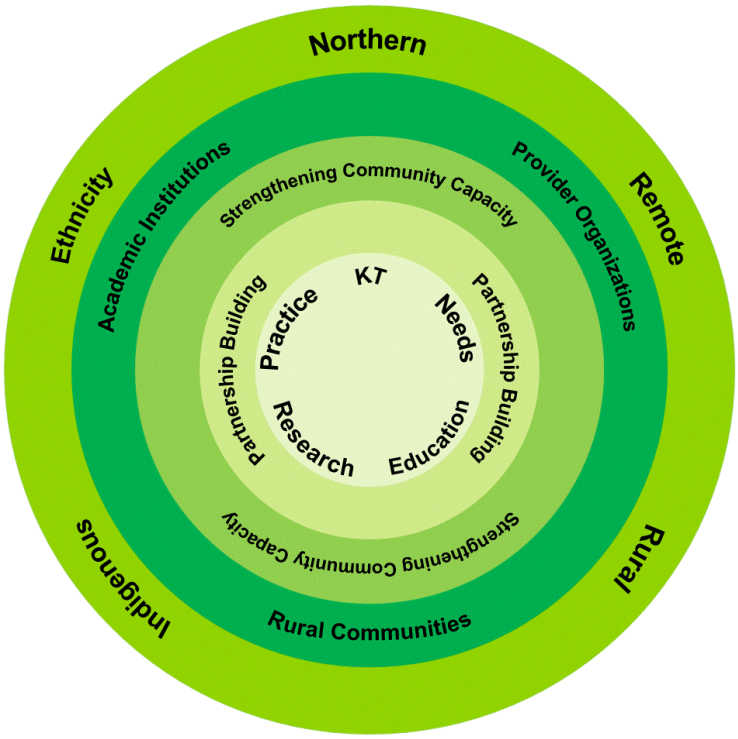
Building from the results noted above, a model of capacity-building for CC in rural Alberta emerges that differs from the functional emphases and pathways of the original (as shown in Figure 4). While many of the components are the same, what arises from both a policy design and community-based perspective is a model that identifies the different capacity needs of rural, versus remote, versus Northern, Indigenous and ethnic communities. It also positions capacity and capacity-building as both a positive by-product of the necessities of rural CC and as an integral activity of academic, community, and CC provider organizations working as a collective.

The overarching factors of geography (i.e., rural, remote, and Northern locations), ethnicity (certain cultural groups are more prominent in some rural communities than others), as well as the challenges facing Indigenous peoples in rural areas (Health Council of Canada, 2013) influence both the capacity of the community and the ability of various stakeholders to collaborate within it. This became apparent throughout the workshops and their analyses, as local dynamics and histories continue to be important factors in the function and assessment of CC. That said, increases in the frequency and scope of network interactions may be the most critical components to the working of CC in rural Northern Alberta.

This network-based model is innovative in that it shifts the concept of capacity away from being an output (i.e., capacity is a set of assets that are built or maintained) to a more functional model where the actions of different sectors and stakeholders are

not only indicators of capacity, but are the actions that build, maintain and evolve community capacity in a way that suits the contexts, audiences, and values of rural CC. This delineation provides a key area of operational emphasis for rural CC—maintaining the adaptability of the network itself becomes an important target for supporting the individuals and organizations involved.

Figure 4. Revised Community Capacity Model.



Source: ACSRC and ICCER ©.

Such a model speaks to the role and benefits of institutionally-driven activities such as the workshops discussed here. While research, education, knowledge translation (KT), and evidence-informed practice are the subject matter for the workshops, the reality for rural CC is that such assets alone do not result in increased organizational or collective capacity. Rather, it is the partnerships and adaptability of different organizations that support the capacity to both decide and to act in response to CC needs. These collaborations result in activities across organizations that enhance community capacity through increased efficiency and the increased likelihood of innovation, adaptability and responsiveness. As Tsai (2001) states, not only does increased learning take place within and across such a network, but organizational network characteristics may have their effects mitigated by the frequency of interaction itself. What emerges is somewhat paradoxical—the organizational adaptability and collaboration that make rural CC possible also creates a key vulnerability. As the workshops identified, communication and knowledge sharing between organizations was a common challenge; resources were often available, but the flexibility of different rural service providers meant that knowledge and/or information about those resources could be lost as the supports for CC adapted to changing needs.

This project demonstrates that while CC in Northern Alberta is not without its challenges, there are both resources and capacity in place. However, as our results show, there are factors that influence the use of those resources and capacity, and a notable opportunity for PSIs to engage in both the communicative and capacity-building activities in such communities. Specifically, educators can influence the future of service provision in rural areas through the curriculum (Goins et al., 2003; Jervis-Tracey et al., 2016). At the operational level, post-secondary researchers have the potential to incorporate education on rural practice issues and interdisciplinary training for students, and prepare them through practicum placements in remote communities (Goins et al., 2003; Jensen & Royeen, 2002). Perhaps more important, however, is the contribution that can be made to community capacity by enabling and participating in the conversations that reinforce the assets and resources that exist within the local CC network in rural settings.

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