

Continuing care in rural Alberta: A scoping review

Julia Brassolotto

Faculty of Health Sciences, University of Lethbridge

Carly-Ann Haney

Faculty of Health Sciences, University of Lethbridge

Lars Hallstrom

Augustana Faculty, Political Studies, University of Alberta

David Scott

Library, University of Lethbridge

Key Messages

- The literature on continuing care in Alberta primarily focuses on quality assurance and improvement and the changing structure of the continuing care workforce.
- Little is known about the continuing care needs of rural Albertans.
- Future research ought to explore rural assets and challenges related to continuing care provision.

Across Canada the demand for continuing care services is increasing. However, little is known about the implications this has for rural communities. This scoping review identifies several key themes in the literature related to continuing care in Alberta. These include contextual factors, quality assurance and improvement, and workforce issues. We identify the ways in which rural dynamics are included in, or omitted from, this literature and recommend areas for future research on rural continuing care provision. Further research on residential care services in rural communities should work towards bridging the rural health, academic, and organizational literature on continuing care. This synthesis will help to position rurality as a determinant of health and to situate continuing care services in specific rural settings.

Keywords: Alberta, continuing care, long-term care, rural

Les soins continus dans les régions rurales de l'Alberta : un examen de l'étendue des connaissances

La demande de soins de santé continus est en hausse partout au Canada. Toutefois, les incidences de cette situation auprès des communautés rurales sont très peu documentées. Le présent examen des connaissances recense plusieurs thèmes clés dans la documentation reliée aux soins continus en Alberta. Ceux-ci comprennent les facteurs contextuels, l'assurance et l'amélioration de la qualité et les problèmes de main-d'œuvre. Nous avons trouvé les façons dont les dynamiques rurales sont incluses dans cette documentation ou absentes de celle-ci et nous recommandons des thèmes pour des recherches futures sur la prestation de soins continus dans les régions rurales. D'autres recherches sur les soins de santé en établissement dans les communautés rurales devraient s'efforcer de combler le fossé entre la documentation sur la santé rurale, la

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

Correspondence to / Adresse de correspondance: Julia Brassolotto, Faculty of Health Sciences, University of Lethbridge, 4401 University Drive, Lethbridge, AB T1K 3M4. Email/Courriel: julia.brassolotto@uleth.ca

documentation universitaire et la documentation organisationnelle sur les soins continus. Cette synthèse permettra de positionner la ruralité comme un déterminant de la santé et de situer les services de soins continus dans des paramètres ruraux particuliers.

Mots clés : Alberta, soins continus, soins de longue durée, rural

Introduction and background

Alberta's continuing care (CC) sector includes three integrated services that are provided in rural, urban, and ex-urban settings (Government of Alberta 2017). In this scoping review, we focus on CC in rural settings. Though the sources included in our review may vary in their definitions of "rural," our understanding of rural includes geographic, political, social, and cultural aspects of rural places. For instance, a community can be considered rural in terms of its geographic location or isolation, census geography, population density, distance from large urban centres, local industries such as agriculture or resource extraction, cultural traditions, and collective identity.

In the context of CC, we consider Ramp's (1999) notion that the question "what is rural?" is a political one. Because health issues are constructed and experienced differently in rural settings, we should address the contexts for health service provision, "but also that in which they are received, demanded, or substituted" (Ramp 1999, 7). Stout (1999, 6) claims that in rural communities, "institutions such as hospitals and schools are more than just facilities in the functional sense. They are also *cultural signs and symbols*; if they close, 'moral and material replacements' are needed." In other words, the rural locale can also be understood as both a locality-based and socioculturally-based method to better comprehend the framing and definition of populations, health needs, and services responses (Keating and Phillips 2008; Bourke et al. 2012). Without sufficient attention to rurality, it can be challenging to meet the CC needs of rural residents. For the purposes of this paper, we choose to define "rural" in a broad manner that is consistent with the policy-based conception of "rural" historically used by the Government of Alberta (rather than a distance, population, or demographic definition). As a result, rural (as defined by relatively recent provincial initiatives such as the Rural Alberta Development Fund and Alberta Rural Development Network) includes all communities outside the four largest

urban centres (Calgary, Edmonton, Red Deer, and Lethbridge).

Using this spatial and population-based definition, CC is a significant institutional response to the health and care needs of Albertans. With an aging rural population, an increasing prevalence of dementia, and increasingly complex chronic care needs of residents, the demand for CC services is growing (Suter et al. 2014). This is particularly pronounced in rural Canada, where labour flight to urban areas has led to significant demographic asymmetries between older and younger residents (Hanlon and Halseth 2005). Though CC is not limited to seniors, older adults comprise a significant and increasing proportion of the CC patient base. The Demographic Planning Commission (2008) has projected that by 2031, one in five Albertans will be a senior, pointing to increasing and well-documented demand for CC services.

In recent years, Alberta has been active in health care reform. The amalgamation of 12 separate health entities led to the formation of Alberta Health Services (AHS), the country's largest single health authority. AHS's CC sector is currently defined by three "layers" of service provision. These services range from home care services (such as nursing, rehabilitation, and personal support services provided in clients' own homes) to supportive living services (which are provided in congregate settings and offer clients accommodations, meals, housekeeping, and social activities in addition to professional and personal support services). Long-term care services offer 24-hour residential nursing and personal care for clients with complex care needs including cognitive, movement, and developmental challenges. Since the 1990s, Alberta's CC sector has undergone several structural changes, with preferential investment in home care and supportive living. These changes align with systemic efforts to support aging-in-place and independent living as policy goals (Alberta Health 2008). Within this context, rural areas experience distinct conditions for care that are often overlooked in broader health system analyses, but have been

well-documented by Canadian geographers. For instance, rural Canada experienced health care restructuring in the 1990s that led to health care service centralization in urban centres, a withdrawal of government support services, challenges with recruiting and retaining health professionals, limited supports for (but increasing reliance upon) informal care providers, and a limited amount of research and data on rural health and health services (Hanlon and Halseth 2005; Thien and Dolan 2011; Fiske et al. 2012; Leipert et al. 2012; Kulig and Williams 2012).

At the same time, many rural communities across Canada exhibit tremendous resilience and firm commitments to high quality community care and support for older adults (Keating and Eales 2012). For the past two decades, Alberta has been the country's leading provincial economy, and yet the province experiences many of the same CC trends identified across the nation. Because the rural health literature seldom intersects with provincial health services literature, little is known about the implications of changes in CC for rural Albertans. This is unfortunate given that both health and social care are embedded in place (Hanlon et al. 2007). As scholars engaged in empirical work in the field of rural residential care, we undertook a scoping review to explore the extent, range, and nature of the existing literature (Arksey and O'Malley 2005). We have limited our focus to Alberta because CC standards and health care service delivery fall under provincial jurisdiction. We sought to: (1) identify gaps in knowledge about this topic; (2) define content to direct our research; and (3) identify key research priorities for improving residential care in rural Alberta. This project also seeks to position rural CC within a broader critical and equity-based approach to health, place, rurality, and the productive logics underlying the role of rural and agricultural communities in Canada, as well as the continuing neo-liberal orientation of health and continuing care policy toward larger urban centres. While both Canada and Alberta lack a rural framework, strategy, or policy at this time, the broader trend toward urbanization has been identified as consistent with the devolution of responsibility (but not authority) to municipal governments and agencies and the re-shaping of politics and policy (Brenner and Theodore 2002).

Our review has identified several contextual influences on CC, systemic priorities related to

quality assurance and improvement, and the changing structure of the CC workforce. In what follows, we highlight the inclusion and exclusion of rural Alberta in CC literature and recommend areas in need of further inquiry. Though provincial in nature, the themes and recommendations generated from our review have applicability across rural Canada. While different provinces have varying degrees of policy responses to the "rural question" the results presented here speak to not only the conventional and nearly universal characteristics of rurality (distance and population density), but also the political economy underlying both health care and CC responses to those rural dynamics. Specifically, the underlying "policy design" of rural CC (Bobrow and Dryzek 1987) hinges on (1) the value proposition of shifting services away from government and the public sector; (2) servicing the historically conservative rural voting base (who, particularly in Alberta, are characterized by both fiscal and social conservatism); and (3) a rural context and identity of individualism, place, and homogeneity that marginalizes many of the social determinants of health. Because of their existing contributions to scholarship on rural health and aging, we see health and human geographers as particularly well-positioned to take up these themes and begin to fill the gaps that we have identified.

Methods

In order to synthesize the knowledge in this field, we followed the protocol outlined by Arksey and O'Malley (2005) to conduct an iterative, team-based scoping review. The first stage was to identify the research question. This review poses the broad question: what is known about the continuing care system in Alberta? Articles focusing solely on home care were excluded from our search as they did not provide insight about residential care facilities. The consideration of rural was addressed in the analysis of the final search results, rather than as a search term. This was done in anticipation of limited rural-focused CC literature. Search terms were identified through consultations between the researchers and a health sciences librarian and a scan of the titles and subject headings of preliminary search results. To maintain sensitivity, only the inclusion criteria concerning CC and Alberta were included in the search terms.

The second stage was identifying the relevant studies. The following 12 electronic databases were searched on November 3 and 4, 2016 by the health sciences librarian: Canadian Research Index, CBA Complete, CINAHL, MEDLINE, PAIS International, ProQuest Dissertations & Theses A&I, PsycINFO, Scopus, Social Services Abstracts, Social Work Abstracts, SOCindex, and Sociological Abstracts. These databases were selected to ensure that relevant published and grey literature from a range of disciplines would be included in the review. The search strategy was first developed for MEDLINE (Table 1) and then adapted for the other 11 databases.

When possible, subject headings from controlled vocabularies (e.g., MeSH) were used in the search. When a subject heading did not exist for a search term, it was entered in the search string as a keyword, with phrase searching (e.g., “continuing care”) and truncation (e.g., Alberta*) used when appropriate. Boolean operators connected subject headings and keywords as shown in Table 1. In accordance with the inclusion criteria listed above, search results were limited to items written in English and published since 1990. In those databases that index newspaper articles and wire feeds, filters were applied to exclude these records from the search results. Otherwise, no limits were placed on publication type.

Table 1
MEDLINE search strategy for the scoping review.

Search terms:

1. exp Long-Term Care [MeSH]
2. exp Assisted Living Facilities [MeSH]
3. exp Homes for the Aged [MeSH]
4. exp Nursing Homes [MeSH]
5. "continuing care".tw.
6. "supportive living".tw.
7. 1 or 2 or 3 or 4 or 5 or 6
8. Alberta*.mp.
9. 7 and 8
10. limit 9 to yr="1990–Current"
11. limit 10 to English

Note: MeSH stands for medical subject heading; exp used with a MeSH term to include all narrower MeSH terms; .tw used to conduct keyword search of title, abstract; .mp used to conduct keyword search of title, abstract, heading word, table of contents, key concepts, original title, tests & measures; quotations denote a phrase search; * after keyword indicates truncation (e.g., code* will retrieve “codes,” “code,” “coded”).

The third stage was study selection. The bibliographic information (e.g., title, abstract, authors, subject headings) for each search result was imported into EndNote X7 for deduplication and review. A total of 681 results were returned from the 12 database searches. After duplicates were removed, 467 unique records remained for potential inclusion in the study. Two researchers independently reviewed the title and abstract information in these records, excluding 347 items which did not meet the inclusion criteria. Items were excluded if there was no actual focus on CC services, if there was a focus on unpaid or informal care work, if the materials were from trade publications or newsletters, if the study was from outside of Alberta, or if there was a clinical focus testing the efficacy of a tool or intervention.

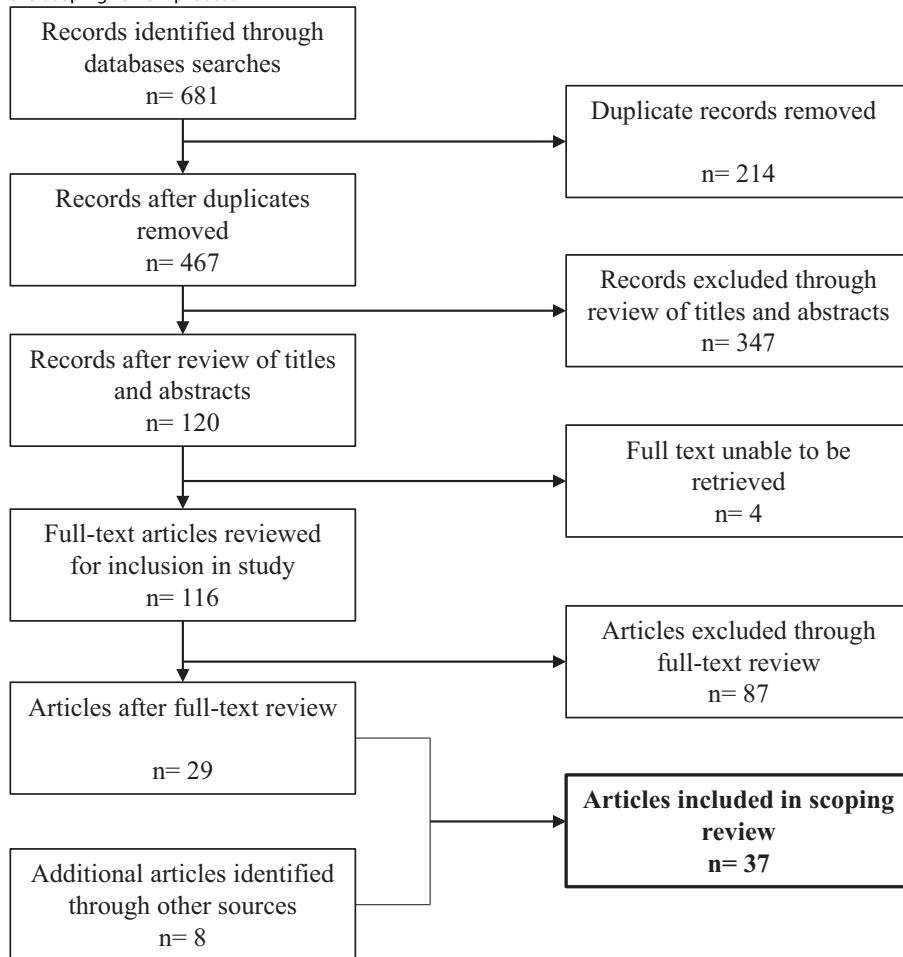
Of the 120 remaining records, the full texts of 116 were gathered for full-text review. Four items could not be retrieved through the library’s collections or interlibrary loan. The researchers independently conducted the full-text review, removing a further 87 items from consideration and identifying 29 items for inclusion in the study.

Following this review process, purposive searches were conducted to find relevant grey literature not retrieved through the database searches. The grey literature was included to capture systemic shifts, priorities, and practices identified by stakeholders who have the capacity to influence the CC sector. These searches targeted websites of non-profit organizations and government bodies, including the Alberta Continuing Care Association, the Health Quality Council of Alberta, the Government of Alberta, the Institute for Continuing Care Education and Research (ICCEER), and AHS. Google searches were also performed using different combinations of the search terms listed above. Through this stage of the review process, a further 8 items were identified for inclusion in the study, bringing the total number of included items to 37. This process is depicted in Table 2 below.

The fourth stage of the scoping review protocol was charting the data, which involved “synthesizing and interpreting qualitative data by sifting, charting, and sorting material according to key issues and themes” (Arksey and O’Malley 2005, 26). The data were sorted according to the authors’ names, year of publication, origin of study, discipline or source, methodology, area of focus, and inclusion of rural.

Table 2

Flow diagram for the scoping review process.



We searched each publication for references to “rural,” “small town,” “remote,” “Northern,” and other key terms that could indicate rurality. We noted (a) if “rural” was included and (b) in which ways (e.g., referenced in comparison to urban travel times, acknowledged the need for a rural nursing recruitment strategy, etc.).

The fifth and final stage of the review was collating, summarizing, and reporting the results from stage four. Of the 37 sources retrieved, 22 were academic articles, 14 were Government of Alberta reports, and one report was from ICCER, an independent collaborative network of post-secondary institutions, CC provider organizations,

and regulatory bodies. Of the 22 academic articles, 16 were based on empirical research and the remaining articles (n=6) were commentary pieces or policy reviews. The disciplinary perspectives (determined by journal’s focus and author affiliation) included were nursing, medicine, and health economics. This is largely consistent with the provincial approach to CC policy design noted above, even though the social, informal, and collaborative elements of rural CC are very important (ICCER 2013). The majority of sources were from Alberta, but some studies were conducted across the Prairie provinces (n=4). This variety of sources and source types allowed for a diverse

assortment of stakeholder perspectives. The sources were published in years ranging from 1991 to 2015, capturing many of the significant developments in the CC sector. These include the introduction of Alberta's Resident Classification System (RCS) in the 1980s, the introduction of the Resident Assessment Instrument Minimum Data Set (RAI-MDS) in the 1990s, the amalgamation of regional health authorities into a centralized provincial health services organization in 2008, changing nursing home demographics, and CC workforce utilization.

After reading through the full-text articles and preparing the table of results, the researchers independently noted the most prominent themes in the academic and grey literature. We then met to discuss, collapse or expand, and finalize these themes. These themes are discussed in the results section below (Table 3).

Results

Overall, we identified three overarching themes in the literature: (1) contextual factors; (2) quality assurance and improvement; and (3) workforce considerations. These emphases speak to some of the larger issues facing CC in Alberta, such as the costs and effects of different models of CC; the tensions between private, familial, and public care models; the social and policy paradigms within which CC is situated; and the related financial and human resources challenges of providing care.

Contextual factors

While most of the literature addressed specific policies and practices of CC, several pieces provided insight into exogenous factors such as policy trends and broader environments for care. Several economics-oriented

Table 3

Final list of articles.

Themes	Number of articles (of 37 total)	Article reference
Contextual factors	9	Alberta Health (1991) Duncan and Reutter (2006) Estabrooks et al. (2013) Fernandes and Spencer (2010) Government of Alberta (2007, 2008, 2010) Jacobs et al. (1997) Reichwein (2011)
Quality assurance and improvement	18	ACCES (2011) Alberta Health and Wellness (2000) Armstrong-Esther (1994) Auditor General of Alberta (2005) Austin et al. (2009) Dyason et al. (2015) Eggertson (2013) Estabrooks, Hoben et al. (2015) HQCA (2014a, 2014b, 2015) Janzen and Warren (2005) Mitton et al. (2003) O'Rourke et al. (2011) Oelke et al. (2009) Prins and Webber (2005a, 2005b) Semradek et al. (1994)
Workforce considerations	11	ACCA (2012a, 2012b) Alberta Health Services (2016) Estabrooks, Squires et al. (2015) HQCA (2015) ICCER (2013) Knopp-Sihota et al. (2015) Mallidou et al. (2013) O'Rourke et al. (2013) Suter et al. (2014)

sources examined the organizational setting for care, including factors such as regional dynamics and drivers, fiscal and financial policies (Jacobs et al. 1997; Fernandes and Spencer 2010), and workforce dynamics. Several authors from nursing and public interest groups provided a more critical examination of the social, political, and economic contexts within which CC is provided (Duncan and Reutter 2006; Reichwein 2011). There was a general emphasis upon power dynamics, asymmetries, and ongoing concerns with how CC sits within, and across, both private and public spheres. These works target and prioritize different levels and units of analysis, ranging from the macro (policy and societal) level, to the meso (health care systems) level, and frequently the micro level of individuals' experiences providing or receiving CC services. Little of this discussion included geographical considerations, references to small or Northern communities, or cultural aspects of rural care provision. There was also little discussion of local resource extraction industries, changing demographics, Indigenous peoples' health needs, and rural health care restructuring—all of which have distinct implications for care in rural communities.

Quality assurance and improvement

The majority of the literature included in our review focused on assessing and improving the quality of CC services at meso and micro levels. At the meso level, we identified an emphasis on efficiency, equity, improved health outcomes, and the sustainability of the CC sector as priority areas for improvement. Discussions of quality improvement surfaced in public and expert consultations, evaluations of tools such as the RCS (Armstrong-Esther 1994; Semradek et al. 1994) and the RAI-MDS (O'Rourke et al. 2011; Estabrooks, Hoben et al. 2015; Estabrooks, Squires et al. 2015), critical reviews of policies such as the CC waitlist policy (HQCA 2014b), reviews of government standards (Prins and Webber 2005a), discussion of funding priorities, and other health services research (Mitton et al. 2003). The perspectives of multiple stakeholders, often the family members of care recipients, informed the micro level focus. These perspectives were expressed in family experience surveys (Janzen and Warren 2005; HQCA 2014a, 2015) and analyses that look at supporting successful staff and family relationships (Austin et al. 2009). More generally this work includes both formal and informal caregiving and advanced care planning

(Dyason et al. 2015). The literature commonly points to the importance and need for system(s)-level perspectives to support care and to assist formal and informal caregivers in navigating the CC sector.

This theme of quality assurance and improvement highlights several systemic priorities, as well as areas that have received attention and evaluation over the past 27 years. Specifically, these priorities have included resident admission and retention, meeting complex needs, family involvement in caregiving, staffing, engagement with support services outside of facilities, and an increasing focus on patient-centred models of care. There is also concern with system(s) navigation as it relates to transitions between acute, primary, and continuing care and the challenges of policy harmonization and implementation across the province.

For rural areas, these priorities are complemented by issues of distance, including the need to travel for testing or specialized care in urban areas, as well as challenges created by a lack of transit or readily available transportation—especially for seniors (ACCES 2011; ICCER 2013). The First Available Bed Policy, for instance, was identified as particularly challenging for rural residents who have limited residential care options and often have to relocate to another community (ACCES 2011). Other rural priorities include the importance of informal caregiving and support services, opportunities and challenges presented by technological interventions such as telehealth, and the shifting landscape of family engagement in care and care planning. There was some acknowledgement of differences between urban and rural centres, but limited engagement with these rural issues and priorities in the literature.

The literature that focused on quality assurance and improvement also highlighted several emerging priorities in CC. These include the need for a seniors health care strategy (Eggertson 2013), a supportive living framework, further exploration of what it means to age in the right setting, CC education and research, community-based models of care (Oelke et al. 2009), and patient-specific issues such as the appropriate use of anti-psychotics in residential care facilities.

Workforce considerations

As demand for CC has increased in Alberta, the sector has faced a number of workforce-related challenges. These challenges are associated with the

recruitment and retention of care workers in the CC sector, staffing levels in facilities, and changes in staff roles and responsibilities over time. These issues reveal themselves in discussions of labour strategies (ACCA 2012a, 2012b); the increased role of health care aides (HCAs) and their use of time; results from stakeholder consultations (O'Rourke et al. 2013); the importance of role clarification, accountability, and identification; discussion of workforce utilization (Suter et al. 2014); and discussions of missed and/or rushed care (Knopp-Sihota et al. 2015). Sources that address workforce issues expressed the need for rehabilitation and recreation staff (ICCER 2013), challenges associated with complex care-giving needs, and the changing roles of nursing staff and HCAs. For instance, results from the Health Quality Council of Alberta's Family Experience Survey (HQCA 2015) reveal that the most commonly highlighted concern for respondents was staffing levels. Family members indicated that staffing levels affected all areas of resident care. Low staffing levels meant that there were often not enough staff available to monitor residents, address their basic needs, or provide psychosocial care. Family members also noted that when the number of permanent full-time staff was too low or staff turnover was too high, there were delays and residents experienced unmet needs. Similarly, the Alberta Continuing Care Association (ACCA 2012b) labour market study claimed that funding was insufficient to provide staffing levels appropriate to the rising acuity levels and related care needs.

As staffing demands and funding change, there is a growing recognition that there has been a shift in the organization and structure of CC labour. For example, Registered Nurses (RNs) are increasingly working as administrators or supervisors, and HCAs and Licensed Practical Nurses (LPNs) are providing the majority of direct resident care (ACCA 2012a). Changes to staff mix have allowed for flexibility and diversity in the composition of care teams, but have also generated unanticipated consequences.

Despite a growing reliance on HCAs, and the growing demands of care provision, HCAs are an unregulated workforce and the training, competencies, and capacity of these care providers is a significant challenge. HCAs in Alberta can have as few as 19 weeks of formal college-level training and the Alberta HCA training program is the shortest in

Canada (Mallidou et al. 2013). Fewer than 50% of HCA participants in a 2015 survey reported attending continuing education opportunities (Estabrooks, Squires et al. 2015). While HCAs must meet the competencies found in the Government's HCA Competency Profile, ensuring that HCAs meet their competencies is the responsibility of their employers. Similarly, participation in a newly created provincial directory is voluntary, inaccessible to the public, and does not track alleged infractions (Estabrooks, Hoben et al. 2015). Another recent survey of HCAs found that 86% of respondents reported being rushed and that the resulting lack of time meant that care tasks were left undone—particularly in rural settings (Knopp-Sihota et al. 2015). The combination of these changes in role, responsibilities, and staff mix all point to the likelihood of a sub-optimal approach to the actual provision of CC and have also led to more inquiry into effective CC workforce strategies.

A key issue within workforce management focuses on the recruitment and retention of care workers. As a result, the provincial CC workforce strategy (ACCA 2012b) considers the impact of changes in the political environment, the economy, socio-demographics of the senior population, technology, and public opinion about CC. Strategies are targeted towards enhancing CC's image and public perception, strengthening recruitment and education of staff, increasing employee engagement and retention, engaging mature workers, and strengthening the validity and reliability of CC workforce data (ACCA 2012b). From the rural standpoint, it is important to note that the strategy acknowledges that recruiting and retaining staff in rural and remote areas is especially challenging and requires specific strategies such as rural mentoring programs, a targeted rural workforce strategy, and virtual training and educational programs.

Discussion: Inclusion of rural and implications for research

This scoping review has provided an overview about what is known about Alberta's CC sector. It also provides insight into how rural needs and priorities are included or omitted from this body of literature. Of the 37 sources included, only 18 explicitly mentioned rural Alberta. When "rural" was mentioned, it was seldom defined or operationalized

and was often cited in a comparative context with a primary focus on urban settings.

Some sources noted that their studies included both urban and rural sites, but did not provide rural-specific findings, analyses, or recommendations (ACCES 2011). There was also an acknowledgement that CC research is often conducted in sites that do not represent rural, making it challenging to generalize findings (ICCER 2013). ICCER (2013) has also noted that inconsistencies in AHS policies particularly affect rural and remote sites and, disproportionately, Indigenous clients. At the organizational level, rurality was identified as a work-related structural variable (Knopp-Sihota et al. 2015). HCAs from rural sites were significantly more likely to feel rushed in their care work. With fewer staff available at these facilities, the authors highlight rural-specific workforce issues in need of attention.

In sum, these results point to some of the urban biases commonly found in Albertan policy and research. As noted above, the resources identified in this review are largely practitioner-oriented with a common assumption that the spectrum of CC is broadly homogeneous. Differentiation of functionality, populations, care, or organizations is, therefore, largely understood as endogenous to CC itself (i.e., something that can be managed or modified) rather than an exogenous influence upon the functionality of care (through access to staffing, infrastructure, clients, etc.) and also the factors shaping variation in demands, expectations, and delivery of care. In other words, being “rural” is not only an intervening or more proximal social determinant of health; it is also a determinant of the nature, scope, and function of CC itself.

Consistent with broader rural health literature, we identified a rural deficit discourse (Bourke et al. 2012) that frames rural health service users as disadvantaged compared to their urban counterparts. Eleven sources, predominantly governments and non-profit organizations, acknowledged distinctly rural challenges. These challenges include a lack of alternative care options and geriatric services, few facilities and longer travel required for family caregivers, having to move outside of one’s community for care (ACCES 2011), recruitment and retention of rural health practitioners, travel for home care providers, funding constraints, small population base, housing and affordability, transportation and operating costs (Alberta Health and Wellness 2000), RNs being required to carry out

administrative duties, higher caseloads, and fewer resources (Auditor General of Alberta 2005). While it is important to identify rural challenges to improve services, this discourse can sometimes contribute to a construction of rural as “problematic, inferior, or undesirable” (Malatzky and Bourke 2017, 157). This is particularly likely if there are no specific recommendations for how to address these challenges, no examination of rural strengths and successes, and no recognition of rural as an upstream determinant of health.

Only one article emphasized rural strengths and assets. Based on an examination of a community-based model of a rural Primary Care Network across CC, Oelke et al. (2009) identified assets such as strong local leadership in rural areas, a greater sense of community ownership, willingness to support local initiatives, and the flexibility of small teams where identification of needs and solutions can be expedited. There is a need for future research to examine the distinct assets, resources, and formal/informal supports available across Alberta’s diverse rural communities. Given that so much of the literature approaches rural from a deficit perspective, it is prudent to turn our attention to rural strengths and opportunities. This would allow us to capitalize on what is working well and to assess both the determinants of capacity, and that capacity itself, of communities tasked with providing health and social care for older adults.

As a means of bridging some of the capacity gaps identified for rural CC, some authors proposed alternative service delivery approaches for rural regions such as telehealth, mobile services, or travelling specialty teams (Alberta Health and Wellness 2000). This also extends to workforce initiatives, including the need for rural mentoring programs for RNs and the development of a targeted rural workforce strategy (ACCA 2012b). Similarly, there is some acknowledgement that determination of appropriate living options and placements ought to consider urban/rural differences and be flexible in response to these differences (HQCA 2014b). However, there is limited empirical work testing these models or evaluating existing rural-specific strategies within CC. Most of the sources that included rural considerations came from the grey literature. This highlights the need and opportunity for scholarly research that accounts for rurality in CC provision—within nursing and medicine, but also within other social science disciplines that are

well-suited to explore the relationships between macro level systems and micro level experiences of local health care needs and services (beyond costing optimizations) to include questions of place, identity, culture, language, policy, politics, and social connections. There is, therefore, a clear need to move beyond simply the recognition of rural challenges and meaningfully engage with the needs, experiences, and realities of rural communities as they shape, and are shaped by, CC.

Opportunities for future research

Our review revealed a dearth of literature on CC in rural Alberta, but also indicated areas for future health services and policy research. Most research on rural aging focuses on informal and unpaid care, or home care. While this is consistent with efforts to support aging in place, many older adults will reside in CC facilities and an improved understanding of these realities is essential. There are widespread expectations that care for older adults in rural communities will be provided voluntarily by family members. However, this work is heavily gendered and further compounded by the increasing migration of working-aged people to urban areas and an aging care workforce. Expectations of voluntary care work reflect assumptions of rural self-reliance that do not always align with lived realities or community capacity (Skinner and Joseph 2007). Furthermore, because residential settings create distinct conditions for care, it is important to distinguish CC sector challenges from those experienced in rural acute care settings.

Given that “rural and remote health are much more than merely the practice of health in another location” (Bourke et al. 2012, 499), there is a need for research on CC provision in rural contexts. Such research ought to assess existing strengths and challenges, anticipate future needs and demographic trajectories, and identify promising practices amongst and between rural communities. This would support the development of policies and improvement of services in ways that are more accurately embedded in place. This is essential for avoiding a “one size fits all” rural strategy developed in urban centres.

Rural Alberta is not homogeneous and communities’ challenges and assets will vary. Changes to the sector will be enabled or constrained by the specific characteristics of the geographic, ethnic, and

cultural locale (Andrews and Evans 2008). Future research should also explore diversity within rural communities, for instance, the ways in which rural CC facilities create welcoming, inclusive, and culturally safe environments for Indigenous peoples, people who identify as LGBTQ2A+, residents from religious groups such as Mennonites or Hutterites, and other groups who may experience marginalization or underrepresentation. As some rural communities become more diverse, and others potentially more homogeneous, it is important that the needs of residents and variability in those needs becomes embedded in local practices and policies of CC.

Conclusion

This scoping review has identified several key themes related to CC in Alberta. These include contextual factors, quality assurance and improvement, and workforce issues. We have also identified the ways in which rural parts of the province are included in, or omitted from, this literature and recommended areas for future research on rural CC. While focused on one province, these results have implications well beyond the provincial context. Much like rural communities elsewhere in the economically developed world, CC in rural Alberta takes place in an often fragmented, but collaborative service landscape. This landscape is characterized by disproportionately aging and aged populations, difficulty in recruiting and retaining service providers, declining infrastructure, and the shift of both medical and social networks to larger urban and ex-urban centres. At the same time, the broader “model” for research, policy, and care is largely urban-normative, reflecting both the broader population trends found in Canada and the ongoing ideological emphasis upon urban spaces, places, and citizens. This emphasis hinges largely upon a neo-liberal logic of competition and comparative advantage in order to attract investment (from both public and private sources) and efficiency. For rural spaces, this also entails a (re)construction of identity that emphasizes urbanity, the socialization of risk, the deterioration of social welfare, and the enlargement of social, health, political, and economic inequities (Brenner and Theodore 2002; CRRF 2015). Future research can work towards bridging the themes of rural health literature with the context-specific findings and processes of the academic and organizational

literature on CC, and needs to engage with the underlying context, values, and audiences driving policy and the provision of care (Hallstrom et al. 2015). This connection will help to address rurality as a determinant of health and health care and to situate CC services in specific rural settings. For this reason, we encourage Canadian geographers and health services researchers to work towards filling the gaps in this literature by producing work that highlights the importance of rural place in CC research. Geographers have made valuable contributions to our understanding of rural health and aging in rural settings and are, therefore, especially well-positioned to examine the impact of rurality on CC.

Acknowledgements

This work was funded through the first author's Alberta Innovates New Investigator Award in Healthy Futures and Well-being in Rural Settings.

References

- ACCA (Alberta Continuing Care Association). 2012a. *Alberta Continuing Care Association: Labour and funding issues jeopardize seniors care*. Edmonton, AB: Marketwired. <http://www.marketwired.com/press-release/alberta-continuing-care-association-labour-funding-issues-jeopardize-seniors-care-1676705.htm>.
- . 2012b. *Workforce strategy for continuing care in Alberta 2012 to 2017*. Edmonton, AB: ACCA.
- ACCES (Alberta Continuing Care Epidemiological Studies). 2011. *Designated Assisted Living (DAL) and Long-Term Care (LTC) in Alberta: Selected highlights from the Alberta Continuing Care Epidemiological Studies (ACCES)*. Edmonton, AB: ACCES Research Group, University of Alberta.
- Alberta Health. 1991. *Residents in Alberta's long term care facilities: A descriptive profile*. Edmonton, AB: Alberta Health.
- . 2008. *Continuing care strategy: Aging in the right place*. Edmonton, AB: Alberta Health.
- Alberta Health and Wellness. 2000. *Healthy aging: New directions for care, public and stakeholder response to the final report of the Long-Term Care policy advisory committee*. Edmonton, AB: Alberta Health and Wellness.
- Alberta Health Services. 2016. *Population estimates of dementia in Alberta*. <http://www.albertahealthservices.ca/assets/about/scn/ahs-scn-srs-addma-2016-peda-update.pdf>.
- Andrews, G. J., and J. Evans. 2008. Understanding the reproduction of health care: Towards geographies in health care work. *Progress in Human Geography* 32(6): 759–780.
- Arksey, H., and L. O'Malley. 2005. Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology* 8(1): 19–32.
- Armstrong-Esther, C. A. 1994. Long-term care reform in Alberta, Canada: The role of the resident classification system. *Journal of Advanced Nursing* 19(1): 105–113.
- Auditor General of Alberta. 2005. *Report of the Auditor General on Seniors Care Programs*. Edmonton, AB: Auditor General of Alberta.
- Austin, W., E. Goble, V. Strang, A. Mitchell, E. Thompson, H. Lantz, L. Balt, G. Lermeyer, and K. Vass. 2009. Supporting relationships between family and staff in continuing care settings. *Journal of Family Nursing* 15(3): 360–383.
- Bobrow, D. B., and J. S. Dryzek. 1987. *Policy analysis by design*. Pittsburgh, PA: University of Pittsburgh Press.
- Bourke, L., J. S. Humphreys, J. Wakeman, and J. Taylor. 2012. Understanding rural and remote health: A framework for analysis in Australia. *Health and Place* 18 (3): 496–503.
- Brenner, N., and N. Theodore. 2002. Cities and the geographies of "actually existing neoliberalism." *Antipode* 34(3): 349–379.
- (CRRF) Canadian Rural Revitalization Foundation. 2015. *State of Rural Canada Report*. Brandon, MB: CRRF. <http://sorc.crrf.ca/>.
- Demographic Planning Commission. 2008. *Demographic Planning Commission findings report*. Edmonton, AB: Government of Alberta. <http://www.seniors-housing.alberta.ca/documents/Demographic-Commission-Report-2008.pdf>.
- Duncan, S., and L. Reutter. 2006. A critical policy analysis of an emerging agenda for home care in one Canadian province. *Health & Social Care in the Community* 14(3): 242–253.
- Dyason, C., J. Simon, and T. L. Wityk Martin. 2015. Advance care planning discussions among residents of long term care and designated assisted living: Experience from Calgary, Alberta. *BMJ Supportive & Palliative Care* 5(1): 48–53.
- Eggertson, L. 2013. Canada needs seniors' health care strategy: CMA report card. *Canadian Medical Association Journal* 185(13): E613–E614.
- Estabrooks, C. A., M. Hoben, J. W. Poss, S. A. Chamberlain, G. N. Thompson, J. L. Silvius, and P. G. Norton. 2015. Dying in a nursing home: Treatable symptom burden and its link to modifiable features of work context. *Journal of the American Medical Directors Association* 16(6): 515–520.
- Estabrooks, C. A., J. W. Poss, J. E. Squires, and G. F. Teare. 2013. A profile of residents in prairie nursing homes. *Canadian Journal on Aging* 32(3): 223–231.
- Estabrooks, C. A., J. E. Squires, L. Hayduk, D. Morgan, G. Cummings, G. Ginsburg, N. Stewart, K. McGilton, S. H. Kang, and P. G. Norton. 2015. The influence of organizational context on best practice use by care aides in residential long-term care settings. *Journal of the American Medical Directors Association* 16(6): 537.e531–537.e510.
- Fernandes, N., and B. G. Spencer. 2010. The private cost of long-term care in Canada: Where you live matters. *Canadian Journal on Aging* 29(3): 307–316.
- Fiske, J., D. Hemingway, A. Vaillancourt, H. Peters, C. McLennan, B. Keith, and A. Burrill. 2012. Healthy policy and the politics of citizenship: Northern women's care giving in rural British Columbia. In *Rural women's health*, ed. B. D. Leipert, B. Leach, and W. E. Thurston. Toronto, ON: University of Toronto Press, 403–422.
- Government of Alberta. 2007. *Supportive living framework*. Edmonton, AB: Government of Alberta.
- . 2008. *Continuing care strategy: Aging in the right place*. Edmonton, AB: Government of Alberta.
- . 2010. *Long-term care accommodation standards and checklists*. Edmonton, AB: Government of Alberta.
- . 2017. *Continuing care system*. Edmonton, AB: Government of Alberta. <http://www.health.alberta.ca/services/continuing-care-system.html>.

- Hallstrom, L., W. Ashton, R. Bollman, R. Gibson, and T. Johnson. 2015. Policy designs in rural Manitoba: Alternatives and opportunities in the midst of change. *Manitoba Law Journal* 38: 185–219.
- Hanlon, N., and G. Halseth. 2005. The greying of resource communities in northern British Columbia: Implications for health care delivery in already-underserved communities. *The Canadian Geographer* 49(1): 1–24.
- Hanlon, N., G. Halseth, R. Clasby, and V. Pow. 2007. The place embeddedness of social care: Restructuring work and welfare in Mackenzie, BC. *Health & Place* 13(2): 466–481.
- HQCA (Health Quality Council of Alberta). 2014a. *Review of Alberta Health Services' continuing care wait list: First available appropriate living option policy*. Calgary, AB: Health Quality Council of Alberta.
- . 2014b. *Review of quality assurance in continuing care health services in Alberta*. Calgary, AB: Health Quality Council of Alberta.
- . 2015. *Long term care family experience survey report*. Calgary, AB: Health Quality Council of Alberta.
- ICCER (Institute for Continuing Care Education and Research). 2013. *Pilot project for the development of a community needs driven research network for continuing care in Alberta: Data analysis and results report*. Edmonton, AB: ICCER.
- Jacobs, P., C. Mills, and M. Hollander. 1997. Financing long-term care in Canada. *Health Care Management* 3(1): 101–105.
- Janzen, W., and S. Warren. 2005. A residential care centre (RCC) for persons with Alzheimer disease (AD): Family satisfaction with formal care. *Journal of Social Work in Long-Term Care* 3(3/4): 37–43.
- Keating, N., and J. Eales. 2012. Diversity among older adults in rural Canada: Health in context. In *Health in rural Canada*, ed. J. C. Kulig and A. Williams. Vancouver, BC: UBC Press, 427–446.
- Keating, N., and J. Phillips. 2008. A critical human ecology perspective on rural ageing. In *Rural ageing: A good place to grow old*, ed. N. Keating. Chicago, IL: The Policy Press: 1–10.
- Knopp-Sihota, J. A., L. Niehaus, J. E. Squires, P. G. Norton, and C. A. Estabrooks. 2015. Factors associated with rushed and missed resident care in western Canadian nursing homes: A cross-sectional survey of health care aides. *Journal of Clinical Nursing* 24(19-20): 2815–2825.
- Kulig, J. C., and A. Williams. 2012. *Health in rural Canada*. Vancouver, BC: UBC Press.
- Leipert, B. D., B. Leach, and W. E. Thurston. 2012. Introduction: Connecting rural women's health across time, locales, and disciplines. In *Rural women's health*, ed. B. D. Leipert, B. Leach, and W. E. Thurston. Toronto, ON: University of Toronto Press, 3–20.
- Malatzky, C., and L. Bourke. 2017. Reproducing rural health: Challenging dominant discourses and the manifestation of power. *Journal of Rural Studies* 45: 157–164.
- Mallidou, A. A., G. Cummings, C. Schalm, and C. A. Estabrooks. 2013. Health care aides use of time in a residential long-term care unit: A time and motion study. *International Journal of Nursing Studies* 50(9): 1229–1239.
- Mitton, C., C. Donaldson, and P. Manderville. 2003. Priority setting in a Canadian long-term care setting: A case study using program budgeting and marginal analysis. *Canadian Journal on Aging* 22(3): 311–321.
- Oelke, N. D., L. Cuning, K. Andrews, D. Martin, D. MacKay, K. Kuschminder, and V. Congdon. 2009. Organizing care across the continuum: Primary care, specialty services, acute and long-term care. *Healthcare Quarterly* 13: 75–79.
- O'Rourke, H. M., K. D. Fraser, A. M. Boström, M. A. B. Baylon, and A. E. Sales. 2013. Regulated provider perceptions of feedback reports. *Journal of Nursing Management* 21(8): 1016–1025.
- O'Rourke, H. M., G. F. Teare, A. Sales, C. Maxwell, and K. Draper. 2011. Prioritizing information for quality improvement using resident assessment instrument data: Experiences in one Canadian province. *Healthcare Policy* 6(3): 55–67.
- Prins, R., and L. Webber. 2005a. *Achieving excellence in continuing care: Final report of the MLA task force on continuing care health service*. Edmonton, AB: Government of Alberta.
- . 2005b. *Seniors Report: What we heard & draft recommendations*. Edmonton, AB: Government of Alberta.
- Ramp, W. 1999. Rural health: Context and community. In *Health in rural settings: Contexts for action*, ed. W. Ramp, J. Kulig, I. Townshend, and V. McGowan. Lethbridge, AB: University of Lethbridge, 1–13.
- Reichwein, B. P. 2011. Alberta's long-term care services are in crisis: Government's relentless pursuit to privatize long-term care. *Healthcare Papers* 10(4): 51–56.
- Semradek, J., M. C. Hornbrook, D. McKenzie, P. Giovannetti, C. Charles, and C. Schalm. 1994. Long-term care reform in Alberta, Canada. Alberta's resident classification system: Fact, fiction and future prospects. *Journal of Advanced Nursing* 20(6): 1182–1185.
- Skinner, M., and A. Joseph. 2007. The evolving role of voluntarism in ageing rural communities. *New Zealand Geographer* 63(2): 119–129.
- Stout, M. D. 1999. Mobilization in community finds expression. In *Health in rural settings: Contexts for action*, ed. W. Ramp, J. Kulig, I. Townshend, and V. McGowan. Lethbridge, AB: University of Lethbridge, 215–222.
- Suter, E., S. Deutschlander, E. Makwarimba, A. Wilhelm, K. Jackson, and S. W. Lyons. 2014. Workforce utilization in three continuing care facilities. *Health Sociology Review* 23(1): 65–76.
- Thien, D., and H. Dolan. 2011. Emplacing care: Understanding care work across social and spatial contexts. In *Valuing care work: Comparative perspectives*, ed. C. Benoit and H. Hallgrimsdottir. Toronto, ON: University of Toronto Press, 23–41.