RURAL OLDER ADULT TRANSITIONS IN CARE

A thesis submitted to the Committee on Graduate Studies in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy in the Faculty of Arts and Science

TRENT UNIVERSITY

Peterborough, Ontario, Canada

Canadian Studies PhD Graduate Program

January 2023

Abstract

Rural Older Adult Transitions in Care

Laura Iona Leone Poulin

Aligning health services with aging populations is the fundamental issue of modern Canadian health policy, yet rural older populations still experience compromised patient safety and poor-quality care as they transfer between care settings. As such, contemporary scholars acknowledge that more contextually sensitive studies are needed to better understand the unique health and care experiences of this vulnerable population across the care continuum.

Informed by inquiry in critical gerontology, health services and human geography, my dissertation attends to this gap in research by revealing the interplay between older adult health construction and the influence of multidimensional contexts on rural older adult transitions in care. Using a community-based approach, I conduct a case study on Haliburton County that encompasses three phases (e.g., a rural community inventory, go-alongs and semi-structured interviews) and focuses on two types of transitions in care (when an older adult is transferred from a hospital to a long-term care home and when an older adult is transferred from a hospital to a home in the community). In total, 19 patients, 24 informal supports, 51 front-line staff and five administrators/managers participated in my dissertation, resulting in 99 total participants being included in 19 go-alongs and 85 semi-structured interviews.

My results indicate that multi-leveled facets of the rural care context continually attend to and hinder rural older adult health during transitions in care. In particular, sectored divisions, urban centrism, biomedicine and ageism inhibit rural care providers

from leveraging their strengths to attend to the heterogeneity of rural older adult health and the nuances of rural care contexts. I then argue the need for macro health systems reform to embrace the relationality of rural older adult transitions in care and to capitalize on the strengths inherent in rural communities.

To foster knowledge mobilization of my findings, I provide a foundation of information and recommendations for the community partners (Haliburton Highlands Health Services and Seniors Care Network) as well as questions to inform research, policy and practice. Establishing the first study of rural older adult transitions in care where a researcher accompanies older adults and their informal supports across care settings, my dissertation will help prepare Canada for the impact of the aging population and transform transitional care provision to meet the needs of all Canadians in the 21st century.

Key Words

Transitions in Care, Health Care, Older Adult Health, Rural Health Care, Geriatric Care, Hospital, Long-Term Care, Home Care, Canada.

Acknowledgements

This research was made possible by the older patients, informal supports, health professionals and administrators/managers in Haliburton County who graciously took the time to provide their first-hand knowledge of rural older adult transitions in care. To the older patients and informal supports, thank you for your openness and willingness to participate and for sharing your personal experiences with me. I hope that by sharing your stories and your words that it will compel others to recognize the strengths of rural communities and acknowledge the importance of your experiences across the care continuum.

I would like to thank Haliburton Highlands Health Services (HHHS), Haliburton Extendicare and Seniors Care Network for their roles in the project (e.g., assisting with the design of the research project, helping to recruit participants, providing access to multiple research settings, etc.). I am grateful to Carolyn Plummer (President and CEO at HHHS) and Darcy Burke (Behaviour Supports Ontario Staff) who recognized the value of being involved in and supporting this project and who were my community connection to the participants and the partners.

Financial support was received from the Canada Research Chairs Program, the Canadian Institutes of Health Research (CIHR), the Ontario Graduate Scholarship Program, the Seniors Care Network Geriatric Education Initiative and through numerous internal Trent University scholarships.

I would like to acknowledge the on-going mentorship of Dr. Mark Skinner who consistently provides the right balance of support and aspiration. Thank you for your encouragement, for standing alongside me in the face of adversity and for sharing your

wisdom with me. My hope is that I will be able to guide others with the same dedication, compassion and consistency that you have shown me over the last six years. Thank you to Dr. Mary Fox for your guidance and for continually supporting me in pursing my professional career. In addition, I have benefited from the critical questioning of Dr. Mark Skinner, Dr. Mary Fox, Dr. Donna Patrick, Dr. Kirsten Woodend and Dr. Julia Brassolotto. Their feedback will strengthen my future work and encourage me to think critically about disseminating my dissertation findings. I am also appreciative of Dr. Heather Nicol for chairing my PhD defence and for the research assistance I received from Amber Colibaba and Aarzoo Nathani.

Finally, I would like to acknowledge my family. To my husband Kerri, after my Masters you immediately knew I was destined to complete my PhD even when I denied it. Thank you for not only accepting my feisty, but encouraging me to pursue it. The kindness within you cannot be emulated and I am so grateful to have your love and support each day. To my son Myles, thank you for pursuing your PhD on Daycare alongside me and for asking about my meetings with 'shakira'. To my son Eli, thank you for always asking 'mama working?' as you reminded me to pursue balance in my day-to-day. I am also strangely grateful to both of you for our long 4:30am drives as they truly did shape what's written below. To Cindy and Pat, I am grateful to you for keeping me connected to 'rural' and for continually asking about my research even after others became bored. To me, you have always represented the strengths of living in rural areas and I am not lost on how that influenced my dissertation. To my father, Phil, thank you for caring for mom for so many years. It does not evade me that if you had not insisted that I stay in school that I may not have had time to pursue this PhD. To my sister Emily,

my late mother Chris and my late grandmother Onie, thank you for providing me with examples of what strong women can do. I often think about what all of you have accomplished and it motivates me to pursue what's right, rather than what's easy. I am truly grateful to all of those who have supported me in completing this dissertation no matter how big or small.

Table of Contents

List of Figures

List of Tables

List of Abbreviations

ADL - Activities of Daily Living

ALC - Alternate Level of Care

CIHR - Canadian Institutes of Health Research

FTC - Failure to Cope

HHHS - Haliburton Highlands Health Services

IADL - Instrumental Activities of Daily Living

IV - Intravenous

LHIN - Local Health Integration Network

POA- Power of Attorney

SCN - Seniors Care Network

SDM - Substitute Decision Maker

TCAS - Trent Centre for Aging & Society

WHO - World Health Organization

Glossary

Activities of Daily Living - A term used to describe the competencies required to independently care for oneself including but not limited to: eating, bathing, mobility, etc.

Alternate Level of Care - A designation given to patients in hospital when their acute medical needs have been stabilized but they cannot be discharged as they are awaiting a 'bed' in another sector.

Bed Flow, Systems Flow, Patient Flow - The movement of patients through the health care system. This movement can be between care sectors or between departments/services in one organization. For example, the flow of patients from the emergency department into acute care.

Biomedical Model - The dominant model used in Westernized medicine where health is defined based on the absence of illness. This model focuses on disease, diagnoses and physical aspects of health rather than acknowledging the ways that sociocultural and psychosocial factors influence health.

Complex Systems Theory - Health systems foster and inhibit health through interdependencies between and within micro, messo and macro levels of society (Khan et al., 2018). As such, health care provision shapes and is shaped by societal characteristics such as socioeconomics, culture, geography, politics and history (Khan et al., 2018).

Complex Adaptive Systems Theory - is a theory that adds to complex systems theory, outlining that health systems are constantly shifting in response to broader facets of society (Khan et al., 2018).

Contextually Sensitive - Embracing spatial polygamy (see spatial polygamy definition).

Continuum of Care - An integrated system of care that is provided to patients over time and which may include many health and social services from different sectors (Swan, Haas & Jessie, 2019).

Follow-Up - Making contact with patients after discharge to identify barriers to successful transitions to other care settings and to ensure the provision of on-going support.

Holistic Care - Encompassing sociocultural, psychosocial, biological/medical, spiritual and personalized constructions of health into the care provided.

Identity - A term used to describe the intersectionality of an individual including but not limited to how they identify in terms of gender, sexuality, ethnicity etc.

Implementation Science - The scientific study of methods and strategies to ensure the knowledge translation of evidence-based practice into health policy and front-line care.

Older Adult Health Construction - The contributing factors that shape interpretations and presentations of older adult health.

Informal Support - Any person that has a connection to a patient and provides support for their health and care including but not limited to: family, friends, neighbours, colleagues, community members, etc. The level of support provided by each informal support ranges greatly and is not necessarily on-going.

Instrumental Activities of Daily Living - A term used to describe the competencies required to independently care for oneself in the community, including but not limited to: grocery shopping, preparing meals, housekeeping, taking medications, etc.

Intersectionality - the categories of difference that contribute to diverse social practices, institutional relationships, culture and power differentials (Harris, 2016) which generate the unique experiences of people in society.

Knowledge Translation - The application of foundational knowledge into practice.

Length of Stay - The total number of days a patient has resided in hospital, including the number of days spent in the emergency department.

Linear Algorithm of Care - a set of rules that determine if a patient qualifies for discharge resources.

Local Health Integration Network[1] - Prior to 2021, the government of Ontario established Local Health Integration Networks (LHINs) to act as regional authorities to coordinate, integrate and fund health services at a local level including hospitals, community health centres, long-term care homes, mental health and addictions agencies and community support service agencies.

Ontario Health Teams - In 2021, the government of Ontario re-organized the provision and delivery of health care services into Ontario Health Teams.

Patient-Centred Care - Patient-centred care encompasses a range of activities from patient's involvement in front-line care to the public's involvement in developing health policy (Higgins et al., 2016). Health professionals, administrators, educators and policy makers have all developed different meanings of this term to shape research, policy and

[1] Please note that at the time that this research was conducted the LHINs were designated as regional health authorities in the province of Ontario. The Ministry of Health was in the process of reorganizing health care into Ontario Health Teams at the time that this dissertation was published.

practice (Higgins et al., 2016). Whole-system patient-centred care identifies the common goal of streamlining services to personalize care provision (i.e. a focus on patient's goals, needs and preferences) across the care continuum (Flumian, 2018; Khan et al., 2018).

Place-Based Attachments - Facets of local contexts influence residents' lives, perceptions, wants, needs, actions and attitudes, which fosters a connection between residents and the places that they live.

Power of Attorney - A legal document that gives the authority for another person to make decisions regarding property, finances and medical care if a person has been deemed incapable of doing so. Power of Attorney papers are divided by 1) finances, property and estate and 2) personal/medical care.

Psychosocial Aspects of Health - Mental, emotional, social and spiritual aspects of health.

Quality of Life - The World Health Organization defines quality of life as "an individual's perception of their position in life in the context of culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (WHO, 2012, p.11)

Relationality - the interconnection between domains that are experienced concurrently but that are often studied and provided for independently of one another. For instance, spatial polygamy and aging experiences are often studied independently, yet influence each other through their simultaneous interaction.

Rurality - a term used to describe the place-based attachments of rural residents (See place-based attachments definition).

Social Determinants of Health - Social and economic factors that influence health (Canadian Public Health Association, 2021).

Social Positioning - The societal status of an individual based on the social stratification of society.

Social Stratification - The way society categorizes people into groups based on socioeconomic and sociocultural factors, which stipulates an individuals' power and social status with relation to others.

Spatial Polygamy - is the characterization of how people interact with multiple contexts simultaneously across time and place (Mathews, 2011). For example, rural older populations experience their connection with their rural communities and care environments simultaneously.

Strength-Based Inquiry - Attempting to highlight the assets of a particular domain.

Substitute Decision Maker - a person that by law is entitled to make decisions regarding property, finances and medical care if a person has been deemed incapable of doing so and in absence of Power of Attorney papers. A hierarchy of substitute decision makers is designated under the Ontario's Health Care Consent Act (Speak Up Ontario, 2021).

Transfer Events/Transitional Care Events - Admissions or discharges of patients.

Transitional care - is a model of care that employs a collaborative and streamlined approach to care for patients across care settings to ensure coordination and continuity of care (Hirschman et al., 2015). The benefits of this model have been linked to improving the health outcomes and quality care of patients, while also contributing to increased health system efficiencies such as reducing readmissions and overall health care costs (Hirschman et al., 2015).

Transitions - The experiences of patients as they interact with the health system over time and care setting**.**

Urban Centrism - The dominance and prioritization of systems, structures and processes that more readily align with and provide support for populations in urban centres.

CHAPTER 1

"It's like when you go to hospital, it is marked as just one incident in your overall experience. Their needs to be better reflection on what happens before a patient is admitted, while they are in hospital and after a patient is discharged."

1 Introduction to My Dissertation

1.1 Introduction

Patient transitions are not transfers, are not discharges and are not admissions. As conveyed in these remarks by an older rural Canadian, transitional care events are marked as just one incident in the health and care experiences of those in later life. Certainly, 'Transitions in care' (when patients transfer between care settings) provide insight into the complex experiences of patients over time and place and reflect both patients' interactions with other people and the diverse settings [(including in the context of rural aging (Fox et al., 2021)] in which care is provided (Shahsavari, Zarei & Mamaghani, 2019). With these experiences at front of mind, this chapter introduces my thesis: "Rural Older Adult Transitions in Care".

I begin this chapter by situating myself as a researcher and reflecting on the importance of aligning health systems with older populations. I then introduce the conceptual model that frames my dissertation and identify the advantages of Haliburton

County as a research setting. I conclude this chapter by reflecting on the broader approach and impact of my dissertation and outline the focus and organization of the subsequent chapters.

1.2 Situating Myself as a Researcher

In many ways my positionality as a researcher is representative of the unique transitional care experiences of rural older adults. Originally from Parkdale in downtown Toronto, I never intended to invest almost half my life to improving the care provided to older adults in less populated areas. My decision to relinquish my urban roots and move to Thunder Bay, Ontario was the catalyst that started this on-going experience. Faced with few job prospects, I accepted a recreation therapist position in long-term care as a stop gap until I could find an alternative. I never turned back. Instead, I was intrigued by the interactions between people: the stories, the love, the hate. I sought out continual improvement, always taking on higher leveled positions with the intent of changing services to better support the older patients I had left behind. Despite a variety of positions across many levels and fields (e.g., a social worker, a policy analyst, a geriatric consultant and a director), the implications of my actions were always confined by divisions that compartmentalized change. When I worked for private industry, I was unable to disseminate progressive approaches to memory care that would have revolutionized geriatric services in the public system. As a geriatric consultant in Peterborough, Ontario I was required to decline services to older patients from Haliburton County, as I was told to prioritize the older patients from the hospital in which I worked. The more I sought out change, the more I realized that my actions regularly undermined the progress that I had made in previous roles. For example, as a social

worker in long-term care, I refused the very same patients with responsive behaviours who in hospital I had advocated to admit. Divisions and fragmented approaches to change were everywhere. My academic background in Outdoor Recreation, Social Work and Health Administration was particularly germane to expose me to these deep-seated divisions. Affecting administration and front-line staff, registered nurses and recreation therapists, the emergency department and acute care, hospital and long-term care, the antagonism generated between human stakeholders as a result of these divisions seemed in stark contrast to the definition of 'care' that we had been hired to provide. Turning to scholarship in an attempt to evoke change, I was faced with systemic gender discrimination four times in the pursuit of my doctoral studies from the very institutions that informed and funded research to address the impact of systemic inequality. As a Caucasian female with access to many resources, I will never claim to be oppressed; however, these experiences allowed me to reflect on how difficult it would be for those without privilege or capacity to address engrained discrimination. Through my study of geriatric populations over the last decade, I have realized that distinct disciplines compartmentalize older people's experiences of aging, health and care in the same way as they do in practice. Rather than acknowledging the relationality of older adult experiences over time and place, researchers frequently perform studies divided by sector, discipline, profession or diagnosis. In addition, few studies incorporate formal and informal caregivers' perspectives simultaneously or generate knowledge on the interaction between the stratified authorities of care provision that my experience in health care readily exposed. Mimicking the transitional care experiences of rural older adults, my positionality as a researcher is unique, multi-leveled, conflicted and continues.

1.3 Importance of Aligning Health Services with Aging Populations

Fueled by aging populations around the world, older adult health and care has become a major focus of research, policy and practice in the 21st century (Allen et al., 2017). While the COVID-19 pandemic has precipitated societal readiness for health systems transformation, health scholars have argued the need to better align health care services with geriatric populations for over three decades (Allen et al., 2017). Indeed, the models of care used in North America more readily reflect 20th century medicine and undermine the chronic conditions and multi-morbidities of geriatric populations (Banerjee, 2015). Older adults' experiences of care are then defined by compromised safety, health and quality of care (Lawless et al., 2020; Scott, 2017) as contemporary health services are designed for patients who are middle aged and present with only one disorder or isolated medical episode (Banerjee, 2015). As a result, poor communication (Allen et al., 2017; Moore et al., 2017), inadequate medication reconciliation (Allen et al., 2017; Moore et al., 2017), a lack of discharge follow-ups (Elliott et al., 2018) and a predominant focus on acute care in Western societies (Banerjee, 2015) impede the care provided to older adults across the care continuum. These deficits contribute to increased rates of infection, adverse events and medication errors that lead to the health decline of older patients (Layman et al., 2020; Tomlinson et al., 2020). Faced with sectored divisions between medical and community care, older patients are passed back and forth between health services with little support (Lawless et al., 2020). Since the aging of the population will increase the number of older adults accessing health care services, initiatives that aim to align the health system with the needs of older adults are required to establish national health system efficiency (Allen et al., 2017).

1.3.1 Geriatric Models of Transitional Care to Generate Health Systems Reform

Investigating older adult transitions in care provides insight into how to better align Canada's health services with the older populations that they serve. Undoubtedly, health scholars have exposed the connection between effective transitional care and quality health care service delivery by uncovering the system efficiencies (Blum et al., 2020) and improved health outcomes that can be gained when transitional care is optimized (Naylor et al., 2017; Tomlinson et al., 2020; Hang et al., 2021). In particular, enhancing transitional care results in resource and financial efficiencies as well as multi-leveled system improvements (Hirschman et al., 2015) by increasing patient and caregiver satisfaction (Goncalves-Bradley et al., 2016), lowering hospital readmission rates (Gallagher et al., 2017; Fønss et al., 2021) and reducing patient length of stays (Goncalves-Bradley et al., 2016; Kansagara et al., 2016).

Acknowledging that older adults require increased support, a central theme of transitions in care research focuses on creating geriatric transitional care models (Facchinetti et al., 2020; Hang et al., 2021). This approach refocuses care on patients and their caregivers rather than on the elements and processes that more readily benefit health care organizations or professionals (Greysen et al., 2016). Although numerous transitional care models are designed specifically to improve older adult transitions in care (Facchinetti et al., 2020; Moore et al., 2017; Clarke et al., 2017), contemporary scholars continue to find that transitional care is not individualized and therefore does not reflect the populations being treated or account for the distinct settings in which care is provided (Kansagara et al., 2016).

One method of generating more effective transitions is to examine the diverse experiences of older adults across the care continuum. This approach to research contributes to better understandings of the unique needs of patients with multiple chronic conditions (Ploeg et al., 2017). Despite this benefit, few studies gather consumers' and providers' perspectives on older adults' experiences of care (Allen et al., 2017; Ploeg et al., 2017) (See Brooks et al., 2021, Elliott et al., 2014 and Mitchell et al., 2018 for some notable exceptions) or account for the perspectives of older adults, family members and health care providers concurrently (Allen et al., 2017). Moreover, transitional care research typically does not consider the implications of cultural and racial diversity which is essential to develop effective services (Barreto et al., 2021). Gathering more insight from multiple users on their unique experiences of transitions in care is then critical to foster more effective geriatric transitional care models (Allen et al., 2017).

In addition, contextualized studies on older adult care experiences account for the factors that enable and constrain the social interactions and processes that construct older adult health (Allen et al., 2017; Ploeg et al., 2017). Ploeg et al. (2017) indicate, however, that the experiences of older adults are not well understood either within the broad context of community or over time. Researchers who explore peoples' perspectives of transitions in care do so retrospectively which results in a lack of consideration of multidimensional contexts. This approach to research negates the interactional elements that exist between hospitals and community (Kansagara et al., 2016) and does not allow for data collection as older patients and informal supports are experiencing transitions in care. This focus of contemporary research creates a gap in effective evidence to guide the implementation of transitional care that accounts for the complexity of health care

settings (Kansagara et al., 2016). A call for further research has then been made to investigate the spatiality and temporality of older adult experiences across the care continuum to better align health care services with the older populations that they serve (Allen et al., 2017).

1.3.2 Why Rural Older Adult Transitions in Care?

Although evidence-based transitional care strategies have been developed (CIHR, 2017; SCN, 2017), the Canadian Institutes of Health Research Transitions in Care Initiative identifies that a gap exists in the application of these strategies for older populations specifically in rural communities (CIHR, 2017). To date, few researchers have answered this call (See references for exceptions: Hardman & Newcomb, 2016; Fels et al., 2015) leaving a void in analysis that accounts for the experiences of multiple stakeholders involved in rural older adult transitions in care. Nowhere is this void more prominent thn in Ontario, where the Ministry of Health continues to allocate funding to health integration efforts (e.g., Bundled Care Integrated Funding Models) but only conducts pilot projects in urban areas (Government of Ontario, 2018a). Erasing the voices of older populations in rural communities, these governmentally driven initiatives perpetuate the short-comings of previous governments to recognize the urban centrism of contemporary models of service provision.

1.4 Research Goals and Objectives

Table 1.1 outlines the overall goal and four objectives that frame my dissertation.

Table 1.1 Research Goals and Objectives

To better understand the interplay between older adult health construction and the influence of multidimensional contexts on the transitional care of rural older adults
1. To observe and gain the perspectives of older adults, informal supports, front-line staff and administrators/managers on how rural older adult health is constructed
2. To examine the rural care context in which older adult transitional care is provided
3. To understand the experiences of key stakeholders involved in rural older adult transitions in care
4. To provide a foundation of information for regional older adult health care networks (Seniors Care Network & Haliburton Highlands Health Services)

1.5 Conceptual Model for Research

The World Health Organization (WHO) (2015) acknowledges that health care initiatives need to be designed to fit the unique contexts, values and preferences that shape health in local communities. This relational approach to research reveals how socioeconomic, cultural, geographical, political and health system factors interact to foster variations in the realities of health construction (WHO, 2015). Contemporary literature, however, is more often bound by academic disciplines or care settings which compartmentalizes the experiences of patients and their informal supports. Certainly, literature that leverages the complexity of health systems or rural contexts, does not consider patients' experiences of health and care. If the spatial dynamics of a rural context are explored, this analysis does not consider that care systems are integrated, nor does health systems literature account for the rural community in which health systems are embedded. This dearth of inquiry is particularly prominent when investigating older adult health and care, which homogenizes patients' experiences and/or does not account for spatial polygamy.

Pursuing a nascent field of study, my dissertation links the relational approach to research that has emerged in critical gerontology, health services and human geography to uncover the interplay between older adult health construction, the care context and the rural context. This transdisciplinary approach addresses the overall goal of my dissertation (Table 1.1): to better understand the interplay between older adult health construction and the influence of multidimensional contexts on the transitional care of rural older adults.

The conceptual model (Figure 1.1) for my dissertation includes:

- **Older adult health construction:** Encompasses the intersectionality of older adults, the social determinants of health, holistic aspects of health, health dynamism as well as personal needs, insights, preferences, agency and responses to health and care (Associated with objectives one and three)
- **Care context:** the integration of formal health services, formal social services and informal supports (Associated with objectives two and three)
- **Rural context**: the historical, economic, political, social, cultural, geographic, demographic, dynamic and contested facets of rural communities (Associated with objectives two and three)

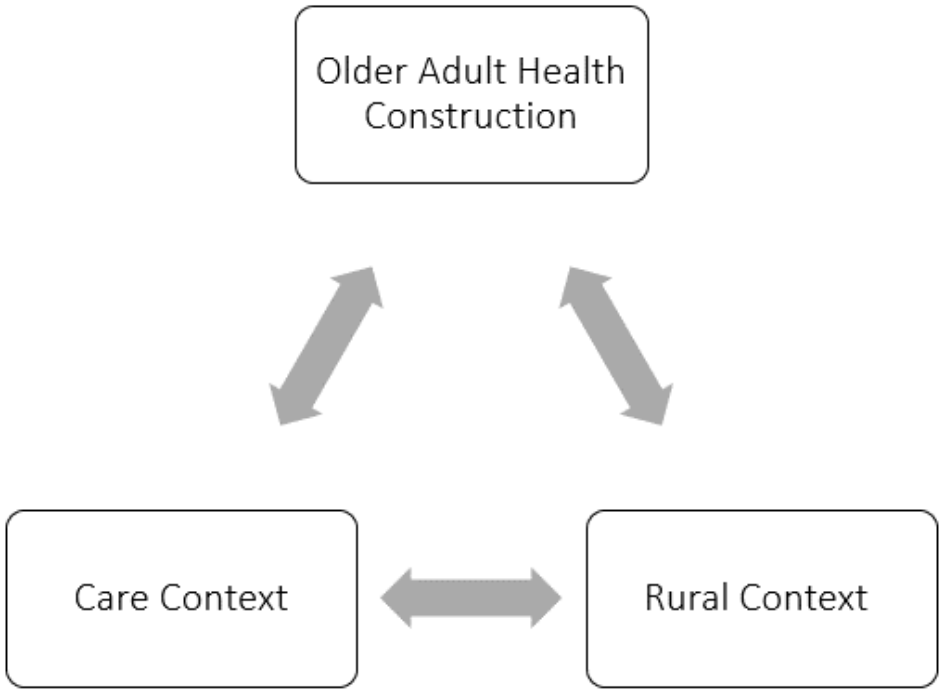


Figure 1.1: Conceptual Model for Research

1.6 Haliburton County - an Ideal Research Setting

Haliburton County provided an ideal setting for my dissertation to address the urban centric nature of contemporary research. In this section I outline the prominent strengths of the region that challenge the barriers that scholars have commonly connected to rural areas. For a more detailed community profile on the social and economic characteristics of Haliburton County please refer to Hurlington (2018). In addition, I can provide the rural community inventory I performed in my dissertation that generated a comprehensive review of the demographics, governmentally funded health and social services as well as the informal groups in the area.

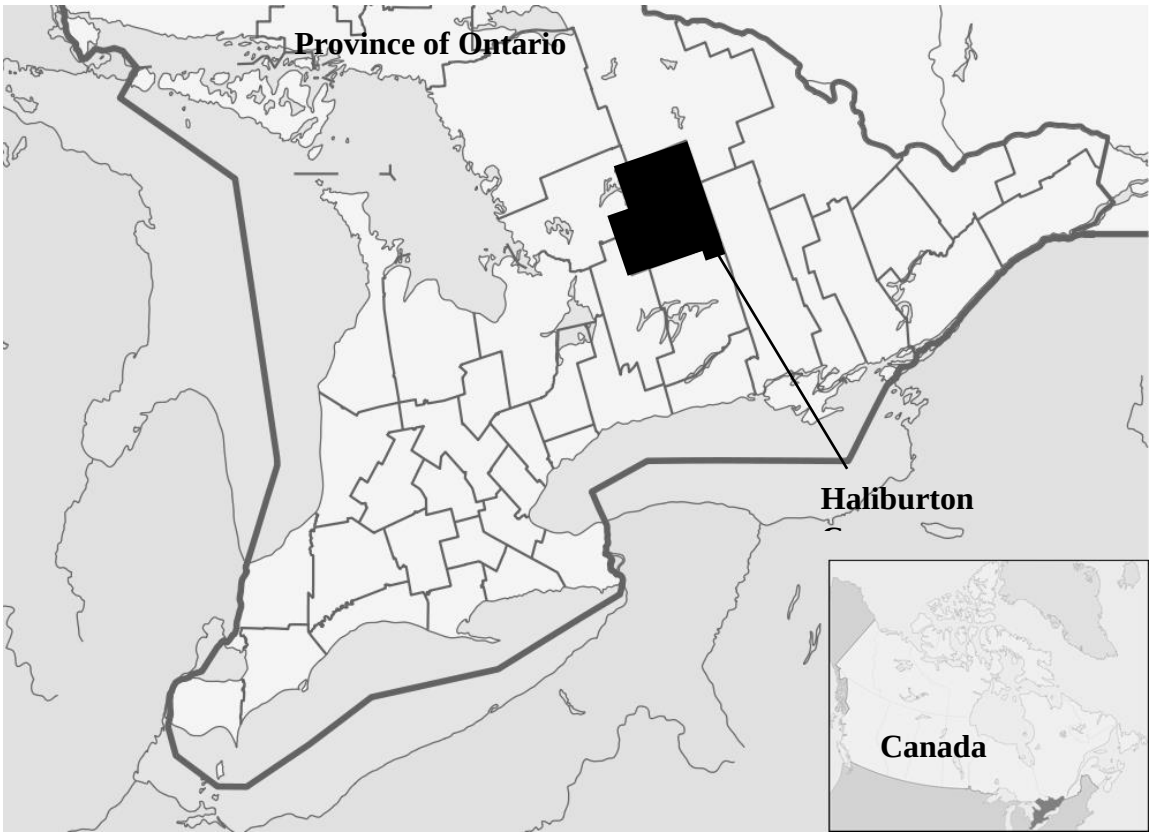


Figure 1.2: Map Indicating the Location of Haliburton County in Ontario, Canada.

1.6.1.1 Expansive Distance, Small Population and Youth Outmigration

Haliburton County is located approximately two and a half hours from Toronto and has a total population of 18, 062 (Statistics Canada, 2021). The county is divided into four municipalities: Algonquin Highlands, Dysart et al., Highlands East and Minden Hills. Two villages, Minden and Haliburton, provide the majority of the amenities for the county including the two hospitals and three long-term care homes. Many social services and specialized medical services are provided to residents out-of-county in Lindsay (99 km away from Haliburton village), Peterborough (100 km away from Haliburton Village) and Toronto (215 km away from Haliburton Village), which means that residents travel long distances for care and must have access to reliable transportation. As Hanlon and Poulin (2021) explain these spatial configurations (i.e., small population, geographic

remoteness) can disadvantage rural areas as places to attract health care workers, which coupled with the outmigration of young adults can disrupt the care and support networks within rural areas. Indeed, the care provided in Haliburton County is affected by the imbalance between the need for care and personal support workers (Local Employment Planning Council, 2019) as well as the outmigration of youth in general (Government of Ontario, 2020).

Despite these rural commonalities, Haliburton County has an abundance of local residents who routinely collaborate to overcome these types of obstacles. To offset the aforementioned barriers of remoteness, several transportation and ride share programs have been founded (e.g., Haliburton County Community Transportation Pilot Project, Rural Transportation Options). To address the outmigration of youth, Haliburton County residents have focused on providing youth oriented initiatives (e.g., Youth Advisory Committee, Youth Engagement Team) and recreation/social clubs (e.g., Youth Wellness Hub, Haliburton Highlands Outdoors Association, DH3-Dance Happens Here, Haliburton) as a means of increasing the migration of younger populations and care providers to the area. These innovative approaches made Haliburton County a captivating case to examine the interplay between multidimensional contexts and rural older adult transitions in care.

1.6.1.2 Shifting Economies and Forward Momentum

Haliburton County residents are challenged by a region dominated by primary resource economies [with employment in mining and farming (County of Haliburton, 2017)]. While primary resource economies can contribute to economic desolation in rural areas (Hanlon & Skinner, 2016), Haliburton County residents have put forth a concerted

effort to grow arts, entertainment, tourism, culture and recreation in the region (Local Employment Planning Council, 2019) and several community groups encourage local economic development (Haliburton County Development Corporation, Haliburton County Community Cooperative, U-Links Centre for Community Based Research, etc.) to adapt to the changing global market. In contrast to rural resource economies that tend to lack a focus on the aging population (Hanlon & Skinner, 2016), Haliburton County residents prioritize health initiatives (e.g., Haliburton Highlands Health Services-falls prevention/adult day program, Geriatric Assessment & Intervention Network, etc.), social clubs (e.g., Dorset Seniors Club, Dwight Lakeview Seniors, Port Cunningham Seniors Group, etc.), advocacy committees (e.g., Aging Well Committee, Age-Friendly Communities Working Group, Haliburton County Falls Prevention Network, etc.) and community-based research (e.g., Age-Friendly Haliburton County Report, etc.) for and including the older population. As such, Haliburton County provided a compelling case to study and an optimal community in which to disseminate my research findings.

1.6.1.3 Contested Spaces

Foreshadowing chapter two, a comprehensive connection between older adult health, the care context and the rural context requires leveraging conceptions of contested spaces. Despite a prominent culture of community support and comradery, a quick review of local sources reveals evidence of contested spaces within Haliburton County (Quigley, 2019). In particular, tensions exist between long-term residents of the county and those who have immigrated to Haliburton upon retirement or who reside in Haliburton seasonally (Quigley, 2019). As Hanlon and Poulin (2021) maintain residents who have

vastly different social, economic and environmental relations with rural spaces are more deeply divided by social capital and community.

Nowhere are these resident tensions more evident than in discussions on affordable housing in Haliburton County, especially for those who are aging (SHS Consulting, 2013). Housing prices in Haliburton have increased significantly due to the growing interest from those moving from out-of-county. These rising costs have made housing unaffordable to low-moderate households that live in the county year round and have contributed to a lack of affordable independent living or assisted living housing for older adults in general (SHS Consulting, 2013). Furthermore, the cost of housing has been recognized as a contributing factor in the outmigration of younger adults who are needed to care for the aging population (SHS Consulting, 2013). Haliburton County was then an ideal case for reflecting on the contested spaces that shape rural older adult transitions in care.

1.6.1.4 Integrated Health System

Lastly, Haliburton Highlands Health Services (HHHS) provides an innovative example of a rural organization that has streamlined its services in an effort to work together towards a whole system patient-centred vision (see chapter two). Indeed, HHHS represents a progressive health leader in rural care provision by providing acute care, long-term care and community care under one organization. HHHS also has services that are tailored to the needs of local residents. For example, the work routines of paramedics in Haliburton County have been adapted so that they can provide 'home checks' to older residents and an affordable transportation option has been developed through a collaboration between formal health services, community services and local volunteers.

Entrenched jurisdictional divisions, however, continue to divide primary, secondary and tertiary care, which acts as a barrier to health integration within Haliburton County. The confliction between local integration efforts and macro care governance then made Haliburton County an interesting case to study the interplay between multidimensional contexts and rural older adult transitions in care.

1.7 Broad Approach and Impact of Research

My dissertation focuses on rural older adult transitions in care in partnership with Seniors Care Network (SCN), Haliburton Highlands Health Services (HHHS), Haliburton Extendicare and Trent University/Trent Centre for Aging and Society (TCAS) with funding from the Canadian Institutes of Health Research (CIHR) and the Ontario Graduate Studies Scholarship. Performing a case study on Haliburton County using three phases: 1) the rural community inventory 2) go-alongs and 3) semi-structured interviews, my dissertation contributes to the burgeoning interdisciplinary interest in preparing Canada's health care system for the aging population and progresses critical scholarship on the complexity of rural gerontological health and care. Specifically, this research assists in the transformation of service provision to better fit rural communities and provides all Canadians with quality health care that meets the demands of the 21st century.

1.8 Structure of My Dissertation

My dissertation is divided into seven chapters that all begin with a citation that reflects the voices of the participants. In chapter two I discuss the empirical foundations of my dissertation by revealing the relational approach to research that has been independently employed in critical gerontology, health services and human geography. In

chapter three I describe my research design that leverages a transdisciplinary approach. In this chapter I define the research parameters of my dissertation by describing my methods, design, participant characteristics and ethical challenges. Chapters four to six align with research objectives one to three. In particular, in chapter four I present a detailed account of older adult health construction in Haliburton County, which is highly engrained in the rural care context. In chapter five I provide a better understanding of the multidimensional context in which rural older adults experience transitions in care. In chapter six I expose an intimate account of the transitional care experiences of rural older adults that are continually shaped by older adult health construction and the rural care context. Finally, in chapter seven I summarize my research findings and their empirical and theoretical contributions. I then reflect on the limitations of my dissertation, outline recommendations for the community partners and highlight future directions for research, policy and practice. In this way I lay the ground work to embrace the relationality of rural older adult transitions in care that will leverage the strengths of rural communities and better align health services with the older populations that they serve.

CHAPTER 2

"There is not formal coordination of collaborative care, but we have to have a complex response to a complex issue. For good older adult care you need a very strong appreciation for the impact that the social determinants have on aging, especially in a rural environment."

2 Literature Review

2.1 Introduction

This chapter presents a detailed account of the conceptual foundations that frame the health and care of older populations in rural areas. As the participant citation for this chapter suggests, rural older adult transitions in care are complex due to the embodiment of older adult health construction (intersectionality & social determinants of health), the care context (formal health services, formal social services & informal supports) and the rural context. This chapter then mirrors my positionality as a researcher by showcasing how three bodies of research concurrently, yet independently, account for the relationality of aging, health and care. Indeed, gerontology, health services and human geography have all embraced a critical turn to foster relational philosophy in research which exposes the diversity of older adult health and the multidimensionality of context.

I have organized this chapter to align with the three components of the conceptual model. Within these sections I synthesize the progress, gaps and overlaps within critical

gerontology, health services and human geography scholarship. Culminating in an overview of critical rural gerontological health and care, I conclude by introducing a transdisciplinary approach which embraces relationality in research to advance knowledge on rural older adult transitions in care.

2.2 Older Adult Health Construction

With the advancement of critical perspectives in social gerontology and broader health research (Biggs et al., 2020; Kaplan & Berkman, 2016), both 'intersectionality and the 'social determinants of health' account for the heterogeneity and dynamic nature of older adult health. These two paradigms speak to the relationality of aging and health which acts as a starting point from which to investigate the complexity of rural older transitions in care. These pedagogies embrace the multi-layered and dynamic factors that construct older adult health and establish the diversity of personal health and care experiences.

2.2.1 Critical Gerontology and Intersectionality

Critical gerontology underscores the unique nature of older adult health construction by celebrating the variation in aging experiences. This field of study opposes dominant cultural and medicalized definitions of old age that contribute to the homogenization of the older population (Twigg & Martin, 2015; Gullette, 2017). Critical gerontology expands the ways that old age is perceived, embodied and practiced by reflecting on the complex interplay between physiology and the numerous factors that shape aging experiences (Twigg & Martin, 2015). This perspective highlights the sociocultural factors that generate diverse experiences of the older population (Cook, 2018; Gullette, 2017; Twigg & Martin, 2015) by revealing how social, cultural, economic

and physical factors foster a range of psychological, physiological and subjective aging experiences (Kydd et al., 2018; Kotter-Gruhn et al., 2016). Critical gerontology then denounces aging as a collective or uniform process and instead articulates the relationality of old age.

Adopting social constructionism, critical gerontology exposes the fluidity of aging by demonstrating that older adults' experiences are cultivated by exchanges between individuals as well as individuals and social institutions (Cook, 2018; Levi & MacDonald, 2016). Aging experiences then shift in response to interactions, decisions and assumptions of the older person as well as others within society (Kydd et al., 2018). On a personal level, older adults actively reflect on their past relationships and life events, which frames their expectations of the future and gives coherence to their current experiences (Cook, 2018). Aging is then highly dynamic which leads to the heterogeneous experiences of older people over time and place.

In addition, critical gerontology integrates the intersectionality paradigm to identify the ways that gender, sexuality, disability, class and ethnicity foster dissimilar aging realities (Gullette, 2017; Twigg & Martin, 2015). Atewologun (2018) indicates that intersectionality is the simultaneous interaction of numerous social identities that are further altered by societal systems of power, domination and oppression. Challenging societally accepted norms of older populations, this line of inquiry amplifies conceptions of identity by establishing how power differentials are embodied in individuals' experiences (Twigg & Martin, 2015; Gullette, 2017). This relational approach to understanding aging counters old age as a fixed identity category by recognizing that this classification more readily benefits researchers, medical professionals and service

providers (Ayalon & Tesch-Romer, 2018). The intersectionality paradigm then contests the homogenization of aging populations by unmasking the diversity of aging experiences that result from social inequality.

Critical health studies that leverage the intersectionality paradigm identify the health disparities of individuals beyond biomedical diagnoses and expose how social positioning leads to the privilege and disadvantage of patients (Gkiouleka et al., 2018; Bastos et al., 2016; Hsieh & Ruther, 2016; Williams et al, 2016; Gulliford, 2019). Certainly, institutional stratification and engrained oppression dominate patients' care experiences (Gkiouleka et al., 2018; Gulliford, 2019) which result in barriers to access (Bastos et al., 2018; Hsieh & Ruther, 2016), health disparities (Hsieh & Ruther, 2016; Gulliford, 2019), discrimination (Bastos et al., 2018; Kulesza et al., 2016; Gulliford, 2019) and stigmatization (Kulesza et al., 2016) of people who identify differently than the dominant norm (For the purposes of my dissertation identity is a term that is used to describe the intersectionality of an individual including but not limited to how they identify in terms of gender, sexuality, ethnicity, etc. This results in people identifying differently than the dominant norm due to ethnicity, ethnic "difference", sexual orientation, and other forms of "otherness"). Inceptive studies that combine age, intersectionality and care, uncover that aging stereotypes and discrimination in the health care system lead to the physical, mental and social health disparities of older patients (Johnson et al., 2019; Chrisler, Barney & Palatino, 2016). This relational approach to research then showcases the impact of systemic ageism in health care by revealing how older patient's needs and wants are often reduced or out-right ignored (Chrisler et al., 2016).

Despite the evolution of relational scholarship on aging and health, there is still a lack of multidimensional, multi-method and multi-generational analysis to respect the complexity of aging experiences or the intra-individual variability between older populations (Kotter-Gruhn et al., 2016). This gap is prominent in health research where the biomedical model of health lends itself to the scientific management of old age (Carney & Gray, 2015). For example, studies on older adult health typically ignore the social, political, economic and cultural factors that impact age (Dionigi, 2015) and are not conducive to capturing a holistic appreciation of older adult experiences (Gullette, 2017; Dionigi, 2015). This type of inquiry then minimizes the enabling and constraining factors that modify older peoples' experiences and/or their fluctuating perceptions of health and care (Dionigi, 2015).

Moreover, scholars acknowledge that intersectionality in health scholarship is still in its infancy (Bastos et al., 2018) and is absent from research on rural older adult health and care (Poulin et al., 2020). As such, my colleagues and I propose that the intersectionality paradigm holds great potential to attend to the persistent and diverse health inequities of and within rural older populations (Poulin et al., 2020). The use of this relational approach to research can generate programs and services that are adaptable to the diversity of rural older populations which can lead to the increased effectiveness and efficiency of rural health services (Poulin et al., 2020). Furthermore, this relational approach to research can counter the deficit focus of current research on rural older adult health and redress the lack of regard for rural older adults in both health care policy and practice (Poulin et al., 2020). Leveraging critical gerontology and the intersectionality

paradigm in particular, then may help to advance understandings of the interplay between older adult health construction and rural older adult transitions in care.

2.2.2 Broader Health Research and Social Determinants of Health

Linking medicine and social science, critical health scholars distinguish health as an adaptive and dynamic state (Sturmberg, Martin & Katerndabl, 2014; Poulin, Skinner & Hanlon, 2020). This relational approach to research encompasses the interacting values, expectations and images of health by making sense of the numerous factors that converge to construct health (Sturmberg et al., 2014; Poulin et al., 2020). Specifically, the unpredictability of patient presentations, the range of health interpretations and the inconsistency of health engagement account for the spatiality and temporality of health (Sturmberg et al., 2014).

Part of recognizing this relational approach to health research is embracing the social determinants of health. Deemed the fundamental building blocks of health status (Lewis, 2015; Martin et al., 2018), the social determinants of health encompass the interplay of social, economic, political, environmental, educational and individual circumstances (Keohane, 2015; Khan et al., 2018; WHO, 2015). Certainly, social behaviours and social conditions imprint upon peoples' health experiences and establishes that biology alone cannot predict the pathology or trajectory of health (Cockerham, 2016). Numerous studies on the social determinants of health solidify this link between social contexts and an individual's susceptibility to specific health conditions and chronic diseases (Cockerham, 2016). Emphasizing the heterogeneity of health, the social determinants of health paradigm then establishes how health is constructed by many interacting factors.

In Canada, the federal government formally endorses the social determinants of health [(e.g., income and social status, employment and working conditions, education and literacy, physical environments, healthy behaviours, health service access, gender and culture, childhood experiences, social supports and coping skills, and biology and genetic endowment (Government of Canada, 2018)], which has resulted in a significant increase in the data collected on the health inequalities of older Canadians. This research exposes how inequities in access, treatment, health status and the high prevalence of chronic diseases and multi-morbidities impede the welfare of older patients (Hege et al., 2018).

Despite the advantages of this relational approach to health research, there is still a void in effectively mobilizing knowledge on the social determinants of health into practice. This barrier to knowledge translation results from compounded diagnoses, indirect causal relationships between social conditions and health outcomes as well as the dominance of the biomedical model (Veillard et al., 2015). Further contributing to the problem, Deber (2017) maintains that policy shifts that align with the social determinants of health can actually increase health inequities between Canadians. As such, the social determinants of health are not well represented in policy (Midgley & Surender, 2019) and major investments have yet to be made to support health beyond biomedical definitions (Lewis, 2015).

To redress this barrier to knowledge mobilization, Nagata et al. (2011) outline that social determinants of health research needs to better account for the variability in the ways in which individuals, groups and regions view their health (Nagata et al., 2011). Undoubtedly, the use of the social determinants of health in rural research is rare (Singh

et al., 2017) and these determinants are not considered in studies on rural older populations (see Kolak et al., 2020 for an exception). Adopting this auspicious paradigm is then not only vital to fill this gap in contemporary research but also promises to broaden understandings of the interplay between older adult health construction and rural older adult transitions in care.

2.3 Care Context

Featuring trends in broader health service research, this section attests to the complexity of the care context that shapes older adult health and care. While numerous theoretical models have been designed to guide care provision, research rarely investigates the impact of formal health services, formal social services and informal supports concurrently. This gap underscores the importance of a relational approach to research that considers the influence of multidimensional care contexts on rural older adult transitions in care.

2.3.1 Multidimensional Care Contexts

Appraising the current state of health systems integration is necessary to appreciate the care context which influences later life experiences. Providing an overview, the health systems integration movement indicates that streamlining health systems results in better quality care for patients. Indeed, this movement challenges the traditional hierarchal structures and cultures that fragment patient care (Buccieri, 2016; Embuldeniya et al., 2018; Flumian, 2018; Keohane, 2015; WHO, 2015) and the dominance of medicalized models of health that negate other inter-sectoral factors (Keohane, 2015; WHO, 2015). The aforementioned approach to health, fosters power differentials that enable professional divisions and centralizes acute care, while

overlooking the essential role that primary and community services have on health prevention and complex health problems (Bayliss et al., 2015; Buccieri, 2016; Keohane, 2015; Oelke et al., 2015; Valentjin et al. 2015; WHO, 2015). As such, researchers propose that differences in funding structures, histories, policies, legislation and governance impede collaboration between the health and social sectors (Buccieri, 2016; Keohane, 2015; WHO, 2015). This realization has motivated many Canadian provinces, such as Ontario, to streamline their health and social services to better reflect patients' needs (Flumian, 2018).

To move beyond the sectored divisions of contemporary care contexts, critical health scholars propose that complex systems theory provides a more comprehensive account of health care contexts. This paradigm considers the influence of socioeconomics, culture, geography, politics and history that both foster and inhibit health through interdependencies between and within micro, messo and macro levels of society (Choi, Blumberg & Williams, 2016; Embuldeniya et al., 2018; Grudniewicz et al., 2015; Hendry, 2016; Keohane, 2015; Khan et al., 2018; May, Johnson & Finch, 2016; Valentjin et al., 2015; WHO, 2015; Farnanova et al., 2016). For instance, resource allocation for disease specific initiatives may shift funding away from affordable housing. This shift may strengthen a patient's health through improved management of specific disease related symptoms but may also inhibit that same patient's health by restricting their ability to obtain adequate housing. This theory then emphasizes that the heterogeneity of patients' experiences is due to the embodiment of complex care contexts (Farnanova et al., 2016; Khan et al., 2018; Valentjin et al., 2015; WHO, 2015).

The complex adaptive systems theory also accounts for the dynamic nature of care contexts. This theory indicates that health systems self-adjust themselves through interactions, negotiations, feedback loops and adaptive mechanisms that foster unpredictability within the health system (Carey & Crammond, 2015; May et al., 2016; Valentjin et al., 2015). Due to this dynamism, simplistic linear approaches to health care are ineffective as new information is continually being introduced (Embuldeniya et al., 2018; Flumian, 2018; Khan et al., 2018; May et al., 2016). New technology, political elections, market fluctuations, medical advancements and staff turnover are just some of the factors that contribute to the ever-changing nature of the care context.

In addition, human stakeholders continually shape the care context (Embuldeniya et al., 2018; Evans, Grudnewicz & Tsasis, 2018; Khan et al., 2018; May et al., 2016) through human norms, actions, attitudes, values and preferences (Choi et al., 2016; Embuldeniya et al., 2018; Evans et al., 2018; Grudniewicz et al., 2015; Hendry, 2016; Khan et al., 2018; Keohane, 2015; May et al., 2016; Valentjin et al. 2015; WHO, 2015). As such, the care context encompasses the conflicting belief systems and power hierarchies that exist between diverse health professionals and organizations (Buccieri, 2016; Evans et al., 2018; Flumian, 2018; WHO, 2015). Although these interpersonal tensions are particularly problematic across the care continuum, there is a dearth of research that provides insight into how to improve these relations between health professionals or sectors (Mertons, Pype & Deveugele, 2018; Reeves, Xyrichis & Zwarenstein, 2017). For example, there are numerous studies on interprofessional practice (Morgan, Pullon & McKinlay, 2015; Otsuka et al., 2019), yet this research fails to define the health care setting in which the proposed recommendations are best suited

or acutely fixates on teams within one organization or sector. This dearth in research is then detrimental to older patients since they frequently interact with many professionals across many organizations and sectors (Rosen et al., 2018).

Despite the value of complexity paradigms, contemporary scholars underscore the challenge of health care planners to practically apply these theories within entrenched social and political structures that are designed to impose order (Khan et al., 2018; May et al., 2016). Indeed, complexity thinkers recognize that traditional administrative methods, such as static policies (that aim to reduce or control the uncertainty of care settings) are unproductive as they are too rigid to attend to contextual nuances (Flumian, 2018; Khan et al., 2018; May et al., 2016). In contrast, flexible procedures and governance foster innovation and enable the technology and system restructuring needed for more effective care (Choi et al., 2016; Flumian, 2018; Hendry, 2016; Keohane, 2015). Health scholars then indicate the need to balance standardization and flexibility to ensure that health governance, policy, resources and overarching priorities align with local expertise, attitudes and values (Grudniewicz et al., 2015; Hendry, 2016; Keohane, 2015; Valentjin et al., 2015). This relational approach to health services research concentrates on the need for a whole system patient-centred vision (Flumian, 2018; Hendry, 2016; Keohane, 2015; May et al., 2016; WHO, 2015) by converging efforts around the common goal of streamlining services to personalize care provision across the care continuum (Flumian, 2018; Khan et al., 2018).

Although a whole system patient-centred vision is the fundamental driver of integrative care, some researchers note that patient-centred care is not an innovative concept and one that is represented in theory but not in practice (Keohane, 2015;

Valentjin et al., 2015). This lack of patient-centredness is prominent in divisions between the health and social sector but can also be observed amongst organizations within the same sector (Santana et al., 2018). Since health care focuses on organizational outputs rather than performance as an integrated system (Abelson et al., 2017; Buccieri, 2016; Flumian, 2018; Hendry, 2016; Keohane, 2015; Sutherland & Busse, 2016; WHO, 2015), this design places the focus of health care on broader leveled mandates such as quality performance and financial accountability (Tikkanen et al., 2020). WHO (2015) notes that this focus results in other models of care such as disease specific services, health financing and macroeconomic politics competing with patient-centred paradigms. These macro factors along with distinctions in professional bodies (DiBenigno, 2017) and the prominence of the biomedical model of health (Feo & Kitson, 2016) impede the efficacy of a whole system patient-centred vision in practice.

Furthermore, there is a large disconnect between health providers' and patients' perceptions of health (Ploeg et al., 2017) and patients have fluctuating abilities and desires to be engaged in their care. These varying perceptions, abilities and desires to be engaged in care lead to variability in patients' experiences (Hirschman et al., 2015), which explains why even if health providers theoretically agree on patient-centred care, the interventions and actions of care staff can still diverge. Researching the interplay between the systems providing care (professionals, communities, organizations etc.), those receiving care (patients, informal supports, etc.) and the processes of care (approaches, interventions, assessments, etc.) then leads to more fitting methods to practically apply patient-centred paradigms in practice (Barello et al., 2014). This relational approach to health services research is essential to attend to the needs of older

populations since the goals of older adults, their caregivers and systems continually conflict (Ploeg et al., 2017). In particular, older adult care is not holistic or patient focused but instead is designed around single disease specific conditions (Ploeg et al., 2017). Ensuring that research includes the interactions of varying levels within care contexts is then essential to analyze older adult experiences of health and care.

Finally, informal supports need to be respected as members of the care team. Even though research stresses that informal supports (e.g., family members, friends neighbours etc.) are vital to quality care (Buck et al., 2015), health care literature rarely includes these individuals (Lilleheie et al., 2020). Since 25% of all Canadians provide some kind of informal support to a relative (Statistics Canada, 2020), which significantly reduces the need for formal services (Lilleheie et al., 2020), a focus on health professionals alone limits interpretations of the care context. Kemp and her associates (2013) propose the convoys of care theory to address this gap in theorization by considering the unique structures and functions of each person's support network that over time is molded by contextual factors such as care environments, community and personal agency (Kemp et al., 2013). This framing merges patients' formal and informal support networks and provides a better representation of the multidimensional care context that influences patient care.

Reflecting on the multi-leveled and dynamic nature of care contexts, this relational approach to health services research appreciates the interlinkage between formal and informal care in both the health and social sector rather than restricting research parameters by the governmentally defined divisions of the current health system. Embracing a relational approach to research is then conducive to generating a better

understanding of the multidimensional care context that influences rural older adult transitions in care.

2.4 Rural Context

A critical turn in human geography reveals the spatial polygamy of rural communities by exposing the interplay between people and places that shifts over time (Doheny & Milbourne, 2017). Indeed, rural residents influence and are influenced by micro, messo and macro structures of community, which results in rural residents' identities, values and ideologies being highly engrained in the rural context in which they live (referred to as 'rurality' by rural scholars) (Doheny & Milbourne, 2017; Shucksmith & Brown, 2016). This multidimensional understanding of rural contexts is used by critical rural gerontologists to reflect on the interactional elements of rural communities that shape common practices, experiences and relations of aging populations (Skinner, Winterton & Walsh, 2021). More work, however, is needed to embrace this relational approach when researching rural older adult health and care (Poulin et al., 2020). This section will then outline the evolution of critical rural gerontological health that is pivotal to analyze the interplay between the multidimensional rural context and rural older adult transitions in care.

2.4.1 Multidimensional Rural Contexts

Rural scholars critique studies that frame rural communities as the antithesis of urban centres (Skinner et al., 2020; Scharf, Walsh & O'Shea, 2016; Shucksmith & Brown, 2016; Herron & Skinner, 2018; Poulin et al., 2020; Poulin & Skinner, 2020). Instead, rural residents and communities are interconnected on several levels with each other and with other people and communities (Herron & Skinner, 2018; Yang, Noah &

Shoff, 2016; Kramer & Raskind, 2017; Schinasi et al., 2018; Milligan, 2018) exposing the interplay between social, political, economic and cultural elements that shape rural life (Herron & Skinner, 2018; Poulin et al., 2020; Poulin & Skinner, 2020; Yang et al., 2016). This line of inquiry shows that simplistic representations of rural contexts fail to reflect the strengths and engagement of rural residents (Poulin & Hanlon., 2019) and challenges solely deficit accounts of rural communities (Poulin et al., 2020). Critical rural scholarship then exposes how local communities can adapt to shifting community needs by leveraging their strengths and their strong interconnections between people and place (Skinner & Hanlon, 2016). Unveiling a heterogeneous rural collectivity, this relational approach to research fosters critical conceptions of rural areas (Scharf et al., 2016; Poulin et al., 2020).

This multidimensional interpretation of the rural context appreciates the complexity of aging in rural communities. Previously marked as retirement utopias, rural communities are now renowned for fostering heterogeneous aging experiences (Skinner et al., 2020; Kaye, 2021; Skinner & Winterton, 2018; Poulin & Skinner, 2020). Pivotal work in critical rural gerontology then underlines the interconnection between older adult identity, individual actions and rural places (Winterton et al., 2020; Scharf et al., 2016) as well as better encompasses the uniqueness of rural ideologies, values, needs and attitudes (Skinner et al., 2020; Skinner, Andrews & Cutchin, 2018). Acknowledging the distinct experiences of older adults in rural communities, the multi-factorial interconnections of the rural context are more prominently accounted for in this relational approach to research (Scharf et al., 2016).

Moreover, this critical work highlights the spatial dynamics of place across diverse life courses (Scharf et al., 2016; Skinner, Andrews & Cutchin, 2018; Skinner & Hanlon, 2016; Skinner & Winterton, 2018; Finlay, 2017; Skinner et al., 2020). Specifically, rural older adults' experiences shift in response to demographics, globalization, political economy and the welfare of the local community (Scharf et al., 2016; Skinner & Hanlon, 2016; Skinner & Winterton, 2018; Scharf et al., 2016; Skinner et al., 2018; Skinner & Hanlon, 2016; Finlay, 2017). This relational approach to research distinguishes the spatiality and temporality of rural aging by uncovering that unique aging experiences are fostered by numerous interactions between and within different contexts over time (Finlay, 2017; Winterton et al., 2020). Some critical rural gerontology scholars contend that probing the connection between aging and rural contexts unearths contested spaces (Skinner et al., 2018; Skinner & Winterton, 2018). In particular, older adults negotiate numerous competing factors in rural communities that act to both inhibit and enrich their aging experiences (Skinner & Winterton, 2018). The contested spaces paradigm thus yields a multi-faceted examination of rural communities by revealing the ways in which political, social and cultural space generate power differentials between local residents (Skinner & Winterton, 2018). Linking intersectionality with rurality, critical rural gerontologists also clarify that processes, structures and interactions within rural communities foster power imbalances between rural residents due to gender, ethnicity, sexuality, socio-economics and age (Skinner et al., 2020; Kaye, 2021; Herron & Skinner, 2018). Embracing the influence of multidimensional rural contexts then provides insight into the tensions and inequities that exist between rural older populations.

Embracing this critical turn in rural scholarship, health geographers outline how communities shape the health outcomes, services and experiences of rural residents (Herron & Skinner, 2018; Yang et al., 2016). Rural communities are then recognized as interactional as they shape residents' experiences of health and care (Herron & Skinner, 2018; Yang et al., 2016; Kramer & Raskind, 2017; Schinasi et al., 2018; Milligan, 2018). This relational approach to research uncovers that rural health embodies the economic, political, geographical and socio-cultural norms of rural places which influence the health behaviours, interventions and outcomes in local contexts (Herron & Skinner, 2018; Yang et al., 2016; Schinasi et al., 2018; Milligan, 2018). For example, place-based research explores health care access and utilization rates (Herron & Skinner, 2018; Schinasi et al., 2018) as well as health disparities (Yang et al., 2016; Schinasi et al., 2018; Milligan, 2018) between rural communities. This research also challenges the myth that romanticizes the close-knit connections in rural regions (Shucksmith & Brown, 2016) through analyses of informal care that account for shifts in industry, social welfare and demographics (Herron & Skinner, 2018; Milligan, 2018). Moreover, this relational approach to research produces strength-based inquiry by demonstrating the ways that rural residents leverage their strengths to foster home-grown initiatives and partnerships that can improve the health and care of their communities (Skinner & Hanlon, 2016; Herron & Skinner, 2018; Milligan, 2018). This relational approach to research then showcases how older adult health and care is embedded in complex and multidimensional rural contexts.

Despite the development of this relational approach to research, human resource deficits and the health disparities of rural residents are most common in rural health

literature (Herron & Skinner, 2018). This scholarship perpetuates negative stereotypes of rural health practice that have become engrained in popular culture without remarking on the strengths of rural areas (Herron & Skinner, 2018). Studies on rural health also maintain a biomedical focus (Glasgow & Doebler, 2021) as well as fixate on deficits in care provision (Barclay & Phillips, 2018) and the lack of governmental support (Skinner & Hanlon, 2016) in rural areas. Kramer and Raskind (2017) then outline that more work is vital to integrate place-based theory into research to ensure effective knowledge mobilization of the complexity of the rural context (Kramer & Raskind, 2017). Since rural places can assist with healing or nurture negative health behaviours, this relational approach to research can more effectively account of the influence of the spatial and temporal dimensions of rural health (Herron & Skinner, 2018; Bell et al., 2018).

This relational approach to research is most important to establish the interlinkage between rural health and critical gerontology. In particular, Poulin et al. (2020) propose that linking critical gerontology and health geography involves investigating the social, economic, political and cultural factors that are embedded in rural communities. Since older adults shape and are shaped by the rural communities in which they live (Scharf et al., 2016; Skinner & Winterton, 2018) normative behaviours, social relationships, values, attitudes and religion have large implications on the ways that older adults experience health and care in rural communities (Poulin et al., 2020). Specifically, this relational approach to research accounts for the spatiality and temporality of rural older patients' experiences. Herron and Skinner (2013) verify the purview of this relational approach to research in their work on the emotional overlay of aging and care in rural Ontario. Determining that negotiations in rural areas lead to 'emotional geographies of care' this

relational approach to research embraces the multilayered impact of rural contexts on carers' experiences.

Notwithstanding the saliency of relational approaches in critical rural gerontological health research, more work is needed to embrace the spatial polygamy of rural older adult health and care. This relational approach to research has the potential to expose the influence of intersectionality on rural older adult health and care which has strengthened both critical rural gerontology (Skinner et al., 2020; Skinner & Hanlon, 2016; Scharf et al., 2016; Skinner et al., 2018; Skinner & Winterton, 2017) and rural health scholarship (Herron & Skinner, 2018) independently. Moreover, this relational approach to research speaks to the contested spaces of rural older adult health and care. While some scholars have applied the concept of contested spaces to health service literature, this scholarship narrowly focuses on the power differentials that result from the conflict between macro service priorities and older adults' wants and needs (Naess et al., 2013). Expanding critical rural gerontological health research is then essential to reflect on the interplay between the multidimensional rural care context and rural older adult transitions in care.

2.5 Chapter Summary

In this chapter I have outlined how a relational approach to research is conducive to examining the health and care experiences of older adults in rural areas. While critical gerontology, health services and human geography independently expose the importance of this relational approach to research, there is a dearth of transitions in care scholarship that considers the heterogeneity of older adult health construction (intersectionality & social determinants of health), the care context (formal health services, formal social

services & informal supports) and the rural context (rurality, contested spaces, socioeconomics, sociocultural relations) simultaneously. Specifically, transitions in care literature that leverages the complexity of health systems or rural communities, does not apply intersectionality or the social determinants of health. If the spatial dynamics of rural contexts are explored, there is no reflection on the complex systems of formal and informal care that are prominent in these regions. Conversely, transitions in care research that exposes the influence of health systems does not appreciate the complexity of the rural community in which health systems are embedded. The absence of these interrelationships in transitions in care result in studies that homogenize rural older patients' experiences rather than account for continuous shifts in older adult health and multidimensional contexts. As such, this chapter illustrates that contemporary literature is more often bound by academic fields and governmentally defined care settings rather than designed to reflect the spatial and temporal experiences of rural older adult health and care.

I then propose a transdisciplinary approach that combines the relational approaches to research that have been independently employed in critical gerontology, health services and human geography to expand knowledge on rural older adult transitions in care. This transdisciplinary approach capitalizes on relational research methods by accounting for the multi-layered, interacting and polarizing elements of older adult health and care in rural communities. Acknowledging that older adults' transitions in care experiences are ongoing, adaptive and conflicted, this transdisciplinary approach highlights the spatiality and temporality of experience that cannot be confined to one specific setting or point in time. Indeed, decision making, place-based attachments,

interpersonal relations, macro governance and organizational procedures are not experienced in isolation but combine to form the health and care experiences of rural older populations over time and place. This relational approach to research is then pivotal to attend to the overall goal of my dissertation: to better understand the interplay between older adult health construction and multidimensional contexts on rural older adult transitions in care.

In chapter three I provide details on my research methods and design that leverage this transdisciplinary approach. Specifically, I utilize three phases, multiple care settings and a diverse range of participants and community partners to expose the spatiality and temporality of rural older adult transitions in care.

CHAPTER 3

"We are such a close community, and we try to make sure we take care of our own because they would do the same."

3 Research Design and Methods

3.1 Introduction

As the participant citation for this chapter infers, reciprocity and inclusivity play a large role in shaping rurality in Haliburton County and thus these characteristics are embedded into my methods and project design. In particular, I employed a community based research approach using three phases: 1) a rural community inventory, 2) go-alongs and 3) semi-structured interviews. I also considered two types of transitions in care: 1) when an older adult transitions from hospital into a long-term care home and 2) when an older adult transitions from a hospital back to their residential home in the community. My methods and project design encompass the critical turns in gerontology, health services and human geography and align with the conceptual model (Figure 1.1) from chapter one.

I begin this chapter by situating my methods and research design within the conceptual model and by presenting the overall philosophical foundations of my

dissertation. In the subsequent sections, I identify the community partners and I outline the three phases of my research design. I then provide a comprehensive description of the ethical challenges that affected my dissertation. Finally, I present my methods of data collection, organization and analysis and I conclude by outlining how my findings chapters are organized.

3.2 Linkage between the Conceptual Model, Methods and Objectives

My research design and methods are informed by a community-based participatory research approach and by the relational approach to research used in gerontology, health services and human geography (see chapter two). I employed three phases to conduct the research. In alignment with objective one and two, the first phase (the rural community inventory) investigates the three components of the conceptual model (e.g., older adult health construction, the care context and the rural context) providing a comprehensive background on older adult health construction and the rural care context in Haliburton County. The second phase (go-alongs) uncovers observations and perceptions of older adults, informal supports, and front-line staff in alignment with objectives one to three (e.g., older adult health construction, the rural care context, transitional care experiences). Finally, the third phase (semi-structured interviews) outlines the perceptions of older adults, informal supports, front-line staff and administrators in alignment with objectives one to three. In combination, these three phases include several methodologies to explore the perceptions and experiences of the stakeholders involved in rural older adult transitions in care.

While the majority of the data I collected in my dissertation were qualitative [through the rural community inventory (internet sources), go-alongs (observations and

verbal data) and semi-structured interviews (verbal data)], I collected some quantitative data in the rural community inventory in phase one (demographic data collected from Statistics Canada). My dissertation, however, has not been identified as a mixed methods study since the quantitative data from phase one were solely used to reflect on the qualitative data retrieved through the subsequent phases of my dissertation. This positioning is supported by Clark and Veale (2019) who reveal that collecting quantitative data can extend thinking and interpretations of qualitative research without being designated as mixed methods research.

In phase one, I adapt a community inventory developed by Halseth & Ryser (2004) to provide a comprehensive account of older adult health construction and the rural care context in Haliburton County. In phase two and three, I actualize ethnographic philosophy through the collection of observational and verbal qualitative data. Ethnographic health research builds on existing research to "illuminate our understanding of relational phenomena that affect the quality of care" (Collingridge & Gantt, 2019, p. 442). Designed to distinguish between the behaviours and perceptions of the stakeholders (Collingridge & Gantt, 2019), this philosophical approach helped to account for the discrepancy between the knowledge of the participants and their actions during rural older adult transitions in care. This framing then allowed me to compare the participants' diverse constructions of older adult health and experiences of rural older adult transitions in care.

My dissertation also considers the spatial and temporal dimensions of the participants' experiences. Specifically, my project design encompasses the interplay between older adult health construction (social determinants of health, intersectionality),

health systems (formal health services, formal social services, informal supports) and rural communities (unique rurality, multidimensional rural places, contested spaces) by embracing the relational approach to research used in gerontology, health services and human geography scholarship. Aligning with the fundamental components of community-based participatory research, I also include a diverse range of participants and community partners and provide feedback to them (see objective four) as a way to ensure vast dissemination of my research findings. Table 3.1 outlines the three central elements of the conceptual model and links these elements to my methods, methodologies and objectives. I describe these aspects of my methods and research design more thoroughly in the subsequent sections of this chapter.

Table 3.1 Link between Conceptual Model, Research Objectives and Methods

To better understand the interplay between older adult health construction and the influence of multidimensional contexts on the transitional care of rural older adults				
Conceptual Model	**Research Objectives**	**Methodology**	**Methods**	**Questions**
Older Adult Health (1)	・ To observe and gain the perspectives of older adults, informal supports, front-line staff and administrators/managers on how rural older adult health is constructed ・ To understand the experiences of key stakeholders involved in rural older adult transitions in care	・ Case Study ・ Processes ・ Experiences & Perceptions of Stakeholders	・ Community Inventory ・ Go-Along Method ・ Semi-Structured Interviews	1) What factors do older adults, their informal supports, front-line staff and administrators/managers use to construct older adult health in Haliburton County? 2) What enhances and inhibits older adult health as patients' transition through the rural health system?
Care Context (2)	・ To better understand the rural care context in which older adult transitional care is provided ・ To understand the experiences of key stakeholders involved in rural older adult transitions in care			1) What are the formal health/social services that support older adult health and the transitional care of older adults in rural communities? 2) What formal health/social services are missing to support older adult health and rural older adult transitions in care? 3) What role do informal supports play in supporting older adult health and rural older adult transitions in care?

Rural Context (3)	• To better understand the rural care context in which rural older adult transitional care is provided • To understand the experiences of key stakeholders involved in rural older adult transitions in care			1) What are the socio-demographics of Haliburton County? 2) What are the key historical, cultural, political, economic and social factors that influence older adult health and rural older adult transitions in care? 3) What community infrastructure exists to support older adult health and rural older adult transitions in care?

3.3 Research Design and Methods

3.3.1 Qualitative Case Study

I strategically chose a case study on Haliburton County to catalyze in-depth qualitative information gathering on one rural care context in alignment with the relational approach to research established in critical gerontology, health services and human geography scholarship (see chapter two). The case study methodology provides social scientific investigation that encompasses the intricate relationship between and within micro, messo and macro levels of a community (Schwandt & Gates, 2018). This methodology then can account for the shifts in political economy, demographics and socio-cultural relations (Poulin et al., 2020; Kydd et al., 2018; Khan et al., 2018) that exist in rural areas. Haliburton County also provides an interesting rural care context to study as it exhibits unique strengths (such as a large network of volunteers, many initiatives to support community members with low income, several outdoor clubs and activities) and barriers (limited medical services, large geographic expanse and youth outmigration) to support older adult health and care (see chapter one). As such, a case study on Haliburton County was ideal to analyze the interplay between older adult health construction, the multidimensional rural care context and rural older adult transitions in care.

3.3.2 Benefits of Community-Based Participatory Research

Capitalizing on the benefits of a community-based participatory research approach, I collaborated with organizations who had a common interest in older adult care in Haliburton County (e.g., Haliburton Highlands Health Services, Haliburton Extendicare, Seniors Care Network and Trent University/The Trent Centre for Aging and

Society). Community-based participatory research allows research priorities to be shaped by community members, which provides a collective approach to inquiry and social change through multiple knowledge sources (Jason & Glenwick, 2016). I engaged the community partners through various methods of communication from in-person meetings to email exchanges. Since community engagement is formed through a moral commitment to the wellbeing of the partner's interests (Wood, 2016), this communication ensured that the community partners shaped the design of my dissertation and clarified their capacity for inclusion. Each community partner was pivotal to the authenticity and comprehensiveness of my dissertation despite having different levels of involvement (see Table 3.2).

Table 3.2 Community Partners

The Partners			
Organization Name	**Organization Description**	**Involvement**	**Method of Engagement**
Haliburton Highlands Health Services	Haliburton Highlands Health Services is a leader in innovative rural health care provision which is divided into two sites located in Haliburton Village and Minden Village. Providing an example of an integrated health system, Haliburton Highlands Health Services delivers a range of services from acute care and long-term care to community and mental health services. Many of the services provided at Haliburton Highlands Health Services are also specifically designed for older adults (e.g., Geriatric Assessment and Intervention Network, falls prevention program, etc.).	➢ Haliburton Highlands Health Services provided access to the participants ➢ The President and CEO of Haliburton Highlands Health Services reviewed my thesis proposal and provided ethics approval ➢ An organization-wide presentation on my findings will be provided to Haliburton Highlands Health Services and Haliburton Highlands Health Services will be consulted to determine next steps for dissemination	➢ In-person meetings ➢ E-mails ➢ Conference calls ➢ Organization-wide presentation on my research findings
Seniors Care Network	Seniors Care Network is a health network in the central east region of Ontario and is considered a regional expert on older adult health care. Haliburton County falls under the Seniors Care Network's catchment area.	➢ Seniors Care Network acted as an advisor providing feedback on my thesis proposal ➢ Funding for my dissertation was provided through the Seniors Care Network Geriatric Education Initiative ➢ An organization-wide presentation on my findings will be provided to Seniors Care Network and Seniors Care Network will be consulted to	➢ Previously collaborated on a research project which assisted with relationship formation and engagement ➢ In-person meetings ➢ E-mails ➢ Conference calls

		determine next steps for dissemination	➢ Organization-wide presentation on my research findings
Haliburton Extendicare	Haliburton Extendicare is the only other long-term care home in the county and is located in Haliburton Village. The long-term care home is run by the Extendicare Corporation, which provides a range of other older adult health services in Ontario including retirement living and home care.	➢ Haliburton Extendicare provided access to the participants ➢ The administrator reviewed my thesis proposal and provided ethics approval	➢ In-person meetings ➢ E-mails ➢ Conference calls
Trent University/Trent Centre for Aging and Society	Trent University is a small, primarily undergraduate university located in close proximity to Haliburton County. The university is home to the Trent Centre for Aging and Society which fosters relationship building between aging scholars, professionals and students in the field. Trent Centre for Aging and Society engages with many world renowned aging scholars and encourages thought provoking and innovative research in gerontology.	➢ Trent University provided the resources, supervisorial guidance and ethics review process needed to realize the potential of this critical analysis. ➢ My thesis was supervised by the Canada Research Chair in Rural Aging, Health and Social Care, Dr. Mark Skinner, which contributed to the authenticity of the research design and overall findings. ➢ In addition, Trent Centre for Aging and Society provided opportunities to engage with other professionals and educators interested in older adult care ➢ Trent Centre for Aging and Society will play an essential role in the dissemination of my research findings	➢ In person meetings ➢ E-mails ➢ Conference Calls ➢ Presentation on my research findings

3.4 Project Design: A Three Phased Approach

I employed a case study of Haliburton County using a multi-phase approach to gather mainly qualitative data. The three phases of my dissertation included: 1) a rural community inventory 2) go-alongs and 3) semi-structured interviews with older patients, informal supports, front-line staff and administrators/managers. This multi-phase approach attempted to avoid the narrow findings that result when only one form of data collection is used (Schwandt & Gates, 2018) and aimed to account for the influence of context (Valentjin et al., 2015). Phase two and phase three were conducted concurrently, subsequent to phase one. These phases were designed to align with the pedagogical foundations examined in chapter two as well as the conceptual framework for my dissertation.

3.4.1 Phase One: Rural Community Inventory

In phase one, I adapted Halseth and Ryser's (2004) rural community inventory (Appendix A). The adapted rural community inventory has three sections which align with the conceptual model (Figure 1.1): Older adult health construction, the rural context and the care context. The first section of the rural community inventory guides the researcher to investigate older adult health construction under sub-sections designed to reflect intersectionality (e.g., age, gender, ethnicity, sexuality, disability, socio-economic status) and the social determinants of health (e.g., gender, ethnicity, income and social status, employment and working conditions, education and literacy, physical environments, healthy behaviours and biology and genetic endowment). The data generated in the first section reveal the health, socio-demographic and socioeconomic characteristics of the Haliburton population (e.g., gender, ethnicity, sexuality, disabilities,

etc.) as well as the types of services available to support marginalized older populations. The second section of the rural community inventory guides the researcher to explore facets of the care context in Haliburton County. The data generated by this section exposes the formal health services, formal social services and informal care groups available in the region. Finally, the third section guides the researcher to investigate the rural context by outlining the historical, economic, political, social, geographic, cultural, dynamic and contested features of the rural community. The rural community inventory conceptualization is detailed in Table 3.3.

To collect the data in phase one, I conducted a detailed internet search on each section and sub-section of the rural community inventory. The data obtained from this search as well as the data source were recorded directly into an encrypted document. As mentioned in the beginning of this chapter, I recorded some quantitative data in the rural community inventory, however, the majority of the data collected in this phase were qualitative. This inventory provided a foundation of knowledge to further explore the influence of rural older adult health construction and the rural care context on rural older adult transitions in care.

Table 3.3: Rural Community Inventory Conceptualization and Limitations

The Rural Community Inventory Design			
Conceptual Model Component	**Theoretical Foundations**	**Justification**	**Limitations**
Older Adult Health Construction	Social Determinants of Health, Intersectionality	➢ To reflect the social determinants of health, socio-demographic information and community groups/services that support the social determinants of health were recorded including: income and social status, employment and working conditions, education and literacy, physical environments, healthy behaviours, gender as well as biology and genetic endowment (Government of Canada, 2018). ➢ To reflect intersectionality, socio-demographic information was gathered on age, ethnicity, gender, sexuality, disability and socio-economic status. Services and informal groups that support social equality were also recorded.	➢ The social determinants of health such as childhood experiences, social supports and coping skills, culture as well as health service access (Government of Canada, 2018) were not captured in the rural community inventory as these factors were more appropriately captured in the subsequent phases of my dissertation. ➢ Only information that was available online was accounted for. ➢ This section provided only preliminary information to shed light on the qualitative data collected in subsequent phases.

Care Context	Health Integration, Informal Supports	➢ This section provided a comprehensive review of the formal health services, formal social services and informal groups that support older adult health and care in Haliburton County. Furthermore, this section identified any partnerships that were formed in the local community between formal service providers and/or informal groups.	➢ Only information that was available online was accounted for. ➢ This section provided only preliminary information on the formal health services, formal social services and informal supports in Haliburton County but was fundamental to shed light on the qualitative data collected in subsequent phases.
Rural Context	Unique rurality, multidimensional rural places, contested spaces, and relational understandings of health	➢ The information collected in this section encompassed the historical, political, economic, social and cultural factors that shape older adult health and care in Haliburton County. ➢ This section reflected on the infrastructure, industry, political initiatives and historical events that make Haliburton County unique to other rural communities. ➢ Evidence of shifting political economies, social relations and community tensions were examined to investigate the contested rural spaces in the area.	➢ The values, attitudes and comradery between community members was gathered in subsequent phases since the rural community inventory did not allow for this type of insight. ➢ Only information that was available online was accounted for. ➢ This inventory provided only preliminary information on the rural community but was fundamental to shed light on the qualitative data collected in the subsequent phases of my research.

3.4.2 Phase Two: Go-Along Method

In phase two I used the go-along method to gather a contextualized account of rural older adult transitions in care. The go-along allows researchers to accompany individual informants as they interact with their physical and social environment (Kusenbach, 2016). Researchers gain a better understanding of their subject's lived experiences by using a mix of observations and interviews, which allows them to listen, observe and ask clarifying questions to those involved (Kusenbach, 2016). The investigative questioning I used in this phase was essential to expose the participants' interpretations of their interactions with others and contributed to the overall rigor of my research findings by focusing on the hallmarks of critical analysis (what, why and how). Considering that go-alongs with multiple informants can relieve some of the discomfort of observational methods (Kusenbach, 2016), including older adults, informal supports and front-line staff in this phase was advantageous to capture the natural processes and interactions of stakeholders involved in rural older adult transitions in care.

I used this method to explore two specific types of transitions in care: 1) when an older adult transitioned from a hospital to a long-term care home and 2) when an older adult transitioned from a hospital back to their residential home in the community. Go-alongs began at the point at which front-line staff identified that the older patient would be discharged and ended no later than 24 hours after the participant was discharged from the hospital. I chose the maximum of 24 hours after hospital discharge as the end point of transitions in care to align with the Ontario Ministry of Long-Term Care Homes Act that stipulates that a formal care plan must be created 24 hours after a resident moves into a long-term care facility (Ontario Ministry of Long-Term Care, 2019). Go-alongs were not

continuous but were conducted intermittently to gather data at pivotal points in the transitional care process.

Taking cues from critical gerontology and health integration literature, this phase aimed to address the dearth of research on the care experiences of older adults (Gullette, 2017; Dionigi, 2015) and their informal supports (Pindus et al., 2018) as well as record the interactional elements between acute and community services (Kansagara et al., 2016). While this approach is just emerging in health research, the go-along utilizes an ethnographic approach to expose the multidimensionality of participants' lived experiences and uncovers how different places and people are inter-linked (Kusenbach, 2016). As such, the go-along was quintessential to account for the spatial polygamy of older adult health construction, the rural care context and rural older adult transitions in care.

The greatest advantage of the go-along method, however, was its ability to acknowledge that participants navigate real and constructed spaces that foster and inhibit health (Kusenbach, 2016). Indeed, spanning organizational boundaries and care contexts, the go-along allowed me to capture the participants' interactions over time and place and account for fluctuations in the participants' experiences. The go-along method was also particularly advantageous not only to underline the strengths and weaknesses of community health service provision but also to highlight the interdependence between life experiences and society (Kusenbach, 2016). As such, the go-along was a useful method to generate a spatial and temporal account of rural older adult transitions in care.

3.4.3 Phase Three: Semi-Structured Interviews

In phase three, I conducted semi-structured interviews. Interviews are a qualitative research technique in human and social sciences that enables interpersonal contact with participants (Brinkmann, 2018). As Brinkmann (2018) suggests semi-structured interviews appreciate the influence of contexts that standard survey data lacks and are highly effective to enable flexibility in dialogue to allow interviewees to focus on the elements of the interview that they deem most important. Interviews also involve continuous clarification to ensure that data interpretation is authentic (Brinkmann, 2018). As such, even though interview guides were developed (Appendix E), the interviews I conducted remained flexible to encourage knowledge-production outside of the questions designated in the interview guides.

I designed the semi-structured interview guides to align with the conceptual model (Figure 1.1) and the objectives of my dissertation (Table 1.1). A distinct guide was developed for each of the participant sub-categories (e.g., older patients, informal supports, front-line staff and administrators/managers) and each guide was divided into the same four sections for easy comparison of the data collected: 1) older adult transitional care 2) older adult health 3) formal health services, formal social services and informal supports and 4) the rural community. Table 3.4 identifies the four sections of the interview guides and the rationale for their design.

Table 3.4 Design of the Semi-Structured Interview Guides

Design of the Semi-Structured Interview Guides			
Section	**Description**	**Theoretical Foundations & Justification**	**Connection to Objectives**
Older Adult Transitional Care	Questions provide a thorough exploration of the experiences of key stakeholders involved in rural older adult transitions in care	➢ Associated with the literature on older adult transitions in care and the research problem identified in chapter one	➢ Objective three
Older Adult Health	Questions investigate different perceptions on what constructs older adult health in Haliburton County	➢ Developed based on the paradigms of older adult health described in chapter two including the social determinants of health and the intersectionality of older adult health	➢ Objective one
Care Context	Questions explore the formal health services, formal social services and informal supports that shape the care context in Haliburton County	➢ Designed to account for the interrelationship between informal and formal care ➢ To address the predominant focus on acute care in research	➢ Objective two
Rural Context	Questions expose the complexity of the rural context (e.g., politics, history, social, culture, contested spaces, etc.)	➢ Questions reflect discourse in rural health and critical gerontology (unique rurality, multidimensional rural places, contested spaces and relational understandings of health)	➢ Objective two

3.5 Participants

I included older adults, informal supports, front-line staff and administrators/managers in my dissertation to ensure a representative sample of those involved in rural older adult transitions in care. This design is well suited to reveal the interconnection between diverse perspectives, such as those between interprofessional team members (Rosen et al., 2018) as well as between health care staff and patients (Ploeg et al., 2017). Including both informal and formal caregivers also allows for investigation into the inter-linkage between informal and formal care which is absent from contemporary research (Kemp et al., 2013). To embrace inclusivity, I also consulted support staff such as housekeeping to provide a rare perspective on the processes and culture of rural older adult transitions in care. The intention of including these participants was to place value on all front-line staff who support rural older adult transitions in care and to gain perspectives of carers who may be less impacted by established paradigms of care or regulated professional bodies. My methods then attend to Kotter-Gruhn et al. (2016) call for more multidimensional analysis by appreciating the ways that rural care contexts construct intra-individual variability during rural older adult transitions in care.

3.5.1 Recruitment

I invited the participants to take part in my dissertation based on the eligibility criteria outlined in Table 3.5 and participation was not restricted if eligible participants were only able to participate in one of the research phases. Taking this adaptive approach was particularly important to appreciate the heavy workloads of front-line staff and the strong emotional responses of older adults and informal supports during transitions in

care. On the other hand, patients that were eminently palliative or exhibited a non-stable, medically acute condition were not actively recruited. This stipulation aimed to not contribute further to the maleficence of participating in my dissertation.

Table 3.5 Eligibility Criteria

Eligibility Criteria	
Type of Participant	**Eligibility**
Older Participants	Any older adult over 65 who is transferred either from a hospital to a long-term care home or from a hospital to a residential home in the community. Older adults who are eminently palliative or have an unstable acute medical condition will not be recruited to participate. (All efforts will be made to include older adults with mental health conditions and cognitive impairments with expressed assent and the Power of Attorney/Substitute Decision Maker's consent).
Informal Support Participants	Any individual (family/non-family) who supports and/or accompanies an older participant during the transitions process. Informal supports are identified by the older participant. If an older adult lacks the capacity to identify informal supports, the Power of Attorney/Substitute Decision Maker is considered their informal support.
Front-Line Staff Participants	Any employee from a hospital, long-term care home or community organization involved in rural older adult transitions in care in Haliburton County. This eligibility criteria includes but is not limited to: physicians, nurses, personal support workers, social workers, rehabilitation staff, recreation staff, housekeeping, dieticians and maintenance staff.
Administrator/ Management Participants	Any administrator/manager who oversees rural older adult transitions in care from hospital to long-term care or from hospital back to a residential home in the community. This eligibility criteria is inclusive of administrators/managers with various levels of responsibility from different sectors within Haliburton County. (Administrators/managers are only involved in the semi-structured interview phase).

The active engagement of the President and CEO of Haliburton Highlands Health Services (HHHS) was fundamental in the recruitment of the participants and the community partners as she formally introduced me to both the administrators/managers within HHHS as well as the administrator at Haliburton Extendicare. The President and CEO also encouraged me to use a recruitment poster (Appendix D) at both HHHS sites and designated the Behavioural Supports Ontario staff to connect me with suitable participants. The Behavioural Supports Ontario staff's prior relationship with the patients, staff and informal supports as well as the script (Appendix C) to inform potential participants about my dissertation, were vital to encourage participation. The Behavioural Supports Ontario staff also informed me if older participants had cognitive impairments that may impact their responses and/or if consent from a Power of Attorney/Substitute Decision Maker and on-going assent were required. In addition, the participant recruitment role of the Behavioural Supports Ontario Staff evolved over the duration of my dissertation as he became both more familiar with the project and the importance of the reciprocity of the research partnership. Progressing to a champion role, the Behavioural Supports Ontario Staff provided me with almost daily communication regarding eligible participants and participant transfers. Considering transfers were often initiated with limited notice, the Behavioural Supports Ontario staff was essential for the successful implementation of phase two. Finally, a question at the end of each interview guide sought to recruit further participants: "Is there anyone you think I should talk to that would have insight into older adult health or the transitional care of older adults?" This question was useful to recruit physicians and/or community members who I may not have otherwise included.

3.6 Ethics Approval

Ethics approval for my dissertation was provided by the Trent University Research Ethics Board, Haliburton Highlands Health Services and Haliburton Extendicare (Appendix F). The ethics proposal included a full description of the research design, the research methods, the participant recruitment script, the participant information letters, the participant consent forms and the participant interview guides. Due to the vulnerability of the research participants, I pursued methods to protect the participants' safety and the anonymity of their responses.

3.7 Ethical Challenges

Shaw et al. (2020) assert that the inclusion of vulnerable populations in research far outweighs the time and resources that it takes to overcome the ethical barriers that perpetuate the social inequality and oppression of subsets of the population. Notwithstanding the importance of including vulnerable populations in research, several ethical challenges impacted my dissertation as a result of their inclusion. For instance, the inclusion of older adults with cognitive impairments required the Power of Attorney/Substitute Decision Makers' consent and continuous assessment of the participants' assent. These circumstances required me to routinely make ethical decisions to determine the best approach with each older patient (e.g., re-approaching participants, terminating participation, etc.). As Novek and Wilkinson (2019) indicate creating a safe research environment for participants with cognitive impairments requires the ethical principles of beneficence (actions should promote good) and non-maleficence (actions should not inflict harm) to be employed by ensuring that all methods, strategies and techniques minimize potential distress to the participant and promote the benefit of

participation. I then aligned my approach to research with recommendations for including participants living with Dementia in research studies [(e.g., avoiding the use of stigmatizing language, coordinating appropriate times and settings for the interviews, participating in rapport development, continuously checking in with participants about their comfort levels and being attentive to the participants' body language (Novek & Wilkinson, 2019)]. Despite all of these precautions and my extensive employment experience directly working with older adults with cognitive impairments, the older patients were still confused by my role as a researcher and/or asked me to play a more active role in their care. Certainly, role ambiguity is common in the process of rapport building, which can blur the lines between researchers and participants especially when research is performed in participants' homes (Novek & Wilkinson, 2019). I then used continuous role clarification and intentional discussions on relationship boundaries to minimize these types of ethical issues.

Ethical considerations regarding recruitment and participation were also required. If eligible recruits declined to participate in all or part of my dissertation, I respected these decisions and no further contact was made. This process was essential to respect that participating in research can contribute to vulnerable populations re-living sources of trauma (Hayre & Muller, 2019). On the other hand, it is recognized that not including these participants may have limited my findings on rural older adult transitions in care.

3.8 Data Collection, Organization and Analysis

A summary of how I collected, organized and analyzed the data is presented in Table 3.6 and is described in more detail under the Data Collection and Organization and the Data Analysis sections.

Table 3.6 Data Collection, Organization and Analysis

Data Collection, Organization and Analysis	
Data Collection: Phase One	➢ The data were divided by the categories defined in the rural community inventory and stored in an encrypted electronic document.
Data Collection: Phase Two	➢ Observational and verbal data were recorded all together in a research notebook ➢ After each session, the recorded data were transcribed and stored in encrypted documents.
Data Collection: Phase Three	➢ The data were recorded in an encrypted electronic document which was identified by participant number, the sub-category of research participant and the care setting (hospital, long-term care, community).
Data Organization	➢ Observational data were recorded in one encrypted document. Memos were used to record the sub-category of the participants involved, their participant number and the care setting. ➢ Verbal data collected during the semi-structured interviews were recorded directly into an encrypted document identified by participant number, participant sub-category and care setting. Any verbal data that was collected in the go-along phase was added to these encrypted documents. ➢ The verbal data from each sub-category of research participant from each care setting were combined into eight larger documents (Table 3.7). The colour-coded legend was then used to colour code all of the organized data sets (one with observational data and eight with verbal data). These coloured data sets were then merged into one encrypted document for analysis.
Data Analysis	➢ Open coding was conducted on the entire colour-coded data set and then the codes were sorted under the research objectives. ➢ The colours represented under each theme were reviewed to determine if the categorized themes were specific to certain stakeholders or settings. ➢ The divergences between observational and verbal data were analyzed. ➢ The data set was visually presented and then was reviewed to acknowledge any unfolding patterns or fixed points of reference. ➢ Any interconnections within and between the objectives were analyzed. ➢ The data collected in phase one of the project were compared with the data collected in the subsequent phases.

3.8.1 Data Collection and Organization

I employed different methods to collect and record the qualitative data obtained in each phase of my dissertation. In phase one, I used a comprehensive internet search to fill in the rural community inventory (Appendix A). The data I recorded in this phase were kept in an encrypted electronic document which was organized by the sections and sub-sections outlined in the rural community inventory (see Table 3.3). The observational data I obtained in phase two were recorded manually into a research notebook and then transcribed into one encrypted electronic document. Memos were used to identify the sub-category of the participants involved in the observation, their participant numbers and the care setting (e.g., hospital, long-term care and community). In phase three, I directly recorded the data from each semi-structured interview into separate encrypted electronic files which were organized by participant number, participant sub-category and care setting. Any verbal data I collected from participants in phase two were added to the corresponding encrypted document.

Since Rutakumwa et al. (2020) argue that audio recordings may be inappropriate with research participants that are exceptionally vulnerable, I intentionally chose not to audio record the semi-structured interviews. My reasoning for not using audio-recording, however, extends beyond the vulnerability of the participants. First, even though I made all attempts to conduct interviews in quiet spaces, the older participant interviews were mainly conducted in the patients' rooms. The use of monitors, bed alarms and other background noises in patients' rooms had the potential to muffle the responses of the participants if they were audio recorded. Second, by recording the data directly into a notebook or an electronic document I was able to include 'memos' directly beside the

participant responses, which allowed me to provide additional context to the data collected (Cope, 2016). For instance, if a participant suggested that a service did not exist but the rural community inventory revealed that it did, I could record this discrepancy. Finally, the ability to write memos beside the data collected allowed me to record discrepancies between the observational and verbal data obtained. For example, some older adults claimed they did not have any health conditions despite prominent physical and cognitive impairments. Memos allowed me to record that the participant did not have insight into their health condition which enhanced my interpretation of the data obtained. Thorne (2011) articulates that contemporary research methods entrust that participants have in-depth and comprehensive knowledge of themselves, their interactions with others and of health care settings which negates the human psychology and socio-cultural elements that construct practice differently in different health care environments. Memos allowed me the ability to document these nuances. To ensure accuracy of the participant transcripts, I informed the participants that they might be asked to repeat themselves, or asked to pause, to allow me to manually record their responses. In addition, I asked the participants if they would like to review the transcript of their interview, however, only two participants performed this retrospective audit.

I conducted data collection based on the principles of saturation and only concluded when no new themes were emerging. Once all of the data were recorded, I combined the verbal data electronic documents from phase three into eight larger documents which were identified by participant sub-category and care setting (hospital, community, long-term care). I combined the administrator/manager interviews into one document irrespective of their care setting to ensure the anonymity of the participants

(five administrators/managers were interviewed, which means that identifying their care setting would have compromised their anonymity). I colour-coded all nine documents (eight verbal data documents and one observational data document) based on The Data Colour-Code Legend in Table 3.7 and then I combined all of the colour-coded data into one encrypted document for analysis. The colour coding method is a qualitative technique used in studies to decipher prominent themes in qualitative data sets (Bree & Gallagher, 2016). I used these colours to represent the participant sub-categories and the observations made under each identified theme.

Table 3.7 Data Colour-Code Legend

The Data Colour-Code Legend	
Observational	Grey
Administrator/Manager	Green
Front-Line Staff - Acute Care	Blue
Front-Line Staff - LTC	Red
Front-Line Staff - Community	Yellow
Informal Support - Community	Orange
Informal Support - LTC	Pink
Patient-Community	Light Blue
Patient-LTC	Purple

3.8.2 Data Analysis

The process of data analysis I used in my dissertation is presented in Table 3.8. I performed open coding of the entire data set (phase two and three) retrospectively. Open coding allows for broad-based discovery using inductive content analysis (Mihas, 2019). This method results in the data being thematically coded into indexed themes by categorizing each line of the transcribed data (Mihas, 2019). Identifying sub-categories under each indexed theme further links the related findings (Mihas, 2019). Once the coding process was complete I sorted the thematic codes under the research objectives and I analyzed the themes within and between the objectives. I then examined the colours

represented under each theme to determine if the categorized themes were specific to certain sub-categories of participants or care setting. I also compared the observational and verbal data to determine if there were gaps between knowledge and practice and I compared the data collected in phase one with the data collected in the subsequent phases. The colour-coding of the data collected in phase two and three was pivotal to rigorously analyze the data and provided depth to my research findings.

3.8.2.1 Incorporating Spatial and Temporal Analysis[2]

Process analysts establish that one of the major challenges of interpreting empirical research is how to account for the flow of experiences over time and place (Jarzabkowski, Le & Spee, 2017). My approach to data analysis then aimed to consider the spatiality and temporality of rural older adult transitions in care. Specifically, by visually displaying all of the themes I was able to identify any unfolding patterns or fixed points of reference between or within the objectives. Jarzbkowski et al. (2017) indicate that this process provides a sense of organization or flow to the data which helps with spatial and temporal analysis.

Table 3.8 Data Analysis Details

Data Analysis Details	
Objectives	・ Themes including all three objectives ・ Themes including two objectives ・ Themes including one objective ・ Contrasts between the objectives ・ Emergent patterns or points of reference to expose the connections between or within the objectives
Type of Transfer	・ Themes identified in both types of transfers ・ Themes only identified in one type of transfer
Sub-Category of Participant	・ Themes between all participant groups ・ Themes between three types of participant groups

[2] Although my dissertation was not defined as a longitudinal study, temporal and spatial findings were generated as a result of my research design which allowed for data to be collected at different times throughout the transitions process and in multiple care settings.

	• Themes between two types of participant groups • Themes only present in one type of participant group • Contrasts between participant responses
Knowledge and Practice	• Divergences between the observational and verbal data • Divergences between phase one data and the data collected in subsequent phases

3.9 Chapter Summary

In this chapter I have outlined the rationale for each aspect of my research design which is strongly interlinked with the conceptual model of my dissertation and empirically grounded in the relational approach to research that was reviewed in chapter two. My research methods and design included a range of community partners and participants as well as capitalized on a multi-phased approach to expose the interconnection between rural older adult health, multidimensional contexts and rural older adult transitions in care.

I have divided my findings chapters based on objectives one to three as follows: Older Adult Health Construction (objective one), Rural Care Context (objective two) and Experiences of Rural Older Adult Transitions in Care (objective three). I have included participant quotations and observations in these chapters to represent the wide range of individuals who participated in my dissertation. While I acknowledge that my findings may not necessarily be unique to people living in rural contexts (see Phillipson & Scharf, 2005), it is important to note that findings acquired in rural settings are nonetheless significant to advance knowledge on the heterogeneity of aging, health and care (Skinner et al., 2021). I address objective four, the provision of information for regional older adult health care networks (Haliburton Highlands Health Services & Seniors Care Network) in chapter seven to align with my contributions to research, policy and practice.

CHAPTER 4

"I think there are sometimes attitudes towards older people. Sometimes being so connected means that there are judgements on some people who have a lower status in the community. A lot of times it is those with poor resources and poor upkeep. This impacts their ability to get help for their health."

4 Findings: Older Adult Health Construction

4.1 Introduction

Answering the calls of rural scholars for more informed definitions of rural health (Gessert et al., 2015), this chapter reveals the intricate network of factors that contribute to the heterogeneity and fluidity of older adult health construction in Haliburton County in alignment with objective one (To observe and gain the perspectives of older adults, informal supports, front-line staff and administrators/managers on how rural older adult health is constructed). As the participant citation for this chapter foreshadows, aspects of the rural care context lead to health and care inequities between rural older people during transitions in care. Indeed, my dissertation exposes the heterogeneous and dynamic nature of rural older adult health that is continually shaped by the rural care context. Much as older adults identify holistic factors that contribute to 'good health', I uncover the barriers to attending to these facets of health during care transitions.

I begin this chapter with a summary of my findings including the participation rates for my dissertation and the characteristics of the participants involved. The remainder of the chapter is divided into four sections to present my findings on older adult health construction: Social Aspects of Health, Economic Aspects of Health, Identity Construction and Holistic Aspects of Health. Table 4.1 provides a summary of the themes and sub-themes in this chapter related to older adult health construction, revealing how rural older adult transitions in care embody the interplay between older adult health construction and the multidimensional rural care context.

Table 4.1 Older Adult Health Construction

Older Adult Health Construction			
Overall Theme	**Themes in Category**	**Connection to the Conceptual Model**	**Connection to the Literature**
Social Aspects of Health	1. Community connection and religion shape support for health, yet place based attachments do not necessarily equate to increased support for health 2. Conflictions between older peoples' pursuits of self-care and social engagement lead to dynamic constructions of rural older adult health 3. Topography and individual preferences for solitude lead to the heterogeneity of rural older adult health	・ Older Adult Health Construction ・ Care Context ・ Rural Context	・ Social Determinants of Health ・ Relationality
Economic Aspects of Health	1. Differences in economic status contribute to health and care inequities between rural older populations 2. Affluence leads to increased independence and support for holistic aspects of health 3. Rural older adults living with lower economic statuses must prioritize aspects of their health and care due to the high cost of living and the additional expenses required to access care in rural communities 4. Stigma restricts older adults living with lower economic statuses from pursuing support for their holistic health		・ Social Determinants of Health ・ Relationality ・ Intersectionality
Identity Construction	1. There is a lack of recognition of gender, sexual and ethnic identities within Haliburton County 2. Traditional gender stereotypes shape rural older adult health		・ Social Determinants of Health ・ Relationality

	3. While policies exist to support diverse sexual identities, care provision homogenizes sexual identity in practice 4. Some health professionals identify the benefits of culturally-based care services, however, more often barriers to providing care to people who identify as having cultures other than the dominant norm are presented 5. Haliburton County is considered to be monocultured. Even older adults who identify as having ethnicities other than the dominant norm do not identify how their identities shape their health and care		• Intersectionality
Holistic Aspects of Health	1. Holistic elements of rural older adult health are interconnected, conflicted and are difficult to articulate 2. Rural older adults may identify holistic elements of their health that are important but in reality pursue other aspects of health 3. Biomedical aspects of health are prioritized in health policy and practice, which influences older adults to focus more prominently on their biomedical health		• Social Determinants of Health • Relationality

4.2 Overall Findings

In total 19 older patients, 24 informal supports, 51 front-line staff and five administrators/managers participated in my dissertation resulting in 99 total participants. In the end, I documented 19 go-along experiences and I conducted 85 semi-structured interviews. While gathering detailed information on the participants was outside the scope of my dissertation, the ethnographic approach I used uncovered several commonalities within the participant sub-groups that are noteworthy. Thus, in this section I discuss the participation rates for the project (Table 4.2) as well as provide a brief review of each sub-category of participant.

Table 4.2 Participation Rates

Phase Two	Older Adults	Informal Supports	Front-Line Staff	Administrators/managers
Go-Alongs in hospital	17	17	-	-
Go-Alongs in a long-term care home	5	7	-	-
Go-Alongs in the community	7	7	-	-
Phase Three				
Semi-structured interviews in hospital	-	-	21	2
Semi-structured interviews in a long-term care home	3	7	25	2
Semi-structured interviews in the community	7	14	5	1
Total Number of Participants per Participant Category	**19**	**24**	**51**	**5**
Total Number of Participants	**99**			
Total Number of Go-Along Events Documented	**19**			
Total Number of Semi-Structured Interviews	**85**			

4.2.1 Participation Rates

Despite some low participant numbers in some sub-categories, the rate of participation was high, representing an expansive sample of the population who were eligible to participate. I documented the reasons participants declined to participate or only participated in one phase of my dissertation. Older patients and informal supports declined to participate in my dissertation due to declining health, family conflict or due to having to navigate the services required for the older patient's increased needs. Older patients who declined to participate used words such as 'stressed', 'frustrated', 'overwhelmed' and 'no time' to describe their regrets for not participating. Further, one older patient died prior to being transferred into long-term care and one patient was still waiting in hospital for long-term care when my dissertation concluded. Front-line staff declined to participate in my dissertation citing 'no time' and suggesting that 'heavy workloads' impacted their ability to participate. Physicians were the hardest front-line staff group to recruit. These front-line staff articulated that they had 'no time', had 'heavy workloads' or that they were about to leave for vacation as reasons for not participating in my dissertation. Table 4.3 provides some background and socio-demographic information on the participants which is then described in more detail under the sub-headings that follow.

Table 4.3 Socio-Demographic Information & Participant Characteristics

Haliburton County Socio-Demographic Information				
Total Population	18,062			
Total Population of Males	9,060			
Total Population of Females	9,005			
Distribution of Population 65 and Older	32.9%			
Median Age	57.5			
Canadian Born Population	17,560			
Number of Immigrant & Non-Permanent Residents	1,570			
Indigenous Population	520			
Marital Status –Married or Common Law	10,725			
No Post-Secondary Certificate, Diploma or Degree	7,935			
% of Owner Households Spending 30% or More of its Income on Shelter Costs	20.8			
Unemployment Rate	9.6			
Average Total Income	$39,258			
Participant Characteristics				
	Older Adults	Informal Supports	Front-Line Staff	Administrators/Managers
Approximate Age Range	65 or older	65 or older	25-65	35-65
Gender	11 females, 8 males	18 females, 6 males	48 females, 3 males	5 females
Professional Designation/Employment	18 retired/unemp	All either retired, unemployed or had flexibility in	3 Physicians, 2 Behavioural Supports Ontario staff, 1	2 Administrators from Long-Term Care, 1 Director, 1 Vice President

	loyed, 1 part-time	their hours of employment	Physiotherapist, 2 Physiotherapist Assistants, 4r Activation Aides, 2 Housekeepers, 2 Resident Assessment Instrument (RAI) Coordinators, Res2ident Coordinators, 1 Discharge Coordinator, 20 Registered Nurses/Registered Practical Nurses, 10 Personal Support Workers, 1 Patient Navigator and 1 Dietician	of Acute Care/Emergency Care and 1 Clinical Services Manager
Health Status/Disability	12 were living with mild to severe cognitive impairments. 13 were living with mild to severe physical disabilities	The majority of informal supports indicated that they had medical conditions and/or were observed to have physical impairments	-	-

(Statistics Canada, 2021)

4.2.2 Older Participant Characteristics

All of the older participants were 65 years of age or older including 11 who appeared to identify as female and eight who appeared to identify as male[3]. This gender ratio was not surprising since there is a higher proportion of women over 65 in Haliburton County (3,030 women versus 2,910 men) and males typically have limited life expectancy when compared to females (Pascariu, Canudas-Romo & Vaupel, 2018). I observed all of the older participants, however, only eight were able to participate in the semi-structured interviews due to presenting cognitive impairments. My foresight to include older participants with varying capacity was critical to ensure an accurate representation of the older patients transitioning between care settings in Haliburton County as 63% or 12 of the 19 older participants were living with mild to severe cognitive impairments. Although I did not ask the older adults about their income level directly, the observations I made during the go-alongs (e.g., living conditions, property and estate, etc.) and the older participants' verbal comments regarding money exposed a large divide in the economic statuses of the older participants. All of the older participants were unemployed or retired except one who was self-employed part-time.

4.2.3 Informal Support Participant Characteristics

The majority of the informal support participants were related to the older patient, with only three identifying as close friends of the older participant. The informal support's relation to the older adult varied including: seven spouses, five sons, eight daughters/daughters-in-laws and one sister. There were six informal supports who

[3] The gender identification of the older patients was determined by interacting with them and may not fully represent how they self-identify.

appeared to identify as male and 18 who appeared to identify as female[4]. This high proportion of female informal supports is reflective of the literature that indicates women predominantly take on caregiving roles (Miller et al., 2016). Certainly, many daughters-in-laws took on these caregiving roles, yet no sons-in-laws participated in my dissertation. The majority of the informal supports were older in age (approximately over 65) and I observed that several of the informal supports had their own medical conditions. All of the informal supports were either retired, unemployed or had flexibility in their hours of employment, which allowed them to take on these supportive roles.

4.2.4 Front-Line Staff Characteristics

The front-line staff participants had interdisciplinary backgrounds including: three Physicians, two Behavioural Supports Ontario staff, one Physiotherapist, two Physiotherapist Assistants, four Activation Aides, two Housekeepers, two Resident Assessment Instrument (RAI) Coordinators, two Resident Coordinators, one Discharge Coordinator, 20 Registered Nurses/Registered Practical Nurses, ten Personal Support Workers, one Patient Navigator and one Dietician. The variety of positions held by the front-line staff is a strength of my dissertation as it allowed for the analyzation of multiple perspectives from individuals with different professional designations. Specifically, interprofessional collaboration, which is necessary for the effectiveness and efficiency of health care processes (such as transitional care), is hindered by professional groups with distinct cultures that form as a result of professional identities, role boundaries and power differentials (Morley & Cashell, 2017). The inclusion of this wide

[4] The gender identification of the informal supports was determined by interacting with them and may not fully represent how they self-identify.

range of front-line staff participants, therefore ensured an accurate account of the care context in Haliburton County.

Out of the 51 front-line staff participants only three appeared to identify as male[5]. This gender ratio is common in health care settings and Borkowski and Meese (2021) acknowledge that this predominance of women alters the work place and care environment. Despite national rural health research that illustrates that rural front-line health care professionals are aging (MacLeod et al., 2017), the front-line staff participants' ages ranged greatly (estimated age of the participants ranged from 25-65) and several younger staff revealed that they had moved back to Haliburton after moving away for a period of time. The diverse ages of front-line staff participants then emphasize the importance of conducting contextually sensitive research that does not homogenize rural health care settings.

4.2.5 Administrator/Manager Characteristics

The administrators/managers had a range of titles including: two administrators from long-term care, one director, one vice president of acute care/emergency care and one clinical services manager (estimated age of participants ranged from 35-65). There were no male administrators/managers at the time of my dissertation[6]. Interestingly, health system scholars maintain that there is an absence of women in health care leadership roles, signaling that women face a glass ceiling when it comes to obtaining high level positions (Chisholm-Burns et al., 2017). The dominance of women in

[5] The gender identification of the front-line staff was determined by interacting with them and may not fully represent how they self-identify.
[6] The gender identification of the administrators/managers was determined by interacting with them and may not fully represent how they self-identify.

leadership roles in health care in Haliburton County further emphasizes the importance of highlighting the contextual differences between care contexts.

4.3 Social Aspects of Health

Social aspects of health play a prominent role in older adult health construction in Haliburton County. This front-line staff describes:

> *Social isolation is pretty dangerous. Sometimes these patients fall through the cracks [during transitions in care]. They don't have local supports and those are the ones that have a more difficult time at home [after discharge] because they don't have people to help them socialize or get food and that impacts their physical and mental health and their motivation to take care of themselves. (Front-Line Staff - Hospital 15)*

Social isolation then results in decreased access to informal support during transitions in care as community connection shapes the care provided to older people in the region.

While social aspects of health may also be vital to the health of older people living in urban centres, the lack of available public services in Haliburton County contributes to rural older people relying more heavily on informal supports. Certainly, the idea of 'neighbours helping neighbours' is engrained in the close knit rural community, which enhances residents connections with each other and the support available to older people throughout transitions in care. These participants explain:

> *It's about staying in the town that you were in for years and being with the people that you worked for, being with their families and knowing a lot of people. It makes a difference to your health [during transitions in care] (Older Adult - Long-Term Care 27)*

> *The local community has a positive influence on older adult health. I feel that community members are always willing to help [during transitions in care]. Neighbours helping neighbours. (Front-Line Staff - Community 1)*

This informal support network then shapes older adult health and the transitional care provided in the region.

Religion, especially Christianity, influences the health of older people in this community and is a pronounced feature of the strong informal support network in Haliburton County. These participants explain:

> *So religion can be a big thing in your health. And we have lots of prayers to turn to and we have others who support us [during transitions in care]. When I feel bad about my health I focus on my prayers to help me heal. I can't imagine if you didn't have God. (Older Adult - Community 55)*

> *It's hard without religion to keep going. People with a faith have something and someone to depend on [during transitions in care]. When they are thinking about how to help other people, you are helped just as much as you help other people. (Informal Support - Long-Term Care 33)*

Prominent in these quotations is the ways that religion shapes older adult health during transitions in care. While religion helps some older people to cope with physical health decline and the unpredictability of health in Haliburton County, the 23 churches in the community also provide various levels of transitional care support. These participants describe:

> *I think our church groups do support older adult health for sure. We can call them and they will come visit people [prior to discharge]. And they do have other exercise activities and a falls program [after discharge]. (Front-Line Staff - Hospital 5)*

> *Without the church behind me all this time, helping me travel to Peterborough to see my husband, I wouldn't have been able to see him [after hospital discharge] but there was always someone travelling back and forth. I would be lost without them. (Informal Support - Long-Term Care 26)*

Older adults who are connected with the church then benefit from the strong informal support network in the region. In particular, members of the congregation provide the

holistic care and ancillary tasks (e.g., friendly visiting, falls program, exercise classes, support with moving, cleaning, transportation, snow removal, lawn maintenance, etc.) which are not encompassed in the publicly provided transitional care.

It is important to recognize, however, that informal support in Haliburton County is not experienced equally by all older adults in the region. Certainly, a subgroup of rural older people experience a decline in their health during transitions in care due to their lack of inclusion within the community. This informal support shares:

> *Even though I get frustrated or annoyed with him for not taking care of himself [after hospital discharge], I feel like he has been defined in the community as a [taken out for anonymity]. He's now lost all connection and this contributes to [him] falling lower and lower. (Informal Support - Community 31)*

Notable in this narrative is that older adults do not uniformly benefit from the strong informal support network in Haliburton County during transitions in care. Instead, certain subpopulations of older adults have limited social supports, which leads to a decline in their health after hospital discharge.

Ongoing tension between the idealism of self-care in Westernized societies and the pursuit of social engagement also frame rural older adult health in the region. This older adult explains why she has little time to socially engage with others after hospital discharge:

> *It takes enough for me to keep things clean and take care of myself. (Older Adult - Community 55)*

Older adult health is then continually shaped by older adults' pursuit of independence (in activities of daily living and instrumental activities of daily living), which can limit their social engagement with others. Providing evidence of the dynamic nature of rural older adult health, shifts in physical health then can alter older peoples' pursuit of other aspects

of their health during transitions in care. Although physical health decline likely also affects urban older adults' pursuit of social engagement, elements of the rural care context exacerbate the social isolation of rural older adults after hospital discharge. This participant expresses:

> *There is a large distance between places. The community is vastly spread out. It leads to social isolation [after hospital discharge] when there is so much that seniors could get involved in. (Front-Line Staff - Hospital 22)*

As this participant implies rural older adults' pursuit of social engagement is affected by topography. Specifically, rural older adults spend an exorbitant amount of time travelling to and from as well as coordinating and attending appointments related to their physical and medical health (both activities of daily living and instrumental activities of daily living). Since rural amenities and care services are dispersed throughout and external to the county, rural older adults have little time and energy to commit to their social health after hospital discharge. Features of the rural care context then influence rural older adults to prioritize the same biomedical models of health which are used to evaluate independence (activities of daily living, instrumental activities of daily living) within our health care system.

Despite identifying that social engagement is pivotal to 'good health', rural older adults' individual preferences also routinely conflict with their pursuit of social health after hospital discharge. This hospital staff describes:

> *We are very spread out here geographically and a lot of our elderly population is isolated… but a lot of them isolate themselves [after hospital discharge] for their own reasons and that's a hard one. (Front-Line Staff - Hospital 7)*

Individual preferences then shape older adults attention to social health during transitions in care emphasizing the heterogeneity of older adult health in rural areas.

4.3.1 Discussion of 'Social Aspects of Health' Findings

Attending to social aspects of health is imperative to support transitions in care especially in rural areas (Miller, Lin, & Neville, 2019). Specifically, decreased socialization and social supports as well as increased social isolation can lead to frequent readmissions, poor care experiences and health decline in rural populations (Miller et al., 2019). Social interaction with friends, families, peers and communities also contributes to the overall mental and physical well-being of older people as they age (Plexa et al., 2021). This informal network is particularly critical for older adults to retain their independence and to age-in-place (Plexa et al., 2021). Despite these benefits, the health inequalities of people living in rural communities have been connected to a lack of appreciation of the social aspects of health (Singh et al., 2017) and older adults living in rural communities are also known to be less socially active than their urban counterparts (Vogelsang, 2016). This limited social interaction has been linked to limited transportation, vast travel distances and fewer social programs available in rural areas (Danes, 2020) which can lead to the health decline of rural older people (Henning-Smith, Moscovice & Katy Kozhimannil, 2019).

My findings in this section substantiate this prior literature by identifying the importance of appreciating the influence of the social aspects of health on rural older adult transitions in care. Certainly, Haliburton County has a strong informal support network that provides ancillary and holistic transitional care supports to rural older adults, especially for those who are members of the local churches. On the other hand,

my novel finding that place-based attachments inscribe varying levels of access to informal support during transitions in care provides a striking example of the diversity of rural older adult health that shifts over time and place (Poulin et al., 2021). In particular, a subgroup of rural older adults have limited social supports and/or are not a part of the strong religious informal network in the county which leads to their health decline after hospital discharge. This finding is not to suggest that placed based attachments are bifurcated but rather that rural communities are not universally supportive of aging populations (Hennessy & Innes, 2021) during transitions in care.

Establishing another innovative finding on transitions in care, neoliberal constructions of self-care shape the daily routines of rural older adults after hospital discharge. This finding establishes that rural older adults use the same evaluations of independence used within our health system (activities of daily living & instrumental activities of daily living) (Mlinac & Feng, 2016), despite identifying social aspects of health that they perceive lead to 'good health'. This finding aligns with Dane (2020) who suggests that rural older adults' pursuit of social aspects of health are altered by the rural care context as long travel distances leave less time for rural older adults to focus on social aspects of their health during transitions in care. Furthermore, individual preferences can outweigh pursuits of social health and lead to increased social isolation of rural older adults after hospital discharge. Rural older adult health is then heterogeneous continually shifting in response to individual preferences and facets of the rural care context (e.g., religious affiliation, community inclusion, topography, etc.) throughout transitions in care.

4.4 Economic Aspects of Health

"The patients that are wealthy, are healthy." Economic status influences the health of older adults in Haliburton County and contributes to inequities in health care access during transitions in care. Specifically, rural older adults with higher economic statuses have increased access to transitional care options to attend to their health. These participants explain:

> *In this particular case he was able to afford to live in his home and we were able to pay for a full-time caregiver [after hospital discharge]. That meant that he had three square meals a day, she would bring him a newspaper, check in on him, do laundry, housekeeping. That allowed him to maintain his independence but not everyone has that luxury. (Informal Support - Community 73)*

> *Patients that are moving from hospital [to Long-Term Care] are the patients on the private list. This is an example of where money matters. (Front-Line Staff - Hospital 32)*

Rural older patients with high economic statuses more frequently transition back to their residential homes with privately paid supports and/or are able to access private residential care out-of-county. When accessing long-term care, older adults with affluence are able to pay for private or semi-private rooms, which results in them moving significantly faster out of hospital. These transitional care options provide support for health beyond biomedical and physical care and decrease the use of inappropriate care options (i.e. hospital). Affluence then helps older adults to fill the gaps in publicly available care services and decreases wait-times and inappropriate care options that can hinder older adult health during transitions in care.

In contrast, rural older adults with lower economic statuses offer long-term narratives of health decline during care transitions. These participants describe:

> *He always had a problem managing money and he lost his previous farm…Eventually he lost his job and the smoking and drinking increased…He has gotten more frail now [after hospital discharge]. (Informal Support - Community 31)*
>
> *I would like more money to support me to go [to a retirement living home out-of-county] by taking on odd jobs but I can't do that anymore because my health is bad. (Older Adult - Community 68)*

While lower economic statuses impact older peoples' health even prior to hospitalization, the lack of formal non-biomedical support provided during transitions in care exacerbates the challenges faced by rural older patients (e.g., fewer discharge options, longer hospital stays, frequent displacement out of county, increased readmissions, etc.). Notable in these quotations is the influence of the protestant work ethic that is engrained in Westernized culture which implies that economic status is interrelated with work rather than a prescription of societal structures. Surely, these participants indicate the ways that 'work' shapes older adult health and the ability of older adults to care for themselves during transitions in care.

While economic status may also impact the health of older people living in urban areas, the heightened cost of living in rural settings combined with limited services in the region results in rural older people having to focus more attentively on the prioritization of their money. These participants share how income prioritization leads to a lack of attention to certain areas of health after hospital discharge:

> *That's rural-it's not that they don't want to go to the dentist it is they are choosing between that and putting food on the table. (Administrator/Manager 50)*
>
> *Not having as much money means I can't afford to eat well after paying bills and the up keep of the house. (Older Adult - Community 30)*

> *Where we live it is hard to get an MRI or a CT scan…There is transportation for medical appointments at a reduced cost but the clients are not supported once at their destination. If it is going to drain their funds. They can't. They won't. (Front-Line Staff - Community 3)*

These participants then shed light on the ways that the rural care context decreases older adults' abilities to attend to holistic aspects of health after hospital discharge. Specifically, the high cost of living in rural areas (e.g., food, utilities, transportation etc.) results in older adults with lower economic statuses struggling to attend to holistic facets of their health. For example, securing good nutrition and transportation present as barriers after hospital discharge due to high food prices and travel costs (e.g., vast distances, gas prices, overnight stays and food costs for medical appointments out of county, etc.) that dissuade rural older adults from attending to their health. As such, rural older adults who can afford it regularly access medical care, ancillary care and healthy food after hospital discharge, whereas rural older adults with lower financial means must prioritize how they use their money to support their health.

Increasing access to support for non-biomedical or physical aspects of health (e.g., nutrition and transportation), however, is more convoluted than just simply making these supports available in the community. Certainly, Haliburton County provides numerous options for residents in need of food (e.g., Highlands Hills Pastoral Charge, The Bag Ladies, Minden Community Food Centre, Haliburton 4Cs Food Bank, Highlands East Food Hub, Cardiff Food Bank, Kinmount Food Bank) and transportation options are available to older people through Haliburton Highlands Health Services (HHHS, n.d.). The participants indicate that stigma presents one reason why older adults

living with lower economic statuses do not reach out for the support available in Haliburton County during transitions in care. This informal support explains:

> *I think he feels shamed and embarrassed because of [Taken out for anonymity] and money issues. He asks to borrow money from lots of people in the community…There are so many people he needs to avoid because he owes them money. That's hard…He's really affected by it. These things all impact his health and his ability to get help or reach out for help [during transitions in care]. (Informal Support - Community 31)*

Rural older adult health decline during transitions in care is then not only associated with the inability to fill the gaps in publicly provided care but also is related to the stigma placed on older people with lower economic statuses in Haliburton County.

4.4.1 Discussion of 'Economic Aspects of Health' Findings

Health scholars suggest that there is an interconnection between economic status and the health of rural residents (Harrington et al., 2020) and older populations in general (Darin-Mattson, Fors & Kareholt, 2017). This research exposes the ways that societal structures and governance shape health and care inequities in rural areas (Brassolotto et al., 2020). For instance, long-term care homes in Ontario are required to designate only 40% of their beds as basic[7] (Patrick, 2011), which does not consider the lower economic statuses of rural residents and the high cost of living in rural areas (Jensen & Ely, 2017). My finding that affluence increases care access and health during transitions in care substantiates this prior research by illustrating the broader impact of provincial care governance that reinforces the social stratification of rural older adult transitions in care. Specifically, affluent rural older adults are able to fill the voids in publicly provided care

[7] In Ontario, long-term care homes have three types of accommodation: basic, semi-private and private. While there are costs associated with basic accommodation, government subsidies exist for residents who are unable to pay the full cost of these rooms. Residents in semi-private and private rooms do not qualify for these subsidies (Government of Ontario, 2022).

(e.g., privately paid support to age-in-place, to physical and non-biomedical care, to transportation, to good nutrition, etc.), which provides them with increased support to maintain their health throughout transitions in care. While affluent older adults in urban areas may also have increased access to support after hospital discharge, the high cost of living in rural areas combined with large travel distances and few in-county health services increases the costs associated with filling in the gaps of publicly provided care in rural areas.

Analyzing the influence of the social determinants of health, health scholars indicate that inequitable access to services is far more complex than providing services to support non-biomedical health (Penman-Aguilar et al., 2016). Certainly, community culture surrounding non-biomedical aspects of health can develop in rural communities, which can lead to vulnerable patients valuing self-reliance (Knight & Winterbotham, 2019). My findings that stigma and the protestant work ethic shape care access during transitions in care provides an example of how community culture can influence the support available to rural older populations. This finding aligns with Hanlon and Poulin's (2021) conception of rural older adult health by establishing how supports for health are embedded in the sociocultural and socioeconomic relations that exist within rural areas. Rural older adult health is then shaped by multi-leveled aspects of the rural care context (e.g., stigma, available publicly and privately funded care, travel distances, cost of living, etc.), which inevitably leads to the heterogeneity of rural older adult health during transitions in care.

4.5 Identity Construction

Limited knowledge of gender, sexual and ethnic identities influence older adult health in Haliburton County. There are no or limited services/supports for older people who identify differently than the dominant norm (e.g., people who identify differently than the dominant norm because of ethnicity, ethnic "difference", sexual orientation, and other forms of "otherness"). As a result, rural older people do not experience transitional care services that consider their unique identities and must travel far distances (98 km+) after hospital discharge to receive support equivalent to those available in urban centres. Even though rural health professionals exhibit some knowledge about older people who identify differently than the dominant norm, older participants and their informal supports regularly avoid these discussions. Consider this interaction with an older adult from the community:

> Older Adult from the Community 30*: I don't think that gender, ethnicity or sexuality affect your health. I don't think so.*
>
> Interviewer: *Can you tell me more about why sexuality doesn't impact older adult health?*
>
> Older Adult from the Community 30*: I guess I don't know if relationship status impacts my health.*

This interaction represents the lack of understanding of identity construction and/or the lack of comfort of residents within Haliburton County to engage in discussions about identity construction and its influence on rural older adult health. As such, my findings in this section are limited but important to forge next steps in research on the interlinkage between identity construction, rural older adult health and transitions in care.

Turning specifically to the lack of focus on gender identity in the region, traditional gender roles and stereotypes shape older adult health construction during rural older adult transitions in care. Examine the following quotes:

> *I don't know if it is stereotypical but men seem hard working and provide for their families…They often feel they have to be that stronger person so they don't ask for help [during transitions in care]. I think women are much more aware of what can help them. They tend to seek help for a problem and men wait it out or they don't know where to go. (Front-Line Staff - Long-Term Care 65)*

> *The women were the main cook and caregiver and then lots of the males who are alone are lacking in good nutrition and hygiene [which affects their health after hospital discharge]. (Front-Line Staff - Long-Term Care 62)*

> *I don't know. Maybe women they are so use to handling the house, if they have had children I think they handle health a bit better [after discharge]. (Older Adult - Community 55)*

These quotations illustrate how women's traditional gender roles (e.g., cooking, caregiving, house work, asking for help, etc.) better prepare them to attend to their health, especially after hospital discharge. Interesting, however, is the ways that neoliberalism, biomedicine and gender identities conflict during transitions in care. For example, women are considered at an advantage after hospital discharge due to their ability to remain independent with their instrumental activities of daily living and activities of daily living (IADL/ADL). On the other hand, men are criticized for not asking for help with their IADLs/ADLs during transitions in care. While these gender stereotypes may also influence older adult health in urban areas, limited participant knowledge on the interconnection between gender identity and old age leads to bifurcated gender stereotypes which influences rural older adult transitions in care.

Similar to the binary depictions of gender, resident knowledge on sexual identity in Haliburton County is limited to traditional heterosexual relationships, with only four participants specifically referencing homosexual relationships as another form of sexual identity. This participant describes how or if they feel sexuality impacts the care provided to older people during transitions in care:

> *We have had homosexual residents before. I don't know. I don't think it impacts their care [during transitions]. There are some residents that just don't say anything. (Front-Line Staff - Long-Term Care 51)*

Remarkable in this statement is that sexual identities are not considered during transitions in care and that older adults who identify differently than the dominant norm may not be sharing how they identify during transitions in care.

Turning to the influence of ethnicity, some participants highlight the importance of culturally-based transitional care services to support the health of older adults who identify differently than the dominant norm. These participants explain:

> *We sometimes will use information on ethnicity to provide cultural groups or language programs to assist patients with more social interaction [after hospital discharge] (Front-Line Staff - Long-Term Care 35)*

> *I think ethnicity, gender and sexuality can influence health. It would impact how they perceive themselves and the types of treatment offered [during transitions in care]. Especially ethnicity. (Front-Line Staff - Hospital 22)*

Notwithstanding this recognition of the importance of culturally-sensitive transitional care services, front-line staff provide very little insight into the needs of older adults with diverse ethnic identities. Instead, rural health professionals identify barriers to providing transitional care for older people with ethnic identities other than the dominant norm. These participants' describe:

> *We have a couple of people who have language barriers and we don't have any translation so that can be hard [during transitions in care] (Front-Line Staff - Hospital 22)*
>
> *I think because we are a small community, I know ethnicity wise, when we have different cultures, some of the clients refuse [care during transitions] from staff. They aren't use to it. (Front-Line Staff - Long-Term Care 66)*

Language barriers and stereotypes regarding older people from cultures other than the dominant norm then shape understandings of older adult health and the transitional care provided in Haliburton County.

Overshadowing rural older adult transitions in care is the common perception that there is a lack of diversity in the region. These participants explain:

> *I don't feel that gender, ethnicity and sexuality impact services or health and that's maybe because we don't have a lot of diversity. (Front-Line Staff - Community 12)*
>
> *We had one lady who was East Indian but we don't really have a lot of diversity here. We are all white. (Front-Line Staff - Long-Term Care 61)*

As these citations suggest, many participants feel that Haliburton County is mono-cultured. According to the rural community inventory, however, three percent of the county's residents are not born in Canada with first generation (1,600), second generation (2,710) and third generation (13,465) immigrants residing in the region. In addition, 520 residents identify as indigenous. Although these statistics provide limited insight into ethnic populations in the region, these figures suggest that Haliburton County is more ethnically diverse than the research participants insinuate. Instead, the participant interpretations of ethnicity seem to align with the lack of visible minorities in the county, which make up only one percent of the population.

Remarkably, even those older adults who identify as having unique ethnic identities insist that ethnicity does not impact their health. These older adults share:

> *I love being Dutch but I am inside and outside Canadian. I don't think it matters to my health. (Older Adult - Long-Term Care 83)*

> *The way you identify in terms of ethnicity? I don't think it does at all. We are all the same it doesn't matter to me. (Older Adult - Community 55)*

Since many older adults do not identify how ethnicity shapes their health, Haliburton County presents an interesting conundrum of how to provide culturally appropriate transitional care services to a population who does not acknowledge diverse identities.

4.5.1 Discussion of 'Identity Construction' Findings

Whitehead, Shaver and Stephenson (2016) suggest that care interventions in rural areas can take identity constructs for granted, which results in minority populations experiencing health disparities when compared with their urban counterparts (Whitehead et al., 2016). Affirming the challenge of analyzing identity paradigms in rural areas (Whitehead et al., 2016), my limited findings in this section question whether populations who identify differently than the dominant norm are not being acknowledged and/or are being underserved during transitions in care. In particular, is the avoidance of conversations about identity and harmful stereotypes minimizing the voices of rural older patients who may identify differently than the dominant norm? Since there is a dearth of research that connects rural older adult transitions in care and identity construction, future investigations are needed to determine if diverse identities do impact rural older adult health or if elements of the rural care context may be contributing to the erasure of identity and the underserving of sub-groups within the older population during transitions in care.

Examining the influence of gender identity, Whitehead et al. (2016) assert that stigma plays a large role in altering the health of rural residents of cisgender, transgender and non-binary individuals. In particular, long travel distances act as a barrier to rural residents prioritizing or seeking out specific care more appropriately aligned with how they identify (Whitehead et al., 2016). My finding that rural older adults who identify differently than the dominant norm must travel far distances (98 km+) after hospital discharge substantiates this prior work, establishing the dearth of support available for rural older people with unique gender identities during transitions in care. Adding to this work, my finding that dichotomous framings of gender identity (male/female) influence rural older adult transitions in care sheds light on the influence of gender stereotypes. While Chrisler et al. (2016) indicate that older women's intersectional identities are harmed by ageism and sexism, I suggest that rural older men are also affected by traditional gender stereotypes during transitions in care. For example, traditional gender stereotypes contribute to older men's health decline and decreases their access to services after hospital discharge. My findings in this section then suggest that more work is needed to further examine the intersection between older adult health, gender identity and transitions in care.

Turning to the intersection between health and sexual identity, stigma (Barrett & Hinchliff, 2018), inequities and access issues gravely impact Lesbian, Gay, Bisexual, Transgender, Intersex or Queer (LGBTIQ) rural older adults (Whitehead et al., 2016). As a result, many older LGBTIQ individuals can remain closeted due to the more conservative and homophobic cultures that may be present in rural areas (Barrett & Hinchliff, 2018; Butler, 2017). My finding that transitional care services rarely consider

sexual identities beyond heterosexual norms provides an example of the erasure of older adult sexual identity in rural areas. More work is then needed in this area to determine if a lack of recognition of sexual identities other than the dominant norm may be leading to a lack of support for a subset of rural older people during transitions in care.

Similar to other identity constructs, people with diverse ethnicities experience health and care inequities which are exacerbated in rural areas (Caldwell et al., 2016). Visible minorities, however, can be at a heightened disadvantage due to the dominance of Caucasian residents in rural communities that contributes to their lack of community inclusion (Abelson, 2016). My finding that language barriers and stereotypes of different cultures can shape the care provided during care transitions adds to this prior literature by highlighting the influence of ethnic identities on rural older adult transitions in care. While some rural health professionals identify the importance of the interrelationship between identity construction, older adult health and transitions in care, further work is needed to expand knowledge in this area, especially to further investigate my finding that suggests that the diversity of rural older people is rarely identified or supported during transitions in care.

4.6 Attending to Holistic Aspects of Health

Although holistic elements influence the health of rural older adults, these facets of health are highly interconnected which makes them difficult to attend to during transitions in care. These participants explain:

> *These factors [of rural older adult health] are all interconnected. If your finances are low that affects your nutrition. Fitness programs held in the community centre are really good for health but how do you get there? How are you going to pay for them? (Front-Line Staff - Community 12)*

> *A lot of people who are socially isolated their mental health declines and then they start to not eat well and become high risk of falls (Front-Line Staff - Hospital 32)*
>
> *A lot of older adults aren't educated here and so they are malnourished, uncontrolled diabetes, lack of mobility, inability to afford healthy food and these all impact their health (Front-Line Staff - Long-Term Care 62)*
>
> *The poverty by far sticks out. A lot of people are living alone on CPP and that's all they have. And the poverty stems from the lack of education, so you don't even know where to start [to support their health]. (Front-Line Staff - Community 1)*

Unquestionably, the interconnection between holistic facets of health leads to intra-individual variability within rural older populations. As such, rural health professionals struggle to attend to holistic elements of health during transitions in care.

In addition, there is a lack of consensus on the various holistic factors that shape older adult health in Haliburton County. Consider the following contrasting statements:

> *I don't think that gender, ethnicity and sexuality do impact older adult health. I think it depends where you are. (Front-Line Staff - Long-Term Care 77)*
>
> *Gender, ethnicity and sexuality do have an effect on older adult health. (Front-Line Staff - Long-Term Care 35)*

Or

> *Education level? Not really. (Older Adult - Community 74)*
>
> *Education influences health. You have to be smart and think about what you need to get better. (Older Adult - Long-Term Care 83)*

These divergent citations provide evidence of the conflicted nature of rural older adult health which often hinders the support provided during rural older adult transitions in care. Indeed, the participants found it difficult to identify all of the holistic factors that shape older adult health and/or express how or why these factors of rural older adult

health were important. Furthermore, rural older adults continually identify certain facets of health (e.g., social health) that are critical to maintaining 'good health' and yet often prioritize other aspects of their health (e.g., biomedical health). These characteristics then make it difficult for rural health professionals to attend to holistic aspects of health during rural older adult transitions in care.

As such, rural health professionals typically provide transitional care in alignment with the biomedical design of the health care system. Certainly, health policy and the language used by rural health professionals (e.g., live at risk, poor decisions, uninformed etc.) reinforce rural older adults' focus on biomedical aspects of health during transitions in care. These participant quotations provide examples:

> *Older adults' values or choices do impact their health whether it is informed or uninformed. People have a right to make poor decisions [during transitions]. To choose what's healthy or not. (Front-Line Staff - Hospital 19)*

> *We have three gentlemen in here that smoke but when they move in here we don't allow them to smoke unless family take them. (Front-Line Staff - Long-Term Care 40)*

Rural health professionals use language (e.g., "poor decisions" used by the participant above) that inadvertently places judgments on older people who do not accept the biomedical care provided during transitions in care. In addition, health care policy limits older adults' abilities to pursue aspects of health beyond the biomedical care provided. This prioritization of the biomedical model in the rural care context then leads to ageism during transitions in care by restricting older peoples' actions and personal agency to attend to holistic constructions of health.

4.6.1 Discussion of 'Attending to Holistic Aspects of Health' Findings

Holistic aspects of health play a large role in influencing both individual and population health (Friedman, 2018). My colleagues and I suggest that in rural communities, these holistic factors lead to older adult health continually shifting over time in response to interactions with others and the places in which people live (Poulin et al., 2020). In contrast, health scholars identify that holistic aspects of health are not well supported in health care policy and practice (Friedman, 2018). Instead, narrow biomedical evaluations of older adult health are used throughout the health care system that subordinate the aging population (Stephens & Breheny, 2018). While this literature is important, it has yet to be considered concurrently or applied to examinations of rural older adult transitions in care.

To fill this gap in contemporary literature, my findings in this section affirm the heterogeneity and dynamic nature of holistic aspects of rural older adult health (Hanlon & Poulin, 2021; Poulin et al., 2020) that fluctuate throughout transitions in care. For example, not all of the participants agree on the same holistic factors that construct older adult health. Adding to this work, I uncover that rural gerontological health can also be conflicted. Certainly, rural older adults' actions do not necessarily align with how they define their health throughout transitions in care. My findings in this section then provide some examples of barriers of supporting holistic aspects of older adult health in policy and practice (Friedman, 2018).

My finding that rural health professionals fall back on biomedical aspects of older adult health during transitions in care due to limited support for other aspects of health, speaks to the engrained nature of biomedicine within our health care system (Friedman,

2018). This focus of care provision, however, can lead to ageism during transitions in care. For example, my finding that rural health professionals place labels on rural older adults during transitions in care illustrates how biomedical prioritization fosters ageism within our current health system (Stephens & Breheny, 2018). Exploring holistic aspects of health then speaks to the interplay between older adult health construction and the rural care context that influence rural older adult transitions in care.

4.7 Chapter Summary

In this chapter I have highlighted the relationality of rural older adult health construction (e.g., heterogeneous, dynamic, interconnected, subjective and conflicted) in alignment with objective one. This chapter reveals that various aspects of the rural care context (e.g., strong informal support network, community stigma, understandings of identity construction, topography, etc.) shape rural older adult health during transitions in care. While older adults identify holistic aspects that contribute to 'good health', I expose the barriers of attending to these aspects of rural older adult health in practice. This chapter then highlights the interplay between older adult health construction, the rural context and the care context that impress upon rural older adult transitions in care.

Adding to these discussions, in chapter five I focus on the multidimensional contexts that influence the transitional care of older adults in Haliburton County. By doing so, I uncover the contested spaces of the rural care context that influence Interprofessional Communication, Care Governance and the Personalization of Care. This exploration exposes the tension between the strengths inherent in rural communities and macro facets of care that continually shape rural older adult transitions in care.

CHAPTER 5

"Maybe I should have done more research, but I don't really understand the system and there are so many levels and so many different staff."

5 Findings: Rural Care Context

5.1 Introduction

In alignment with objective two (To examine the rural care context in which older adult transitional care is provided), this chapter presents a contextual blueprint of the factors that shape older adult transitions in care in Haliburton County. Echoing the participant citation for this chapter, I emphasize the complexity of rural health systems. While strengths inherent in rural communities are conducive to adapting care provision to the heterogeneity of rural older adult health and the nuances of the rural care context, macro features of care continue to overshadow rural older adult transitions in care. Findings in this chapter then emphasize how rural older adult transitions in care is continually shaped by the contested spaces within rural health systems.

I have organized this chapter into three sections: Interprofessional Communication, Care Governance and Personalizing Care. Table 5.1 summarizes the

themes and sub-themes presented in this chapter, exposing the multidimensional rural care context that continually shapes rural older adult transitions in care.

Table 5.1 Rural Care Context

Rural Care Context			
Overall Theme	**Themes in Category**	**Connection to the Conceptual Model**	**Connection to the Literature**
Interprofessional Communication	1. Personal relationships between rural health professionals enhance collaboration and innovation 2. Power differentials between health professionals affect communication 3. Sectored divisions result in communication break down 4. Information beyond physical and medical health is not transferred between care settings 5. Education and training of rural health professionals impact the collection and transfer of information on holistic elements of health 6. Inaccurate information exchange is common due to restrictive eligibility criteria and the dynamic nature of older adult health	· Older Adult Health Construction · Care Context · Rural Context	· Social Determinants of Health · Intersectionality · Health Systems Integration · Contested Spaces
Care Governance	1. Smaller, more integrated health systems decrease the negative ramifications of sectored divisions 2. Care governance does not take into account human resource barriers and service/housing limitations in rural areas 3. Limitations in publicly available care in Haliburton County puts additional strain on aging informal supports	· Older Adult Health Construction · Care Context · Rural Context	· Health Systems Integration · Critical Rural Gerontological Health · Contested Spaces
Personalized Care	1. Rural health professionals work against macro bed flow priorities to attend to a whole-system patient-centred vision	· Older Adult Health Construction · Care Context	· Human Influence in Complex Systems

	2. Macro system goals (e.g., bed flow, biomedicine and acute care priorities) internalize a utilitarian approach rather than a personalized approach to care provision 3. Macro system goals engrain ageism into practice 4. A focus on macro system goals in rural areas leads to unsafe discharges, frequent readmissions and interprofessional conflict	· Rural Context	· Informal Support Networks · A Whole System Patient-Centred Vision · Contested Spaces · Ageism in Care Settings

5.2 Interprofessional Communication

Strong relationships between health professionals in Haliburton County help to enrich interprofessional communication during rural older adult transitions in care. This front-line staff explains:

> *Here, I know all the professionals like the Doctors, Pharmacy. When you want to network it's not a problem picking up the phone and getting information on clients [who are transitioning between care settings]. (Front-Line Staff - Community 3)*

As this participant implies, close personal relationships between rural health professionals lead to an informal network that enriches communication during transitions in care. Specifically, these relationships assist rural health professionals to enhance transitional care provision through regularly collaborating on patient care plans, resolving barriers to discharge (see Appendix G for details on these barriers) and sharing information on available community programs or services.

This informal communication network is also particularly effective to cultivate innovative solutions to improve inter-sectoral communication. For example, over the duration of my dissertation, the Behavioural Supports Ontario Staff began accompanying patients with complex needs from the hospital to long-term care to provide a face-to-face hand off with the receiving staff. This observation provides evidence of the flexible care context in Haliburton County, which allows for transitional care processes to be regularly altered to attend to the heterogeneity of rural older adult health.

Despite the benefits of this strong informal communication network, divisions between health care professional designations shape communication between team members during transitions in care. This hospital staff expresses these concerns:

> *The discharge meeting is not for internal staff it is for the doctor pass off. It's a buy-in for change to have the doctors involved in interdisciplinary teams and we need to get everyone on the same page. The hospital needs to ensure that the managers have a say in the process rather than just the doctors. (Front-Line Staff - Hospital 19)*

This citation indicates that interprofessional communication prior to hospital discharge is hindered by power differentials between doctors, managers and other staff. Communication during transitions is then reflective of the tensions between health professional designations within Haliburton County.

Turning attention to communication between sectors, sectored divisions impede interprofessional communication during rural older adult transitions in care. These care narratives provide examples of these ineffective exchanges:

> *When we were putting her on the crisis list she got admitted to long-term care but the LHIN [Local Health Integration Network] had no idea. She was still working on crisis but [the patient] had already been admitted. (Informal Support - Long-Term Care 81)*

> *Meals on Wheels was setup but they started bringing meals even though I was not there. I had to call them when in hospital to stop but I'll call them again when I get home. (Older Adult - Community 52)*

Highlighting the negative ramifications of sectored divisions, these participants emphasize how fractured intersectoral communication contributes to the inefficiency of rural older adult transitions in care.

An extensive investigation into intersectoral information exchange reveals that the information that long-term care and community care staff receive on older patients is incomplete. These participants describe the information that is missing:

> *I don't get information on psychosocial elements. Like it would be helpful to know about resistance to services. (Front-Line Staff - Community 13)*

> *What I find is that the information you get is very medical but this doesn't really help. You don't get information on what they are like or who they are as people, you have to figure that out for yourself. (Front-Line Staff - Long-Term Care 35)*

As these participants imply, the information exchanged during rural older adult transitions in care is typically biomedical, which leaves gaps in information transfer on holistic health. This lack of focus on holistic elements of health stems from the biomedical focus of hospital care. These front-line staff explain:

> *Social assessments were very time consuming so we don't do them anymore. Now we ask what's on the kardex [tool used by hospital staff to gather patient information] but it's very minimal and physically focused, not so much socially focused. I don't think there are any social questions. (Front-Line Staff - Hospital 32)*

> *I think I collect information on older adult values and choices…I wouldn't say that it is in documentation but maybe on [verbal] report about what a patient values. (Front-Line Staff - Hospital 23)*

These quotations indicate that patient information beyond physical and medical health is rarely and/or inconsistently collected on older adults in hospital, which results in this information not being transferred between care settings.

While biomedical priorities in hospital may also impact information transfer in urban settings, comprehensive geriatric specializations (see Appendix H) are not common in Haliburton County. As such, rural health professionals exhibit a discomfort when collecting patient information beyond physical and medical health. These citations provide examples:

> *We have a medical history and a depression rating scale but we want to make them comfortable, so it's hard to have these blunt conversations. (Front-Line Staff - Long-Term Care 61)*

> *We ask questions on smoking and alcohol and religion usually comes up under informal supports but I do not outright ask it. (Front-Line Staff - Community 1)*

> *Information on ethnicity, gender and sexuality is not collected point blank but if it is offered to us then we make sure it is relayed. (Front-Line Staff - Hospital 22)*

Remarkable in these citations is the discernable discomfort of rural health care staff to engage in conversations about older adult health construction beyond biomedical and physical health. A notable exception to this finding is those rural health professionals with Comprehensive Geriatric Assessment training, which underlines how the education and training of health professionals shape the type of information exchanged during rural older adult transitions in care.

Long-term care and community care staff also identify that the information they receive on new patients is not always accurate and/or current. These participants share:

> *I actually just had this conversation with the LHIN [Local Health Integration Network]. I think I find it challenging because I have access to look at my candidates to long-term care but I may be doing this three to four years in advance. There is a first acceptance at this point, then I do it again three years later to accept them for an actual bed. People change in three years. (Administrator/Manager 78)*

> *Sometimes their presentation changes. Sometimes we get information that patients can transfer and they are continent by themselves and then we lay eyes on them and we know that's not true. (Front-Line Staff - Long-Term Care 43)*

Since rural older adult health fluctuates over time, inaccurate patient information on older patients is often shared between hospital and community/long-term care staff during rural older adult transitions in care.

In addition, long-term care staff note that patients' behaviours are often minimized to secure the older persons placement in long-term care. These quotations demonstrate these concerns:

> *I find the information I get on older patients [during transitions] isn't necessarily accurate. Often their files are adjusted or geared to be accepted to long-term care and we are seeing much different presentations like behaviours that aren't documented well (Front-Line Staff - Long-Term Care 47)*
>
> *We can refuse patients if they have certain behaviours if they are going to put others at risk. This information is not portrayed accurately because the person sending them knows this and doesn't want them to be refused. (Front-Line Staff - Long-Term Care 51)*

These citations establish that inaccurate patient information is shared during rural older adult transitions in care in response to facets of the broader rural care context. In particular, in the absence of other service options in Haliburton County, hospital staff tailor the information they provide on older patients (i.e. minimize documentation on responsive behaviours) to fit long-term care eligibility criteria. Similarly, informal supports provide inaccurate patient information to expedite older peoples' access to long-term care (e.g., informal supports place older patients on the private waiting list for long-term care without the means to afford private accommodation or advocate for older people to be put on the Local Health Integration Network crisis list). Broader elements of the rural care context (e.g., a lack of services and supports for older patients with responsive behaviours, inequitable access to long-term care services, etc.) then lead to the sharing of inaccurate patient information during rural older adult transitions in care.

To contend with missing or inaccurate patient information, rural health professionals outline a distinct preference to initiate brand new assessments on older adults rather than relying on the patient information documented by their colleagues. These staff describe the inefficient alternative of sorting through the information available on older patients:

> *Often that means you have to dig and that's a time suck. It involves calling acute care, the families, the service providers that they may have seen to get access to more records. (Front-Line Staff - Long-Term Care 36)*
>
> *If patients were coming from Minden, it was a long process to try and compile the information on the patient, their history. (Front-Line Staff - Hospital 45)*

These quotations point to how interacting elements of the rural care context shape interprofessional communication in Haliburton County and lead to the inefficiency of rural older adult transitions in care. While all of my findings from this section could easily apply to older adult transitions in care in urban areas, it is important to note that that these inefficiencies are detrimental in rural areas due to the prominence of human resource deficits and small staff teams. Redressing these inefficiencies in information transfer is then essential to enhance rural older adult transitions in care.

5.2.1 Discussion of 'Interprofessional Communication' Findings

Transitions in care scholars establish that poor communication between health professionals leads to inefficient and ineffective care provision across the care continuum (Scotten et al., 2015; Otsuka et al., 2019). In particular, the efficacy of interprofessional communication is linked with older patients' health outcomes (Scotten et al., 2015), readmission rates (Otsuka et al., 2019; Nall et al., 2020) and access to support and resources after hospital discharge (Gray et al., 2020). In rural communities, interprofessional communication is vital to establish high-quality relationships between team members which enhances patient satisfaction during transitions in care (Gilmartin et al., 2022). Turning to the health integration literature, interprofessional communication is hindered by sectored divisions (Clarke et al., 2017), power differentials between health

professionals (Spiridonov, 2017) and the biomedical dominance of older adult care (Longino & Murphy, 2020) and interprofessional education (Rowland et al., 2019).

My findings in this section intersect both transitions in care and health integration literature by showcasing how sectored divisions, power differentials between health professionals and the biomedical dominance of older adult care and interprofessional education affect rural older adult transitions in care. For example, my finding that power differentials between doctors, managers and other staff hinder interprofessional communication prior to hospital discharge highlights the importance of establishing broader structures that support high quality health professional relationships and communication (Gilmartin et al., 2022). On the other hand, my finding that tight knit informal networks in rural settings improve interprofessional communication and foster flexible transitional care services aligns with Hoeft et al. (2018) who suggest that rural health professionals' exhibit enhanced collaboration when compared with their urban counterparts. Certainly, the quality of rural health professional communication allows transitional care provision to continually be adapted to diverse constructions of rural older adult health, yet interprofessional communication is still restricted by broader elements of the rural care context (e.g., sectored divisions, power differentials between health professionals and the biomedical dominance of older adult care and interprofessional education) that hinders interprofessional communication during transitions in care. As such, these overlapping facets of the rural care context (e.g., enhanced informal communication network, sectored divisions, power differentials between interprofessional team members, the dominance of biomedicine in hospital care, health professional education, service deficits, etc.) form contested spaces of

interprofessional communication that lead to ineffective and inefficient rural older adult transitions in care.

5.3 Care Governance

Smaller, more integrated rural health systems are critical to support rural older adult transitions in care. These participants explain:

> *I worked in long-term care so I think I have that perspective to ease the minds of families, in terms of transitioning them. Here a lot of staff work in many sectors or still work in both and that is really helpful in understanding [other sectors]. (Front-Line Staff - Hospital 23)*

> *It's a smaller institution but you feel like there is more hands on [during transitions]. There are less patients but even with the building being smaller, it felt connected. When you are in an urban setting you even have to navigate the hospital and that can be hard. (Informal Support - Community 73)*

Inherent in these responses is that integrated rural health systems encourage health professionals to work in different sectors, which enhances their understanding of different care services and leads to a more 'connected' care environment. Smaller, more integrated rural health systems are then conducive to supporting older patients and their informal supports during transitions in care.

Smaller, more integrated rural health systems also help to break down the sector silos that exist in provincially governed health services by creating a collaborative approach to patient transitions. This administrator expresses:

> *As a smaller integrated network sometimes it helps us to know about what's going on in the other sectors. For example, because I know of issues that are happening in hospital I may not reject patients. Instead, being integrated allows me to go over to acute care to walk over and talk to them. It allows me to work with them to figure out what they can work on, to be able to help that patient to become more appropriate for long-term care. I can then work with them to ensure that those types of interventions are working. (Administrator/Manager 78)*

By integrating health services, health professionals in Haliburton County establish a flexible approach to transitions which is responsive to the heterogeneity of rural older adult health. This enhanced inter-sectoral collaboration can decrease access barriers that often hinder rural older adult transitions in care.

Breaking down these barriers to care governance is particularly important to improve the services provided to rural older populations after hospital discharge. For instance, Haliburton Highlands Health Services (HHHS) provides a multitude of health and social services in the community that combine informal support with not-for-profit and publicly available care services. In doing so, HHHS services are adaptable to fit the unique needs of rural residents, such as those struggling with low income and/or have poor access to nutritious food. Smaller, more integrated rural health systems then encompass a collaborative approach to service provision which is conducive to attending to diverse constructions of rural older adult health.

Notwithstanding the advantages of smaller, more integrated rural health systems, sectored divisions impede the continuity of care of rural older patients by limiting their access to care after hospital discharge. These restrictions result from governmentally determined funding allocation. These administrators/managers describe:

> *There are barriers to being provincially run…Patients who were accessing services when they were in the community can no longer access those services [when they transition], because our funding doesn't cover it. (Administrator/Manager 78)*

> *Once a patient goes into long-term care they can't access anything else in the community despite being integrated under HHHS [Haliburton Highlands Health Services]. They can't see the social worker or the geriatric psychologist. We still can't share those services because they are driven by the government and the different funding sources don't allow for it. (Administrator/Manager 50)*

Remarkable in these statements are the ways that different government funding sources (e.g., municipal, provincial and federal government) impact care access during rural older adult transitions in care.

While these sectored divisions might also affect older people living in urban areas, staffing shortages and limited types of health care professionals available in the Haliburton care context (see Appendix H for details on these limitations) exacerbate the impact of sectored divisions. For example, human resource challenges restrict rural health providers' abilities to implement provincial strategies to support complex older populations after hospital discharge. This participant shares:

> *The Ministry does provide one-on-one for behavioural patients but you have to have the staffing to do one-on-one and it's a process to fill out the application and it is a real challenge to fill those shifts [which limits the supports available to older adults once they have transitioned]. (Front-Line Staff - Long-Term Care 51)*

These human resource issues in Haliburton County are perpetuated by poor working conditions, low remuneration rates, staff burn-out and high turnover rates which are reinforced by characteristics of the rural context (e.g., a lack of things to do for young adults, expansive distances, harsh winters, transportation barriers and cost of living) which deter health professionals to relocate to the area. The interrelationship between the rural context and the care context then continually influences rural older adult transitions in care.

Similarly, service and housing limitations in the Haliburton area (Appendix H) shape the transitional care provided to older people after hospital discharge. Consider these participant responses:

> *They do all the work up but they don't do a lot of the specialized stuff. They stabilize you and then transfer you…I have been shipped from Haliburton to Lindsay, Toronto, Kingston. This is all in the last two years and it's a pain in the ass. I feel like I am going in small circles. (Older Adult - Community 68)*
>
> *BSO [Behavioural Supports Ontario Staff] was supposed to be put in place to combat wait-times for long-term care but as someone pointed out BSO is not going to help with wait-times when there are no beds to go to…That's a real problem. (Front-Line Staff - Hospital 10)*
>
> *There is definitely not a lot of seniors housing, especially that is accessible and affordable. We have two or three towns and we have a little bit of seniors' housing but there isn't enough (Informal Support - Long-Term Care 75)*

As these excerpts demonstrate, gaps in the availability of services/housing options in Haliburton County (e.g., the lack of specialized services, long-term care beds and affordable stratified housing in the region) result in a lack of care options to support older adults after hospital discharge. Since provincial care governance undermines these unique facets of the rural care context care inequities and access barriers are common during rural older adult transitions in care.

As such, increased pressure is put on aging informal supports in Haliburton County to fill the gaps of publicly provided care services. These quotations provide some examples of the vast number of responsibilities informal supports take on during rural older adult transitions in care:

> *After I came home, my granddaughter also helped to go through my house and help clean. The home care didn't really do it. My family did it to make sure I was safe in my home but if I had asked home care staff they wouldn't have been able to do it. (Older Adult - Community 52)*
>
> *I think informal supports are the primary support in our community. The people who visit, take them to the grocery store, monitor their behaviour. People in this rural community rely very heavily on their neighbours for this type of care. (Administrator/Manager 28)*

> *There is so much to consider like moving furniture and signing papers and then on top of that she lost her hearing aids this morning so I spent a big chunk of time just trying to find those. (Informal Support - Long-Term Care 86)*
>
> *I have everything ready for him when he comes home. I am going to put a lift or a ramp in so he doesn't have to have steps. We had sort of a family meeting last night to figure out when we were going to build a ramp. (Informal Support - Community 70)*
>
> *They know them before, during and after and they are the personal continuum of care as a human being more than just their medical. Everybody needs their person. (Front-Line Staff - Hospital 15)*

Informal supports then attend to the numerous tasks, that are limited or not formally provided in Haliburton County, to support rural older adult transitions in care (e.g., housekeeping, home safety and accessibility, instrumental activities of daily living support, behaviour monitoring, friendly visits, moving, looking for lost items, continuity of support etc.). While informal supports likely also provide this care in urban areas, the role of informal supports in Haliburton County is significant due to the additional time intensive and costly tasks associated with keeping older people in their rural homes (e.g., garbage to the dump, firewood, snow plowing, transportation times and distances to appointments or to pick up essentials). Indeed, the formal health and social services provided after hospital discharge attend only to physical and biomedical care needs which places a large strain on the aging informal support network to attend to the heterogeneous elements of rural older adult health.

Features of macro governance then reinforce care inequities during rural older adult transitions in care by not considering holistic constructions of rural older adult health or the diversity of rural care contexts. These participants suggest that this lack of acknowledgement fosters urban centric transitional care provision:

> *There are barriers for those being transferred outside of our LHIN [Local Health Integration Network]. It's hard to get patients out of our LHIN because they look at our postal code and that's it. Even though resources in other counties technically cover our region, they often provide service for those closer first. (Administrator/Manager 28)*
>
> *Since PSWs are organized in Oshawa, they are being sent all over the county without any consistency. These PSWs have no control over their schedules and often they are very frustrated. Bayshore [A home care provider] is also located in Markham so they don't understand rural areas with back roads. It's not efficient that they drive from Markham and make two trips to come to the house. (Informal Support - Long-Term Care 82)*
>
> *In Haliburton they only come one time a day because of the distance. Where he is now [in an urban centre], they can come in for shorter periods but come more often and that makes a difference in taking care of someone. That's more beneficial to his care. That's not practical in a rural setting. Twice a day in a facility is much better than not at all. (Informal Support - Community 71)*

These quotations underscore how urban centric care leads to large catchment areas and ineffective home care coordination that hinder rural older adult transitions in care. Certainly, rural older adults endure ineffective care after hospital discharge in county or must travel long distances/move out of county (between 98 kilometres and 214 kilometres one way) to receive care that is equivalent to the services provided to older people living in urban areas.

5.3.1 Discussion of 'Care Governance' Findings

Allen et al. (2017) maintain that favourable transitional care experiences are strongly co-related with the integration of health services, yet the integration of health services in rural areas is stifled by macro level governance (Barker & Church, 2017; Brassolotto et al., 2020). These broader structures rarely support the needs of rural residents which contributes to care and access inequities of rural older populations (Hanlon & Kearns, 2016). For instance, rural health care provider to population ratios

pale in comparison to urban settings, which leaves rural organizations struggling to deliver effective care to the populations that they serve (Fleming & Sinnot, 2018). Further complicating care provision in rural areas, human resource challenges are shaped by demographics, topography, climate and cost of living (Zihindulai, Ross & MacGregor, 2018), yet these elements of rural care contexts are not considered in the models of care used in rural areas (Wakerman & Humphreys, 2019). As such, Milbourne (2012) showcases how a culture of diminished expectation leads to a heavy reliance on informal caregivers to support rural older people as they age.

While this literature on the implications of macro care governance in rural areas is significant, it is not commonly considered when analyzing rural older adult transitions in care. Instead, post-discharge services in rural areas are deemed limited or inadequate (Griffin et al., 2022) without further analyzing the role of macro care governance in shaping service provision in rural areas. My findings in this section fill this gap in contemporary literature by illustrating the concurrent influence of macro care governance and the rural context on older adult transitions in care. For example, my finding that governmentally determined funding allocation impedes the continuity of care of rural older adults affirms the influence of sectored divisions (Kitzman et al., 2017). On the other hand, my finding that facets of the rural context (e.g., a lack of things to do for young adults, expansive distances, harsh winters, transportation barriers, cost of living, lack of stratified housing and long-term care beds, etc.) reinforce human resource challenges and limit housing/service options after hospital discharge emphasizes why these sectored divisions are particularly detrimental within rural communities.

My findings in this section substantiate prior research on the inequities and care access issues experienced by rural older populations during transitions in care (Gilmartin et al., 2022). For example, my finding that informal supports fill gaps in publicly provided services during care transitions affirms rural older populations' heavy reliance on informal caregivers in response to health and social service deficits in rural areas (Milbourne, 2012). My finding that contested spaces of care governance influences rural older adult transitions in care, however, appears to be novel. Specifically, I suggest that on the one hand, smaller, more integrated rural health systems allow transitional care to be adapted to the heterogeneity of rural older adult health. On the other hand, macro care governance (e.g., large catchment areas, support for older patients with responsive behaviours, inappropriate home care models used in rural areas) leads to urban centric approaches to care that undermine features of rural older adult health construction (beyond biomedical health) and the rural care context (e.g., long travel distances, gaps in the availability of services/housing options, staffing shortages and limited types of health care professionals available). Contested spaces of care governance in rural areas then continually shape the transitions in care of rural older populations.

5.4 Personalized Care

Rural health professionals acknowledge that the whole-system patient-centred vision described in chapter two is essential to support rural older adult transitions in care. As such, rural health professionals sometimes disregard provincially driven bed flow[8]

[8] 'Patient flow' or 'bed flow' refers to the efficiency of patient admissions and discharges to attend to the movement of individuals through the health care system. Minimizing length of stay and alternative care designations in hospital are central features of this approach.

priorities to attend to diverse constructions of rural older adult health or the nuances of the rural care context. These hospital staff explain:

> *Often because we don't have the big hospital pressure I'll admit we keep patients a bit longer so they won't come back and so that home care can be put in place properly. (Front-Line Staff - Hospital 44)*

> *Even in emerge they will often admit people if there is an available bed for failure to cope or COPD [Chronic Obstructive Pulmonary Disease] exacerbations and their anxiety about it. That doesn't happen in bigger hospitals. I worked at PRHC [Peterborough Regional Health Centre] and it's a lot different there. (Front-Line Staff - Hospital 14)*

Hospital staff then keep older adults a few extra days to recover or admit patients even without pressing acute care needs (called 'social admits') as a means of personalizing rural older adult transitions in care. While these actions increase patient length of stay and/or oppose the biomedical triage priorities in hospital, these actions of hospital staff help to reduce the negative ramifications of macro care provision which is not flexible to adapt to unique facets of the rural care context (e.g., human resource deficits, limited housing and specialized services, etc.) or the heterogeneity of rural older adult health (beyond biomedical health). This rural approach to transitional care decreases the care aversions, readmissions and health decline of rural older patients. As such, Haliburton's smaller, more integrated health system allows health professionals to minimize the bed flow pressures that often exist in more urban areas.

Despite this dedication to a whole-system patient-centred vision, front-line staff still struggle to personalize rural older adult transitions in care due to the engrained nature of 'bed flow culture'. These front-line staff explain:

> *In hospital we focus on what we need to get them to a point of discharge rather than their own personal goals. We want to know where are they coming from and where are they going rather than their own goals. (Front-Line Staff - Hospital 8)*

> *There is always a pressure to fill beds and the pressure comes from management, because an empty bed isn't bringing money in. (Front-Line Staff-Long - Term Care 63)*

Indeed, macro features of care provision such as overarching philosophies, policies, funding allocation and quality management internalize bed flow priorities into the rural care context.

These macro influences are detrimental to rural older populations being discharged from hospital. In particular, when bed flow priorities are combined with the biomedical and the acute focus of hospital settings, older patients are discharged from hospital based on what is best for patients from a systems level rather than personalizing transitions in care. These front-line staff describe:

> *I send people home I am not comfortable sending home, that aren't going to cope. It could be failure to cope, not normally medical reasons. Usually if it is a medical issue we admit them. (Front-Line Staff - Hospital 24)*

> *Sometimes we send patients too soon or we send them home and we know they are going to be back in a couple days…Sometimes it is the hospital trying to push them out to open up more beds. (Front-Line Staff - Hospital 18)*

> *It frustrates me that there is a push to get them out. If patients aren't ready to go home and the doctor sends them home because there is nothing medically wrong but we know that they aren't coping due to other reasons than it is frustrating to see them come back in. (Front-Line Staff - Hospital 23)*

As these citations illustrate, macro system goals (e.g., bed flow, biomedical and acute care priorities) lead to unsafe discharges and the frequent readmission of rural older patients by not attending to heterogeneous constructions of rural older adult health. Instead, these macro system goals act as a utilitarian approach to transitional care which

does not allow rural health professionals to remain attentive to the personalized needs, preferences and goals of older patients.

Macro system goals then frame older patients as barriers to maintaining bed flow within the health care system. This participant explains:

> *We have a tendency not wanting to admit people who are waiting for a long-term care bed. There would be a fear of getting stuck with that patient. Since we have such a small number of beds, we are fearful our beds will get filled up and since we have so many people waiting for long-term care beds then we get put in a crisis when true acute care people come in. (Front-Line Staff - Hospital 9)*

Markedly, older patients are viewed as obstructing the effective care of others if their needs, preferences or goals (e.g., pressing social needs, cognitive impairments, mental health conditions, responsive behaviours, addictions as well as those individuals designated as failure to cope or alternate level of care) do not align with the macro goals of the health care system. Ageism is then engrained into transitions in care and is reflected in the language used by rural health professionals. For example, older adults are frequently referred to as ‘beds’, ‘bed blockers’, ‘boomerangs’, ‘social admits’, ‘FTC’, ‘ALC’, ‘new admits’ and ‘frequent flyers’ during rural older adult transitions in care. This dissociative language acts as a safeguard for rural health care providers by allowing them to distance themselves from circumstances where macro system goals are prioritized over the needs, preferences and goals of older patients.

While these macro care goals also likely influence older adult transitions in care in urban areas, the lack of publicly available services in Haliburton County combined with the prevalence of aging informal supports contributes to rural older adults becoming at risk of adverse events after hospital discharge (e.g., readmission, displacement, health decline, etc.). As such, rural hospital staff experience moral dilemmas as they attempt to

navigate these macro priorities and the individual needs, preferences and goals of rural older patients during transitions in care. In particular, hospital staff must decide between focusing on bed flow priorities and discharging patient's home to potentially unsafe care environments (e.g., lack of home care, no support for holistic aspects of health, etc.) or allowing them to remain in hospital where their health will decline.

This focus on macro system goals also leads to intersectoral conflict during transitions in care which contrasts the enhanced interprofessional collaboration that typically occurs in Haliburton County. This participant shares:

> *I think transitions are a huge blame game. For example there is a patient that has gone back and forth and the hospital is blaming us for not being able to manage the patient in the community. Then there's other times when it does work but there is no recognition of that. (Front-Line Staff - Community 2)*

Antagonism is then generated between health professionals due the prioritization of macro systems goals during rural older adult transitions in care.

5.4.1 Discussion of 'Personalized Care' Findings

Within Ontario, governmentally driven priorities place value on bed flow (Health Quality Ontario, 2019) through funding allocation (Ministry of Health and Long-Term Care, 2019), policies (Government of Ontario, 2018b) and quality indicators (HHHS, 2020). For example, funding for long-term care in Ontario is directly connected to maintaining an overall occupancy rating of 97% in the long-term care home, which results in every day a bed is left empty potentially threatening the full operational funding available. Although rural hospital funding models are not connected with patient length of stay, hospital quality performance indicators (designated by the Local Health Integration Network) still evaluate hospital operations based on bed flow priorities

(alternate level of care designations and patients' length of stays) (HCSS, 2020). In addition, quality indicators mandate the tracking of some readmission data (e.g., congestive heart failure, substance abuse conditions, mental health, chronic obstructive pulmonary disease, etc.), yet the readmission rates of older patients with complex needs (e.g., those with multiple morbidities, cognitive impairments, responsive behaviours, those who are designated as failure to cope, etc.) are not accounted for.

Focusing on these types of broader system goals then engrains ageism into front-line practice (Wyman, Shiovitz-Ezra & Bengel, 2018). For example, the Home First Philosophy[9] impacts older adult autonomy during transitions in care as the Ministry of Health and Long-Term Care does not insure hospital stays if patients refuse to accept hospital physicians' decisions to discharge (London Health Sciences Centre, 2021). In addition, yearly reports from Health Quality Ontario (2019) describe patients waiting in hospital for long-term care or assisted living as an 'increasing problem' as they impede the effective care provided to others (Health Quality Ontario, 2019). Since the majority of alternate level of care patients are older adults, this focus on 'bed blockers' perpetuates ageist undertones that place blame on older patients rather than on macro systems that do not consider individual patient's needs. Interestingly, this approach to governance is in direct contrast of the World Health Organization's action plan on ageing and health that suggests policy must counteract the tendency of institutional health procedures to engrain ageist social norms (WHO, 2017).

Turning to contemporary research on transitions in care, studies on older adults continually emphasize that personalizing care is paramount to increase the quality of

[9] Home First Philosophy mandates that hospital staff focus on discharging older patients home to wait for long-term care (Government of Ontario, 2018b).

older adult transitions and reduce readmission rates (Finlayson et al., 2018; Fønss et al., 2021). As such, several transitional care interventions aim to support the personalized goals of older patients (Hwang et al., 2018). This literature contends that system level and organizational level approaches to care transitions must be altered to better encompass patients and their caregivers experiences and perspectives (Greysen et al., 2016).

While some studies have exposed the drawbacks of broader biomedical and acute care priorities on caring for older patients (Tsui, Kim & Spencer, 2020; Mudge et al., 2021), especially during transitions in care (Gallagher et al., 2017), there is a dearth of research that considers the implications of bed flow priorities on rural older adult transitions in care. My findings in this section fill this gap by establishing how bed flow priorities combine with other macro system goals (e.g., biomedicine and acute care) to limit front-line staffs' attention to rural older peoples' personal goals, needs and preferences. For example, my finding that rural health professionals face moral dilemmas during transitions in care exposes the divergence between utilitarian and personalized approaches to caring for rural older patients. This finding contrasts prior literature that presents bed flow as a vital part of care provision (Murrell, 2020; Gonzalez et al., 2019; Destino et al., 2019; Pryce et al., 2021) by identifying that bed flow priorities can hinder rural health professionals' attention to the heterogeneity of rural older adult health or the nuances of the rural care context.

Similarly, discussions of systemic ageism within the health care system are common (Wyman et al., 2018), yet till now there has been little research that shows how ageist practices are connected to prioritizing broader health system goals such as bed flow, biomedicine and acuity in combination. In addition, my novel finding that rural

health professionals use discriminative labels to safeguard themselves from the implications of broader health system priorities sheds light on prior findings on the ageist attitudes of front-line staff (Heyman, Osman & Natan, 2020). Rural older adult transitions in care then reflect the contested spaces within the rural care context, illuminating the continuous clash between macro system priorities and the provision of personalized care of rural older populations.

5.5 Chapter Summary

In this chapter I have exposed the complexity of rural health systems by presenting a multi-layered account of the contextual features that impress upon rural older adult transitions in care. Deep-seated in these explorations are the interactions between older adult health construction, the rural context and the care context. Notwithstanding the strengths of smaller, more integrated rural health systems, I demonstrate how broader contextual elements (sectored divisions, health professional education, divisions between health professionals, urban centrism, biomedicine, bed flow priorities and ageism) inhibit rural care providers from attending to the heterogeneity of rural older adult health and the nuances of the rural care context. As such, these contested spaces that have been exposed by analyzing 'Interprofessional communication', 'Care Governance' and 'Personalized Care' continually shape rural older adult transitions in care.

Attesting to the influence of the rural care context, in chapter six I explore the wide ranging experiences of rural older adult transitions in care. In particular, I speak to rural older adults' experiences of Communication, On-Going Support and Personalized

Care. In this chapter I reveal how contemporary health services often undermine or conflict with rural older adult health construction during transitions in care.

CHAPTER 6

"It's a system that doesn't work for every patient because every patient is different."

6 Findings: Experiences of Rural Older Adult Transitions in Care

6.1 Introduction

Presenting my findings that correspond with objective three (To understand the experiences of key stakeholders involved in rural older adult transitions in care), this chapter accounts for the diverse and fluctuating experiences of rural older adult transitions in care. Mirroring the participant citation for this chapter, the heterogeneity of older adult health construction (e.g., health literacy, cognitive abilities, dynamism, preferences, rurality, and agency) is rarely supported during transitions in care and often conflicts with the formal services provided. While rural health professionals and facets of the rural care context can enhance transitional care experiences, macro features of the rural care context often inhibit the realization of these strengths in practice.

To organize this chapter I have divided my findings under three broad themes: Communication, On-Going Support and Personalized Care. Table 6.1 outlines the dominant themes and sub-themes in this chapter which underscore the spatial and temporal dimensions of rural older adult transitions in care.

Table 6.1 Experiences of Rural Older Adult Transitions in Care

Experiences of Rural Older Adult Transitions in Care			
Overall Theme	**Themes in Category**	**Connection to the Conceptual Model**	**Connection to the Literature**
Communication	1. Rural health professionals personalize the communication they provide to older patients which helps them to form a connection 2. Health professional designations and sectored divisions result in older patients frequently having to repeat their personal information 3. Bed flow priorities and a focus on acuity in hospital lead to accelerated/delayed discharges and communication break down 4. Older patients are given little information about what to expect after hospital discharge and only retrospectively identify questions that they should have asked 5. Systemic ageism in the health care system hinders older adults and informal supports from reaching out for help	· Rural Context · Care Context	· Rural Gerontological Health · Health Integration Scholarship · Ageism in the Health Care System · Complex Systems
On-Going Support	1. Rural health professionals breakdown sectored silos which enhances older adult experiences 2. On-going support is inconsistent due to human resource challenges in Haliburton County 3. Urban centric and biomedical care provision do not support holistic aspects	· Rural Context · Care Context · Older Adult Health Construction	· Rural Gerontological Health · Health Integration Scholarship · Complex Systems

	of health or the tasks required for older adults to age-in-place in rural communities 4. Bed flow priorities combined with the limited and/or inappropriate care available in Haliburton County lead to common events that result in the health decline of rural older populations 5. Older adults with affluence are able to avoid these adverse experiences through increased access to alternative care and housing options		
Personalized Care	1. Rural health professionals use their community connections to personalize care 2. Bed flow priorities lead to expedited discharges and pressures on rural older adults to accept discharge and/or care options that do not align with the ways that they construct their health 3. The heterogeneity of rural older adult health conflicts with the formal care provided leading to 'care refusals' 4. The dynamism of rural older adult health makes it difficult to support over time and place	・ Rural Context ・ Care Context ・ Older Adult Health Construction	・ Rural Gerontological Heath ・ Ageism in the Health Care System

6.2 Communication

Communication between front-line staff and patients/informal supports enhances the transitional care experiences of rural older adults. These participants explain:

> *I would say that family meetings were essential to support our transition. We had several and it helped to validate the issues and concerns that the family had. I had a team who have been able to work with us for several days and analyzed the person and they really took the time to help get us all on the same page. That doesn't happen everywhere. (Informal Support - Community 73)*

> *I know everybody introduces themselves and says hi; We try and really communicate with them to make connections. That helps. (Front-Line Staff - Hospital 7)*

Common in these quotations is how rural health professionals use communication to foster connection with older patients and their informal supports during transitions in care. While communication is also important during transitions in care in urban areas, rural health professionals readily adapt their approaches to communication to attend to the personal needs and/or concerns of rural older patients/informal supports during transitions in care which is perceived to not occur in other care settings.

Notwithstanding the enhanced communication that can occur during rural older adult transitions in care, rural older adults and their informal supports point to the challenges of information exchange that hinder their experiences. These participants share:

> *When you get checked in you explain 5 times why you are there and everyone always asks all the same questions. They ask me all these questions over and over and it's the same questions. Why with the technology we have they cannot record it. I am just going to record it when I first come in via voice recording and then I can just play it for each professional I meet. It's like there is no information transfer. (Older Adult - Community 68)*

> *It's frustrating because the patient's history is right there in the primary care office and they aren't even looking at it. If it wasn't for my sister and I they would know nothing about mom. Why aren't they accessing her medical history? (Informal Support - Community 57)*

> *We did have to tell long-term care a lot of information. It was the exact same information that we gave to the hospital. (Informal Support - Long-Term Care 87)*

Markedly, both rural older patients and their informal supports exhibit fatigue during transitions in care as they describe their presenting symptoms, medical history and care needs to multiple front-line staff both within and between care settings (e.g., upon admission to a new care setting, when meeting a new staff with a different professional designation, and when meeting a staff who was visiting from a different sector prior to discharge). Sectored divisions and distinctions between health professional designations then impede the transitional care experiences of rural older adults.

Despite providing all of this information to staff, rural older patients and their informal supports lack concrete details on the discharge process (e.g., dates, times and locations). This informal support describes:

> *Well I thought he would be discharged in the next couple days but I was surprised that he was being discharged [today] and I arrived and he was all ready to leave. I was surprised there wasn't a phone call saying he was ready to go home. (Informal Support - Community 69)*

Indeed, discharge and admission dates and times frequently are accelerated or delayed without always being communicated to rural older adults and their informal supports. Interestingly, aspects of the rural care context play a significant role in this communication breakdown. For example, if a significant number of patients need to be admitted to hospital, rural older peoples' discharges are expedited without warning to accommodate the new patients requiring acute care. Similarly, hospital staff prioritize

their work routines based on acuity, which results in rural older adults' discharges frequently being delayed due to their lack of urgency. Much as rural health professionals spend a significant amount of time preparing rural older patients and their families for discharge, the unpredictability of other features of the rural care context result in unforeseeable circumstances that lead to communication breakdown during transitions in care.

Rural older patients are also given limited information on what their new reality will be like after hospital discharge and only retrospectively recognize their need for more information. These older patients share:

> *Every day I had people coming in, but no one was explaining what was going to happen. They should get someone who works in long-term care to come and explain to you how it is and what you need to know. The staff could have explained what I was getting into better. The person I was rooming with, the patient next to me, tried to get in bed with me and sat on me because he has dementia, but I didn't know that that was a possibility when I moved in. I should have been told that could happen. (Older Adult - Long-Term Care 27)*

> *I also had a question about my bms [bowel movements]. I haven't had one since being in hospital and I'd like to take Metamucil, but I don't know if it will conflict with my new meds. I'm not really sure who I talk to about that. (Older Adult - Community 68)*

As these quotations suggest, rural older adults and their informal supports often only retrospectively identify information that they would have wanted prior to hospital discharge. While older adults moving into long-term care want more information about what life will be like in their new home (e.g., what they can bring, how roommates are determined etc.), older adults from the community want more information specifically about their health and care needs after transitioning (e.g., medication interaction, equipment use, etc.). Since there is a lack of follow-up between care sectors, older adults

and their informal supports feel frustrated after hospital discharge as they adjust to their new realities.

Despite having numerous questions, rural older adults and informal supports rarely contact the hospital after discharge. This informal support summarizes why she does not reach out:

> *As you age, you feel that you are being ignored and that your issues are not as important as those people who are 30-40 and that it's expected that you will decline. It's throughout the system, it starts with doctors and goes all throughout from nurses, care workers. I have a very strong opinion that when people get older we get ignored. We feel like medical people shrug us off and that this is just what is supposed to happen [after discharge]. Because we don't get the attention we need, it all just builds up and our health gets worse. (Informal Support - Community 46)*

Ageism then contributes to rural older adults and informal supports not reaching out for help after hospital discharge, which contributes to their health decline. While all of my findings from this section could easily apply to older adult transitions in care in urban areas, it is important to note that human resource concerns in Haliburton County exacerbate these barriers to communication. The combination of these facets of the rural care context then lead to inefficient and ineffective communication during rural older adult transitions in care despite the strong informal communication network present in the county.

6.2.1 Discussion of 'Communication' Findings

Communication is a critical aspect of older adult transitions in care since older patients typically have multi-morbidities and chronic conditions that increase their interaction with a diverse range of health professionals across multiple health care sectors (Clarke et al., 2017; Weeks et al., 2016). As such, effective communication is commonly

emphasized in contemporary models of older adult transitions in care (Allen et al., 2020; Powers, 2021) underscoring the need for reciprocal information exchange between health providers (Clarke et al., 2017) as well as between front-line staff, patients and informal supports (Farrier, Stefox & Fiest, 2019; Ng & Luk, 2019).

Even though communication is imperative to effective care transitions, there are few studies that document the impact of communication on older adult transitions in care from a patient and informal support perspective (Brooke et al., 2021). Brooks et al. (2021) and Mitchell et al. (2018) aim to fill this gap by exploring urban older adults' and informal caregivers' experiences of communication during transitions in care. This research emphasizes that there is a lack of communication between health providers from different sectors which contributes to patients and their informal caregivers feeling unprepared for hospital discharges. Specifically, communication breakdown increases patients' stress during care transitions as they are continually required to repeat their personal information to numerous care providers (Brook et al., 2021). While patients express that they share a breadth of information with front-line staff, they feel that they receive little guidance on what to expect after hospital discharge. This lack of communication contributes to them feeling overwhelmed and abandoned by hospital staff during care transitions (Mitchell et al., 2018). These urban accounts of older adults' and their informal supports' experiences of communication during care transitions are valuable. On the other hand, there is a dearth of research that reflects specifically on rural older patients' and informal caregivers' experiences of communication during transitions in care.

My findings in this section fill this gap in transitions in care literature by presenting rural older adults' and informal supports' experiences of communication during transitions in care. Substantiating prior transitions in care research performed in urban settings, my findings in this section demonstrate the negative ramifications of communication breakdown. In particular, my finding that rural older patients and their informal supports continually repeat their personal information both within and between care settings showcases the implications of communication breakdown that result from professional designations and sectored divisions (Clarke et al., 2017). In addition, I suggest that bed flow priorities lead to rural older adults' experiencing accelerated or delayed discharges which are often not well communicated to them during transitions in care.

In contrast to these ineffective experiences of communication during care transitions, my finding that rural health professionals personalize the communication they provide during transitions in care reveals how rural older patients' connections with staff can enhance their experiences. This finding supports prior research that suggests that rural health professionals have strong connections with their patients and other health care providers which improves care coordination (Kuroda et al., 2021). My findings in this section then showcase how facets of the rural care context (e.g., sectored divisions, health professional designations, bed flow priorities, ageism, the superior communication provided by rural health professionals, etc.) can concurrently enhance and hinder rural older adults' experiences of communication during transitions in care.

6.3 On-Going Support

On-going support during transitions in care is appreciated irrespective of rural older patients' needs or discharge location. Consider these patients' narratives:

> *My nurse practitioner came to my house to follow-up…it was amazing. She phoned me the next day to clarify my medication and pain and from that phone call she made an update to my meds and made sure my meds and bowels were working well. She explained my meds and why I was having trouble with my bowels. (Older Adult - Community 55)*

> *The staff knowing that she needed to have her [taken out to maintain anonymity] with her and the staff member going over to check on her the day of admission really helped. He was able to help with her transition. This helped to situate her, especially to have that staff that she knew. It didn't feel like they were passing her off, it was just about the patient. It was very personal care and that's the best. It was huge to have that person she knew there and help her settle. (Informal Support - Long-Term Care 75)*

Breaking down sectored silos that impede transitional care, on-going support helps rural older people transition after hospital discharge. While on-going support may also enhance the transitional care experiences of older adults in urban centres, the support within Haliburton County is perceived to exceed the care provided in other care contexts. For example, the hospital staff informally follow up with rural older patients and their informal supports after hospital discharge. These staff describe:

> *I live in town and so I frequently see families in the community and this allows me to follow-up even in the grocery store. (Front-Line Staff - Hospital 32)*

> *When you bump into patients at the grocery store or you are related. That's what makes quality [transitional] care in our community because it could be your grandparent next and so you provide care the way you would want your family to be treated. (Administrator/Manager 50)*

Markedly, rural health professionals informally follow-up with older adults and their informal supports in the community as a means of confronting the negative impact of sectored divisions on transitions in care.

Even though informal follow up in rural communities can enhance older adults' experiences, not every older adult benefits from on-going support during transitions in care. Consider the contrast in this rural older patient's narrative to the ones presented earlier in this section:

> *When she first got home she was very confused. I mean she couldn't remember how to use her phone and struggled with her remote, but we managed. I am not sure what could have been done to help her when she got home. I know there use to be support for going home but I don't think it is being kept up well. (Informal Support - Community 56)*

This patient's narrative demonstrates the inconsistency of support that is provided to rural older people after hospital discharge that is interrelated with the human resource deficits in the area. This front-line staff explains:

> *We can't always send a nurse with every transfer. Then you end up working short and that's not good for patients. Sometimes they don't need a nurse and get one even though that takes the nurse away from elsewhere. It makes a huge difference when you pull staff and you have a small staff roster. You don't know what's coming through that door. (Front-Line Staff - Hospital 9)*

Remarkable in this quotation is that human resource challenges limit the on-going support that can be provided during rural older adult transitions in care. As such, the rural care context shapes the transitional care experiences of rural older adults.

Providing further evidence of the influence of the rural care context, home care provision in Haliburton County affects rural older peoples' experiences of on-going support after hospital discharge. These participants maintain:

> *Often they would call us to let us know that home care could not send someone until 5pm. Well getting someone dressed at 5pm for the day isn't really helpful, but then if you cancelled the care, it would be marked as a cancelled visit [and your home care hours would be reduced]. (Informal Support - Long-Term Care 82)*

> *The most recent [complaints?] from older adults is that they are promised all kinds of support when they get home, but none of that support materializes. One older adult living at home waited three weeks and didn't get help. (Informal Support - Community 54)*

> *I think that chores when I get home are going to be really hard and I don't really have any supports for that. I have not been connected with any community programs to support this. I need help with cutting the grass, fixing my truck and getting the garbage to the dump. (Older Adult - Community 68)*

> *I have had an OT, a PT, someone from GAIN, they have all let me know that the carpet is a tripping hazard. I have gone to the office. All those professionals have gone to the office, but they still won't change it [the carpet was identified in a home assessment prior to hospital discharge as a safety hazard]. (Older Adult - Community 52)*

The ineffectiveness of home care provision in Haliburton County then shapes older peoples' experiences of on-going support after hospital discharge. Certainly, these quotations establish how the urban centric and biomedical care models used in home care provision do not support holistic aspects of health or the tasks required for older adults to age-in-place in their rural homes. As such, rural older adults experiences of on-going support during transitions in care are shaped by models of care that do not readily align with the ways that they construct their health or the places that they live.

Adding to these challenges, older adults and informal supports perceive that bed flow priorities lead to older patients being discharged prematurely from hospital. This participant describes:

> *I was very surprised that he was being discharged. He had just started to eat and he was still talking jibberish, he wasn't thinking clearly. He*

> *thought he was in Lindsay. I was disappointed that he was being let go. I am assuming that they pushed to get him out. There is definitely a pressure on staff to get patients out of hospital before they are ready. They put some Band-Aids on your problem and send you on your way. (Informal Support - Community 31)*

Bed flow priorities combined with the limited or inappropriate care options available after hospital discharge then hinder rural older adults' experiences of on-going support. As such, rural older adults experience one or more of the following transitional care events: 1) older adults move out-of-county to obtain adequate levels of care, 2) remain in hospital longer due to the unavailability of appropriate care, 3) seek out long-term care services prior to requiring 24 hour support 4) are readmitted back to hospital and/or 5) just accept the home care available in the region even though it does not fit their care needs.

These transitional care events then lead to the health deterioration of older adults over time. These participants explain:

> *I was in and out of hospital for several months. I'd be home for a few days, a week or so, but I would always end up back in. I was down in Peterborough for awhile, Toronto for awhile, up here in hospital. I finally came into hospital very confused and very weak and now after being in and out of hospital I am thankful to be alive. (Older Adult - Long-Term Care 27)*

> *She was in hospital for four months. That's a pretty long time to wait for long-term care. It was probably pretty hard on her to be in hospital so long. The care that she received at the hospital was great, but she wasn't stimulated and I don't know if she would have deteriorated cognitively if she had been transferred sooner. It's not really a great place for them. (Informal Support - Long-Term Care 90)*

> *There is something wrong with the way the wait-list to get into long-term care is done. It's like patients put their name down because they know that the wait is so long, but then patients aren't ready when their name comes up. A lot of times people come to long-term care earlier than they use to and this decreases their life span because they don't*

> *know when the next bed will come available. (Front-Line Staff - Long-Term Care 36)*

A lack of on-going support during transitions in care then leads to common transitional care events (frequent readmissions, long hospital stays, early entry into long-term care, accepting care that did not align with their needs, moves out-of-county) that contribute to the health decline of rural older populations over time.

Conspicuously, affluent rural older adults circumvent many of these adverse experiences of transitional care by seeking out private services to fill the voids in publicly funded care. This informal support affirms this advantage:

> *The patient had a full time caregiver which meant that he didn't have to go in and out of hospital. This allowed him to be autonomous within his own home and leave hospital sooner. (Informal Supports-Community 71)*

While rural older adults with affluence still experience bed flow pressures, their access to private care after hospital discharge allows them to avoid the negative ramifications associated with relying on publicly available services for on-going support. Economic status then influences rural older adult experiences of transitions in care.

6.3.1 Discussion of 'On-Going Support' Findings

Contemporary transitional care models stress the importance of providing on-going support to older populations (Hirschman et al., 2015). Even though this type of support is critical to older adults' experiences of care after hospital discharge (Hirschman et al., 2015), the majority of transitional care supports focus on helping patients and caregivers self-manage their own care (Slatyer et al., 2019). Hestevik et al. (2019) then expose the detriment of these contemporary transitional care models which are not conducive to supporting older people. In particular, a lack of on-going support can result

in long hospital stays and frequent readmissions (Elliott et al., 2018), which can lead to the health deterioration of older patients and poor quality care over time (Calero-Garcia et al., 2017).

Challenging the provision of on-going support in rural areas, the availability of governmentally-funded services in rural communities leave gaps in supporting older adult care (Quinlan et al., 2020). For example, contemporary models of home care provision do not consider large driving distances, poor road conditions and inclement weather (Terry et al., 2015), which act as barriers to providing on-going support after hospital discharge. Rural health scholars then highlight the detriment of 'one-size fits all' models of care that are not conducive to providing adequate support in rural communities (Wakerman & Humphreys, 2019). In contrast, Jackman, Myrick and Yonge (2012) argue that rural nurses can enhance the provision of on-going support in rural communities by relying on the close knit community to overcome gaps in care. While contemporary scholarship highlights these strengths and barriers, the first-hand experiences of rural older adults and their families of on-going support during transitions in care are rare (see Hestevik et al., 2019 and Allen et al., 2017 that document urban older patients' and informal supports' experiences of on-going support).

My findings in this section substantiate prior research on the importance of on-going support during transitions in care by providing insight into rural older adults' and their informal supports' experiences of transitions in care. Specifically, my finding that rural health professionals provide informal follow up after hospital discharge illustrates how on-going support can foster quality transitional care experiences in rural areas. This finding provides an example of how rural health professionals can enhance on-going

support throughout transitions in care by overcoming macro barriers such as sectored divisions (Jackman et al., 2012).

In contrast, my finding that older adults' and informal supports' transitional care experiences are influenced by bed flow and biomedical prioritization as well as urban centrism emphasize the pronounced influence of macro priorities on providing on-going support in rural communities. In particular, these macro priorities combined with limited community services (e.g. a lack of stratified care, long-term care beds, home care services, etc.) and human resource deficits lead to rural older adults experiencing common transitional care events (e.g., long-hospital stays, frequent readmissions, premature entry into long-term care, move out-of-county to obtain adequate levels of care and/or just accept home care that does not adequately fit their needs) that lead to their health decline.

On the other hand, my finding that rural older adults with higher economic statuses are able to circumvent many of these adverse transitions in care experiences provides an example of how social inequality contributes to inequitable care access (Gkiouleka et al., 2018) of rural older adults after hospital discharge. Indeed, rural older adults with higher economic statuses have increased access to on-going support (e.g., private care that fills in the gaps of publicly funded services) which enhances their experiences of transitions in care. Facets of rural older adult health construction and the rural care context then continually shape the transitional care experiences of rural older adults over time and place.

6.4 Personalized Care

Personalizing transitional care improves rural older adults' experiences across the care continuum. These participants describe:

> *The discharge was text book. The BSO [Behavioural Supports Ontario] really helped with that soft hand over to ensure that staff got to know the ins and outs of her behaviour. Long-term care also sent over a staff and I was able to review her medication, the behavioural notes, typical routines, report on her food intake. It made the difference [during her transition]. (Front-Line Staff - Hospital 22)*

> *Supportive housing is able to get to know patients and those simple things like knowing that mom likes lemon meringue pie. It's a simple thing. It's hard to put your finger on but it makes a difference [after hospital discharge]. (Informal Support - Community 57)*

> *When you can have long conversations with family and provide information and reassurance that makes a huge difference in supporting transitions and making them successful (Front-Line Staff - Hospital 5)*

Although personalizing transitional care services may also improve the experiences of older adults living in urban areas, the following participants perceive that rural health professionals are more familiar with their patients and informal supports from the community. This community connection makes it easier to personalize the transitional care services they provide. These participants share:

> *This is a smaller town and most of the patients are from the community. We do know them and that makes it easier [to support them during transitions] that we know them and their family. (Front-Line Staff - Hospital 8)*

> *In our little hospital, I feel that it [the transition] went easier because it is a small community and I think it [the transition] was more personable because everyone knows everybody but I don't think you would get that in a big centre. (Informal Support - Long-Term Care 90)*

Community connection then assists rural health professionals to personalize transitional care which augments the experiences of rural older adults.

Rural health care providers, however, recognize that there are limitations to personalizing transitions in care. This administrator/manager explains:

> *It [transitions in care] is so hard for people and it's full of hard decisions. For us it often becomes common place. These are important stories and we don't always hear them. (Administrator/Manager 6)*

This administrator/manager expresses the shortcomings of the transitional care provided in Haliburton County by insinuating that transitional care experiences are often treated as homogeneous.

Analyzing the factors that homogenize transitional care, macro system goals establish a utilitarian approach to care that impedes the personalization of transitional care services. As such, rural older adults and their informal supports express how bed flow priorities lead to poor experiences of transitional care. These participants share:

> *The CCAC put pressure on me to put more long-term care homes on our list. It is only because I am a strong advocate that I haven't. It's a lot of pressure when that is not what we want. (Informal Support - Community 33)*

> *My number came up so I had to move, otherwise someone else would take the bed and then you have to go on the bottom of the list if I didn't want to go. Then I don't know how long it would take to get in again, so there was a lot of pressure. (Older Adult - Long-Term Care 27)*

> *No one really cared that I was leaving so much as they were getting another patient in… The doctor just came in and said you might as well go home. So I said fine and so I let the nurses know and then the nurse confirmed and I got dressed, got myself ready and left. I found out I was going to leave the day of. (Older Adult - Community 55)*

Remarkable in these quotations is the language used such as 'my number came up', 'it was a lot of pressure' and 'no one really cared', which epitomize the lack of personalized

support that is provided during transitions in care. Certainly, bed flow priorities lead to expedited discharges and pressure being put on rural older adults to accept discharge and/or care options that do not align with the ways that they construct their health. As such, many rural older adults indicate that hospital discharges feel apathetic as health professionals quickly shift from their discharge needs to those needs of the new patient coming in.

Unquestionably, the heterogeneity of rural older adult health continually challenges rural health professionals to personalize the transitional care provided. These participants describe:

> *I just need myself, I don't need a lot of help. I was living by myself before I came here. I'll use my walker more. I'll be fine. I'm not worried about a thing when I get home. (Older Adult - Community 94) [Observational data revealed that this patient had a moderate cognitive impairment, was receiving the maximum amount of home care hours available and had three adult children taking turns caring for her when formal care was unavailable]*

> *Since he is making his own decisions, he doesn't have a POA [Power of Attorney]. He has capacity, but he doesn't always make good decisions about his health [referring to not accepting home care after transitioning back to his residential home] (Informal Support - Community 98)*

> *When she was in the hospital, we would have the same thing. They would review aggressive treatment, but she didn't want more investigations, but she kept asking about it. (Informal Support - Long-Term Care 81)*

Inherent in these responses is that rural older adults do not always have insight into their health, do not always make decisions that prioritize their physical health and/or may change their mind about care interventions throughout transitions in care. In contrast, the observations reveal how formal care services require that older adults' care needs

conform to a linear algorithm (i.e., a set of rules that determine if a patient qualifies for discharge resources). For instance, if an older adult requires more than X number of home care hours, then from a systems perspective the patient should move into long-term care. Due to the limited community care options available in Haliburton County, this rigid algorithm regularly conflicts with rather than provides personalized support for heterogeneous constructions of rural older adult health.

As such, ageism is an engrained feature of rural older adults' experiences of transitions in care. These narratives provide examples:

> *The doctor still made an appointment even though we said we didn't want the surgery but what I wanted to know is how to best look after my fracture. It was a waste of time. (Older Adult - Community 55)*

> *[The patient] is frustrated because he wants to concentrate on his legs because he feels that that is what is going to get him home but the physio doesn't want to do that. He doesn't want to accept physio on his arm and the physio knew that and wanted to work on it anyway. (Informal Support - Long-Term Care 89)*

Prominent in these narratives are the ways that older patients' goals, needs and preferences are negated during rural older adult transitions in care. On the other hand, if older adults decline the services and/or supports proposed during transitions in care, it is referred to by rural health professionals and informal supports as 'refusal of care'. These sentiments place judgment on older people rather than on the health system, which is not flexible to attend to older patients' personal goals, needs and preferences. Transitions into long-term care are particularly problematic as rural older adults continually identify that moving into long-term care is not a 'choice', but a threshold in which personal care requirements exhaust the supports that can be provided in their community. Rural older

adults' choices and autonomy are then labeled as 'care refusals' rather than supported during transitions in care.

This confliction between formal support and rural older adult health construction is most prominent in discussions about 'future planning' which are initiated by front-line staff during transitions in care. In particular, rural older people and their informal supports intentionally or unintentionally reject their need to plan for biomedical decline, indicating how the community care services available (i.e. home care and long-term care) are misaligned with their current identities and lifestyles. These participants explain:

> *They don't want to leave their home, their privacy, their independence. Living in a rural area is very personality dependent as there are many who like being alone and when they are not able to it can be difficult to transition to this lifestyle [into long-term care]. (Front-Line Staff - Long-Term Care 35)*

> *My mom didn't want to move to Minden even though she was offered supportive housing. She doesn't want to make a plan. She struggles having people come into her home all the time, especially when she doesn't know when they are coming. (Informal Support - Community 57)*

Rural older adults and informal supports then passively or actively reject the need to plan for potential future care needs during transitions in care by outlining how these services conflict with their current rural identities and/or life style preferences. Certainly, the communal environments of long-term care as well as the urban centric and biomedical focus of home care services clash with older adults' rurality. Rural older adults and informal supports then frequently 'refuse' to plan for potential physical care needs during transitions in care, attempting instead to prioritize other holistic aspects of their health (e.g., independence, their rurality, etc.).

The dynamic nature of rural older adult health also regularly conflicts with the rigidity of formal transitional care support that focuses on future planning. Specifically, rural health professionals struggle to personalize transitional care due to the unpredictability of older adult health over time. These participants describe:

> *We didn't expect his health to decline so fast and him to become weak. It's the uncertainty of not knowing what's coming. Will he continue to get weaker? Will he make his follow-up appointments in Lindsay? I don't have any answers. (Informal Support - Long-Term Care 89)*
>
> *It's a rollercoaster. She would get better and then worse. You were planning on how to get her home, and then all of a sudden she can't, and then maybe you think she can. (Informal Support - Long-Term Care 87)*
>
> *I think seniors in hospital often don't accept what they need in hospital and then after getting home they can't get the services that they need in place if they didn't expect to need it. You don't know what you need till you get home. (Informal Support - Community 54)*

Rural health professionals then grapple with continually adjusting transitional care plans to fit the fluctuations of rural older adult health.

6.4.1 Discussion of 'Personalized Care' Findings

Transitions in care scholars argue that personalizing care for older people across care settings minimizes readmissions and improves patient well-being (Hestevik et al., 2019; Orsulic-Jeras et al., 2020; Baxter et al., 2018). This personalized support can range from fostering strong relationships between care providers and patients to adapting rigid structures and processes to attend to older patients' complex needs (Kuluski et al., 2017). The diversity of the aging population, however, challenges the provision of personalized support for older adults during transitions in care (CIHR, 2017). Specifically, the

multifaceted needs of older adults (Kogan, Wilber & Mosqueda, 2016) challenge health professionals to personalize the care provided to older populations (Hennings & Froggatt, 2019), especially across health care sectors (Kuluski et al., 2017).

Turning to rural communities, research on personalized support during transitions in care highlights the rural context as a critical feature of quality care transitions (Garvin et al., 2021). Indeed, personalized support can enhance care coordination in rural areas which can increase care access during rural older adult transitions in care (Garvin et al., 2021). Rural studies on personalized support during transitions in care, however, are limited (see Gilmartin et al., 2022 for a notable exception) and the first hand experiences of personalized support of rural older adults and their informal supports are unaccounted for.

My findings in this section affirm the benefits of personalized transitional care provision by accounting for the first-hand experiences of rural older adults and their informal supports during transitions in care. For example, my finding that rural older adults' and informal supports' experiences of transitions in care are enhanced by rural health professionals' familiarity with them from the community supports prior research that emphasizes how facets of rural communities can improve personalized support during transitions in care (Garvin et al., 2021). On the other hand, my finding that aspects of the rural care context rarely support the heterogeneity and dynamic nature of rural older adult health construction (e.g., health literacy, cognitive abilities, agency, preferences, health presentations, linear algorithms) reinforces the challenges of health providers to provide personalized support for the diversity of older populations (Kuluski et al., 2017). I add to transitions in care scholarship by suggesting that the provision of

personalized support during care transitions is challenged by diverse facets of rural older adult health that either are not accounted for or conflict with the formal care provided (e.g., biomedical focus, bed flow priorities, universality of the contemporary care options, etc.). As such, aspects of the rural care context both concurrently enhance and hinder rural older adults' experiences of transitions in care.

6.5 Chapter Summary

In this chapter I have demonstrated the multi-faceted elements that impress upon the transitional care experiences of older adults in Haliburton County in alignment with objective three. Even though aspects of the rural care context can enhance rural older adults' experiences of transitions in care, the heterogeneity and fluidity of older adult health is not well attended to and often conflicts with the formal services provided. As such, my dissertation accounts for the spatiality and temporality of rural older adult transitions in care which is continually shaped by the interplay between older adult health construction and the multidimensional rural care context.

In the final chapter, I frame my findings within broader discourse on rural older adult health and care and provide critical contributions to research, policy and practice. I also present the limitations of my dissertation and propose future directions to generate relational models (i.e., models that incorporate the interconnection between domains of care that are experienced concurrently) of rural older adult transitions in care. Concluding with three sets of recommendations, my closing comments shed light on the contemporary crossroads of rural geriatric care that offer an opportunity for change.

CHAPTER 7

"I just think that everything is all related and influences health."

7 Discussion and Conclusion

7.1 Introduction

Researchers and policy makers recognize the value of supporting the transitional care experiences of vulnerable populations, yet there is a dearth of research that acknowledges the transitional care experiences of older adults in rural communities. My dissertation attends to this gap by leveraging critical gerontology, health services and human geography to better understand the interplay between older adult health construction and the influence of multidimensional contexts on rural older adult transitions in care. I used four objectives to accomplish this overall goal: 1) To observe and gain the perspectives of older adults, informal supports, front-line staff and administrators/managers on how rural older adult health is constructed, 2) To examine the rural care context in which older adult transitional care is provided, 3) To understand the experiences of key stakeholders involved in rural older adult transitions in care and 4) To provide a foundation of information for regional older adult health care networks (Seniors Care Network & Haliburton Highland Health Services).

As the participant citation for this chapter suggests rural older adult transitions in care are highly relational, continually shaped by the interconnection between older adult health construction, the rural context and the care context. Although these facets are often studied in isolation of each other, my dissertation highlights the value of studying the intersection of these aspects of health and care. Indeed, this transdisciplinary approach reveals the multi-leveled influence of the rural care context that concurrently attends to and clashes with rural older adult health during transitions in care. My dissertation is then relevant far beyond the transfer of older populations between care settings as it exposes the ways that macro facets of care provision continually overshadow the strengths of rural care contexts.

In this final chapter I begin by showcasing how I have fulfilled research objectives one to three and evolved contemporary discussions on the relationality (embracing the interconnection between domains of care that are experienced concurrently) of rural older adult transitions in care. I then summarize the broader implications of my work and the limitations of my analysis. Attending to objective four, I provide three sets of recommendations to generate a foundation of information to ensure vast dissemination of my findings. Finally, I propose future questions for research, policy and practice to advance understandings of the relationality of rural older adult transitions in care.

7.2 The Relationality of Rural Older Adult Transitions in Care

Affirming the value of relational approaches to research, much has been gained from investigating the interplay between older adult health construction,

multidimensional contexts and the transitional care of rural older adults. As such, this section is structured to account for the interplay between these objectives.

7.2.1 Rural Older Adult Health Construction and Transitions in Care

By analyzing rural older adult transitions in care, my dissertation affirms the contrast between health literacy and the reality of health construction. While health scholars indicate the need to improve the health literacy of older patients (Uemura, Yamada & Okamoto, 2021) and informal supports (Haikio, 2021), my dissertation suggests instead that rural older adults define their health differently than the care models used during transitions in care. Rowles (2019) characterizes this conundrum between knowledge and practice in later life as he describes his residential choices that readily conflict with his 30-year career as an environmental gerontologist. Rather than opting for an age-friendly home that would allow him to age in place, he confirms that those in later life prioritize feelings, leisure, lifestyle and interpersonal relations that rarely co-inside with planning for potential physical losses (Rowles, 2019). Aligning with Rowles work, rural older populations more readily identify holistic facets that contribute to 'good health' (e.g., community connection, religion, affluence, rurality, etc.) and do not always prioritize their physical health during transitions in care. As such, 'care refusal' and interpersonal conflict is common during care transitions as rural older people attempt to prioritize rurality and holistic aspects of their health. Holistic facets of health, however, are highly interconnected, conflicted and difficult to identify, which results in rural health professionals often falling back on the biomedical and urban centric care models engrained within the health care system.

My findings on rural older adult health construction raise important questions about the implications of multidimensional contexts that alter older adult health in rural communities. Certainly, features of the rural care context produce the stratification of personal health priorities during transitions in care. For example, rural older adults with limited financial means must prioritize basic necessities over accessing other formal services or programs that might otherwise enhance their health. Although economic status likely overshadows the transitions in care of urban older adults, aspects of the rural care context (e.g., cost of living, transportation, stigma, topography, etc.) impede the progress of rural communities to support holistic aspects of rural older adult health. My dissertation then demonstrates how the rural care context generates personal health priorities which affect rural older patients' engagement with and access to support during care transitions.

Attending to the calls from Nagata et al. (2011) to generate contextually sensitive understandings of the social determinants of health, my dissertation establishes that broader powers such as neoliberalism, social stratification and the protestant work ethic shape the realities of rural older adult health construction. Since health systems and structures embody these broader influences, rural older adults continually struggle to reach out for support for their health during transitions in care. For example, the superiority of maintaining autonomy and independence during care transitions has roots in Westernized and biomedical definitions of health (Valles, 2020). These broader features of the rural care context generate inequities between rural older populations. For instance, older adults with lower economic statuses experience transitional care barriers due to the social stratification of care access (e.g., both home care and long-term care).

Although many critical gerontologists maintain that these macro features contribute to tensions between older populations (Twigg & Martin, 2015; Kydd et al., 2018; Stephens & Breheny, 2018), my dissertation demonstrates that these macro facets of care also lead to polarized definitions of rural older adult health during transitions in care.

The link between older adult health and identity construction is an interesting point of departure from which to analyze the influence of the rural care context. In particular, older people who identify differently than the dominant norm (e.g., because of ethnicity, ethnic "difference", sexual orientation, and other forms of "otherness") are not recognized in Haliburton County which leads to the insistence that identity construction does not influence rural older adult transitions in care. On the other hand, prior studies emphasize that older people who identify differently than the dominant norm experience health and care inequities in rural areas (Whitehead et al., 2016; Butler, 2017; Caldwell et al., 2016) and systemic oppression is a common feature of macro care structures (Kydd et al., 2018). Further investigation is then needed to determine if rural older people who identify differently than the dominant norm are not being acknowledged and/or are not accessing support that they need during transitions in care. Analyzing these contextual interactions is fundamental to attend to the heterogeneity of rural older adult health and to challenge systemic discrimination that is deeply rooted in macro care systems (Dickman, Himmelstein & Woolhandler, 2017).

In summary, my dissertation affirms the heterogeneity and dynamic nature of rural older adult health that is undermined within macro features of the rural care context. While strengths in rural communities are critical to support rural older adult health during transitions in care, macro features of the rural care context homogenize care provision by

not embracing flexibility, rurality or holistic health in their design. I then point to the need for transformation of these macro facets of our health care system rather than continually insisting that rural older adults redefine the ways that they construct their health.

7.2.2 Appreciating the Relationality of Rural Health Systems and Older Adult Transitions in Care

Tensions between the strengths inherent in rural communities and macro facets of health care provision generate contested spaces that shape rural older adult transitions in care. Specifically, my dissertation identifies that rural health care providers invest time and resources to actively counteract macro features of care that undermine the heterogeneity and dynamism of rural older adult health. This multidimensional lens refocuses rural health research away from binary constructions of rural care contexts as solely 'romanticized' or 'deficient'. Instead, sectored divisions, urban centrism, biomedicine, bed flow culture and ageism restrict the innovation and strengths of rural care provision. Absolutely, rural older adult transitions in care embody these contested spaces suggesting that formal care provision must be adapted to better fit rural older adult health construction and the strengths inherent in rural communities.

7.2.2.1 Urban Centrism

Confronting urban centrism in research, policy and practice is a requisite of rural discourse (Skinner et al., 2021), yet there is a dearth of health scholarship that contributes to multi-leveled investigations of urban framings of rural older adult health and care. Leveraging the work of Herron and Skinner (2013), my dissertation affirms that urban centrism shapes rural health systems and perpetuates inequitable experiences of rural

older adult transitions in care. Surely urban centric models reinforce rural narratives of diminished expectation (Milbourne, 2016) and warrant a heavy reliance on informal supports (Gibson et al., 2019) and volunteers (Blair, Bateman & Anderson, 2019). Urban centric features of care then continually hinder rural older adult transitions in care despite the progressive steps forward taken in Haliburton County to attend to the heterogeneity of rural older adult health.

The influence of urban centrism is multi-leveled, embedded in the design of rural health systems, which inevitably shapes inequities and service access issues during rural older adult transitions in care. At a macro level, the provincial government reinforces rigid jurisdictions of sectored care through funding allocation and quality management that are detrimental to older populations (Araujo de Carvalho et al., 2017). This lack of health integration results in increased costs related to unnecessary hospitalizations and emergency room visits as well as premature entry into long term care (Di Pollina, 2017). In rural communities, however, these divisions are pronounced due to the limited community services and housing options available to support rural older populations after hospital discharge. In spite of the jurisdictional inclusion of rural residents under regional services, my dissertation mimics my positionality as a researcher by exposing how large catchment areas result in access barriers of rural older populations during transitions in care. In particular, vast travel distances and the prioritization of patients located closest to where services are administered result in access barriers of rural older populations which are not experienced by their urban counterparts.

In long-term care, evidence of urban centrism is connected with the care models used to determine admission. Specifically, the provincial designation of private, semi-

private and basic beds does not reflect the lower economic statuses of rural residents or the high cost of living in rural areas. Demonstrating that urban centrism engrains social stratification into rural health systems, my dissertation then indicates that rural older adults more frequently move out-of-county or seek out loop holes (e.g., put their names on semi-private/private wait-lists without the means to afford it or advocate to be put on the Local Health Integration Network crisis list for long-term care) to circumvent the misalignment of these health system designs.

The provision of home care services in rural regions point to the inappropriateness of urban care models to support rural older adult transitions in care. These urban models do not consider large geographic expanses, demographics and inclement weather that have been extensively discussed by rural scholars (Terry et al., 2015). Indeed, providing home care services such as getting older people dressed for the day at dinner time do little for older adults who transition back to their rural homes. My dissertation also establishes a wide range of tasks (e.g., property maintenance, trips to the dump, groceries and transportation) that are not publicly provided but are required to support rural older adults after hospital discharge. Urban centric home care provision then puts more pressure on aging rural informal support networks as they attempt to compensate for the misalignment of the care provided. I then challenge the urban centric models used throughout transitions in care and argue that these models more readily align with the urban centres in which they are created.

Considering the multi-leveled impact of urban centrism reframes understandings of health and care inequity in rural areas (Zhang & Wang, 2020). Certainly, my dissertation illustrates that common transitional care events (e.g., long-hospital stays,

frequent readmissions, premature entry into long-term care, displacement out-of-county to obtain timely access to care and/or just accept home care that does not adequately fit their needs) are not generated solely by service deficits but result from the misalignment of publicly funded care. Urban centrism then plays a role in the health decline of rural older adults during transitions in care as publicly funded care services do not attend to rural older adult health or function in the rural communities in which older people live.

Notwithstanding these challenges to urban centrism, rural care providers actively work against urban centrism in their daily practice. On an administrative level, senior leadership confront urban centrism as they work towards integrating services against jurisdictional divisions and funding allocation that reinforce sectored care provision during transitions in care. On a front-line level, rural health care staff scramble to fill staffing shortages when attempting to provide on-going transitional care support. Rural care providers then inefficiently commit time and resources to counter the urban dominance of modern care.

Moreover, the strengths of rural communities are overshadowed during transitions in care. In particular, Haliburton County is rich in community organizations that support the social determinants of health and Haliburton Highlands Health Services is well renowned for embracing innovation in integrated care. My dissertation then counters the deficit focus of rural health research by exposing the strengths of rural health systems and rural residents (health professionals and informal supports) that continually adapt transitional care to the heterogeneity and dynamism of rural older adult health. Even though these strengths are vital to enhance transitional care provision, macro features of care continually counter the effectiveness of these pursuits. I then advocate that urban

centrism within the health system requires remedying to capitalize on the strengths of rural communities and enhance the transitional care provided to rural older populations.

7.2.2.2 Biomedical Model of Health

While biomedicine has dominated research, policy and practice since the mid-1900s, it is only in the last few decades that scholars have drawn attention to the negative impact that this model has on caring for older populations (Lyman, 1989; Koch & Webb, 1996; Wilberforce et al., 2016; Longino & Murphy, 2020). This biomedical prioritization results in services that are not equipped to manage geriatric conditions (e.g., cognitive impairments, responsive behaviours, chronic conditions, multi-morbidities, etc.) or attend to the social determinants of health (Provencher et al., 2015). Since rural communities have limited staff, access to specialists and few community services, this misalignment is more pronounced in rural health systems which affects the populations that they serve (Iglehart, 2018; Bennett et al., 2019; Gesler, Rabiner & DeFriese, 2018).

My dissertation substantiates this prior scholarship by revealing the detrimental effects of health care services that prioritize biomedicine in rural areas. This biomedical prioritization leaves deficits in rural older adult transitions in care by negating holistic aspects of rural older adult health. While rural health professionals continually attempt to circumvent the negative ramifications of macro biomedical priorities (e.g., admitting failure to cope patients with pressing social needs, extending length of stay even when a medical issue has been resolved, etc.) the engrained nature of biomedicine results in unsafe discharges of rural older people from hospital and deficits in home care provision after hospital discharge. This biomedical focus then impedes rural older adults'

transitional care experiences and leads to inefficiencies in rural health care practice (e.g., readmissions, aversions to care, redundant information collection, etc.).

Addressing the prioritization of biomedicine, however, requires transformation within and beyond the health care system (e.g., educational institutions, professional bodies, etc.). For example, quality management, funding allocation (HCSS, 2020), health professional education, reporting guide lines (College of Nurses of Ontario, 2021a; CPSO, 2021), information transfer and the prioritization of biomedicine in hospital settings reinforce biomedical constructions of rural older adult health. This biomedical focus conflicts with how rural older adults construct their health and does not consider the implications of the rural care context. I then align myself with other health scholars that advocate for geriatric services to better encompass holistic models of health (Taylor, Buchan & van der Veer, 2019; Ribeiro et al., 2017). Certainly, considering relationality in care provision (i.e., the interconnection between domains of care that are experienced concurrently) may lead to more efficient rural health systems by aligning transitional care services with the ways that rural older adults construct their health.

7.2.2.3 Bed Flow Culture

Fluctuating definitions of patient-centred care are prominent in care provision (Higgins et al., 2016), outlining how paradigms are often interpreted differently by people at varying levels of the health care system (Evans et al., 2018; Grudniewicz et al., 2015; May et al., 2016; Valentjin et al. 2015; WHO, 2015). My dissertation supports this prior research by pointing to the predicament of attending to population health and individualized health simultaneously. In particular, analyzing rural older adult transitions in care reveals the conflict between utilitarian goals of the health care system and the

personal goals, preferences and needs of rural older patients. For example, bed flow culture is engrained into macro structures of care (e.g., quality management, funding allocation etc.) to ensure quick turn-over as well as minimize patients' length of stay and alternative level of care rates in hospital. In urban centres these bed flow priorities reduce wait-times (Murrell, 2020; Gonzalez et al., 2019; Destino et al., 2019), improve care access (Gonzalez et al., 2019) and patient safety (Pryce et al., 2021; Murrell, 2020) as well as address overcrowded emergency departments (Gonzalez et al., 2019; Murrell, 2020). On the other hand, in rural communities, bed flow priorities result in rural health professionals having to navigate moral dilemmas during transitions in care. Specifically, rural health professionals must weigh the negative impact of extended hospital stays on older populations (Calero-Garcia et al., 2017) with the detriment of discharging older patients to rural home environments with inadequate supports (e.g., does not support rural tasks required to age in place, few specialized programs, lack of affordable stratified housing). As such, rural health professionals sometimes choose to keep rural older patients in hospital longer or admit them despite their acute medical concerns being resolved. These actions of rural hospital staff aim to avoid the negative consequences of frequent readmissions and/or expedited/unsafe discharges that lead to the health deterioration of older populations in their region. Since quality indicators only track disease specific readmissions (HCSS, 2020), the detriment of bed flow priorities on rural older adult readmissions (e.g., older adults with chronic conditions, co-morbidities, social determinants of health, responsive behaviours, etc.) is not accounted for.

Moreover, bed flow priorities conflict with the strengths of rural areas. For instance, rural health professionals personalize the communication that they provide

during transitions in care, yet rural older adults still feel expedited through the health care system and experience pressure to accept care that does not align with the ways that they construct their health. Analyzing tensions across the care continuum, inter-sectoral conflict between rural health professionals is caused by the combination of bed flow priorities and the limited holistic care options to support older populations in rural areas. As such, hospital staff sometimes fall back on their acute or biomedical service mandates to not 'get stuck' with older patients for which their services and staffing ratios are not designed. Fostering the sharing of inaccurate patient information to circumvent other sector 'refusals', these circumstances lead to antagonism between rural health professionals who otherwise identify as having strong bonds and enhanced communication. Redressing these macro system priorities is then essential to embrace the strengths of rural health systems and better align transitional care services with rural older adult health construction.

This account of rural older adult transitions in care is critical to expose how prior research undervalues the influence of the rural care context as well as the spatiality and temporality of older patients' experiences. For example, contemporary research on bed flow or the link between hospitals and older adult health decline are exclusively conducted in urban settings and do not consider the breadth of literature on the detriment of older adult readmissions (Shebehe & Hansson, 2018; Fønss et al., 2021). As such, I challenge the acceptance of hospitals as definitively detrimental to the health of older populations and instead align myself with other health scholars who propose the need to redefine the divisive sectored, biomedical and episodic approach to care that devalues the needs of older populations in contemporary practice (Banerjee, 2015).

7.2.2.4 Systemic Ageism in Health Care

Health governance continues to ignore the pleas of researchers and health care providers to address systemic ageism engrained in longstanding structures of care (Kilaru & Gee, 2020). While more than 55% of older adults over 65 routinely access emergency care in Ontario (CIHI, 2010), hospitals continue to be acute episode focused employing a reactionary response that is detrimental to the aging population (Banerjee, 2015). Similarly, physicians recognize that 87-98% of their patients are older adults (Slade, Shrichand & DiMillo, 2019), yet the majority of physicians are still paid based on fee-for-service models that devalue the multi-morbidities and chronic conditions of older patients (Anumudu, Awan & Erickson, 2019). Finally, health professional training still minimally focuses on the facilitation of geriatric practice (Slade et al., 2019) despite the prevalence of older patients requiring care. This review of the literature points to the ineffectiveness of 'elderly friendly' initiatives within broader systems that continue to devalue older adults' needs (Karki, Barhatta & Aryal, 2015).

My dissertation substantiates prior research on the engrained nature of ageism within the health care system by establishing that the prioritization of sectored divisions, biomedicine, episodic care, bed flow priorities and urban centrism internalize ageism within rural health systems. In particular, these macro driven priorities establish rural older patients as barriers to health systems efficiency (Appendix G), which distracts attention away from the larger transformations needed to better attend to rural older adult health. This rhetoric is so engrained that older adults, themselves, are concerned about their strain on the system and experience deflation when they fail to fit the services provided (Banerjee, 2015). The consequences of ageism are then cyclical: older adults

avoid reaching out for support until the point of crisis, which increases the cost of care (Clarke et al., 2017; Levy et al., 2020) and perpetuates the stigmatization of older populations.

The implications of systemic ageism are pronounced during rural older adult transitions in care. For instance, health professionals embrace the need to respect the autonomy of patients (Sixsmith et al., 2017; Weeks et al., 2018) and yet there are few care options for rural older adults to actually exercise this right. These ageist prescriptions then generate conflict between loved ones and formal care providers due to the expectation that rural older adults will just accept this linear progression of biomedical care.

While rural health professionals use future planning as a means of protecting older patients from the negative ramifications of broader access issues, this approach requires rural older adults to plan for their potential future physical care needs which is not expected of any other age cohort. Even though rural older adults and informal supports attempt to reject ageism within the system (by evading or not determining their need to plan), these circumstances inadvertently result in the crisis nature of health care transitions (Magilvy & Congdon, 2001). Furthermore, since health is not a static concept, dynamic presentations of rural older adult health conflict with the rigidity of planning and are complicated by trajectories of health that cannot be accurately predicted or prescribed (Skilbeck, Arthur & Seymour, 2017). Ageism within the health system then leads to inefficient transitional care practices that do not embrace the heterogeneity or dynamism of rural older adult health.

The persistent connection between aging and physical decline is an interesting point of departure to examine ageism during rural older adult transitions in care. Care practices, clinical assessments and personal narratives reinforce constructions of aging that link older populations with medical deterioration and mortality (Kydd et al., 2018). These prescriptions of aging are heavily refuted by critical gerontologists due to their universalizing nature (Kydd et al., 2018). At the same time, my dissertation suggests that undervaluing the impact of physical health deterioration on aging populations negates the reality of some older people during transitions in care. For example, many rural older adults must prioritize their physical health after hospital discharge due to large travels distances associated with attending to their activities of daily living and their instrumental activities of daily living. Recognizing this paradox of not presuming that older adults will decline but supporting them during decline then presents the quandary of generating non-ageist rural transitional care.

Eisen asserts that the erasure of vulnerable populations and the acceptance of discrimination becomes the norm through the use of language in day-to-day life (Eisen, 2021). By analyzing the lexicon used during rural older adult transitions in care, my dissertation provides insight into how systemic ageism is overlooked in health care practice. In particular, rural health professionals use ageist language to safeguard themselves from the negative implications of broader aspects of the health system which are out of their control. In addition, phrases like ‘care refusal’ and ‘live at risk’ place judgments on rural older adults when their goals, needs or preferences do not fit the services or equipment provided. Research on ageism in health care then needs to move beyond fixating on the actions of front-line staff (Burnes et al., 2019; Rababa et al., 2020)

to abolish discriminatory practice (Rababa et al., 2020). Instead, I propose that the ageist language used by rural health professionals is representative of a larger systemic disregard of older populations within the health care system and within the education provided to health professionals. I then sympathize with rural health professionals who are routinely required to present undesirable care 'choices' to older patients during care transitions and argue that redressing macro facets of care (e.g., urban centrism, biomedicine, sectored divisions, bed flow, biomedical focus of health professional education etc.) may improve patients' experiences, while also addressing ageist health care culture.

7.3 Contributions to Research, Policy & Practice

Fostering transitional care services that align with the ways that rural older populations define their health and local care contexts may lead to improved experiences of transitions in care as well as efficiencies in rural health systems. I suggest, however, that this approach to transitional care services will require relationality (the interconnection between domains of care that are experienced concurrently) to be acknowledged more in research, policy and practice. Specifically, relationality will help to draw on the strengths of rural communities rather than focus solely on public service deficits during rural older adult transitions in care. This approach marks first steps toward aligning transitional care with the needs, preferences and goals of local populations and the diverse places in which older people live.

7.3.1 Contributions to Research

My dissertation suggests the need for theoretical and methodological reform to embrace a relational approach to research. In particular, research typically

compartmentalizes rural older adult transitions in care by discipline or care setting which undervalues the spatial and temporal dimensions of care experiences (See Elliott et al., 2014 and Brooks et al., 2021 for notable exceptions). Expanding transitions in care research to include patients' experiences across multi-leveled care contexts may expose the root causes of inequities experienced by and within rural older populations. For example, critical aging scholars routinely argue the need to combat neoliberalism that negatively associates decline and dependency with later life (Kotter-Gruhnet al., 2016; Stephens & Breheny, 2018; Chasteen & Cary, 2015). A relational approach to research would instead feature the injustices within the health system that render inequitable services for disabled (Iezzoni et al., 2021) and aging populations (Karki et al., 2015) particularly in rural areas (Siconolfi et al., 2019) as well as consider older adults' perceptions of dependency and disability (Tkatch et al., 2017). Taking a relational approach to research then elicits multi-leveled dialogue on later life by embracing the multidimensional contexts that produce spatial and temporal understandings of rural older adult health and care. In addition, this approach to research may assist with knowledge translation by challenging macro driven concepts (e.g., neoliberalism, protestant work ethic, social stratification, ageism etc.), while also providing support for the reality of later life experiences that are shaped by these broader constructions.

Advancing the application of the contested spaces paradigm, a relational approach to research considers that rural older adult transitions in care are not just defined by the tensions generated between human agents but are also shaped by opposing elements of rural care contexts (e.g., rural strengths vs. urban centrism, the biomedical model vs. holistic health construction, episodic medicine vs. chronic diseases/co-morbidities, and

utilitarian goals vs. patient goals, etc.) that polarize front-line practice. This relational approach to research advances rural gerontological health scholarship by altering conversations away from rural 'deficits' or 'romanticized' interpretations of rural care contexts to focus on the macro elements of care that do not readily align with the ways that rural older adults construct their health or the communities in which they live. Evolving knowledge on these conflicted spaces claims that rural health systems both enhance and inhibit rural older adults' care experiences simultaneously. For instance, older patients may value the smaller intimate community of care established in rural health systems, yet at the same time may describe the discrimination that they endure. This relational approach to research then confronts urban centric bias and interpretation of research that rarely presents rural care environments as more than just a setting in which research is conducted.

To support this pedagogical reform, new methods are needed to foster in-depth analysis. Thorne (2011) notes that modern health scholarship does not align with the contextual nuances of health settings or the variability of human experiences. This lack of critical application in health scholarship is propagated through research methods that rely heavily on participant insights and are based predominantly on personal narratives rather than the vicarious nature of stakeholder's experiences (Thorne, 2011). Certainly, contemporary methods assume that participants have in-depth and comprehensive knowledge of themselves, their interactions with others and the settings that shape their experiences, which reduces research outcomes to those that can be identified by participants (Thorne, 2011).

My dissertation redresses this methodological gap by exposing the interactional elements of rural older adult transitions in care across multiple scales. This contextually sensitive approach mirrors the spatiality and temporality of rural older adult transitions in care by leveraging the rural community inventory, go-alongs and semi-structured interviews. While each one of these qualitative approaches is beneficial, it is the concurrent use of these methods that expose the relationality of rural older adult transitions in care.

Evaluating the use of the three methods I used in my dissertation individually, the rural community inventory was particularly advantageous to expand rural gerontological health scholarship beyond deficit discourse. Specifically, rural scholars have long focused on the breadth of resources available in rural regions to support community residents (Halseth & Ryser, 2004), yet rural health research narrowly focuses on the implications of public service deficits (Poulin et al., 2020). While it is critical to critique the inequity and access issues experienced by rural residents, broadening knowledge on health resource availability to include social services, secular and non-secular community groups, private industry and local governance is an effective method to generate an appreciation of the rural and care context simultaneously. Surveying these community resources is pivotal to extend research beyond the confines of governmentally defined services and investigate experiences of formal and informal care simultaneously. Rural gerontological health methods must then better reflect that health care is not solely the provision of provincially funded services but a collaborative effort between older adults, communities, loved ones and health providers that are highly dependent on one another.

Appreciating this interdependence, the go-along method is vital to embrace the care experiences of older populations vary over time and place. Since health care practice and perceptions continually adjust to social, political, economic and human influences (Grudniewicz et al., 2015; May et al., 2016), the go-along method allows for a contextually sensitive account of these interacting elements. This relational approach to research expands inquiry beyond urban care provision or patient experiences within defined care settings or sectors. Benefiting from the use of an informed researcher, the go-along leverages the positionality of the principal investigator to improve analysis and knowledge translation. Since clinician's practice is second nature (Ross, Rogers & Duff, 2016), the go-along is also pertinent to document the factors of care that are highly engrained in front-line work routines (Ross et al., 2016) and provides observations of care experiences that may be difficult to articulate in words. The go-along then is conducive to the exploration of rural older adult health and care experiences across multiple scales and better accounts for the human systems established in complexity scholarship. Even though the go-along method is only just emerging in the health care field, my dissertation affirms the advantage of this relational approach to research in analyzing the nuances of front-line practice.

Although semi-structured interviews are common in health research, it is rare to include agents from all levels of the health system as well as patient and health professional perceptions simultaneously. Attempting to address this gap, I included participants from several layers of the health care system to minimize the bias of one type of stakeholder. Surely, feedback from only certain professional designations (Wang et al., 2018) or health consumers (Sims-Gould et al., 2017), reinforces divisions between health

professionals and hyper-focuses on the actions of front-line staff. The engagement of administrators, health professionals, ancillary staff, informal supports and older patients then generates a comprehensive account of rural older adult transitions in care and recognizes the value of multi-leveled interpretations of the same events.

In addition, the thematic coding I used was particularly germane to enhance the data analysis of my research findings. This approach to data analysis designated specific colours to the sources of the data obtained which allowed for the identification of themes that would not have been possible using other methods (e.g., the identification of divergent observations/perceptions between various levels of health care staff, health sectors, the comparison of the perceptions/observations of patients and health professionals, etc.). Using the colour-coding approach also allowed themes to be identified between observations and verbal data which presented the opportunity to analyze the discrepancy between participants' knowledge and their actions. This method then advances the field of implementation science by providing an avenue to expand methodological approaches to assist with knowledge translation. Augmenting the qualitative approaches typically used to examine rural older adult health and care, my methodological approach provides a multidimensional account of rural older patients' experiences over time and place.

7.3.2 Contributions to Policy

My dissertation reveals the contested spaces generated in rural health systems as a result of macro governance that is not effective in rural communities and does not align with the ways that rural older adults construct their health. Recognizing the value of rural places, considering relationality in policy challenges the multi-leveled dominance of

urban centrism, sectored divisions, biomedicine, bed flow culture and ageism that often overshadow the strengths inherent in rural communities. This focus on relationality emphasizes the need for broader health systems transformation by illustrating that macro care models reinforce inequities of and within rural older populations during transitions in care.

To attend to the misalignment of macro health systems, rural communities need to be better acknowledged as heterogeneous but equal to their urban counterparts at a provincial level. While Local Health Integration Networks distinguish rural health systems from urban centres, macro priorities, jurisdictional divisions, service allocation, staffing models, funding structures and quality management still impede rural health care providers from truly embracing integrated health care practices that fit the needs of local populations. For example, rural stakeholders are required to team up with distant counties to pilot integrative care projects at a provincial level (Government of Ontario, 2021a), since participation and applications require staffing resources that are not available in rural communities. Similarly, national, provincial and local governance employ different definitions of rural, yet the universalizing nature of these definitions rarely fit local contexts which leads to inequitable resource distribution in rural areas (Bennett et al., 2019). Rural deficits are then reinforced by broader care governance that does not allow for the integration, adaptation and innovation needed to support rural older adult transitions in care. Undoubtedly, provincial models of care accept rural experiences of displacement, home care inadequacies, long travel distances and large catchment areas as equivalent to the care provided in urban centres. Inequities of rural older populations are then overlooked by provincial governance that reinforce urban centrism in macro care

policies, priorities and structures. Considering relationality in policy lays bare the detriment of these rigidities and points to the need for flexibility and local control of rural health systems to better attend to the rural older populations that they serve.

Advancing discussions on systemic ageism, considering relationality in policy requires the reframing of older adults as impediments to system efficiency as this rhetoric distracts public attention away from the essential role of provincial governance in needed health systems restructuring. Unquestionably, health scholars indicate that the modern design of health care is half a century shy of requiring transformation and sectored divisions, episodic medicine and biomedical models are ineffective for the mass populations of older adults that they serve (Banerjee, 2015). Adding to this conversation, macro priorities of bed flow fuel the discrimination of older populations, especially in rural areas. Considering relationality in policy then acknowledges the multi-leveled impact of macro driven care and demonstrates the need for broader health systems transformation. Providing evidence to advocate for this health systems change, my dissertation offers a voice to rural health providers and older adults to challenge these macro health policies that perpetuate systemic ageism in health care practice.

Aligning rural health systems with rural communities and rural older adult health construction may also contribute to health systems efficiency. In particular, provincially driven priorities and structures impede the potential of integrating rural health systems and hampers the innovation potential of rural health care providers. My dissertation underlines how these misalignments foster the inefficient use of rural health services (e.g., frequent readmissions, early entry into long-term care, long hospital stays, etc.), lead to the redundant work routines of rural health professionals and place additional

strain on aging informal support networks in rural communities. My dissertation then inverts narratives of older adults as impediments to systems efficiency by suggesting that health care resources can be more efficiently used by designing health policy to better support the rural communities and the older populations that they serve. For example, policies that focus on patient flow could be adjusted to minimize hospital readmission rates of rural older people. Such a rural centric approach to health policy would draw on the enhanced collaboration of rural health care providers to minimize the use of costly hospital services while also better attending to the needs, preferences and goals of rural older people. Embracing the strengths of rural communities and the ways that rural older adults construct their health then has potential to redress urban centrism in health care policy that shapes rural older adult transitions in care.

Considering relationality in policy, however, must extend beyond health care since power differentials and the siloed practices of interprofessional team members lead to inefficiencies and interpersonal conflict during transitions in care. While health care scholars have demonstrated the need to improve education on interprofessional communication during transitions in care (Balogun et al., 2015), my dissertation exposes how professional bodies and educational institutions shape the biomedical care provided. Knowledge mobilization of my findings then must extend beyond the changes required within the health care system to foster transformation of health professional regulatory bodies and health professional education that influence care provision. It is only through considering relationality in policy that rural older adult transitional care can embrace the strengths of rural communities and better attend to the heterogeneity of rural older adult health.

7.3.3 Contributions to Practice

My dissertation establishes that formal health services must consider the heterogeneity of rural older adult health as an on-going process over time and place. This acknowledgment of relationality in practice requires the identification and redressing of front-line practices within and between care settings that more readily align with macro care models or service mandates rather than the rural older patients being served. For example, analyzing rural older adult transitions in care underscores the importance of tracking readmission rates, attending to the heterogeneity of rural older adult health (e.g., cognitive impairments, responsive behaviours, social needs, addictions, rurality, etc.) and providing follow-up after hospital discharge. In addition, considering relationality in practice appreciates the spatiality and temporality of care experiences, which may result in more efficient rural health care practice (e.g., reduce readmissions, care aversions, redundant information collection and transfer as well as misaligned work routines).

To embrace relationality in practice, the care options available to rural older adults during transitions in care must be expanded to provide rural older patients with opportunities to exercise their autonomy. Indeed, my dissertation highlights that current transitional care choices are bifurcated, which limits rural older adults to accept linear algorithms (i.e., a set of rules that determine if a patient qualifies for discharge resources) of biomedical care or none at all. I then suggest the need to expand transitional care services beyond public service deficits, to draw on the many informal and privately available supports in rural communities. In particular, rural communities are home to innovative collaborations, private businesses as well as secular and non-secular informal groups that are often not drawn upon during rural older adult transitions in care.

Leveraging these strong rural support systems while simultaneously advocating for macro systems change is then pivotal to enhance the transitional care provided in rural regions. Considering relationality in practice may lead to the identification of alternative care models that better align with rural older populations, which can then be proposed to the Ontario Health Teams as an alternative to the urban centric models currently employed.

Analyzing communication during rural older adult transitions in care yields insight into how to consider relationality in practice. For example, my dissertation uncovers that more concrete information about what to expect after discharge is needed, yet rural older adults and informal supports only identify the information they require after hospital discharge. Confirming the value of follow-up after hospitalization (Jackson et al., 2015), rural health professionals already endorse the need for this change by informally following up with older patients in the community. Much as web-based education (Sabir et al., 2019) and mobile apps (Crandall & Shake, 2016) might improve information transfer after hospital discharge in urban areas, these recommendations are likely not feasible in Haliburton County due to the limitations of broad band in the area. Alternatively, considering relationality in practice may expose the strengths of non-governmental supports in rural communities (e.g., the enhanced support provided by religious congregations, local high schools, informal community groups, etc.) that could be leveraged to provide follow up after hospital discharge. Confronting macro facets of care while simultaneously generating rural centric methods of care practice is then the key to providing more effective rural older adult transitions in care.

7.4 Limitations

In terms of limitations, the inclusion of participants with cognitive and physical impairments posed a challenge to interpreting the data. In particular, participants with cognitive impairments often provide short answers that may not be fully focused or can be open to interpretation (Cridland et al., 2016). Similarly, individuals with physical disabilities face barriers to participating in research, such as diminished hearing or speech. I minimized the impact of these limitations by capitalizing on the strengths of an ethnographic phenomenological method. Specifically, Murphy et al. (2014) recommend that observations and memos can ground the data obtained from individuals with cognitive impairments and improve the interpretation of research findings. I then used memos to record body language, reactions to others, if cueing was required and if the participant's responses could not be directly connected back to the questions I posed. I also used assistive devices, such as pocket talkers, and multiple shorter interview sessions to increase the ability of older participants to engage in my dissertation. Regardless of these approaches, it is still recognized that the inclusion of these older populations may have impacted my interpretation of the data collected.

Distinct from their urban counterparts, rural residents maintain overlapping relationships and a duality of roles that impact their participation in research and the accurate portrayal of their responses (Heslop, Burns & Lobo, 2018). Population size and limited positions in rural communities can also contribute to issues of anonymity (Strijker et al., 2020). Even with the rigorous methods I used to address these limitations, the threat of potential identification may have limited the responses of the participants. From an administrator/manager and front-line staff position, the participant responses may have

been altered due to fears of retribution from their employer. From a patient and informal support perspective, some participants might have feared that their responses would impact the care that they or their loved ones received.

There were low participant numbers in some sub-categories of the data I retrieved, which is reflective of research conducted in rural settings. For example, Haliburton Highlands Health Services has only 15 acute care beds and six administrators/managers. Furthermore, the 198 kilometres round trip to the research site (Haliburton County) played a role in limiting my interactions with potential participants despite my perseverance. Notwithstanding these limitations, the participation rates were high and represented the majority of those individuals who were eligible to participate (e.g., 5 out of 6 of the administrators/managers participated in my dissertation).

From a macro perspective, provincially mandated initiatives and long wait-lists for provincial services also played a role in limiting participation. Indeed, the Home First philosophy mandated by the Ontario government focuses on discharging older patients home to wait for long-term care (Government of Ontario, 2018b). This policy then decreased the number of older adult transfers that occurred directly from hospital into long-term care. In addition, long wait times for long-term care in the central east region of Ontario results in older adults waiting a median of 280 days in the community and 195 days in hospital for these services (Health Quality Ontario, 2021). Even with a seven month span dedicated to data collection, these wait-times greatly limited the number of patients that transferred to long-term care from hospital during the duration of my dissertation.

The participation of Haliburton Extendicare front-line staff and administrators/managers was limited only to phase two of the project. Despite the ethics approval from the organization, the corresponding administrator retired half way through my dissertation. The new administrator expressed that due to this change in leadership and extreme staffing shortages, the staff at Haliburton Extendicare could no longer participate in the semi-structured interviews. This interrupted participation illustrates the challenge of rural health care providers to seek out innovative approaches to rural care provision due to the implications of human resource deficits within the rural care context.

It should be noted that the Local Health Integration Network (LHIN) was invited to participate in my dissertation, however, after several months of correspondence, the board of ethics denied my ethics proposal even after the approval of three other formal ethics reviews. Ultimately, the board determined that the anonymity of the LHIN participant could not be adequately protected despite the rigorous methods detailed in my ethics proposal. The lack of participation by the LHIN was disappointing. Nonetheless, their absence from my dissertation is a prime example of the jurisdictional barriers and fragmentation of the health system that my dissertation has indubitably exposed.

The representation of populations who identify differently than the dominant norm is limited in my dissertation as I did not directly ask how the participants' identify. Although this question would have enriched my findings, I avoided this question to not expose the participants to highly sensitive conversations that would increase the maleficence of participating in my dissertation. Therefore, the data in my dissertation may have been limited by a lack of self-disclosure of participants who wish to avoid

categories of identification or who may construct their identities differently than the dominant norm.

Reflecting on the methods I employed in my dissertation, it is essential to note the draw backs of my research design. For example, even though my clinical background in health care was vital to generate a valuable data set, the transferability of my research design is limited since researchers without a clinical background may not produce the same quality of results. In addition, urban centrism impacted the data generated in the rural community inventory as I relied only on online sources. Although the community inventory produced an extensive account of the Haliburton care context, I retrospectively identified that community members likely use other communication mediums due to the limitations of broad band in the area. Surveying local information boards, newspapers and initiating conversation with rural residents may have generated a more comprehensive account of the rural care context. Moreover, due to the ever-evolving nature of on-line information by the time I completed the rural community inventory many of the data points were already out-of-date (e.g., websites, contact information, programs, services, etc.). Determining adaptive methods to account for the fluctuating nature of rural community services is then required to generate service inventories that do not become obsolete over time.

Experience bias likely impacted how I collected and interpreted the data since the pursuit of my dissertation was intentional to represent the voices of those who I had worked with and alongside. Shaw et al. (2020) reveal the positionality of researchers can lead to high hopes for certain research outcomes, yet my prior experience working in geriatrics was vital to the effectiveness of the go-along method (Hawkins & Poulin,

2019). As such, I used methods sanctioned by Johnston et al. (2016) to minimize my bias including: regularly assessing the usability, credibility, trustworthiness and auditability of the data collected (Johnston et al., 2016). This approach places value on the information provided by the participants and enables the final outcomes to accurately reflect the participant perspectives (Johnston et al., 2016). The process of asking clarifying questions was also useful to validate my observations and ensure that they truly reflected the perspectives and lived experiences of the participants.

Finally, transcribing the semi-structured interviews directly into encrypted documents may have also restricted the data collected and the analysis of my results. Specifically, without an audio recording of the semi-structured interviews, my interpretation of the transcripts could not be verified. Regardless of the steps I took to ensure an authentic account of the participant interviews (see chapter three), it is recognized that I may not have recorded or interpreted some of the data accurately. The reasoning for using these methods (see chapter three), however, far out-weigh these limitations.

7.5 Emergent Questions for Research, Policy and Practice

The complexity of rural older adult heath provides a foundation from which to expand research, policy and practice. Certainly, understandings of rural older adult health must advance beyond static or objective definitions to generate and support nuanced interpretations (Sturmberg et al., 2014). My dissertation augments the work of Sturmberg et al. (2014) by recognizing that health is an ever-evolving process, shaped by individual and broader contexts. Considering relationality (the interconnection between domains

that are experienced concurrently) in research, policy, and practice warrants further inquiry into how rural older peoples' personal hierarchies of health prioritization lead to the competing needs and preferences which can impact their care access and engagement. Since rural older populations who identify differently than the dominant norm experience health inequities (Whitehead et al., 2016; Butler, 2017), additional analysis of these contextual features may determine how local areas enhance and/or contribute to the oppression of these vulnerable populations in rural areas. This spatial and temporal interpretation of rural older adult health and care is then fundamental to future developments in the field.

Key to appreciating the relationality of health, is answering the calls of critical gerontologists to avoid the compartmentalization of aging experiences imposed by governments, professions and academics that do not support rural older adult transitions in care as an on-going experience over time. This multi-leveled analysis unearths the influence of macro approaches to care (e.g., sectored divisions, urban centrism, biomedicine, bed flow culture, ageism, etc.) that inscribe broader system goals into rural front-line practice. Further identifying how these macro facets conflict with the needs, preferences and goals of rural older people is then essential to effectively transform rural health systems to better support the older populations that they serve.

Even though rural communities can be ideal environments to enhance rural older adult transitions in care, rural health discourse fixates on deficits and inequities in an attempt to catalyze change on a policy level. Attempts to redress this deficit focus of rural health research has often romanticized rural communities, leading to binary depictions of rural care contexts (Poulin et al., 2020). My dissertation alters these narratives by

revealing the short falls of macro elements, which restrict the potential and innovation possible in rural health systems. Notably, quality performance, funding allocation, system priorities, educational institutions and professional regulatory bodies distract attention away from the strengths of rural areas and the needs, preferences and goals of rural older patients. Identifying and leveraging the strengths of rural communities is then pivotal to generate rural centric health care practice that effectively and efficiently support rural older adult transitions in care.

As a starting point, Table 8.1 presents emerging questions for research, policy and practice that align with my dissertation objectives and signify new directions to expand both national and international knowledge on rural older adult transitions in care. Specifically, three future priorities are critical to embrace relationality: 1) identify relational models of care 2) redress the misalignment of macro health systems and 3) establish multi-leveled symbiotic relationships. I then further explore these themes in the succeeding sub-sections.

7.5.1 Identifying Relational Models of Rural Older Adult Transitions in Care

To embrace relational models of transitions in care, health care providers, researchers and policy makers must appreciate the on-going experiences of rural older adults and identify contextually sensitive care models that more readily align with rural older adult health. While rural health providers should take the lead on developing relational models of transitions in care, further research may be essential to introduce rural administrators to alternative models of care that may be more fitting in their rural areas and assist rural care providers to identify strengths that may help to better support rural older adult transitions in care.

Identifying relational models of rural older adult transitions in care may also require attention to patient data inefficiencies within and between care settings. This focus on data management queries how health technology might enhance rural older adult transitions in care by redressing the repetitious collection and synthesis of patient information. Exploring health technologies is then pivotal to reduce inefficiencies and limit the misalignment of information collection, transfer and use across the care continuum (Chouvarda et al., 2015). Although Ontario has recognized the need to embrace health technologies, funding is being allocated to pilot projects that reinforce sectored divisions of care and/or are disease specific (Government of Ontario, 2017), which are counter-intuitive to the effective care of geriatric populations (Banerjee, 2015), especially in rural areas. I then advocate for relational models of rural older adult transitions in care to enhance health technology and data management rather than contributing further to rural health system inefficiencies by using urban centric approaches to care provision.

To assist policy makers to realize the need to embrace relational models of rural older adult transitions in care, rural care providers should identify how these rural centric approaches reduce older patients' reliance on formal services. For example, tracking readmissions and providing follow-up are avenues that allow for the recording of transitional care experiences over time and place. Researchers can then support relational models of rural older adult transitions in care by evaluating the efficacy (e.g., financial benefits, improvements in work routines, quality of care, etc.) of aligning rural health systems with the ways that rural older adults construct their health and the communities in which they live.

7.5.2 Redressing the Misalignment of Macro Health Systems

Although it is essential to identify relational models of rural older adult transitions in care, implementing these models may require identifying and redressing the misalignment of macro elements of care at a policy level. Performing an audit of rural practices may then be necessary to document aspects of rural care provision that more readily reflect macro influences. This multi-leveled analysis may be pivotal to identify aspects of policy, jurisdiction, performance management, funding allocation and system priorities that do not readily align with the ways that rural older adults construct their health or the communities in which they live. Researchers can support relational models of rural older adult transitions in care by quantifying the inappropriate use of current health services and generating tools which help rural care providers to establish the negative ramifications of macro care models in rural areas. For instance, a tool that evaluates administrative decisions, processes and procedures for the prevalence of macro care priorities would assist rural health providers to ensure their practices are continually adapting to better fit the older populations that they serve.

Embracing these changes may require redressing the rigidity of health care governance to foster adaptability on a regional level. As complexity scholars suggest flexible care services are needed to actively adjust to patients' needs over time and place (May et al., 2016). This approach shifts health governance away from bureaucratic and top-down policies to empower local communities to provide holistic care. Establishing avenues to represent the voices of rural older populations, this approach ensures input from vulnerable populations that are not currently being heard. Resulting in informed

rather than prescribed services, rural communities are then empowered to adapt services to better fit the heterogeneity and dynamic nature of rural older adult health.

While government recognition of flexibility is essential to adapt front-line practice, professional bodies, educational institutions, accreditation agencies, unions and other broader entities that influence care need to recognize their role in embracing relational models of rural older adult transitions in care. For example, the College of Nurses of Ontario works regularly with the Ministry to alter the scope of front-line practice and yet these suggestions to alter front-line practice maintain the prioritization of physical and biomedical care in nursing roles (College of Nurses of Ontario, 2021b). Similarly, health professional practice is dominated by caring for older populations but university programs typically only offer specializations and courses in aging rather than integrating geriatric and social care into all elements of health professional education. The on-going identification and redressing of these misalignments is then fundamental to improve rural older adult transitions in care.

7.5.3 Establishing Symbiotic Multi-Leveled Partnerships

The realization of relational models of rural older adult transitions in care may require researchers, policy makers and health care providers to engage in symbiotic relationships. While previous studies have advocated for increased health care placements in rural areas (Johnson, Wright & Foster, 2018), the majority of placements in the health care field are provided only to university students in a few academic disciplines. Establishing health care placements for students beyond the health professions (e.g., computer science, engineering programs, the trades, etc.) then represents the next step in providing valuable practical education. This approach fosters

innovation in rural health care practice by leveraging knowledge from different disciplines to enhance the care provided. Similarly, regional seniors' organizations can fulfil their organizational mandates by forging partnerships with rural care providers and sharing their expertise in comprehensive geriatric care interventions. These partnerships can increase health professional competencies in comprehensive geriatric assessment, while increasing regional organizations' deliverables as regional experts on geriatric care. Symbiotic partnerships are then essential to support relational models of rural older adult transitions in care.

Local partnerships may also be pivotal to ensure that all rural residents champion relational models of rural older adult transitions in care. Certainly, the holistic health of rural residents can be enhanced during older adult transitions in care through synergetic partnerships between formal and informal care providers (e.g., public services, community services, private businesses, secular community groups, non-secular community groups, educational institutions, research partners, etc.). For example, formal care providers may benefit from establishing award programs for high school volunteers that support the holistic health of older adults in the community. Since rural health placements increase the retention of health professionals (Smith et al., 2017), a program of this nature may also rectify human resource deficits that are common in rural areas. Similarly, since prior research has emphasized that Power of Attorney/Substitute Decision Maker roles are all-encompassing (Fitzpatrick & Grace, 2019), engaging informal supports that are not authorities of care may be useful to support patients with non-medical aspects of health that are not well attended to in current models of rural

older adult transitions in care. Recognizing the benefits of symbiotic partnerships fosters collaboration to establish relational models of rural older adult transitions in care.

Table 7.1 Emergent Questions for Research, Policy and Practice

Research Objectives	Emergent Questions for Research	Emergent Questions for Policy	Emergent Questions for Practice
1. Older Adult Health Construction	-Do populations who identify differently than the dominant norm exist in rural regions and if so are they experiencing health and care inequities? -What insight can be gained from analyzing the competing health priorities of older adults on care access and engagement?	-How can policy be tailored to the personal goals, needs and preferences of rural older people while still providing care for the collective? -How can policy be adapted to reflect the voices of older patients who are not currently being represented? -What role can the understanding of older adult health construction play in adapting health policy and governance at all levels to better support regionalized health care?	-How can the recognition of older adult health construction support new models of care in rural regions? -Who will challenge, advocate and lead new approaches to service provision that better support relational understandings of older adult health?
2. Multidimensional Contexts	-What other contested spaces exist in rural health systems (e.g., biomedical models vs. holistic health construction, rural strengths vs. macro care governance, enhanced rural interprofessional collaboration vs. sectored divisions, etc.)? -What are the financial incentives of health integration in rural regions? -What barriers exist to establishing a relational approach to rural older adult transitions in care (that consider the heterogeneity of rural older adult health construction and the	- What is needed by the provincial government to foster health system transformation to reconstruct modern structures and priorities of care provision to embrace a relational approach to rural older adult transitions in care? -How could national and provincial governments better acknowledge the need for flexibility within rural health systems?	-What are the strengths of rural health systems and what community solutions can be generated to reflect rural strengths and the older populations that they serve? -How can health technology be used to enhance transitional care provision?

	multidimensional rural care context) and what supports are needed?		
3. Transitional Care Experiences of Older Adults	-How can the relational approach to research used in my dissertation be leveraged to expand knowledge of older adult experiences across the care continuum? -What models of care could be developed to support older patient experiences over time and place?	-How can macro health policy and governance better align with the on-going experiences of older patients over time and place? -What partnerships can be made between high-level and local-level decision makers to focus on continuity of care?	-How does tracking readmission rates and providing follow-up after hospital discharge improve older adult care experiences in rural areas? -How can recognizing transitions in care as a process over time and place better support the holistic health of rural older peoples' experiences?
4. The Interplay	-What tools can be developed to help rural health care providers to evaluate their administrative decisions and identify front-line practices that more readily align with macro care models? -What alternative care models already exist or could be adapted to better support rural older populations across the care continuum? -What quantitative research methods could be developed to better reflect spatial and temporal understandings of older adult health and care in rural communities?	-What role can regional seniors' organizations play in supporting relational models of rural older adult transitions in care? -What role can regionalized health authorities play in supporting rural health systems to embrace relational models of rural older adult transitions in care?	-What elements of practice do not readily align with the heterogeneity and dynamism of rural older adult transitions in care? -What mutually beneficial partnerships can be generated both within and external to rural communities to support relational rural older adult transitions in care models? -How do professional bodies, educational institutions, accreditation agencies, unions and other broader entities need to change to embrace relational models of rural older adult transitions in care?

7.6 A Foundation of Information and Recommendations

This section summarizes the overall findings and recommendations generated from my dissertation. Since leveraging feedback from rural residents is pertinent to produce relational models of rural older adult transitions in care, the first set of recommendations reflects common ideas from the semi-structured interviews to assist the community partners to consider ideas generated by local stakeholders. Recommendations specifically for Haliburton Highlands Health Services and Seniors Care Network have also been generated in accordance with the different needs of these organizations.

7.6.1 Findings on Rural Older Adult Health

- Rural older adult health shifts both within and between care settings in response to the rural care context (e.g., community connection, topography, economic status, cost and access to supports for health, high cost of living, stigma, etc.) and individual preferences (e.g., religion, independence, solitude, etc.).
- Rural older adult health is conflicted (e.g., pursuit of independence vs. dependency, identification of holistic aspects of health vs. actions that prioritize biomedical aspects of health, etc.).
- Holistic facets of rural older adult health are highly interconnected, which makes them difficult to identify and difficult to attend to in practice.
- Older adult health is heterogeneous. Not everyone agrees on the same elements that construct older adult health and not everyone has access to the same resources (e.g., informal supports, finances, transportation, etc.) to support their health.
- There is a lack of recognition of diversity in Haliburton County and the ways that gender, sexuality and ethnicity influence older adult health.

7.6.2 Findings on the Rural Care Context

- The rural care context has many strengths (e.g., strong relationships between rural health professionals, smaller, more integrated health systems, community connection, supportive informal support network, a plethora of informal and formal services to attend to the social determinants of health, etc.) that are routinely overshadowed by macro facets of the health care system (e.g., sectored divisions, biomedical and urban prioritization, bed flow priorities, systemic ageism, etc.).
- Care governance does not consider the heterogeneity of rural older adult health construction (e.g., rurality, holistic aspects of health, agency, responses to care, economic status, access to informal support, etc.) or the rural care context (e.g.,

high cost of living, topography, rural tasks required to age-in-place, human resource barriers, service housing limitations, etc.) which results in increased strain being put on rural informal supports to fill the gaps in publicly provided care.

- Information transfer on patients both within and between care settings is ineffective (e.g., biomedically focused, inaccurate, tailored to eligibility criteria or out of date, etc.) and inefficient (health professionals both within and between care settings are initiating brand new assessments on patients).
- System priorities in hospital (e.g., bed flow, biomedicine, acuity, etc.) lead to rural health professionals facing moral dilemmas of either attending to the utilitarian goals of the health care system or the needs, preferences and goals of rural older patients.
- Many residents within Haliburton County do not recognize their own diversity and/or how diverse identities shape health and care.

7.6.3 Rural Older Adult Experiences of Transitional Care

- The strengths inherent in the rural care context enhance the transitional care experiences of rural older adults by routinely adapting care provision to the heterogeneity of rural older adult health and the rural care context (e.g., increased personalized communication and care, informal follow up, etc.).
- Macro facets of the rural care context (e.g., bed flow and acuity priorities, health professional designations, sectored divisions, systemic ageism, urban centrism, biomedicine, linear algorithms of care, etc.) lead to poor transitional care experiences of rural older adults (e.g., repeat their information frequently within and between care settings, unprepared for what to expect after hospital discharge, accelerated/delayed/unsafe discharges, do not reach out for help after hospital discharge, no support for holistic facets of health or the tasks required to age-in-place, pressures to accept discharges or services that do not align with how they construct their health, etc.).
- Macro facets of care make it challenging for rural health professionals to attend to the heterogeneity and dynamism of rural older adult health (e.g., health literacy, cognitive abilities, human agency, preferences, facets of health beyond biomedicine, identity construction, etc.) and lead to intersectoral/interpersonal conflict and ageism during transitions in care.
- These macro facets of care combined with the limited services and housing options available in rural areas leads to common transitional care events that lead to the health decline of rural older adults: 1) move out-of-county to obtain adequate levels of care, 2) remain in hospital longer due to the unavailability of appropriate care, 3) seek out long-term care services prior to requiring 24 hour support 4) are readmitted back to hospital and/or 5) just accept the home care available in the region even though it does not fit their care needs.
- Rural older adults with affluence are able to avoid these common transitional care events by paying for care beyond what is provided publicly. In contrast, rural

older adults with lower economic statuses must prioritize their money to support their health which often results in them not accessing supports after hospital discharge.

- Being connected with the church and/or well-integrated within the community increases the informal support available to rural older adults during transitions in care. This informal support fills in the gaps of publicly available care services during transitions. On the other hand, not all older patients benefit from increased community connection (e.g., stigma, stereotypes of individuals who identify differently than the dominant norm, etc.).

7.6.4 Recommendations from the Project Participants

- There needs to be better recognition that health is an on-going experience that cannot be compartmentalized by setting or professional discipline.
- Health services need to reflect: care beyond physical/medical conditions, health prevention, chronic care management and individual patient's needs.
- Care transitions are not 'just a transfer', but a huge life change.
- More effective information transfer is needed between care settings.
- Collaborative care planning with patients and informal supports is ideal.
- Follow-ups after hospital discharge are important.
- Informal supports that are not the power of attorney are an untapped resource and these individuals want more of a role in the transitional care process.
- There is a need for alternative housing between community and long-term care and a staff member that supports transitions between care settings would be helpful.
- Technology is underutilized during transitions in care.
- Increased use of respite beds in the county would assist with older adult transitions into long-term care.

7.6.5 Recommendations for Haliburton Highlands Health Services

- Further identify and leverage the strengths within Haliburton County to increase collaboration between publicly available health and social services, private businesses, not-for-profits and informal community groups to enhance support during transitions in care (e.g., attention to holistic aspects of health, rural tasks required to age in place, follow up between care settings, what to expect after discharge, etc.) and to fill the gaps in publicly available care (e.g., limited specialized services, human resource barriers, accessible/affordable housing, stratified care options, etc.).
- Increase rural health professional education on Comprehensive Geriatric Assessments and redress aspects of work routines that limit attention to holistic aspects of health regardless of care sector (e.g., bed flow priorities, acuity, biomedicine, etc.).

- Track emergency room visits and hospital readmissions of all older adults and more concretely identify why they require readmission.
- Establish mechanisms of information transfer between rural health professionals both within and between care settings that reduce repetitive patient information collection and inaccuracies (e.g., intersectoral collaborative care planning). For example, adapting the Comprehensive Geriatric Assessment to fit the Haliburton context could provide a common assessment for all health professionals regardless of care sector or health designation. One care plan for each patient should be continually adjusted rather than a brand new assessment be initiated each time a patient is admitted. Ensure that informal supports also have access to view and add to these care plans.
- Explore diversity within Haliburton County and how it shapes rural older adult experiences of health and care differently than the dominant norm.
- Develop a whistle blowing system that allows all administrators/managers, health professionals, older patients and informal supports to identify facets of care that impede the autonomy and agency of rural older adults during transitions in care.
- Develop a whistle blowing system that allows all administrators/managers, health professionals, older patients and informal supports to identify facets of care that are ineffective and/or lead to inefficiencies in transitional care provision.
- Develop a whistle blowing system that allows all administrators/managers, health professionals, older patients and informal supports to identify facets of care that limit the flexibility of rural health professionals to attend to the heterogeneity and dynamic nature of rural older adult health.
- Create a local communication strategy with local seniors' advocacy groups and the Seniors Care Network to routinely present these macro barriers of care to governing bodies (municipal, provincial and federal). Advocate to redress these macro barriers and reallocate funding to the localized collaborations proposed.

7.6.6 Recommendations for Seniors Care Network

- Work with care providers in Haliburton County to develop a whistle blowing system that allows administrators/managers, health professionals, older patients and informal supports to routinely point out aspects of health care provision that impede the autonomy and agency of rural older adults during transitions in care.
- Work with care providers in Haliburton County to develop a whistle blowing system that allows administrators/managers, health professionals, older patients and informal supports to routinely point out aspects of health care provision that are ineffective and/or lead to inefficiencies during rural older adult transitions in care.
- Work with care providers in Haliburton County to develop a whistle blowing system that allows administrators/managers, health professionals, older patients and informal supports to routinely point out aspects of health care provision that limit the flexibility of rural health professionals to attend to the heterogeneity and dynamic nature of rural older adult health.

- Help implement these whistle blowing systems in other rural communities to generate data to support the need for macro health systems transformation.
- Work with care providers in Haliburton County and other rural communities to develop a communication strategy to advocate for macro health systems change in rural communities using the findings from my dissertation and the findings from the whistle blowing systems developed.
- Conduct research on the diversity within and between rural older populations to establish how identity construction shapes older adult experiences of health and care.
- Provide Comprehensive Geriatric Assessment education to health professionals in Haliburton County to increase comfort in collecting and transferring information beyond biomedical health and care.

7.7 Final Thoughts

My dissertation establishes the need for macro health systems reform by uncovering the relationality of rural older adult transitions in care. While rural health systems have many strengths they are often overshadowed by the implications of macro aspects of care that hinder rural health care providers from attending to the heterogeneity of rural older adult health and the nuances of rural care contexts. This macro driven approach leads to inefficiencies in rural health systems and older adult care aversions during transitions in care. Much as the spread of COVID-19 has precipitated politicians, health experts and the media to engage in conversations about older adult health and care, current proposals for policy reform perpetuate national standards (HSO, 2021) and provincial investments into sectored care (Government of Ontario, 2021b). These top-down approaches work within rather than reinvent the macro systems that structure geriatric care provision. I then align myself with health scholars and seniors advocates that propose the need for broader health systems transformation in Canada (Banerjee, 2015; Seniors for Social Action, 2021) and suggest that this contemporary climate can act as the catalyst to align health services with the diversity of the older populations being

served. Embracing this relational approach marks next steps in transforming our health care system by drawing on local strengths to provide quality care for aging populations now and for generations to come.

8 References

Abelson, J., Allin, S., Grignon, M., Pasic, D., & Walli-Attaei, M. (2017). Uncomfortable trade-offs: Canadian policy maker's perspectives on setting objectives for health systems. *Health Policy, 121*, 9-12. doi: https://doi.org/10.1016/j.healthpol.2016.10.007

Abelson, M. J. (2016). 'You aren't from around here': race, masculinity, and rural transgender men. *Gender, Place & Culture*, 23(11), 1535-1546. doi: 10.1080/0966369X.2016.1219324

Allen, J., Hutchison, A., Brown, R., & Livingston, P. (2017). User experience and care integration in transitional care of older people from hospital to home: A meta-synthesis. *Qualitative Health Research, 27*(1), 24-36. doi: https://journals.sagepub.com/doi/pdf/10.1177/1049732316658267?casa_token=gGXdUws7LFwAAAAA:sUddR2mVIT7f7D8Ay-fcF7Yab0nZJaEVNu5GSBJiwWOctgPCsbbMk6VntSNE8QyPrY6Di-Ej-W8S

Allen, J., Hutchinson, A. M., Brown, R., & Livingston, P. M. (2020). Communication and coordination processes supporting integrated transitional care: Australian healthcare practitioners' perspectives. *International Journal of Integrated Care, 20*(2). doi: 10.5334/ijic.4685

Anumudu, S. J., Awan, A. A., & Erickson, K. F. (2019). Do salaried physician specialists provide less care to patients with chronic disease? *JAMA Network Open, 2*(11), e1914885. doi:10.1001/jamanetworkopen.2019.14885

Araujo de Carvalho, I., Epping-Jordan, J., Pot, A. M., Kelley, E., Toro, N., Thiyagarajan, J. A., & Beard, J. R. (2017). Organizing integrated health-care services to meet

older people's needs. *Bulletin of the World Health Organization*, 95(11), 756–763. doi: https://doi.org/10.2471/BLT.16.187617

Atewologun, D. (2018). Intersectionality Theory and Practice. *Oxford Research Encyclopedia of Business and Management.* doi: https://oxfordre.com/business/view/10.1093/acrefore/9780190224851.001.0001/acrefore-9780190224851-e-48.

Ayalon, L., & Tesch-Romer, C. (2018). *Contemporary perspectives on ageism*. Cham, Switzerland: Springer International Publishing.

Balogun, S. A., Rose, K., Thomas, S., Owen, J., & Brashers, V. (2015). Innovative interprofessional geriatric education for medical and nursing students: focus on transitions in care, *QJM: An International Journal of Medicine*, 108(6), 465–471. doi: https://doi.org/10.1093/qjmed/hcu226

Banerjee, S. (2015). Multi-morbidity-older adults need health care that can count past one. *The Lancet,* 385(9969), 587-589. doi: https://doi.org/10.1016/S0140-6736(14)61596-8

Barclay, L., & Phillips, A. (2018). Rural and remote health research: Does the investment match the need? *The Australian Journal of Rural Health*, 26, 74-79. doi: https://doi.org/10.1111/ajr.12429

Barello, S., Graffigna, G., Vegni, E., & Bosio, C. (2014). The challenges of conceptualizing patient engagement in health care: A lexicographic literature Review. *Journal of Participatory Medicine, 6*(e9). doi: https://www.researchgate.net/profile/Serena-Barello/publication/263088534_The_Challenges_of_Conceptualizing_Patient_En

gagement_in_Health_Care_A_Lexicographic_Literature_Review/links/02e7e539f4fd3196b4000000/The-Challenges-of-Conceptualizing-Patient-Engagement-in-Health-Care-A-Lexicographic-Literature-Review.pdf

Barker, P., & Church, J. (2017). Revisiting health regionalization in Canada: More bark than bite? *International Journal of Health Services, 47*(2), 333–351. doi: https://doi.org/10.1177/0020731416681229

Barreto, E. A., Guzikowski, S., Michael, C., Carter, J., Betancourt, J. R., Tull, A., Tan-McGrory, A., & Donelan, K. (2021). The Role of Race, Ethnicity, and Language in Care Transitions. *American Journal of Managed Care*. 27(7), e221-e225.

Barrett, C., & Hincliff, S. (2018). *Addressing the sexual rights of older people: Theory, policy and practice*. New York, NY: Routledge.

Bastos, J., Harnois, C., & Paradies, Y. (2016). Health care barriers, racism, and intersectionality in Australia. *American Journal of Preventative Medicine. 50*(6), 746-755. doi: https://doi.org/10.1016/j.socscimed.2017.05.010

Batuecas-Caletrío, J., & Rodríguez-Martín, B. (2020). Family and personal coping process after a haemorrhagic stroke, a life-history. *Current Psychology*. https://doi.org/10.1007/s12144-020-01204-2

Baxter, R., O'Hara, J., Murray, J., Sheard, L., Cracknell, A., Foy, R., Wright, J., & Lawton, R. (2018). Partners at Care Transitions: exploring healthcare professionals' perspectives of excellence at care transitions for older people. *BMJ Open*, 8(9), e022468. doi: 10.1136/bmjopen-2018-022468

Bayliss, E., Ellis, J., Shoup, J., Zeng, C., McQuillan, D., & Steiner, J. (2015). Effect of continuity of care on hospital utilization for seniors with multiple medical conditions in an integrated health care system. *Annals of Family Medicine, 13*(2), 123-129. doi: https://www.annfammed.org/content/annalsfm/13/2/123.full.pdf

Bell, S., Foley, R., Houghton, F., Maddrell, A., & Williams, A. (2018). From therapeutic landscapes to health spaces, places and practice: A scoping review. *Social Science & Medicine, 196*, 123-130. doi: https://doi.org/10.1016/j.socscimed.2017.11.035

Bennett, K.J., Borders, T.F., Holmes, G.M., Kozhimannil, K.B., & Ziller, E. (2019). Implications of definitions that inadequately encompass rural people and places. *Health Affairs, 38*(12). doi: https://doi.org/10.1377/hlthaff.2019.00910

Biggs, S., Hendricks, J., & Lowenstein, A. (2020). *The need for theory: Critical approaches to social gerontology.* Routledge.

Blair, A., Bateman, C., & Anderson, K. (2019). "They take a lot of pressure off us": Volunteers reducing staff and family care burden and contributing to quality of care for older patients with cognitive impairment in rural hospitals. *Australasian Journal on Ageing, 38*, 34-45. doi: https://doi.org/10.1111/ajag.12612

Blum, M. R., Oien, H., Carmichael, H. L., Heidenreich, P., Owens, D. K., & Goldhaber-Fiebery, J. D. (2020). Cost-Effectiveness of Transitional Care Services After Hospitalization with Heart Failure. *Annals of Internal Medicine,* 172, 248-257. doi: 10.7326/M19-1980

Borkowski, N., & Meese, K. (2021). *Organizational behavior in health care.* Burlington, MA: Jones & Barlett Learning.

Brassolotto, J., Caspar, S., Spenceley, S., & Hanley, C. (2020). Long-Term Care in Rural Alberta: Exploring Autonomy and Capacity for Action. *Journal of Long-Term Care*, 80-90. doi: https://doi.org/10.31389/jltc.31

Bree, R.T. & Gallagher, G. (2016). Using Microsoft Excel to code and thematically analyse qualitative data: a simple, cost-effective approach. *All Ireland Journal of Higher Education*, 8(2), 2811-28114.

Brinkmann, S. (2018). The interview. In Denzin, N. & Lincoln, Y. (Eds.), *The SAGE Handbook of Qualitative Research*, Thousand Oaks, CA: SAGE Publications, Inc.

Brooks, L., Stolee, P., Elliott, J., & Heckman, G. (2021). Transitional Care Experiences of Patients with Hip Fracture Across Different Health Care Settings. *International Journal of Integrated Care,* 2(2).

Buccieri, K. (2016). Integrated social housing and health care for homeless and marginally housed individuals: A study of the housing and homelessness steering committee in Ontario, Canada. *Social Sciences, 5*(2),15. doi: https://doi.org/10.3390/socsci5020015

Buck, H., Harkness, K., Wion, R., Carroll, S., Cosman, T., Kaasalainen, S., Krworuchko, J., … Arthur, H. (2015). Caregivers' contributions to heart failure self-care: A systematic review. *European Journal of Cardiovascular Nursing, 14*(1), 79-89. doi: https://doi.org/10.1177/1474515113518434

Burholt, V., & Dobbs, C. (2012). Research on rural ageing: Where have we got to and where are we going in Europe? *Journal of Rural Studies, 28*(4), 432-446. doi: https://doi.org/10.1016/j.jrurstud.2012.01.009

Burnes D., Sheppard, C., Henderson C.R., Wassel, M., Cope, R., Barber, C., & Pillemer, K. (2019). Interventions to reduce ageism against older adults: A systematic review and meta-analysis. *American Journal of Public Health,109*(8), e1-e9. doi: https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2019.305123

Butler, S. (2017). LGBT aging in the rural context. *Annual Review of Gerontology & Geriatrics, 37*(1). doi: 10.1891/0198-8794.37.127

Caldwell, J. T., Ford, C. L., Wallace, S. P., Wang, M. C., & Takahashi, L. M. (2016). Intersection of living in a rural versus urban area and race/ethnicity in explaining access to health care in the United States. *American Journal of Public Health, 106*(8), 1463-1469. doi: https://doi.org/10.2105/AJPH.2016.303212

Calero-Garcia, M. J., Ortega, A. R., Navarro, E., & Calero, M.D. (2017). Relationship between hospitalization and functional and cognitive impairment in hospitalized older adults patients. *Aging & Mental Health, 21*(11), 1164-1170. doi: https://doi.org/10.1080/13607863.2016.1220917

Canadian Institute for Health Information (CIHI). (2010). *Seniors' use of emergency departments in Ontario 2004-2005 to 2008-2009.* https://secure.cihi.ca/free_products/seniors_ed_e.pdf

Canadian Institutes of Health Research (CIHR) (2017). *Transitions in Care*. Distributed at the CIHR Transitions in Care Strengthening Workshop, Toronto, ON.

Canadian Public Health Association. (2021). *What are the social determinants of health?* https://www.cpha.ca/what-are-social-determinants-health

Carey, G., & Crammond, B. (2015). Systems change for the social determinants of health. *BMC Public Health, 15*(662), 1-10. doi:10.1186/s12889-015-1979-8

Carney, G., & Gray, M. (2015). Unmasking the 'elderly mystique": Why it is time to make the personal political in ageing research. *Journal of Aging Studies, 35,* 123-134. doi: https://doi.org/10.1016/j.jaging.2015.08.007

Chasteen, A., & Cary, L. (2015). Age stereotypes and age stigma connections to research on subjective aging. *Annual Review of Gerontology and Geriatrics, 35*(1), 99-119. doi: http://dx.doi.org/10.1891/0198-8794.35.99

Chisholm-Burns, M., Spivey, C., Hagemann, T., & Josephson, M. (2017). Women in leadership and the bewildering glass ceiling. *American Journal of Health-System Pharmacy, 4*(3), 312-324. doi: https://doi.org/10.2146/ajhp160930

Choi, B., Blumberg, C., & Williams, K. (2016). Mobile integrated health care and community paramedicine: An emerging emergency medical services concept. *Annals of Emergency Medicine, 67*(3), 361-366. doi: https://doi.org/10.1016/j.annemergmed.2015.06.005

Chouvarda, I. G., Goulis, D. G., Lambrinoudaki, I., & Maglaveras, N. (2015). Connected health and integrated Care: Toward new models of chronic disease management. *Maturitas, 82*(1), 22-27. doi: https://doi.org/10.1016/j.maturitas.2015.03.015

Chrisler, J., Barney, A., & Palatino, B. (2016). Ageism can be hazardous to women's health: Ageism, sexism, and stereotypes of older women in the healthcare system. *Journal of Social Issues, 72*(1), 86-104. doi: 10.1111/josi.12157

Clark, K., & Veale, B. (2019). Strategies to enhance data collection and analysis in qualitative research. *Radiologic Technology*, *89*(5), 482-485. doi: 10.1136/

Clarke, J., Bourn, S., Skoufalous, A., Beck, E., & Castillio, D. (2017). An innovative approach to health and care delivery for patients with chronic conditions. *Population Health Management,* 20(1), 23-30. doi: 10.1089/pop.2016.0076

Cockerham, W. (2016). *Medical sociology. (13th Edition).* Routledge: New York, NY.

College of Nurses of Ontario. (2021a). *Practice standard.* https://www.cno.org/globalassets/docs/prac/41001_documentation.pdf

College of Nurses of Ontario. (2021b). *Scope of practice: Proposed changes.* https://www.cno.org/en/learn-about-standards-guidelines/scope-of-practice--proposed-changes/

College of Physicians and Surgeons of Ontario (CPSO). (2021). *The Practice Guide*. https://www.cpso.on.ca/admin/CPSO /media/Documents/physician/polices-and-guidance/practice-guide/practice-guide.pdf

Collingridge, D. & Gantt, E. (2019). The quality of qualitative research. *American Journal of Medical Quality, 34*(5) 439–445. doi: https://journals.sagepub.com/doi/pdf/10.1177/1062860608320646?casa_token=8afsJQWi6zwAAAAA:ylU9Zz_m5PGMMMzVayDmzpidZAWy2gFhhf6R93NdtWzb5SFxV_1TDQBO_eJyxzky07ASDEF77hkZ

Cook, P. (2018). Continuity, change and possibility in older age: Identity and ageing-as-discovery. *Journal of Sociology, 54*(2), 178-190. doi: https://doi.org/10.1177/1440783318766147

Cope, M. (2016). Transcripts: Coding and analysis. In Kitchin R. & Thrift N. (Eds.), *International Encyclopedia of Human Geography* (pp. 350–354). Oxford, UK: Elsevier.

County of Haliburton. (2017). *Official plan- Schedule F mineral & mineral aggregate resources.* https://www.haliburtoncounty.ca/en/planning-and-maps/resources/Documents/Schedule-F---Mineral-and-Mineral-Aggregate-Resources.pdf

Crandall, J. K., & Shake, M. (2016). A mobile application for improving functional performance and health education in older adults: A pilot project. *Journal of Aging Science, 4*(2), 1-5. doi: 10.4172/2329-8847.1000151

Cridland, E. K., Phillipson, L., Brennan-Horley, C., & Swaffer, K. (2016). Reflections and recommendations for conducting in-depth interviews with people with dementia. *Qualitative Health Research*, 26(13), 1774–86.

Danes, S. M. (2020). *Building Social Support in Rural Communities.* https://conservancy.umn.edu/bitstream/handle/11299/213308/Building%20social%20support%20in%20rural%20communities.pdf?sequence=1

Darin-Mattsson, A., Fors, S., & Kareholt, I. (2017). Different indicators of socioeconomic status and their relative importance as determinants of health in old age. *International Journal for Equity in Health*, *16*(173), 1-11. doi: https://doi.org/10.1186/s12939-017-0670-3

Deber, R. (2017). *Treating health care: How the system works and how it could work better.* Toronto: ON: University of Toronto Press.

Destino, L., Bennett, D., Wood, M., Acuna, C., Goodman, S., Asch, S. M., & Platchek, T. (2019). Improving patient flow: Analysis of an initiative to improve early discharge. *Journal of Hospital Medicine, 14*(1), 22-27. doi: 10.12788/jhm.3133

DiBenigno, J. (2018). Anchored Personalization in Managing Goal Conflict between Professional Groups: The Case of U.S. Army Mental Health Care. *Administrative Science Quarterly*, 63(3), 526-569. doi:10.1177/0001839217714024

Dickman, S. L., Himmelstein, D. U., & Woolhandler, S. (2017). Inequality and the health-care system in the USA. *The Lancet*, 389(10077),8-14. doi: https://doi.org/10.1016/S0140-6736(17)30398-7.

Dionigi, R. (2015). Stereotypes of aging: Their effects on the health of older adults. *Journal of Geriatrics*. doi: http://dx.doi.org/10.1155/2015/954027

Di Pollina, L., Guessous, I., Petoud, V., Combescure, C., Buchs, B., Schaller, P., Kossovsky, M., & Gaspoz, J. (2017). Integrated care at home reduces unnecessary hospitalizations of community-dwelling frail older adults: A prospective controlled trial. *BMC Geriatrics*, *17*(53), 1-10. doi: https://doi.org/10.1186/s12877-017-0449-9

Doheny, S., & Milbourne, P. (2017). Community, rurality, and older people: Critically comparing older people's experiences across different rural communities. *Journal of Rural Studies*, 50, 129-138. doi: https://doi.org/10.1016/j.jrurstud.2016.12.003.

Eisen, M. (2021, April 6th). *An Evening with Dr. Max Eisen: Holocaust Survivor*. Trent University, Peterborough, ON, Canada.

Elliott, J., Forbes, D., Chesworth, B. M., Ceci, C., & Stolee, P. (2014). Information sharing with rural family caregivers during care transitions of hip fracture patients. *International Journal of Integrated Care*, 14(e018):1-13.

Embuldeniya, G., Kirst, M., Walker, K., & Wodchis, W. (2018). The generation of integration: The early experience of implementing bundled care in Ontario,

Canada. *The Millbrook Quarterly, 96*(4), 782-813. doi: https://onlinelibrary.wiley.com/doi/pdf/10.1111/1468-0009.12357

Evans, J., Grudnewicz, A., & Tsasis, P. (2018). Trial and error, together: Divergent thinking and collective learning in the implementation of integrated care networks. *International Review of Administrative Sciences, 84*(3), 452-468. doi: https://journals.sagepub.com/doi/pdf/10.1177/0020852318783063?casa_token=AvpFlP-AmtYAAAAA:-EA6GXV6LhlNQIdA4TLTFDivAM1bnY3tQuw5z8Ito6dNsg8uE8zuyrfO5N36iZkSpIv8IMxMp2Bf

Facchinetti, G., D'Angelo, D., Piredda, M., Petitti, T., Matarese, M., Oliveti, A., & Grazia De Marinis, M. (2020). Continuity of care interventions for preventing hospital readmission of older people with chronic diseases: A meta-analysis. *International Journal of Nursing Studies*, 101. doi: https://doi.org/10.1016/j.ijnurstu.2019.103396.

Farnanova, E., Kirvan, C., Verma, J., Mukerji, G., Akunov, N., Phillips, K., & Samis, S. (2016). Triple aim in Canada: Developing capacity to lead to better health, care and cost. *Journal of Quality in Health Care, 28*(6), 830-837. doi: 10.1093/intqhc/mzw118

Farrier, C., Stefox, H., & Fiest, K. (2019). In the pursuit of partnership: The patient and family engagement in critical care medicine. *Current Opinion in Critical Care, 25*(5), 505-510. doi: 10.1097/MCC.0000000000000643

Fels, J. Allard, B. L., Coppin, K., Hewson, K., & Richardson, B. (2015). CCRN Evolving Role of the Transitional Care Nurse in a Small Rural Community. *Home Healthcare Now,* 33(4), 215-221. doi: 10.1097/NHH.0000000000000219

Feo, R., & Kitson, A. (2016). Promiting Patient-Centred Fundamental Care in Acute Healthcare Systems. *International Journal of Nursing Studies*, 57, 1-11. Doi : https://doi.org/10.1016/j.ijnurstu.2016.01.006

Finlay, J. (2017). Spatial polygamy in later life: The many geographies of aging. *Innovation in Aging,* 1(1), 603. doi: 10.1093/geroni/igx004.2111

Finlayson, K., Chang, A. M., Courtney, M. D., Edwards, E. E., Parker, A.W., Hamilton, K., Pham, T. D. X., & O'Brien, J. (2018). Transitional care interventions reduce unplanned hospital readmissions in high-risk older adults. *BMC Health Services Research,* 18, 956. doi: https://doi.org/10.1186/s12913-018-3771-9

Fitzpatrick, K., & Grace, M. (2019). Dementia Patients' Transition to Residential Aged Care: Carers' and Social Workers' Experiences. *Australian Social Work,* 72(3), 287-298. doi: 10.1080/0312407X.2018.1536155

Fleming, P., & Sinnot, M. (2018). Rural physician supply and retention: factors in the Canadian context. *Canadian Journal of Rural Medicine,* 23(1), 15-20.

Flumian, M. (2018). *The management of integrated service delivery: Lessons from Canada.* https://webimages.iadb.org/publications/english/document/Innovations-inPublic-Services-Delivery-Issue-No-6-The-Management-of-Integrated-ServiceDelivery-Lessons-from-Canada.pdf

Fønss, R. L., Grode, L. B., Lange, J., Barat, I., & Gregersen, M. (2021). Impact of transitional care interventions on hospital readmissions in older medical patients:

a systematic review. *BMJ Open*, 11, e040057. doi: 10.1136/bmjopen-2020-040057

Hanlon, N., & Kearns, R. (2016). Health and rural places. In Shucksmith, M., & Brown, D. L. (Eds.), *Routledge International Handbook of Rural Studies.* London, UK: Routledge.

Fox, M. T., Sidani, S., Butler, J. I., Skinner, M. W., Macdonald, M., Durocher, E. … Dahlke, S. (2021). Optimizing hospital-to-home transitions for older persons in rural communities: a participatory, multimethod study protocol. *Implementation Science Communications*, 2(81). doi: https://doi.org/10.1186/s43058-021-00179-w

Friedman, N. L. (2018). Toward Addressing Social Determinants of Health: A Health Care System Strategy. *Permanente*, 22, 18-095.

Gallagher, N. A., Fox, D., Dawson, C. & Williams, B. C. (2017). Improving Care Transitions: Complex High-Utilizing Patient Experiences Guide Reform. *The American Journal of Managed Care*, 23(10), *e347-e352.*

Garvin, L. A., Pugatch, M., Gurewich, D., Pendergast, J. N., & Miller, C. J. (2021). Interorganizational Care Coordination of Rural Veterans by Veterans Affairs and Community Care Programs: A Systematic Review. *Medical care*, 59(Suppl 3), S259–S269. doi: https://doi.org/10.1097/MLR.0000000000001542

Gesler, W. M., Rabiner, D. J., & DeFriese, G. H. (2018). *Rural Health and Aging Research: Theory, Methods, and Practical Applications.* New York, NY. Routledge.

Gessert, C., Waring, S., Bailey-Davis, L., Conway, P., Roberts, M., & Van Wormer, J. (2015). Rural definition of health. *BMC Public Health, 15*(378), 1-14. doi: https://doi.org/10.1186/s12889-015-1658-9

Gibson, A., Holmes, S. D., Fields, N. L., & Richardson, V. E. (2019). Providing care for persons with dementia in rural communities: Informal caregivers' perceptions of supports and services. *Journal of Gerontological Social Work, 62*(6), 630-648. doi: 10.1080/01634372.2019.1636332

Gilmartin, H. M., Battaglia, C., Warsavage, T., Connelly, B., & Burke, R. E. (2022). Practices to support relational coordination in care transitions: Observations from the VA rural Transitions Nurse Program. *Health Care Management Review*, 47(2), 109-114. doi: 10.1097/HMR.0000000000000300

Gkiouleka, A., Huijts, T., Beckfield, J., & Bambra, C. (2018). Understanding the micro and macro politics of health: Inequalities, intersectionality and institutions- A research agenda. *Social Science & Medicine, 200*, 92-98. doi: https://doi.org/10.1016/j.socscimed.2018.01.025

Glasgow, N., & Doebler, S. (2021). Policy and program challenges to delivering health and social care services to rural older people. In M. Skinner, R. Winterton and K. Walsh (Eds.). *Rural Gerontology: Towards Critical Perspectives on Rural Ageing* (pp.117-129). London: Routledge.

Goncalves-Bradley, D., Lannin, N., Clemson, L., Cameron, I., & Shepperd, S. (2016). Discharge planning from hospital. *Cochrane Database of Systematic Reviews, 1*(5), 1-103. doi: https://doi.org/10.1002/14651858.CD000313.pub5

Gonzalez, J., Ferrer, J., Cataldo, A., & Rojas, L. (2019). A proactive transfer policy for critical patient flow management. *Health Care Management Science, 22*, 287-303. doi: https://doi.org/10.1007/s10729-018-9437-7

Government of Canada. (2018). *Social determinants of health and health inequalities.* https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

Government of Ontario. (2018a). *Bundled care (Integrating Funding Models).* http://www.health.gov.on.ca/en/pro/programs/ecfa/funding/ifm/#wave_1

Government of Ontario. (2018b). *Excellent care for all.* http://www.health.gov.on.ca/en/pro/programs/ecfa/action/community/com_homefirst.aspx

Government of Ontario. (2022). *Long-Term Care Accommodation Costs and Subsidy*. https://www.ontario.ca/page/get-help-paying-long-term-care

Government of Ontario. (2017). *New health technologies coming to Ontario*. https://news.ontario.ca/en/release/44204/new-health-technologies-coming-to-ontario

Government of Ontario. (2021a). *Ontario Health Teams.* https://health.gov.on.ca/en/pro/programs/connectedcare/oht/#meet

Government of Ontario. (2020). *Ontario population projections update, 2019-2046.* https://www.fin.gov.on.ca/en/economy/demographics/projections/

Government of Ontario. (2021b). *Protecting People's Health.* https://budget.ontario.ca/2021/health.html

Gray, C. S., Tang, T., Armas, A., Backo-Shannon, M., Harvey, S., Kuluski, K., Loganathan, M. … Nelson, M. (2020). Building a Digital Bridge to Support Patient-Centered Care Transitions From Hospital to Home for Older Adults with Complex Care Needs: Protocol for a co-design, implementation and evaluation study. *JMIR Research Protocols,* 9(11), e20220. doi: 10.2196/20220

Greysen, S. R., Harrison, J. D., Kripalani, S., Vasilevskis, E., Robinson, E., Metlay, J., Schnipper, J. L., … Auerbach, A. D. (2017). Understanding patient-centred readmission factors: a multi-site, mixed-methods study. *BMJ Quality & Safety*, 26, 33-41. doi: http://dx.doi.org/10.1136/bmjqs-2015-004570

Griffin, J. M., Kaufman, B. G., Bangerter, L., Holland, D. E., Vanderboom, C. E., Ingram, C., Wild, E. M., Dose, A. M., Stiles C., & Thompson, V. H. (2022). Improving Transitions in Care for Patients and Family Caregivers Living in Rural and Underserved Areas: The Caregiver Advise, Record, Enable (CARE) Act. *Journal of Aging & Social Policy.* doi: 10.1080/08959420.2022.2029272

Grudniewicz, A., Evans, J., Baker, R., & Wodchis, W. (2015). Implementing a "low-rules" provincial integrated care initiative in Canada: The role of environmental & organizational context. *International Journal of Integrated Care, 15*(5). doi: https://doi.org/10.5334/ijic.2075

Gullette, M. (2017). *Ending ageism or how not to shoot old people*. New Brunswick: Rutgers University Press.

Gulliford, M. (2019). Discrimination and public health. *The Lancet Public Health, 4*(4), 173-174. doi: 10.2190/HS.44.4.b

Haikio, K. (2021). *Family carers' perspectives on care for older people living with dementia: Interactions and involvement with health services, and the role of health literacy.* Oslo, Norway: Oslo Metropolitan University.

Halseth, G., & Ryser, L. (2004). *Building rural capacity in the new economy: Service provision in rural and small town Canada: Cross-Canada summary report*. Rural and Small Town Studies Program, Prince George, BC: University of Northern British Columbia.

Hang, J. A., Naseri, C., Francis-Coad, J., Jacques, A., Waldron, N., Knuckey, R., Hill, A. M. (2021). Effectiveness of facility-based transition care on health-related outcomes for older adults: A systematic review and meta-analysis. *International Journal of Older People Nursing*, 16(6), e12408. doi: 10.1111/opn.12408.

Hanlon, N., & Poulin, L. (2021). Rural health & aging: Making way for a critical gerontology of rural health. In Skinner, M., Winterton, R. & Walsh, K. (Eds.), *Rural gerontology: Towards critical perspectives of rural ageing.* London, UK: Routledge.

Hardman, B., & Newcomb, P. (2016). Barriers to primary care hospital follow-up among older adults in rural or semi-rural communities, *Applied Nursing Research*, 29, 222-228. doi: https://doi.org/10.1016/j.apnr.2015.05.003.

Harrington, R. A., Califf, R. M., Balamurugan, N. B., Benjamin, R. M., Braund, W. E., Hipp, J., Konig, M., Sanchez, E., & Maddox, K. E. J. (2020). Call to Action: Rural Health: A Presidential Advisory From the American Health Association and American Stroke Association. *Circulation*, 141, e615-e644. doi: https://doi.org/10.1161/CIR.0000000000000753

Harris, K. (2016). Reflexive voicing: A communicative approach to intersectional writing. *Qualitative Research, 16*(1), 111-127. doi: 10.1177/1468794115569560

Hawkins, S., & Poulin, L. (October, 2019). Exploring the application of a qualitative shadowing method in clinical research and continuing professional development: "Go-along" reflections from specialized geriatrics services. *Navigating the Tides of Aging Together: The 48th Annual Scientific and Educational Meeting of the Canadian Association*. Talk presented at 48th Annual Scientific and Educational Meeting of the Canadian Association, New Brunswick, Canada

Hwang, U., Dresden, S. M., Rosenberg, M. S., Garrido, M. M., Loo, G., Sze, J., Gravenor, S., … Richardson, L. D. (2018). Geriatric Emergency Department Innovations: Transitional Care Nurses and Hospital Use. *Journal American Geriatric Society*, 66, 459-466. doi: https://doi.org/10.1111/jgs.15235

Hayre, C., & Muller, D. (2019). *Enhancing healthcare & rehabilitation: The impact of qualitative research.* Boca Raton, FL: Taylor & Francis Group.

Health Quality Ontario. (2019). *Measuring up.* https://www.hqontario.ca/System-Performance/Yearly-Reports/Measuring-Up-2019

Health Quality Ontario. (2021). *Wait-times for longer-term care homes.* https://www.hqontario.ca/System-Performance/Long-Term-Care-Home-Performance/Wait-Times

Health Standards Organization. (HSO) (2021). *National long-term care services standard.* https://healthstandards.org/uncategorized/national-long-term-care-services-standard/

Hege, A., Ball, L., Christiana, R. W., Wallace, C., Hubbard, C., Truesdale, D., Hege, J., & Fleming, H. (2018). Social Determinants of Health and the Effects on Quality of Life and Well-being in 2 Rural Appalachia Communities. *Family & Community Health*, 41(4), 244-254. doi: 10.1097/FCH.0000000000000201

Hendry, A. (2016). Creating an enabling political environment for health and social care integration. *International Journal of Integrated Care*, *16*(4), 1-3. doi: 10.5334/ijic.2531

Hennessy, C. H., & Innes, A. (2021). Social Relations, Connectivity and loneliness of older rural people. In Skinner, M., Winterton, R., & Walsh, K. (2021). *Rural Gerontology: Towards Critical Perspectives on Rural Ageing* (pp.199-209). London, UK: Routledge.

Henning-Smith, C., Moscovice, I., & Kozhimannil, K. (2019). Differences in Social Isolation and It's Relationship to Health by Rurality. *The Journal of Rural Health*, 35(4), 540-549.

Hennings, J., & Froggatt, K. (2019). The experiences of family caregivers of people with advanced dementia living in nursing homes, with a specific focus on spouses: A narrative literature review. *Dementia*, 18(1), 303-322. doi: https://doi.org/10.1177/1471301216671418

Herron, R., & Skinner, M. (2018). Rural places and spaces of rural health and health care. In Crooks, V., Andrews, G., & Pearce, J. (Eds.), *Routledge Handbook of Health Geography*. Routledge: Oxon, Ox.

Herron, R. V., & Skinner, M. W. (2013). The emotional overlay: Older person and carer perspectives on negotiating aging and care in rural Ontario. *Social Science & Medicine, 91,* 186-193. doi: https://doi.org/10.1016/j.socscimed.2012.08.037.

Heslop, C., Burns, S., & Lobo, R. (2018). Managing qualitative research as insider-research in small rural communities. *Rural & Remote Health, 18*(3), 1-5. doi: https://doi.org/10.22605/RRH4576

Hestevik, C. H., Molin, M., Bebasey, J., Bergland, A., & Bye, A. (2019). Older persons' experiences of adapting to daily life at home after hospital discharge: A qualitative metasummary. *BMC Health Services Research, 19*(224). doi: https://doi.org/10.1186/s12913-019-4035-z

Heyman, N., Osman, I., Natan, M. B. (2020). Ageist attitudes among healthcare professionals and older patients in a geriatric rehabilitation facility and their association with patients' satisfaction with care. *International Journal of Older People Nursing*, 15(e12307). doi: https://doi.org/10.1111/opn.12307

Higgins, T., Larson, E., & Schnall, R. (2016). Unraveling the meaning of patient engagement: A concept analysis. *Patient Education and Counseling*. doi: http://dx.doi.org/10.1016/j.pec.2016.09.002

Hirschman, K., Shaid, E., McCauley, K., Pauly, M., & Naylor, M. (2015). Continuity of care: The transitional care model. *The Online Journal of Issues in Nursing, 20*(3). doi: 10.3912/OJIN.Vol20No03Man01

Hoeft, T., Fortney, J., Patel, V., & Unutzer, J. (2018). Task sharing approaches to improve mental health care in rural and other low resource settings: A systematic

review. *The Journal of Rural Health*, *34*(1), 48-62. doi: https://doi.org/10.1111/jrh.12229

Home and Community Support Services (HCSS) (2020). *Hospital service accountability agreements: Haliburton highlands health services*. http://centraleastlhin.on.ca/accountability/Agreements/HAPS-HSAA.aspx

Hsieh, N., & Ruther, M. (2016). Sexual minority health and health risk factors: Intersection effects of gender, race, and sexual identity. *Drug and Alcohol Dependence, 169*, 85-91. doi: https://doi.org/10.1016/j.amepre.2015.11.016

Hurlington, K. G., (2018). *Something out of nothing? Place-based Resilience in Rural Canadian Youth.* PhD Dissertation, Peteborough, ON: Trent University

Iezzoni, L. I., Rao, S. R., Ressalam, J., Bolcic-Jankovic, D., Agaronnik, N. D., Donelan, K., Lagu, T., & Campbell, E. G., (2021). Physicians perceptions of people with disability and their health care. *Health Affairs, 40*(2), doi: https://doi.org/10.1377/hlthaff.2020.01452

Iglehart, J.K. (2018). The challenging quest to improve rural health care. *The New England Journal of Medicine, 378*(5), 473-479. doi: https://healthyeastadams.org/library/The%20Challenging%20Quest%20to%20Improve%20Rural%20Health%20Care.pdf

Jackman, D., Myrick, F., & Yonge, O. J. (2012). Rural nursing in Canada: A voice unheard. *Online Journal of Rural Nursing and Health Care. 10*(1), 60-69. doi: https://doi.org/10.14574/ojrnhc.v10i1.74

Jackson, C., Shahsahebi, M., Wedlake, T., & DuBard, A. C. (2015). Timeliness of Outpatient Follow-up: An evidence-based approach for planning after hospital

discharge. *The Annals of Family Medicine, 13*(2), 115-122. doi: https://doi.org/10.1370/afm.1753

Jarzabkowski, P., Le, J., & Spee, P. (2017). Taking a strong process approach to analyzing qualitative process data. In Langley, A. & Tsoukas, H. (Eds.), *The SAGE Handbook of Process Organization Studies*, London, UK: SAGE Publications Ltd.

Jason, L. A., & Glenwick, D. S. (2016). *Handbook of Methodological Approaches to Community-Based Research*. New York, NY: Oxford University Press.

Jensen, L., & Ely, D. (2017). Measures of Poverty and Implications for Portraits of Rural Hardship, In Tickamyer, A., Warlick, J., & Sherman, J. *Rural Poverty in the United States*, New York Chichester, West Sussex: Columbia University Press. https://doi.org/10.7312/tick17222-005

Johnson, M., Freeman, R., Karpiak, S., Brennan-Ing, M., Seidel, L., & Sieger, E. (2019). The intersectionality of stigmas among key populations of older adults affected by HIV: A thematic analysis. *Clinical Gerontology, 42*(2),-137-149. doi: 10.1080/07317115.2018.1456500

Johnson, G. E., Wright, F. C. & Foster, K. (2018). The impact of rural outreach programs on medical students' future rural intentions and working locations: a systematic review. *BMC Medical Education,* 18, 196. doi: https://doi.org/10.1186/s12909-018-1287-y

Johnston, C., Wallis, M., Oprescu, F., & Gray, M. (2016). Methodological considerations related to nurse researchers using their own experience of a phenomenon within phenomenology. *Journal of Advanced Nursing, 73*(3), 574-584. doi: 10.1111/jan.13198

Kansagara, D., Chiovaro, J., Kagen, D., Jencks, S., Rhyne, K., O'Neil, M., Kondo, K., Relevo, R., Motu'apuaka, M., Freeman, M., & Englander, H. (2016). So many options, where do we start? An overview of the care transitions literature. *Journal of Hospital Medicine, 11*(3), 221-230. doi: https://doi.org/10.1002/jhm.2502

Kaplan, D. B., & Berkman, B. (2016). *The Oxford Handbook of Social Work in Health and Aging.* Oxford University Press.

Karki, S., Bhatta, D. N., & Aryal, U. R. (2015). Older people's perspectives on an elderly-friendly hospital environment: An exploratory study. *Risk Management Healthcare Policy,* 8, 81-89. doi: 10.2147/RMHP.S83008

Kaye, L. W. (2021). *Handbook of Rural Aging*. New York, NY: Routledge.

Kemp, C., Ball, M., & Perkins, M. (2013). Convoys of care: Theorizing intersections of formal and informal care. *Journal of Aging Studies, 27*(1), 15-29. doi: https://doi.org/10.1016/j.jaging.2012.10.002

Keohane, K. (2015). *A problem shared? Essays on the integration of health and social care*. London, UK: The Social Market Foundation.

Khan, S., Vandermorris, A., Shepherd, J., Begun, J., Lanham, H., Uhl-Bien, M., & Berta, W. (2018). Embracing uncertainty, managing complexity: Applying complexity thinking principles to transformation efforts in health care systems. *Health Services Research, 18*(192), 1-8. doi: https://doi.org/10.1186/s12913-018-2994-0

Kilaru, A. S., & Gee, R. E. (2020). Structural ageism and the health of older adults. *JAMA Health Forum*. doi: 10.1001/jamahealthforum.2020.1249

Kitzman, P., Hudson, K., Sylvia, V., Feltner, F., & Lovins, J. (2017). Care Coordination for Community Transitions for Individuals Post-stroke Returning to Low-

Resource Rural Communities. *Journal of Community Health*, 42, 565–572. doi: https://doi.org/10.1007/s10900-016-0289-0

Knight, B., & Winterbotham, S. (2019). Rural and urban older adults' perceptions of mental health services accessibility. *Aging & Mental Health, 24*(6), 978-984. doi: 10.1080/13607863.2019.1576159

Koch, T., & Webb, C. (1996). The biomedical construction of ageing: Implications for nursing care of older people. *JAN, 23*(5) 954-958. doi: https://doi.org/10.1046/j.1365-2648.1996.10014.x

Kogan, A. C., Wilber, K., & Mosqueda, L. (2016). Person-centered care for older adults with chronic conditions and functional impairment: A systematic literature review. *Journal of the American Geriatrics Society, 64*(1), e1-e7. doi: https://doi.org/10.1111/jgs.13873

Kolak, M., Bhatt, J., Park, Y. H., Padrón, N. A., Molefe, A. (2020). Quantification of Neighborhood-Level Social Determinants of Health in the Continental United States. *JAMA Network Open.* 3(1), e1919928. doi: 10.1001/jamanetworkopen.2019.19928

Kotter-Gruhn, D., Kornadt, A., & Steohan, Y. (2016). Looking beyond chronological age-Current Knowledge and future directions in my thesis of subjective age. *Gerontology, 62*, 86-93. doi: https://doi.org/10.1159/000438671

Kramer, M. R., & Raskind, I. G. (2017). Is a person's place in the home (neighborhood)? *Epidemiology (Cambridge, Mass.), 28*(6), 798–801. doi: https://doi.org/10.1097/EDE.0000000000000725

Kulesza, M., Matsuda, M., Ramirez, J., Werntz, A., Teachman, B., & Lingren, K. (2016). Towards greater understanding of addiction stigma: Intersectionality with race/ethnicity and gender. *Drug and Alcohol Dependence, 1*(169), 85-91. doi: https://doi.org/10.1016/j.drugalcdep.2016.10.020

Kuluski, K., Ho, J. W., Hans, P. K., & Nelson, M. (2017). Community Care for People with Complex Care Needs: Bridging the Gap between Health and Social Care. *International Journal of Integrated Care*, 17(4), 2. doi: https://doi.org/10.5334/ijic.2944

Kuroda, M., Ohta, R., Kuroda, K., Yamashiro, S. & Kita, K. (2021). The Seamless Communication on a Rural Island in Japan: A Qualitative Study from the Perspective of Healthcare Professionals. *International Journal of Environmental Research and Public Health*, 18(18). doi: https://doi.org/10.3390/ijerph18189479

Kusenbach, M. (2016). *The go-along method.* GmbH Basel, Switzerland: Birkhause Verlag.

Kydd, A., Fleming, A., Gardnes, S., & Hafford-Letchfield, T. (2018). Ageism in the third age, contemporary perspectives on ageism, In Ayalon, L. & Tesch-Romer, C. (Eds.), *Contemporary Perspectives on Ageism* (pp.115-130). New York, NY: Springer International.

Lawless, M. T., Marshall, A., Mittinty, M. M., & Harvey, G. (2020). What does integrated care means from an older person's perspective? A scoping review. *BMJ Open*, 10(e035157). doi:10.1136/bmjopen-2019-035157

Layman, S. N., Elliot, W. V., Regen, S. M. & Keough, L. A. (2020). Implementation of a pharmacist-led transitional care clinic. *American journal of Health-System Pharmacy*, 77(12), 966-971. doi: https://doi.org/10.1093/ajhp/zxaa080

Levi, S., & MacDonald, J. (2016). Progress on understanding ageism. *Journal of Social Issues, 72*(1), 5-25. doi: 10.1111/josi.12153

Levy, B. R., Slade, M. D., Chang, E., Kannoth, S., & Wang, S. (2020). Ageism amplifies cost and prevalence of health conditions. *The Gerontologist, 60*(1), 174-181. doi: https://doi.org/10.1093/geront/gny131

Lewis, S. (2015). A system in name only: Access, variation and reform in Canada's provinces. *The New England Journal of Medicine, 372*, 497-500. doi: https://www.researchgate.net/profile/Steven-Lewis-12/publication/271839839_A_System_in_Name_Only_-_Access_Variation_and_Reform_in_Canada%27s_Provinces/links/55d6074c08aed6a199a44db6/A-System-in-Name-Only-Access-Variation-and-Reform-in-Canadas-Provinces.pdf

Lilleheie, I., Debesay, J., Bye, A., Bergland, A. (2020). Informal caregivers' views on the quality of healthcare services provided to older patients aged 80 or more in the hospital and 30 days after discharge. *BMC Geriatrics*, 20(97). doi: https://doi.org/10.1186/s12877-020-1488-1

Local Employment Planning Council. (2019). *Community labour market plan 18/19.* https://haliburtonchamber.com/wp-content/uploads/2018/06/CLMP-Final-REDUCED-SIZE.pdf

London Health Sciences Centre. (2021). *Discharge Planning.* https://www.lhsc.on.ca/patients-visitors/discharge-planning

Longino, C. F., & Murphy, J. W. (2020). *The old age challenge to the biomedical model: Paradigm Strain and Health Policy*. New York, NY: Routledge.

Lyman, K. A. (1989). Bringing the social back in: A critique of the biomedicalization of dementia. *The Gerontologist, 29*(5), 597-605. doi: https://doi.org/10.1093/geront/29.5.597

MacLeod, M., Stewart, N., Kulig, J., Anguish, P., Andrews, M. E., Banner, D., Garraway, L. … Zimmer, L. (2017). Nurses who work in rural and remote communities in Canada: A national survey. *Human Resources for Health,* 15(34), 1-11.

Magilvy, J. K., & Congdon, J. G. (2001). The crisis nature of health care transitions for rural older adults. *Public Health Nursing*, 17(5), 336-345. doi: https://doi.org/10.1046/j.1525-1446.2000.00336.x

Martin, D., Miller, A., Quesnel-Vallée, A., Caron, N., Vissandjée, B., & Marchildon, G. (2018). Canada's universal health-care system: Achieving its potential. *The Lancet, 391*(10131), 1718–1735. doi: https://doi.org/10.1016/S0140-6736(18)30181-8

May, C., Johnson, M., & Finch, T. (2016). Implementation, context and complexity. *Implementation Science, 11*(141), 1-12. doi: https://doi.org/10.1186/s13012-016-0506-3

McIntosh, K., Morgan, G., & Werner, R. (2017). Financing integrated care. In L. E. Raney, & G. Lasky, C. Scott (Eds.), *Integrated Care: A Guide for Effective Implementation*. Arlington, VA: American Psychiatric Association Publishing.

Mertons, F., Pype, P., & Deveugele, M. (2018). Healthcare professionals' experiences of interprofessional collaboration during palliative patients' transfer of care setting: A focus group study. *International Journal of Integrated Care, 18*(S2): A262, 1-8. doi: https://doi.org/10.5334/ijic.s2262

Midgley, J., Surender, R., & Alfers, L. (2019). *Handbook of Social Policy and Development. Cheltenham,* UK: Edward Elgar Publishing.

Mihas, P. (2019). Qualitative Data Analysis. *Oxford Research Encyclopedia of Education.* doi: https://oxfordre.com/education/view/10.1093/acrefore/9780190264093.001.0001/acrefore-9780190264093-e-1195

Milbourne, P. (2016). Austerity, welfare reform, and older persons in rural places: Competing discourses of volunteerism and community? In M. W. Skinner and N. Hanlon (Eds.), *Ageing Resource Communities: New Frontiers of Rural Population Change, Community Development and Voluntarism* (pp. 74-88). London, UK: Routledge.

Milbourne, P. (2012). Growing old in rural places. *Journal of Rural Studies, 28*(4), 315-317. doi: 10.1016/j.jrurstud.2012.10.001

Miller, K. K., Lin, S. H., & Neville, M. (2019). From Hospital to Home to Participation: A Position Paper on Transition Planning Poststroke. *Archives of Physical Medicine*

and Rehabilitation, 100(6), 1162-1175. doi: https://doi.org/10.1016/j.apmr.2018.10.017.

Miller, A., Mishra, S., Kendall, L., Haldar, S., Pollack, A., & Pratt, W. (2016). Partners in care: Design considerations for caregivers and patients during a hospital stay. *CSCW: Proceedings of the Conference on Computer-Supported Cooperative Work, 2016*(2016), 756-769. doi: https://dl.acm.org/doi/pdf/10.1145/2818048.2819983?casa_token=2PoKjsp3cLIAAAAA%3AGsXBQFeklkrt7XbC6W5eOIBsEtt30rP-cCq7pXW5xueXlaf4EAq4CGohDjHM6awiTgrUXZ3pKFlC

Milligan, C. (2018). *Geographies of care: Spaces, place and the voluntary sector.* Routledge: Abingdon, Oxon.

Mitchell, S. E., Laurens, V., Weigel, G. M., Hirschman, K. B., Scott, A. M., Nguyen, H. Q., Howard, J. M., … Jack, B. W. (2018). Care Transitions From Patient and Caregiver Perspectives. *The Annals of Family Medicine,* 16(3), 225-231. doi: https://doi.org/10.1370/afm.2222

Ministry of Health and Long-Term Care. (2019). *Long-term care homes level-of-care per diem, occupancy and acuity-adjustment funding policy*. http://www.health.gov.on.ca/en/public/programs/ltc/docs/level_of_care_per_diem_funding_policy.pdf

Mlinac, M., & Feng, M. (2016). Assessment of activities of daily living, self-care, and independence. *Archives of Clinical Neuropsychology, 31*(6), 506-516. doi: 10.1093/arclin/acw049

Moore, E., Krupp, E., Dufour, A., Sircar, M., Travison, T., Abrams, A., Farris, G. … Lipsitz, L. (2017). Improving transitions to post-Hospital for elderly patients using a novel video-conferencing program: Echo-care transitions. *The American Journal of Medicine, 130*(1), 1199-1204. doi: https://doi.org/10.1016/j.amjmed.2017.04.041

Morgan, S., Pullon, S., & McKinlay, E. (2015). Observation of interprofessional collaborative practice in primary care teams: An integrative literature review. *International Journal of Nursing Studies, 52*(7), 1217-1230. doi: https://doi.org/10.1016/j.ijnurstu.2015.03.008

Morley, L., & Cashell, A. (2017). Collaboration in health care. *Journal of Medical Imaging and Radiation Sciences, 48*(2), 207-216. doi: https://doi.org/10.1016/j.jmir.2017.02.071

Mudge, A. M., Young, A., McRae, P., Graham, F., Whiting, E. & Hubbard, R. E. (2021). Qualitative analysis of challenges and enablers to providing age friendly hospital care in an Australian health system. *BMC Geriatrics,* 21(147). doi: https://doi.org/10.1186/s12877-021-02098-w

Murphy, K., Fionnuala, J., Hunter, A., Cooney, A., & Dympna, C. (2014). Articulating the strategies for maximizing the inclusion of people with dementia in qualitative research studies. *Dementia, 14*(6), 800-824. doi: 10.1177/1471301213512489

Murrell, K. (2020). Patient safety and quality improvement in healthcare, In Shah, R. K., Godambe, S. A. (Eds.), *Patient safety and quality improvement in healthcare*. Springer, Cham.

Nagata, J., Hernandez-Ramos, I., Kurup, A., Albrech, D., Vivas-Torrealba, C. & Franco-Paredes, C. (2011). Social determinants of health and seasonal influenza vaccination in adults ≥65 years: A systematic review of qualitative and quantitative data. *BMC Public Health, 13*(388), 1-25. doi: https://doi.org/10.1186/1471-2458-13-388

Nall, R. W., Herndon, B., Mramba, L. K., Vogel-Anderson, K., & Hagen, M. G. (2020). An Interprofessional Primary Care-Based Transition of Care Clinic to Reduce Hospital Readmission. *The American Journal of Medicine,* 133(6), e260-e268. doi: https://doi.org/10.1016/j.amjmed.2019.10.040.

Naylor, M. D., Shaid, E. C., Carpenter, D., Gass, B., Levine, C., Li, J., Malley, A., McCauley, K., … Mittman, B. (2017). Components of comprehensive and effective transitional care. *Journal of the American Geriatrics Society, 65*(6), 1119-1125. doi: https://doi.org/10.1111/jgs.14782

Ng, J. H. Y., & Luk, B. H. K. (2019). Patient satisfaction: Concept analysis in the healthcare context. *Patient Education and Counseling, 102*(4), 790-796. doi: https://doi.org/10.1016/j.pec.2018.11.013

Novek, S., & Wilkinson, H. (2019). Safe and inclusive research practices for qualitative research involving people with dementia: A review of key issues and strategies. *Dementia, 18*(3), 1042-1059. doi: https://doi.org/10.1177/1471301217701274

Oelke, N., Suter, E., Dias da Silva Lima, A., & Van Vliet-Brown, C. (2015). Indicators and measurement tools for health system integration: A knowledge synthesis protocol. *Systematic Reviews, 4*(99), 1-8. doi: https://doi.org/10.1186/s13643-015-0090-7

Ontario Ministry of Long-Term Care. (2019). *Long-Term Care Homes Act, 2007, S.O 2007, c.8.* https://www.ontario.ca/laws/statute/07l08#BK12

Orsulic-Jeras, S., Whitlatch, C., Powers, S., & Johnson, J. (2020). A dyadic perspective on assessment in alzheimer's dementia: Supporting both care partners across the disease continuum. *Translational Research & Clinical Interventions, 6*(1), e12037. doi: https://doi.org/10.1002/trc2.12037

Otsuka, S., Smith, J., Pontiggia, L., Patel, R., Day, S., & Grande, D. (2019). Impact of an interprofessional transition of care service on 30-day hospital reutilizations. *Journal of Interprofessional Care, 33*(1), 32-37. doi: https://doi.org/10.1080/13561820.2018.1513466

Patrick, J. (2011). Access to long-term care: The true cause of hospital congestion? *Production and Operations Management, 20*(3). doi: https://doi.org/10.1111/j.1937-5956.2011.01229.x

Penman-Aguilar, A., Talih, M., Huang, D., Moonesinghe, R., Bouye, K., & Beckles, G. (2016). Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the Advancement of Health Equity. *Journal Public Health Management Practice,* 22(suppl 1), s33-s42.

Pindus, D. M., Mullis, R., Lim, L., Wellwood, I., Rundell, V., Aziz, N. A. A., & Mant, J. (2018). Stroke Survivors' and informal caregivers' experiences pf primary care and community health care services – A systematic review and meta-ethnography. *PLOS ONE,* 13(4), e0196185. doi: https://doi.org/10.1371/journal.pone.0196185

Plexa, A., Goncalves, H., Castanheira, R., Marcal, S., Valentim, O., Fonseca, C., & Guedes de Pnho, L. (2021). Impact of Socialization on Active Aging in the

Geriatric Population: Systematic Literature Review. In Garcia-Alonso, J. & Fonseca, C. (eds) *Gerontechnology 3.* IWoG 2020. Lecture Notes in Bioengineering. Springer, Cham. https://doi.org/10.1007/978-3-030-72567-9_20

Ploeg, J., Matthew-Maich, N., Fraser, K., Dufour, S., McAiney, C., Kaasalainen, S., Markle-Reid, M., … Emili, A. (2017). Managing multiple chronic conditions in the community: A Canadian qualitative study of the experiences of older adults, family care givers and health care providers. *BMC Geriatrics, 17*(1), 40. doi: https://doi.org/10.1186/s12877-017-0431-6

Poulin, L., & Hanlon, N. (2019). Leveraging critical rural gerontology to improve rural gerontological health. *Innovation in Aging, 3*(Supplement_1), S399–S399. doi: https://doi.org/10.1093/geroni/igz038.1477.

Poulin, L. I. L., Skinner, M. W., & Hanlon, N. (2020). Rural gerontological health: Emergent questions for research, policy and practice. *Social Science & Medicine, 258*, 1-7. doi: https://doi.org/10.1016/j.socscimed.2020.113065

Poulin, L. I. L., & Skinner, M. W. (2020). Leveraging a contextually sensitive approach to rural geriatric interprofessional education. *Healthcare Management Forum, 33*(2), 70–74. doi: https://doi.org/10.1177/0840470419879456

Powers, J. S. (2021). Geriatric care models. *Geriatrics, 6*(1), 6. doi: https://doi.org/10.3390/geriatrics6010006

Provencher, V., Sirois, M. J., Ouellet, M. C., Camden, S., Allain-Boule, N., & Edmund, M. (2015). Decline in activities of daily living after a visit to a Canadian emergency department for minor injuries in independent older adults: Are frail

older adults with cognitive impairment at greater risk? *Journal of the American Geriatrics Society, 63*(5), 860-868. doi: https://doi.org/10.1111/jgs.13389

Pryce, A., Unwin, M., Kinsman, L., & McCann, D. (2021). Delayed flow is a risk to patient safety. *International Emergency Nursing, 54*, 1-9. doi: https://doi.org/10.1016/j.ienj.2020.100956

Quigley, J. (2019). *Tourism sector talks improvement, resident tension*. https://thehighlander.ca/2019/05/24/tourism-sector-talks-improvement-resident-tension/

Quinlan, C., McKibbin, C., Cuffney, C., Brownson, R., Brownson, C., Clark, J., & Osvold, L. (2020). Barriers to aging in place for rural, institutionalized older adults: A qualitative exploration. *Clinical Gerontologist*, 1-13. doi: 10.1080/07317115.2020.1820651

Rababa, M., Hammouri, A. M., Hweidi, I. M., & Ellis, J. L. (2020). Association of nurses' level of knowledge and attitudes to ageism toward older adults: Cross-sectional study. *Nursing & Health Sciences*, 22(3), 593-601. doi: https://doi.org/10.1111/nhs.12701

Reeves, S., Pelone, F., Harrison, R., Goldman, J., & Zwarenstein, M. (2017). Interprofessional collaboration to improve professional practice and health care outcomes. *Cochrane Database of Systematic Reviews, 10*, 1-145. doi: https://doi.org/10.1002/14651858.CD000072.pub3

Ribeiro, P. C. P. S. V., Marques, R. M. D., & Ribeiro, M. P. (2017). Geriatric care: Ways and means of providing comfort. *Revista Brasileira de Enfermagement, 70*(4), 830-837. doi: https://dx.doi.org/10.1590/0034-7167-2016-0636

Rosen, M., Diaz-Granados, D., Dietz, A., Benishek, L., Thompson, D., Pronovost, P., & Weaver, S. (2018). Teamwork in health care: Key discoveries enabling safer, high-quality care. *The American Psychologist, 73*(4), 433-450. doi: 10.1037/amp0000298

Ross, C., Rogers, C., & Duff, D. (2016). Critical ethnography: An under-used methodology in neuroscience nursing. *Canadian Journal of Neuroscience Nursing, 38*(1), 4-7. doi: https://static1.squarespace.com/static/5b040dcdcc8fed6691b16e17/t/5ccf92cbe5e5f08d2c8fefad/1557107427635/CJNN+-+Spring+2016+final.pdf#page=4

Rowland, P., Anderson, M., Kumagai, A. K., McMillian, S., Sandhu, V. K., & Langois, S. (2019). Patient involvement in health professionals' education: a meta-narrative review. *Advances in Health Science Education*, 24, 595-617.

Rowles, G. D. (2019). Do what I say, not what I do? Challenging contemporary wisdom about residence in old age. *Innovation in Aging, 3*(suppl 1): S223. doi: 10.1093/geroni/igz038.818

Rutakumwa, R., Mugisha, J. O., Bernays, S., Kabunga, E., Tumwekwase, G., Mbonye, M., & Seeley, J. (2020) Conducting in-depth interviews with and without voice recorders: A comparative analysis. *Qualitative Research, 20*(5), 565-581. doi: https://journals.sagepub.com/doi/pdf/10.1177/1468794119884806

Sabir, F. R. N., Tomlinson, J., Strickland-Hodge, B., & Smith, H. (2019). Evaluating the Connect with Pharmacy web-based intervention to reduce hospital readmission for older people. *International Journal of Clinical Pharmacy*, 41, 1239–1246. doi: https://doi.org/10.1007/s11096-019-00887-3

Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., & Lu, M. (2018). How to practice person-centred care: A conceptual framework. *Health Expect,* 21, 429-440. doi: https://doi.org/10.1111/hex.12640

Scharf, T., Walsh, K., & O'Shea, E. (2016). Ageing in rural places, In Shucksmith, M. & Brown, D. (Eds.), *Routledge International Handbook of Rural Studies* (pp.50-61). Oxon: Routledge.

Schinasi, L., Auchincloss, A., Forrest, C., & Diez, A. (2018). Using electronic health record data for environmental and place based population health research: A systematic review. *Annals of Epidemiology, 28,* 493-502. doi: https://doi.org/10.1016/j.annepidem.2018.03.008

Schwandt, T., & Gates, E. (2018). Case study methodology, In Denzin, N. & Lincoln, Y. (Eds.), *The SAGE Handbook of Qualitative Research,* Thousand Oaks, CA: SAGE Publications, Inc.

Scott, J. (2017). Patient Experiences of Safety in Care Transitions. In Aase, K., Waring, J., & Schibevaag, L. (eds) *Researching Quality in Care Transitions.* Palgrave Macmillan, Cham. doi: https://doi.org/10.1007/978-3-319-62346-7_4

Scotten, M., Manos, E. L., Malicoat, A., & Paolo, A. M. (2015). Minding the gap: Interprofessional communication during inpatient and post discharge chasm care. *Patient Education and Counseling*, 98(7), 895-900. doi: https://doi.org/10.1016/j.pec.2015.03.009.

Seniors Care Network (SCN). (2017). *The Senior Friendly Care Framework.* https://www.rgptoronto.ca/wp-content/uploads/2017/12/sfCare_Framework.pdf

Seniors for Social Action. (2021). *Policy and Research.* https://www.seniorsactionontario.com/policyandresearch

Shahsavari, H., Zarei, M., & Mamaghani, J. A. (2019). Transitional Care: Concept analysis using Rodger's Evolutionary Approach. *International Journal of Nursing Services*, 99(103387), 1-7. doi: https://doi.org/10.1016/j.ijnurstu.2019.103387

Shaw, R., Howe, J., Beazer, J., & Carr, T. (2020). Ethics and positionality in qualitative research with vulnerable and marginal groups. *Qualitative Research, 20*(3), 277-293. doi: https://journals.sagepub.com/doi/pdf/10.1177/1468794119841839?casa_token=gJTkGTRzrC0AAAAA:zAghuObcTYtAWe9ouX-lCinlKVnhQPaAII0JsYPFGQ5IuRB814XObabtKTWk7rLX5Mnr0A7VEHo0

Shebehe, J., & Hansson, A. (2018). High Hospital Readmission Rates for participants associated with low Socioeconomic Status in a Swedish Region: a cross-sectional study in primary care. *Scandinavian Journal of Primary Health Care,* 36(3), 300-307. doi: https://doi.org/10.1080/02813432.2018.1499584

SHS Consulting. (2013). *County of Haliburton housing strategy.* https://haliburton.civicweb.net/document/96856

Shucksmith, M., & Brown, D. (2016). *Routledge International Handbook of Rural Studies*. New York, NY: Routledge Taylor & Francis Group.

Siconolfi, D., Shih, R. A., Friedman, E. M., Kotzias, V. I., Ahluwalia, S. C., Phillips, J. L., & Saliba, D. (2019). Rural-urban disparities in access to home-and-community-based services and supports: Stakeholder perspectives from 14

states. *Journal of American Medical Directors Association, 20*(4), 503-508. doi: https://doi.org/10.1016/j.jamda.2019.01.120

Sims-Gould, J., Stott-Eveneshen, S., Fleig, L., McAllister, M., & Ashe, M. C. (2017). Patient perspectives on engagement in recovery after hip fracture: A qualitative study. *Journal of Aging Research*, 1-9. doi: https://doi.org/10.1155/2017/2171865

Singh, G. K., Daus, G. P., Allender, M., Ramey, C. T., Martin, E. K., Perry, C., Reyes, A., & Vedamuthu, I. P. (2017). Social Determinants of Health in the United States: Addressing Major Health Inequality Trends for the Nation, 1935-2016. *International journal of MCH and AIDS*, 6(2), 139–164. doi: https://doi.org/10.21106/ijma.236

Sixsmith, J., Lan Feng, M., Woorych, R., Canham, S., Battersby, L., & Sixsmith, A. (2017). Ageing well in the right place: Partnership working with older people. *Working with Older People*, *21*(1), 1366-3666. doi: 10.1108/WWOP01-20170001

Skilbeck, J. K., Arthur, A., & Seymour, J. (2017). Making sense of frailty: An ethnographic study of the experience of older people living with complex health problems. *International Journal of Older People Nursing, 13*(1), e12172. doi: https://doi.org/10.1111/opn.12172

Skinner, M., Andrews, G., & Cutchin, M. (2018). *Geographical gerontology: Perspectives, concepts, approaches.* New York, NY: Routledge.

Skinner, M., & Hanlon, N. (2016). *Ageing resource communities: New frontiers of rural population change, community development and voluntarism*. New York: Routledge.

Skinner, M., & Winterton, R (2018). Rural ageing: Contested spaces, dynamic places, In Skinner, M., Andrews, G. & Cutchin, M. (Eds.), *Geographical gerontology: Perspectives, concepts, approaches* (pp. 136-148). New York, NY: Routledge.

Skinner, M., & Winterton, R. (2017). Interrogating the contested spaces of rural aging: Implications for research, policy and practice. *The Gerontologist, 58*(1), 15-25. doi: https://doi.org/10.1093/geront/gnx094

Skinner, M., Winterton, R., & Walsh, K. (2021). *Towards Critical Perspectives on Rural Ageing*. London, UK: Routledge.

Slade, S., Shrichand, A., & DiMillo, S. (2019). *Health care for an aging population: A study of how physicians care for seniors in Canada.* Ottawa, ON: The Royal College of Physicians and Surgeons of Canada.

Slatyer, S., Aoun, S. M., Hill, K. D., Walsh, D., Whitty, D., Toye, C. (2019). Caregivers' experiences of a home support program after the hospital discharge of an older family member: A qualitative analysis. *BMC Health Services Research, 19*(220). doi: https://doi.org/10.1186/s12913-019-4042-0

Smith, T., Sutton, K., Pit, S., Muyambi, K., Terry, D., Farthing, A., Courney, C., & Cross, M. (2017). Health professional students' rural placement satisfaction and rural practice intentions: A national cross-sectional survey. *Australian Journal of Rural Health, 26*(1), 26-32. doi: https://doi.org/10.1111/ajr.12375

Speak Up Ontario. (2021). *Substitute decision maker hierarchy.* https://www.speakupontario.ca/resource/the-substitute-decision-maker-hirearchy/

Spiridonov, S. I. (2017). Causes for Ineffective Communication between Medical Specialists. *Journal of IMAB.* 23(3),1623-1626. doi: 10.5272/jimab.2017233.1623

Statistics Canada. (2020). *Caregivers in Canada, 2018.* https://www150.statcan.gc.ca/n1/en/daily-quotidien/200108/dq200108a-eng.pdf?st=dGX06OuH

Statistics Canada. (2021). *Census profile, 2016 census.* https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CD&Code1=3546&Geo2=PR&Code2=47&Data=Count&SearchText=Haliburton&SearchType=Begins&SearchPR=01&B1=All&

Stephens, C., & Breheny, M. (2018). Ageing identities in the twenty-first century: The social and practical effects of talk about being old. In Peel, E., Holland, C., & Murray, M. (Eds.), *Psychologies of Ageing*. Palgrave MacMillian: Cham.

Strijker, D., Bosworth, G., & Bouter, G. (2020). Research methods in rural studies: qualitative, quantitative and mixed methods. *Journal of Rural Studies, 78,* 262-270. doi: https://doi.org/10.1016/j.jrurstud.2020.06.007

Sturmberg, J., Martin, C., & Katerndabl, D. (2014). Systems and complexity thinking in general practice literature: An integrative, historical narrative review. *Annals of Family Medicine, 12*(1), 66-74. doi: https://www.annfammed.org/content/annalsfm/12/1/66.full.pdf

Sutherland, J., & Busse, R. (2016). Canada: Focus on a country's health system with provincial diversity. *Health Policy, 120*(7), 729-731. doi: 10.1016/j.healthpol.2016.06.010

Swan, B. A., Haas, S., & Jessie, A. T. (2019). Care coordination: Roles of registered nurses across the care continuum. *Nursing Economics*, 37(6), 317-323.

Taylor, J. K., Buchan, I. E., & van der Veer, S. (2019). Assessing life-space mobility FOR A more holisitic view on wellbeing in geriatric research and clinical practice. *Aging Clinical and Experimental Research, 31*, 439-445. doi: https://doi.org/10.1007/s40520-018-0999-5

Terry, D., Le, Q., Nguyen, U., & Hoang, H. (2015). Workplace health and safety issues among community nurses: A study regarding the impact on providing care to rural consumers. *BMJ Open, 5*(e008306). doi:10.1136/bmjopen-2015- 008306

Thorne, S. (2011). Toward methodological emancipation in applied health research. *Qualitative Health Research, 21*(4). 443-453. doi: https://doi.org/10.1177/1049732310392595

Tikkanen, R., Osborn, R., Mossialos, E., Djorodjevic, A., Wharton, G. (2020). *International Profiles of Health Care Systems.* https://www.researchgate.net/profile/Adriano-Massuda-2/publication/352750082_The_Brazilian_Health_Care_System/links/60d63a1e299bf1ea9ebe48df/The-Brazilian-Health-Care-System.pdf#page=25

Tkatch, R., Musich, S., MacLeod, S., Kraemer, S., Hawkins, K., Wicker, E. R., & Armstrong, D. G. (2017). A qualitative study to examine older adults' perceptions of health: Keys to aging successfully. *Geriatric Nursing*, 38(6), 485-490, doi: https://doi.org/10.1016/j.gerinurse.2017.02.009.

Tomlinson, J., Cheong, V., Fylan, B., Silcock, J., Smith, H., Karban, K., Bleninsopp, A. (2020). Successful care transitions for older people: a systematic review and meta-analysis of the effects of interventions that support medication continuity. *Age and Ageing*, 49(4), 558–569. doi: https://doi.org/10.1093/ageing/afaa002

Tsui, C., Kim, K., & Spencer, M. (2020). The diagnosis “failure to thrive” and its impact on the care of hospitalized older adults: a matched case-control study. *BMC Geriatrics,* 20(62). doi: https://doi.org/10.1186/s12877-020-1462-y

Twigg, J., & Martin, W. (2015). The challenge of cultural gerontology. *The Gerontologist, 55*(3), 353-359. doi: https://doi.org/10.1093/geront/gnu061

Uemura, K., Yamada, M., & Okamoto, H. (2021). The effectiveness of an active learning program in promoting a healthy lifestyle among older adults with low health literacy: A randomize controlled trial. *Gerontologyy,* 67(1), 25-35. doi: 10.1159/000511357

Valentjin, P., Boesveld, I., Van Der Klauw, D., Ruwaard, D., Struijs, J., Molema, J., Bruijnzeels, M., & Vrijhoef, H. (2015). Towards a taxonomy for integrated care: A mixed-methods study. *International Journal of Integrated Care, 15*(4), 1-18. doi: 10.5334/ijic.1513

Valles, S. (2020). Philosophy of Biomedicine. *The Stanford Encyclopedia of Philosophy,* Edward N. Zalta (ed.). https://plato.stanford.edu/archives/sum2020/entries/biomedicine

Veillard, J., Fekri, O., Dhalla, I., & Klazinga, N. (2015). Measuring outcomes in the Canadian health sector: Driving better value from healthcare. *C.D. Howe Institute Commentary, 438,* 1-15. doi: https://www.cdhowe.org/sites/default/files/attachments/research_papers/mixed/Commentary_438.pdf

Vogelsang, E. (2016). Older adult social participation and its relationship with health: Rural-urban Differences. *Health & Place, 42*, 111-119. doi: https://doi.org/10.1016/j.healthplace.2016.09.010

Wakerman, J., & Humphreys, J. S. (2019). "Better Health in the Bush": why we urgently need a national rural and remote health strategy. *Medical Journal of Australia*, 210(5), 202-203. doi: https://doi.org/10.5694/mja2.50041

Wang, J., Simmons, S. F., Maxwell, C. A., Schlundt, D. G., & Mion, L. C. (2018). Home health nurses' perspectives and care processes related to older persons with frailty and depression: A mixed methods pilot study. *Journal of Community Health Nursing*, 35(3), 118-136. doi: https://doi.org/10.1080/07370016.2018.1475799

Weeks, L. E., Macdonald, M., Martin-Misener, Helwig, M., Bishop, A., Iduye, D., & Moody, E. (2018). The impact of transitional care programs on health services utilization in community-dwelling older adults: A systematic review. *JBO Evidence Synthesis, 16*(2), 345-384. doi: 10.11124/JBISRIR-2017-003486

Weeks, L. E., McInnis-Perry, G., MacQuarrie, C., & Jovanovic, S. (2016). Insights Into Roles for Health-Care Professionals in Meeting the Needs of Older Adults and Unpaid Caregivers During Health-Care Transitions. *Canadian Journal of Nursing Research*, 48(3–4), 70–79. doi: https://doi.org/10.1177/0844562116676579

Whitehead, J., Shaver, J., & Stephenson, R. (2016). Outness, stigma, and primary health care utilization: Among rural LGBT populations. *PLoS ONE*, 11(1). doi: e0146139. https://doi.org/10.1371/journal.pone.0146139

Wilberforce, M., Challis, D., Cavies, L., Kelly, M.P., Roberts, C., & Clarkson, P. (2016). Person-centredness in community care of older people: A literature-based concept

synthesis. *International Journal of Social Welfare, 26*(1), 86-98. doi: https://doi.org/10.1111/ijsw.12221

Williams, A., Sethi, B., Duggleby, W., Ploeg, J., Markle-Reid, M., Peacock, S., & Ghosh, S. (2016). A Canadian qualitative study exploring the diversity of the experience of family caregivers of older adults with multiple chronic conditions using a social location perspective. *International Journal for Equity in Health, 15*(40), 1-16. doi: https://doi.org/10.1186/s12939-016-0328-6

Wood, L. (2016). Community development in higher education: How do academics ensure their community-based research makes a difference? *Community Development Journal, 52*(4), 685-701. doi: 10.1093/cdj/bsv068

World Health Organization (WHO). (2017). *Global Strategy and Action Plan on Ageing and Health.* Geneva, Switzerland: World Health Organization.

World Health Organization (WHO) (2015). *WHO global strategy on people-centred integrated health services*. Geneva, Switzerland: WHO Document Production Services.

World Health Organization (WHO). (2012). *WHOQOL User Manual*. https://www.who.int/publications/i/item/WHO-HIS-HSI-Rev.2012.03

Wyman, M. F., Shiovitz-Ezra, S. & Bengel J. (2018). Ageism in the third age, contemporary perspectives on ageism, In Ayalon, L. & Tesch-Romer, C. (Eds.), *Contemporary Perspectives on Ageism* (pp.115-130). New York, NY: Springer International.

Yang, T., Noah, A., & Shoff, C. (2016). Revisiting the rural paradox in US counties with spatial Durbin modeling. In Howell, F., Porter, J. & Mathews, S. (Eds.),

Recapturing space: New middle range theory in spatial demography. Springer: Cham.

Zhang, J., & Wang, B. (2020). Rural place attachment and urban community integration of chinese older adults in rural-to-urban relocation. *Ageing and Society*, 1-19. doi: 10.1017/S0144686X20001464

Zihindulai, G., Ross, A. J., & MacGregor, R. G. (2018). A rural scholarship model addressing the shortage of healthcare workers in rural areas. *South African Health Review*, *2018*(1), 1025-1715. doi: https://journals.co.za/doi/pdf/10.10520/EJC-144919d3b7

9 Appendices

9.1 Appendix A: Rural Community Inventory

Rural Community Inventory		
Older Adult Health Construction- Intersectionality/Social determinants of Health		
AGE/GENDER DEMOGRAPHICS		
Age	Male	Female
Age 0-4		
Age 5-14		
Age 15-19		
Age 20-24		
Age 25-44		
Age 45-54		
Age 55-64		
Age 65-74		
Age 75-84		
Age 85 and over		
Distribut[i]on of the population 65 and over		
Distribution of the population 85 and over		
Median age of the population		
Drop in Centre that Supports Older Adults		
Health Clinic/Geriatric Services that Support Older Adults		
Resource Centre that Supports Older Adults		
Informal Groups that Support Older Adults		
Advocacy Groups for Older Adults		
Annual Events that Support Older Adults		
Local Initiatives in Support of Older Adults		
Shelter that supports older adults		
Health Clinic/Services that Support Youth		
Resource Centre that Supports Youth		
Shelter that Supports Youth		
Informal Groups that Support Youth		
Advocacy Groups for Youth		
Annual Events that Support Youth		
Local Initiatives in Support of Youth		
ETHNICITY		
Canadian Born population		
Number of immigrant & non-permanent residents		
Number of first generation immigrants		
Number of second generation immigrants		
Number of third generation immigrants		
Indigenous population		
# of visible minorities		
Total population speaking English		
Total population speaking French		
Total population other languages		
Drop in Centre that Supports Ethnic Diversity/ New Immigrants		

Health Clinic/Services that Supports Ethnic Diversity/ New Immigrants	
Resource Centre that Supports Ethnic Diversity/ New Immigrants	
Shelter that Supports Ethnic Diversity/ New Immigrants	
Informal Groups that Supports Ethnic Diversity/ New Immigrants	
Events that Support Ethnic Diversity/ New Immigrants	
Local Initiatives in Support of Ethnic Diversity/ New Immigrants	
Languages spoken in Haliburton County	
Immigration statistics	
GENDER	
Drop in Centres to Support Gender Equality	
Women's Health Clinic/Services	
Men's Health Clinic/Services	
Women's Resource Centre	
Men's Resource Centre	
Women's Shelter	
Men's Shelter	
Informal Women's Groups	
Informal Men's Groups	
Events that Support Gender	
Local Initiatives in Support of Gender Equality	
SEXUALITY	
Drop in Centre to Support Sexual Diversity	
Sexual Health Clinic/Services	
Sexuality Resource Centre	
Shelter/Group Home that Supports Sexual Diversity	
Informal groups to Support Sexual Diversity	
Annual Events that Support Sexual Diversity	
Local Initiatives in Support of Sexual Diversity	
DISABILITY	
Drop in Centre to Support People with Physical Disabilities/Mental Health Conditions	
Health Clinic/Services for People with Physical Disabilities/Mental Health Conditions	
Resource Centre for People with Physical Disabilities/Mental Health Conditions	
Shelter/Group Homes that Support People with Physical Disabilities/Mental Health Conditions	
Informal groups that Support People with Physical Disabilities/Mental Health Conditions	
Annual Events that Support People with Physical Disabilities/Mental Health Conditions	
Local Initiatives in Support of People with Physical Disabilities/Mental Health Conditions	
Private Counselling	

SOCIO-ECONOMIC STATUS/INCOME & SOCIAL STATUS	
Low income prevalence	
Average earnings	
Local Initiatives that Support those with Low-Socio-Economic Status	
Local Groups that Support those with Low-Socio-Economic Status	
Co-Op Housing	
Rent Supplement Units	
Assisted/Subsidized Housing for Older Adults, Families, Low Income Single People, Persons with Disabilities/Special Needs	
Supportive Housing	
Shelter	
EMPLOYMENT & WORKING CONDITIONS	
Employment rate	
Unemployment rate	
Career Training/ Placement Programs	
EDUCATION & LITERACY	
Overall Education	
No Certificate, diploma or degree	
Secondary School Diploma or Equivalent	
Post-Secondary Certificate, Diploma or Degree	
Apprenticeship or trades certificate	
College or non-university diploma	
University Bachelor or above	
Graduate level education	
Major Fields of Study	
High schools	
Community Colleges	
Universities	
Continuing Education	
Literacy Support	
Local Initiatives on education/literacy	
Libraries	
Elementary schools	
PHYSICAL ENVIRONMENTS	
Major Highways	
Major landmarks	
Municipal, Provincial, National Parks	
HEALTHY BEHAVIOURS	
Health Status	
Prevalence of substance misuse/abuse, alcoholism or alcohol misuse	
BIOLOGY & GENETIC ENDOWMENT	
Local Health Demographics	
Care Context	
FORMAL HEALTH SERVICES	
Hospital Services	

Health Centres/services	
Walk-in clinics	
Family Practice	
Nurse Practitioner Services	
Blood/Urine Testing Facility	
Diagnostic /Radiology Care services	
Foot Care	
Occupational Therapy	
Speech Language Therapy	
Chiropractic/ Massage Therapy/ Physiotherapy	
Home Care Services	
Retirement Homes	
Supportive Living Homes	
Long-Term Care	
Respite Care	
Alternative Healing Services/ Opportunities	
Pharmacies	
Dentists/Oral Surgeons	
Medical Supplies/Vendors	
Optometrists	
FORMAL SOCIAL SERVICES	
Substance Abuse & Addiction Services	
Meal delivery services	
Food banks	
Clothing Depots/ Second Hand Clothing Store	
Social Services	
Community Services	
Group Homes	
Emergency Services: Police, Ambulance, Fire	
INFORMAL SOCIAL SUPPORTS	
Informal Support Groups/Resources	
Common law partnerships	
Married partnerships	
Separated partnerships	
Divorced	
Widowed	
Never Married	
Total number of families	
Total number of common-law couple families	
Total number of lone parent families	
Total number of married-couple families	
PARTNERSHIPS	
Between Formal Services	
Between Formal Services & Informal Groups	
Rural Context	
HISTORICAL FACTORS	
Historical Landmarks	

Historical Figures	
Historical Events	
Museum	
ECONOMIC FACTORS	
Predominant Economic Industries	
Legal Services	
Court	
Banks/Credit Unions	
Insurance Offices	
Real Estate Offices	
Farming Association	
Grocery stores	
Farmers Market	
Liquor/Beer Store	
Bakery	
Is Consumer District Concentrated or Dispersed?	
What conveniences are located in the main commercial district (groceries, gas, etc.?	
Community Futures Development Corporations	
Chamber of Commerce	
Aboriginal Business Development Services	
Local Business Development Services /Local development initiatives	
Tourism Boards/Associations	
POLITICAL FACTORS	
Political Initiatives supporting Older Adults	
County & Municipal Planning	
Service Ontario	
Service Canada	
Municipal Assistance office	
Ministry of Transportation	
Band Council	
What is the Governance Structure of the County?	
SOCIAL FACTORS	
Availability of public/private transport options: bus, passenger/freight train, van service, airport, boat/ferry, helicopter, taxi	
Type of transportation used	
Post Office	
Availability of Cell Phone/Internet Service	
Prominent Community Figures	
Cinema	
Curling Rink	
Bowling Lanes	
Municipal Swimming Pool (indoor/outdoor)	
Municipal skating rink (indoor/outdoor)	
Community Centre	
YMCA	
Athletic Club (Public/Private)	

Rotary/Lions Clubs	
Tennis Courts/Clubs	
Skiing Clubs/Trails	
Hiking Clubs/Trails	
Golf Courses	
Camping	
Community Groups, Clubs or Meetings-Adult, Youth, & Older Adult	
Other Recreational activities available	
CULTURAL FACTORS	
Theatre/Performing Arts/Film	
Art Galleries/Initiatives	
Cultural Initiatives	
Indigenous Reserves	
Religious Institutions	
Cultural Drop in Centre	
Culturally Sensitive Health Clinic/Services	
Cultural Resource Centre	
Shelter/Group Home that Supports Cultural Sensitivity	
Informal groups to Support Culture	
Local Initiatives in Support Culture	
GEOGRAPHICAL FACTORS	
Proximity to urban-centre over 150,000	
CENSUS INFORMATION	
Total Population	
EVIDENCE OF DYNAMIC CONTEXT (e.g.,shifting demographics, economies etc.)	
Mobility Status of Residents	
Businesses or social institutions opened in the last 5 years	
Businesses or social institutions closed in the last 5 years	
Potential Industry Shift	
EVIDENCE OF CONTESTED SPACES	

9.2 Appendix B: Participant Information Letters & Consent Forms

The "Transitional Care of Rural Older Adults" Trent University Study Administrator Information and Consent Form

Laura Poulin
Trent University
1600 West Bank Dr.
ESC B313
Peterborough, ON
K9J 7B8

705-748-1011 Ext 7938

lpoulin@trentu.ca

Dear Potential Research Participant,

You are invited to participate in this study that will focus on the transitional care of older adults in rural communities. In particular, the research will explore the experiences of older adults as they are transferred either between a hospital and a long-term care home or between a hospital and a home in the community. The intent of this study is to better understand what factors contribute to older adult health to gain insight into the transitional care of older adults in rural communities.

You are being invited because you are an Administrator/Manager who oversees the transitional care of older adults. With your consent, I am interested in setting up an interview with you to learn about your personal experiences with transitional care of older adults in your community. You will be asked a series of questions in the interview, which can be completed over a number of interview sittings if needed. The interview can last up to 2 hours, but can be as long or short as you wish. The interview can be booked to fit your schedule and in a location of your preference. You will be asked:

- Questions to understand what you feel influences older adult health
- Questions on the local community and how the community influences older adult health
- Questions on the health and social services provided in the community as well as the influence of informal supports on older adult health

- Questions on the transitional care of older adults in your community
- Questions on the type of information collected on older adult patients
- Questions related to policies, structures and governance that support the transitional care of older adults in rural communities

My questions may uncover areas of disagreement or conflict among the various participants (patient, informal supports, you or other staff), and you may feel vulnerable providing answers that may counter other participants' views. This conflict may also directly impact you professionally, as your leadership or other administrative aspects may be criticized. Since I am trying to document what works and what doesn't work in older adult transitions, understanding these aspects of patient transfers is important. Please be assured that I will treat you with the utmost respect throughout the research period. I would like to gain your perspective on the transfer process, but it is your right to choose what to share with me, what not to share with me, to choose not to answer a question I ask, or to choose to end your participation in the study altogether. While it may be known that you are a participant in the study, your privacy and confidentiality as well as your specific contributions will be protected within the limits of the law.

Your participation in the study may be known by others, however, the information that you provide in your interviews will be confidential and only accessible by the research team. The information collected in the study will be recorded either by hand in a research notebook or on a password protected laptop computer depending on the research setting. This information will be kept either on person, in a locked filing cabinet in the Principal Investigator's research office at Trent University or on an encrypted file on the password protected laptop to keep all files confidential. Throughout the duration of the study your name and identifying information will be kept confidential and will be kept anonymous in all analysis, publications and reporting documents. All project information will be destroyed five years after the completion of the project. This attention to confidentiality will minimize the professional risk associated with participating in the study and ensure that your responses do not compromise your employment or your relationships with other staff.

This project has been approved by the Trent University Research Ethics Board, but your participation in the project is entirely voluntary. You are free to answer or not answer any of the questions in the study and you can end your participation in the study at any time without consequence. While you may experience no direct benefit as a result of your participation,

you may value being asked to share your expertise on this important topic and you will have access to any academic publications or public presentations that result from the research.

As a participant in the above project, I understand and agree with the following:

- This project has been approved by the Trent University Research Ethics Board;
- I have been fully informed about the nature of the research and the extent of my participation in the project
- I recognize that there is no direct benefit from my participation;
- My participation in this project is entirely voluntary and I am under no obligation to participate;
- The information supplied during the project will remain confidential and is not an evaluation of my work performance. The information provided will not be shared directly with any supervisorial staff and therefore will not interfere with my employment status or relationships within the workplace;
- I don't have to talk about anything that makes me uncomfortable;
- I may withdraw my participation in the project at any time without consequence;
- The observations made in the study will not interfere or delay any medical treatment or the transfer process itself;
- My identity will not be used in any reports or publications;
- My identity will only be known to the research team although others involved in the patient transfer will be aware of my participation in the study;
- There is a minimal risk that my participation will be known to other participants and community members;
- The information gained from this project will be kept on person, securely stored in encrypted files on a password protected laptop or locked in a filing cabinet in the research team's office at Trent University, to be destroyed after five years;
- I can contact Laura Poulin with any questions about the project, or the Trent University Research Office, (705 748-1011 ext.7938) with any concerns about research ethics;
- I have been provided with a copy of the informed consent form for my own records;
- All of my questions regarding my participation in the research project and consent have been answered to my satisfaction.

Participant Name:_____

Participant Signature:_____

Date:_____

***If emailing this consent please send it to: Laura Poulin**
lpoulin@trentu.ca

***If mailing the consent form please address it to:**
Laura Poulin
Trent University
West Bank Dr. ESC B313
Peterborough, ON.
K9J 7B8

Would you like a copy of the research findings?

Yes ☐ No ☐

If yes, please provide an email or home address where you would like the information sent:

_____
_____
_____
_____

Verbal Consent

Principal Investigator: "The study examining transitional care of rural older adults has been fully explained to me and I am aware of its purpose. I understand that my participation is completely voluntary and that my decision to participate or not will in no way interfere with my employment status or relationships within the workplace and will not be shared with supervisors/managers to act as an evaluation of job performance. I understand that my identity will be protected to the fullest extent of the law, and I understand the methods that will be used to maintain confidentiality of the information I provide."

"Do you agree with the above statement?"

_____Yes _____No, I do not wish to participate.

If yes, record name of participant, and provide interviewer signature authorizing that verbal consent was given.

Name of agreeing participant:_____

Signature of Principal Investigator:_____

Date:_____

If you have any further questions about the research, please contact the principal investigator Laura Poulin (lpoulin@trentu.ca, 705-748-1011 ext. 7938). This study has been reviewed and approved by the Trent University Research Ethics Board. Please direct questions pertaining to this review to Karen Mauro, Certifications and Regulatory Compliance Officer, Trent University, Phone: 705-748-1011 ext 7896, Email: kmauro@trentu.ca.

Would you like a copy of the research findings?

Yes ☐ No ☐

If yes, please provide an email or home address where you would like the information sent:

_____

_____

_____

The "Transitional Care of Rural Older Adults" Trent University Study Front-Line Health Care Staff Information and Consent Form

Laura Poulin
Trent University
1600 West Bank Dr.
ESC B313
Peterborough, ON
K9J 7B8

705-748-1011 Ext 7938

lpoulin@trentu.ca

Dear Potential Research Participant,

You are invited to participate in this study that will focus on the transitional care of older adults in rural communities. In particular, the research will explore the experiences of older adults as they are transferred either between a hospital and a long-term care home or between a hospital and a home in the community. The intent of this study is to better understand what factors contribute to older adult health to gain insight into the transitional care of older adults in rural communities.

With your consent, I will observe you during the patient transfer, if you are directly involved. I will ask the occasional question to document the process of older adult transitional care, but I will not interfere or delay any medical treatment or the transfer process itself.

I am also interested in setting up an interview with you to learn about your personal experiences with transitional care of older adults in your community. You will be asked a series of questions in the interview, which can be completed over a number of interview sittings if needed. The interview can last up to 2 hours, but can be as long or short as you wish The interview can be booked to fit your schedule and in a location of your preference. You will be asked:

- Questions to understand what you feel influences older adult health
- Questions on the local community and how the community influences older adult health

- Questions on the health and social services provided in the community as well as the influence of informal supports on older adult health
- Questions on the transitional care of older adults in your community
- Questions on the type of information collected on older adult patients

My observations of you may include situations of disagreement or conflict among the various participants (patient, informal supports, you or other staff), and you may feel vulnerable being observed during such conflict. Since I am trying to document what works and what doesn't work in older adult transitions, understanding these aspects of patient transfers is important. Please be assured that I will treat you with the utmost respect throughout the research period. During the interviews, I would like to gain your perspective on the transfer process, but it is your right to choose what to share with me, what not to share with me, to choose not to answer a question I ask, or to choose to end your participation in the study altogether. While it may be known that you are a participant in the study, your privacy and confidentiality as well as your specific contributions will be protected within the limits of the law.

The information collected in the study will be recorded either by hand in a research notebook or on a password protected laptop computer depending on the research setting. This information will be kept either on person, in a locked filing cabinet in the Principal Investigator's research office at Trent University or on an encrypted file on the password protected laptop to keep all files confidential. Your participation in the study will be known by others if you are involved in a patient transfer, however, the information that you provide in your interviews will be confidential and only accessible by the research team. Throughout the duration of the study your name and identifying information will be kept confidential and will be kept anonymous in all analysis, publications and reporting documents. All project information will be destroyed five years after the completion of the project. This attention to confidentiality will minimize the professional risk associated with participating in the study and ensure that your responses do not compromise your employment or your relationships with other staff.

This project has been approved by the Trent University Research Ethics Board, but your participation in the project is entirely voluntary. You are free to answer or not answer any of the questions in the study and you can end your participation in the study at any time without consequence. While you may experience no direct benefit as a result of your participation,

you may value being asked to share your expertise on this important topic and you will have access to any academic publications or public presentations that result from the research.

As a participant in the above project, I understand and agree with the following:

- This project has been approved by the Trent University Research Ethics Board;
- I have been fully informed about the nature of the research and the extent of my participation in the project
- I recognize that there is no direct benefit from my participation;
- My participation in this project is entirely voluntary and I am under no obligation to participate;
- The information supplied during the project will remain confidential and is not an evaluation of my work performance. The information provided will not be shared directly with any supervisorial staff and therefore will not interfere with my employment status or relationships within the workplace;
- I don't have to talk about anything that makes me uncomfortable;
- I may withdraw my participation in the project at any time without consequence;
- The observations made in the study will not interfere or delay any medical treatment or the transfer process itself;
- My identity will not be used in any reports or publications;
- My identity will only be known to the research team although others involved in the patient transfer will be aware of my participation in the study;
- There is a minimal risk that my participation will be known to other participants and community members;
- The information gained from this project will be kept on person, securely stored in encrypted files on a password protected laptop or locked in a filing cabinet in the research team's office at Trent University, to be destroyed after five years;
- I can contact Laura Poulin with any questions about the project, or the Trent University Research Office, (705 748-1011 ext.7938) with any concerns about research ethics;
- I have been provided with a copy of the informed consent form for my own records;
- All of my questions regarding my participation in the research project and consent have been answered to my satisfaction.

Participant Name:_____

Participant Signature:_____

Date:_____

***If emailing this consent please send it to: Laura Poulin**
lpoulin@trentu.ca

***If mailing the consent form please address it to:**
Laura Poulin
Trent University
West Bank Dr. ESC B313
Peterborough, ON.
K9J 7B8

Would you like a copy of the research findings?

Yes ☐ No ☐

If yes, please provide an email or home address where you would like the information sent:

_____
_____
_____
_____

Verbal Consent

Principal Investigator: "The study examining transitional care of rural older adults has been fully explained to me and I am aware of its purpose. I understand that my participation is completely voluntary and that my decision to participate or not will in no way interfere with my employment status or relationships within the workplace and will not be shared with supervisors/managers to act as an evaluation of job performance. I understand that my identity will be protected to the fullest extent of the law, and I understand the methods that will be used to maintain confidentiality of the information I provide."

"Do you agree with the above statement?"

_____Yes _____No, I do not wish to participate.

If yes, record name of participant, and provide interviewer signature authorizing that verbal consent was given.

Name of agreeing participant:_____

Signature of Principal Investigator:_____

Date:_____

If you have any further questions about the research, please contact the principal investigator Laura Poulin (lpoulin@trentu.ca, 705-748-1011 ext. 7938). This study has been reviewed and approved by the Trent University Research Ethics Board. Please direct questions pertaining to this review to Karen Mauro, Certifications and Regulatory Compliance Officer, Trent University, Phone: 705-748-1011 ext 7896, Email: kmauro@trentu.ca.

Would you like a copy of the research findings?

Yes ☐ No ☐

If yes, please provide an email or home address where you would like the information sent:

_____

_____

_____

The "Transitional Care of Rural Older Adults" Study Informal Support Information & Consent Form

Laura Poulin
Trent University
1600 West Bank Dr.
ESC B313
Peterborough, ON
K9J 7B8

705-748-1011 Ext 7938

lpoulin@trentu.ca

Dear Potential Research Participant,

You are invited to participate in this study that will focus on the transitional care of older adults in rural communities. In particular, the research will explore the experiences of older adults as they are transferred either between a hospital and a long-term care home or between a hospital and a home in the community. The intent of this study is to better understand what factors contribute to older adult health to gain insight into the transitional care of older adults in rural communities.

With your consent, I will observe the patient transfer process. This will require me to visit the older adult you support in either their home or long-term care home in the 24 hours after they are transferred. I will ask the occasional question to document the process of older adult transitional care, but I will not interfere or delay any medical treatment or the transfer process itself. Once the older adult you support is settled in the new setting, an interview will be set up with you to discuss the observed transfer and to learn about your personal experiences with transitional care in the community. You will be asked a series of questions, which can be

completed over a number of interview sittings, if needed. The interview can last up to 2 hours, but can be as long or short as you wish. The interview can be booked according to your schedule and in a location of your preference. You will be asked:

- Questions to understand what you feel influences the health of the older adult you support
- Questions on the local community and how the community influences older adult health
- Questions on the formal and informal supports in the community
- Questions on the transfer of the older adult you support as well as the transitional care of older adults in general in the community

You, or the person you care for may experience being upset or frustrated during my observations of the transfer or when we discuss aspects of the transfer. This may occur if you or the person you care for are dissatisfied with the transfer process, if you feel that your needs, or the needs of the person you care for, are not being met, etc. Since I am trying to document what works and what doesn't work during older adult transfers, it is important that I understand your true experiences. Please be assured that I will treat you and the person you care for, with the utmost of respect throughout the research period. While I will be interested in discussing all of your views on this process, it is your right to choose what to share with me, to choose not to answer a question I ask, or to choose to end your participation in the study altogether.

The interview will be recorded either by hand in a research notebook or on an encrypted file on the Principal Investigator's computer depending on the

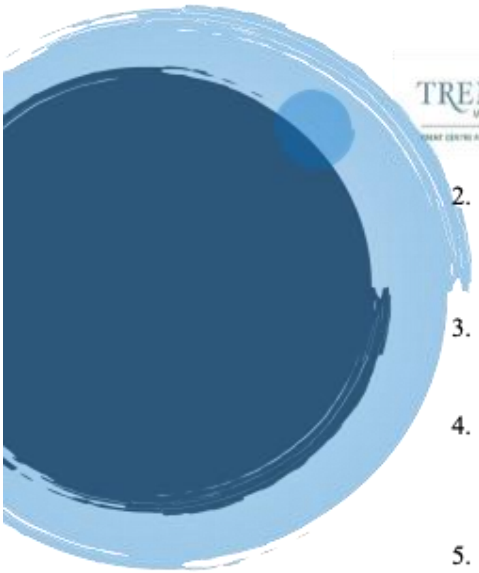
research setting. The information collected from the project will be kept either on person, in a locked filing cabinet in the research office at Trent University or in an encrypted file on a password protected computer to keep all files confidential.

Your participation in the study will be known by others involved in the patient transfer, however, your privacy and the information that you provide will be kept confidential within the limits of the law. Throughout the duration of the study your name and identifying information will be kept confidential and kept anonymous in all analysis, publications and reporting documents. All project information will be destroyed five years after the completion of the project. This will minimize the emotional risk of the participants in the study and ensure that the services that the older adult receives are not compromised by your participation.

This project has been approved by the Trent University Research Ethics Board, but your participation in the project is entirely voluntary. You are free to answer or not answer any of the questions in the study and you can end your participation in the study at any time without consequence. While you or the person you care for, may experience no direct benefit from participation, you may value being asked to share your expertise on this important topic and you will have access to any academic publications or public presentations that result from the research.

As a participant in the above project, I understand and agree with the following:

1. This project has been approved by the Trent University Research Ethics Board;



2. I have been fully informed about the nature of the research and the extent of my participation in the project and recognize that there is no direct benefit from my participation;
3. My participation in this project is entirely voluntary and I am under no obligation to participate;
4. My decision to participate or not will not influence the health or social services that the older adult I support receives now, or in the immediate future;
5. I don't have to talk about anything that makes me uncomfortable;
6. I may withdraw my participation in the project at any time without consequence;
7. The observations made in the study will not interfere or delay any medical treatment or the transfer process itself;
8. My identity will not be used in any reports or publications;
9. Although others involved in the patient transfer will be aware of my participation in the study the information provided in the interviews will be kept confidential;
10. There is a minimal risk that my participation will be known to other participants and community members;
11. The information gained from this project will be kept on person, securely stored on encrypted files on the Principal Investigator's computer or locked in a filing cabinet in the research team's office at Trent University, to be destroyed after five years;

12. I can contact Laura Poulin with any questions about the project, or the Trent University Research Office, (705 748-1011 ext.7938) with any concerns about research ethics;
13. I have been provided with a copy of the informed consent form for my own records;
14. All of my questions regarding my participation in the research project and informed consent form have been answered to my satisfaction.

Participant Name:

_____

Participant Signature:

_____

Date: _____

***If emailing this consent please send it to: Laura Poulin lpoulin@trentu.ca**

***If mailing the consent form please address it to:**
Laura Poulin
Trent University
West Bank Dr. ESC B313
Peterborough, ON.
K9J 7B8

Would you like a copy of the research findings?

Yes ☐ No ☐

If yes, please provide an email or home address where you would like the information sent:

_____
_____

Verbal Consent

Principal Investigator: "The study examining transitional care of rural older adults has been fully explained to me and I am aware of it's purpose. I understand that my participation is completely voluntary and that my decision to participate or not will in no way interfere the medical or social services that the older adult I support receives. I understand that my identity will be protected to the fullest extent of the law, and I understand the methods that will be used to maintain confidentiality of the information I provide."

"Do you agree with the above statement?"

_____Yes _____No, I do not wish to participate.

If yes, record name of participant, and provide Principal Investigator's signature authorizing that verbal consent was given.

Name of agreeing participant_____

Signature of Principal Investigator:_____

Date:_____

If you have any further questions about the research, please contact the principal investigator Laura Poulin (lpoulin@trentu.ca, 705-748-1011 ext. 7938). This study has been reviewed and approved by the Trent University Research Ethics Board. Please direct questions pertaining to this review to Karen Mauro, Certifications and Regulatory Compliance Officer, Trent University, Phone: 705-748-1011 ext 7896, Email: kmauro@trentu.ca.

Would you like a copy of the research findings?

Yes ☐ No ☐

If yes, please provide an email or home address where you would like the information sent:

_____

_____

_____

"Transitional Care of Rural Older Adults" Trent University Study

Laura Poulin
Trent University
1600 West Bank Dr.
ESC B313
Peterborough, ON
K9J 7B8

705-748-1011 Ext 7938

lpoulin@trentu.ca

Dear Potential Research Participant,

This letter is to invite you to participate in the "Transitional Care of Rural Older Adults" study that is being conducted in affiliation with the Trent Centre for Aging and Society and in collaboration with the Seniors Care Network and Haliburton Highlands Health Services. The project is being conducted by Laura Poulin, a PhD candidate at Trent University under the supervision of Dr. Mark Skinner, Professor and Canada Research Chair. This project aims to explore how to effectively provide transitional care for older adults as they are transferred either between a hospital and a long-term care home or between a hospital and a home in the community. The intent of this study is to better understand what factors contribute to older adult health to gain insight into the transitional care of older adults in rural communities

You are being invited because either you are an older adult patient over 65, are an informal support of an older adult patient or a front-line health care worker who is part of the transitional care process. With your consent I will conduct observations of you in hospital and/or in the new long-term care home or home in the community. If you are an older adult, this will require you to agree to have me visit you in either your home or long-term care home in the 24 hours after you are transferred. I will ask the occasional question to document the process of older adult transitional care, but I will not interfere or delay any medical treatment or the transfer process itself. I am also interested in setting up an interview with you

to discuss your personal experiences with transitional care of older adults in your community. The interview can last up to 2 hours, but can be as long or short as you wish. In addition, the interview can be booked to best fit your schedule, can be conducted in a location of your preference and can be conducted over a number of interview sittings, if needed. The interview will consist of:

- Questions to understand what factors participants feel influence older adult health
- Questions on the local community and how the community influences older adult health
- Questions on the health and social services provided in the community as well as the influence of informal supports
- Questions on the transitional care of older adults in the community
- Additionally, health care staff will be asked about the type of information they collect on older adults.

While you may experience no direct benefit as a result of your participation, you may value being asked to share your expertise on this important topic. You will have access to any academic publications or public presentations that result from the research.

Since Haliburton is considered a rural community, the research cannot guarantee absolute anonymity and the other participants will likely be aware of your participation in the study. You may also be asked to provide personal information that may be sensitive. To mediate these risks, your participation in the study will be voluntary and you can withdraw at any time. Private spaces designated by the participants will also be identified to ensure the risks of participation are minimized.

Older Adults/Informal Supports: You, or the person you care for may experience being upset or frustrated during my observations of the transfer or when we discuss aspects of the transfer. This may occur if you or the person you care for are dissatisfied with the transfer process, if you feel that your

needs, or the needs of the person you care for, are not being met, etc. Since I am trying to document what works and what doesn't work during older adult transfers, it is important that I understand your true experiences. Please be assured that I will treat you and the person you care for, with the utmost of respect throughout the research period. While I will be interested in discussing all of your views on this process, it is your right to choose what to share with me, to choose not to answer a question I ask, or to choose to end your participation in the study altogether. To minimize the emotional risk associated with participating in the study, your privacy and the information you provide will be kept confidential within the limits of the law. This will ensure that the services that you receive, or the older adult you support receives, are not compromised by your participation in the study.

Front-line Health Care Staff: My observations of you may include situations of disagreement or conflict among the various participants (patient, informal supports, you or other staff), and you may feel vulnerable being observed during such conflict. Since I am trying to document what works and what doesn't work in older adult transitions, understanding these aspects of patient transfers is important. Please be assured that I will treat you with the utmost respect throughout the research period. During the interviews, I would like to gain your perspective on the transfer process, but it is your right to choose what to share with me, what not to share with me, to choose not to answer a question I ask, or to choose to end your participation in the study altogether. While it may be known that you are a participant in the study, your privacy and your specific contributions will be kept confidential and protected within the limits of the law. To minimize the professional risk associated with participating in the study, the information you provide will be kept confidential to ensure that your responses do not compromise your employment or your relationships with other staff. In addition, the data collected will not be used to evaluate job performance and the information you provide will not be passed on to managers/supervisors/administrators for evaluation purposes.

If you have any further questions about the research, please contact the principal investigator Laura Poulin

(lpoulin@trentu.ca, 705-748-1011 ext. 7938). This study has been reviewed and approved by the Trent University Research Ethics Board. Please direct questions pertaining to this review to Karen Mauro, Certifications and Regulatory Compliance Officer, Trent University, Phone: 705-748-1011 ext 7896, Email: kmauro@trentu.ca

Thank you for your consideration and I look forward to hearing from you,

Laura Poulin

"Transitional Care of Rural Older Adults" Trent University Study

Laura Poulin
Trent University
1600 West Bank Dr.
ESC B313
Peterborough, ON

705-748-1011 Ext 7938

lpoulin@trentu.ca

Greetings,

This letter is to invite you to participate in a study on rural older adult health and health services. The project is being conducted by Laura Poulin a graduate student from Trent University.

You are being invited because you are an older adult patient over 65. With your consent, I will observe as you are transferred from hospital to long-term care or from hospital to a home in the community. I will ask you questions as you are transferred, but I will not interfere with any of the care you will receive.

I am hoping to also interview you. This interview will last about an hour, but you do not need to answer the questions all at one time.

The interview will consist of:

- Questions to understand what impacts your health
- Questions about how the local community impacts your health
- Questions on the services in the community
- Questions on the care that you just received

Participating is voluntary and you can stop at any time.

If you have any questions about the research, please ask or contact Laura Poulin (lpoulin@trentu.ca, 705-748-1011 ext. 7938). For questions or concerns about your rights as a participant contact the Trent University Research Office at 705 748-1011 ext. 7896.

Thank you for your consideration,

Laura Poulin

Assent Form to Participate in the "Transitional Care of Rural Older Adults" Study

Laura Poulin
Trent University
1600 West Bank Dr.
ESC B313
Peterborough, ON
K9J 7B8

705-748-1011 Ext 7938

lpoulin@trentu.ca

Greetings,

This study will focus on rural older adult health and health services. The project is being conducted by Laura Poulin a student from Trent University.

My hope is to observe you as you are transferred from hospital to long-term care or from hospital to home. I will ask you questions as you are transferred, but I will not interfere with any of the care you will receive. I also hope to interview you. The interview will last about an hour, but you do not need to answer the questions all at one time. We can also do the interview in a location of your choice and at a time that is good for you.

The interview will consist of:

- Questions to understand what impacts your health
- Questions about how the local community impacts your health
- Questions on the services in your community
- Questions on the care that you have just received

I will write down my observations and the answers you provide, in a notebook or type them into a computer. This information will be kept private and will not be shared with anyone.

You do not need to answer any questions that you do not feel comfortable answering and you can stop participating in the study at any time.

I understand and agree that:

1. I do not need to answer any questions I do not feel comfortable answering and I can stop participating in the study at any time;
2. My participation will not impact the care or services I receive;
3. All of the information that I provide will not be shared with others;
4. Others in the community might be aware of my participation in the study because of the small population of Haliburton County;
5. The information collected from me will be kept safe and not accessible by others;
6. I can call Laura Poulin with any questions about the project 705-748-1011 Ext 7938
7. I can call Trent University if I have concerns about my rights or I feel I am being treated unfairly (705 748-1011 ext.7938);
8. I have been given a copy of this consent form;
9. All of my questions about the study have been answered.

If you have any further questions about the research, please call Laura Poulin (705-748-1011 ext. 7938). This study has been reviewed and approved by the Trent University Research Ethics Board. Please direct questions pertaining to this review to Karen Mauro, Certifications and Regulatory Compliance Officer, Trent University, Phone: 705-748-1011 ext 7896, Email: kmauro@trentu.ca.

I, _____ confirm that the older adult patient has conveyed verbally (or otherwise) their willingness for me to observe them as they transfer from hospital to their long-term care home/their private home, talk with their Power of Attorney/Substitute Decision Maker, and if possible conduct an interview with them in their long-term care home or their private home after the transfer.

_____

Principal Investigator: Laura Poulin

The "Transitional Care of Rural Older Adults" Trent University Study Patient Information & Consent Form

Laura Poulin
Trent University
1600 West Bank Dr.
ESC B313
Peterborough, ON
K9J 7B8

705-748-1011 Ext 7938

lpoulin@trentu.ca

Dear Potential Research Participant,

You are invited to participate in this study that will focus on the transitional care of older adults in rural communities. In particular, the research will explore the experiences of older adults as they are transferred either between a hospital and a long-term care home or between a hospital and a home in the community. The intent of this study is to better understand what factors contribute to older adult health to gain insight into the transitional care for older adults in rural communities.

With your consent, I will observe you during your transfer. If you are being transferred to a home in the community, this will involve me observing you in hospital and in your home after the transfer. If you are being transferred to a Long-Term Care Home, this will involve me observing you in hospital and in Long-Term Care once you have been transferred. This will require you to agree to have me visit you in either your home or long-term care home in the 24 hours after you are transferred. I will ask the occasional question to document the process of your

care, but I will not interfere or delay any medical treatment or the transfer process itself. Once you are settled in the new setting, an interview will be set up with you to discuss the observed transfer and to learn about your personal experiences with transitional care. The interview can last up to 2 hours, but can be as long or as short as you wish. You will be asked a series of questions, which can be completed over a number of interview sittings if needed:

- Questions to understand what you feel influences your health
- Questions on the health and social services provided in the community and the influence of informal supports on your health
- Questions on your community and how it influences your health
- Questions on the transfer that you just experienced as well as your feelings on what is going well and what can be improved

You may experience being upset or frustrated during my observations of the transfer or when we discuss aspects of the transfer. This may occur if you are dissatisfied with the transfer process, if you feel that your needs are not being met, etc. Since I am trying to document what works and what doesn't work during older adult transfers, it is important that I understand your true experiences. Please be assured that I will treat you with the utmost of respect throughout the research period. While I will be interested in discussing all of your views on this process, it is your right to choose what to share with me, to choose not to answer a question I ask, or to choose to end your participation in the study altogether.

The interview will be recorded either by hand in a research notebook or on encrypted files on the computer depending on the research setting. The information collected will be kept either on person, in a locked filing cabinet in the research office at Trent University or in an

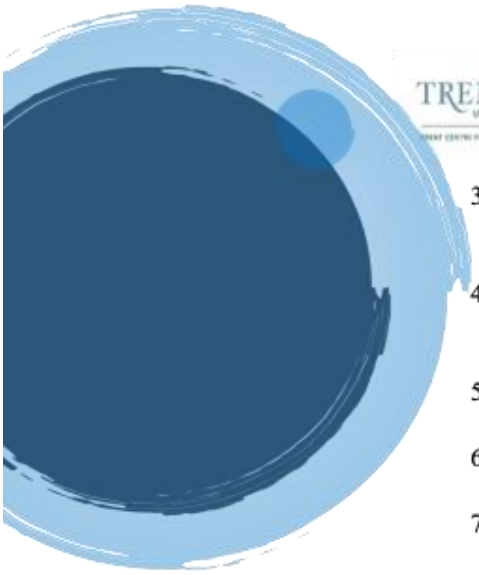
encrypted file on a password protected computer to keep all files confidential.

Your participation in the study will be known by others involved in the patient transfer, however, your privacy and the information that you provide will be kept confidential within the limits of the law. Your name and any information that could be used to identify you will be kept confidential within the research team. This information will be kept anonymous in all analysis, publications and reporting documents. All project information will be destroyed five years after the completion of the project. This will minimize the emotional risk of participating in the study and ensure that the services that you receive are not compromised by your participation

This project has been approved by the Trent University Research Ethics Board. Your participation in the project is entirely voluntary. You are free to answer or not answer any of the questions in the study. You can end your participation in the study at any time without consequence. You may also remove your answers from the study at any time without consequence While you may experience no direct benefit as a result of your participation, you may value being asked to share your expertise on this important topic and you will have access to any academic publications or public presentations that result from the research.

As a participant in the above project, I understand and agree with the following:

1. This project has been approved by the Trent University Research Ethics Board;
2. I have been fully informed about the nature of the research and the extent of my participation in the project and recognize that there is no direct benefit from my participation;



3. My participation in this project is entirely voluntary and I am under no obligation to participate;
4. My decision to participate or not will not interfere with the medical treatment or the health and social services I receive now, or in the future;
5. I don't have to talk about anything that makes me uncomfortable;
6. I may withdraw my participation in the project at any time without consequence;
7. Although others involved in the patient transfer will be aware of my participation in the study, the information I provide during the project will remain confidential & my identity will not be used in any reports or publications;
8. There is a minimal risk that my participation will be known to other participants and community members;
9. The information gained from this project will be kept on person, securely stored on encrypted files on the Principal Investigator's computer or locked in a filing cabinet in the research team's office at Trent University, to be destroyed after five years;
10. I can contact Laura Poulin with any questions about the project, or the Trent University Research Office, (705 748-1011 ext.7938) with any concerns about research ethics;
11. I have been provided with a copy of the informed consent form for my own records;
12. All of my questions regarding my participation in the research project and about the informed consent have been answered to my satisfaction.

Participant Name:

_____

Participant Signature:

_____

Date: _____

If you have any further questions about the research, please contact the principal investigator Laura Poulin (lpoulin@trentu.ca, 705-748-1011 ext. 7938). This study has been reviewed and approved by the Trent University Research Ethics Board. Please direct questions pertaining to this review to Karen Mauro, Certifications and Regulatory Compliance Officer, Trent University, Phone: 705-748-1011 ext 7896, Email: kmauro@trentu.ca.

Would you like a copy of the research findings?

Yes ☐ No ☐

If yes, please provide an email or home address where you would like the information sent:

_____

_____

_____

9.3 Appendix C: Participant Recruitment Script

"Transitional Care of Rural Older Adults" Trent University Study

Script for front-line health care staff when approaching older adult patients who fit the research project criteria

"Hello _____,

I wanted to let you know that you are entitled to participate in a study on rural older adult transitional care. Laura Poulin is a PhD student from Trent University who is trying to better understand the transitional care of older adults in Haliburton County. Do you mind speaking with her so she can give you some more information about the study?"

9.4 Appendix D: Participant Recruitment Poster

Research Study on the Transitional Care of Older Adults in Haliburton County

This project aims to explore how to effectively provide transitional care for older adults as they are transferred either between a hospital and a long-term care home or between a hospital and a home in the community.

Phase One

Document the transitional care process by accompanying the older adult patient as they are transferred. This will involve observing and asking clarifying questions to older adult patients, informal supports and front-line health care staff in hospital prior to the patient transfer as well as after the patient has been transferred to a long-term care home/a home in the community.

Phase Two

Conduct interviews with older adult patients, informal supports, front-line health care staff and Administrators/Managers in hospital, long-term care and community services to gain an understanding of how participants construct older adult health as well as the strengths and barriers of the transitional care of older adults in Haliburton County.

Interested in participating?

Contact Laura Poulin at Trent University: Phone: 705-748-1011 ext. 7938 or Email: lpoulin@trentu.ca

9.5 Appendix E: Semi-structured Interview Guides

"Transitional Care of Rural Older Adults" Trent University Study

Interview Guide for Patients

Just a reminder that this interview is completely voluntary so we can skip any questions you do not feel comfortable with or stop at any time.

Section One: Older Adult Transitional Care

We are going to start by talking about the transfer that you experienced. There are no right or wrong answers.

1. How many times have you been transferred to different health care settings since turning 65 (e.g. Home to hospital, hospital to home, hospital to long-term care, hospital to rehabilitation clinic etc.)?
2. Tell me about the help you received at the hospital to prepare you for the transfer? How could you have been better prepared?
3. Thinking back to your discharge from the hospital what were your most pressing needs? Were these needs adequately met before, during and after the transfer? Explain.
4. What made the discharge from hospital good/not so good (staff rapport, had to repeat yourself, communication)?
5. What would have made the transition easier for you?
6. Do you feel that you and your family/home care staff/long-term care staff were ready for your arrival (e.g. Home support set up or long-term care home room ready to move in)? How could they have been better prepared?
7. Was there something that you wanted staff to ask about or do, but they didn't or information you would have wanted prior to transferring?
8. Were there any questions you had, but didn't get the answers to throughout the transfer?

9. Has what brought you to hospital originally been resolved or better supported now that you are at home/ in a long-term care home?
10. Overall, how would you describe your transitional care experience? How did you feel during the transfer?

Do you feel that there is any pressure to fill beds in LTC?

Section Two: Older Adult Health

These questions help me to understand what things you feel influence your health. There are no right or wrong answers.

11. What aspects of your life do you feel influence your health?
    - Education level
    - Employment/Previous Employment
    - Income level
    - Relationship Status
    - Personal life experiences or events
    - Being a caregiver or not being a caregiver to a dependent
    - Frequency of exercise
    - Nutrition
12. What aspects of your identity do you feel influence your health?
    - The way you identify in terms of gender
    - The way you identify in terms of ethnicity
    - Sexuality
13. What values or choices influence your health?
    - Religion versus no religion
    - Values or morals
    - Smoker/Non-smoker
14. What influences your health that you do not have control over?
    - Genetics
    - Physical or mental health conditions/diagnoses

- Physical or cognitive disabilities

15. In general, what do you feel contributes to good care?

Section Three: Formal Health Services, Formal Social Services & Informal Supports

Your answer to these questions help me to understand a little bit more about the services and people in your community that you can turn to if you need assistance. There are no right or wrong answers

16. Do you feel that the health services in the local community adequately support older adults in the community? Why or why not?
17. Do you feel that the community groups or social services in the local community adequately support older adult's health? Why or why not?
18. In what ways do people in your life such as family, neighbours or friends support you?
19. If no support, what will you do if over time you need more help?
20. What type of health service, community service, community group, informal support or resource is most needed in the community to support older adult health?

Section Four: The Rural Community

Your answers to these questions help me to understand a little bit more about the community in which you live as well as gives me an idea of how your community impacts your health. There are no right or wrong answers.

21. How do you feel that living in your community impacts your health?
22. What do you feel is missing in the community to support you and your health?
23. What do you think is the most important thing to know about living in this rural community? How does it impact your health?
24. What assumptions do people in your community make about older adults? Does this impact your health?
25. Is there any important history or events that shape life in this community? Does this impact your health?
26. How do people get along in this community? Do you feel this impacts your health?

27. How does the community support social activities for older adults like yourself? Does this impact your health?
28. Is there any transportation available in the local community? Does this impact your health?
29. Are there any prominent people in the community that help older adults in your area? Do these people impact your health?
30. How do you feel that the government (municipal, provincial or federal) support or hinder your health?

Section Five: Wrap up

31. Is there anything that we haven't talked about today that you would like me to understand about older adults' health or the transfers of older adults between health care settings?
32. Is there anyone you think I should talk to that would have insight on older adult health or the transitional care of older adults?

"Thank you so much for taking the time to speak with me today. I really appreciate you participating in this study and I hope that the rest of your day is pleasant."

Interview Guide for Informal Supports

Just a reminder that this interview is completely voluntary so we can skip any questions you do not feel comfortable with and stop at any time.

Section One: Older Adult Transitional Care

We are going to start by talking about the transfer of the older adult you support. There are no right or wrong answers.

1. How many times has the person you support been transferred to different health care settings since turning 65 (e.g. Home to hospital, hospital to home, hospital to long-term care, hospital to rehabilitation clinic etc.)?
2. Tell me about the help you received at the hospital to prepare both you and the person you support for the transfer? How could have either of you been better prepared?
3. Do you feel that you/the home care staff/the long-term care staff were ready for the person's arrival? (e.g. Home support set up or long-term care home room ready to move in)? How could you/they been better prepared?
4. Did you feel as though all staff during the transfer were adequately meeting the needs of yourself and the person you support? Were these needs adequately met before, during and after the transfer? Explain.
5. Was there something that you wanted staff to ask about or do, but they didn't or information you would have wanted prior to transferring?
6. Were there any questions you had, but didn't get the answers to throughout the transfer?
7. What made the discharge from hospital good/not so good (staff rapport, repeat information, patient information)?
8. What do you feel would have made the transition easier for you and the person you support?
9. Has what brought the person you support to hospital originally been resolved or better supported now that their at home/in a long-term care home?
10. Overall, how would you describe the transitional care experience? How did you feel during the transfer?

11. How would you describe the transitional care experience of the older adult you support? How do you think they felt during the transfer?

Section Two: Older Adult Health

These questions help me to understand a little bit more about what things you feel influence the health of the older adult you support. There are no right or wrong answers.

12. What do you feel influences the health of the older adult you support?
    - Education level
    - Employment/Previous Employment
    - Income level
    - Relationship Status
    - Personal life experiences or events
    - Being a caregiver or not being a caregiver to a dependent
    - Exercise frequency
    - Nutrition
13. What aspects of identity influence the health of the older adult you support?
    - The way you identify in terms of gender
    - The way you identify in terms of ethnicity
    - Sexuality
14. What values or choices influence the health of the older adult you support?
    - Religion versus no religion
    - Values or morals
    - Smoker/Non-smoker
15. What influences the health of the older adult you support that they do not have control over?
    - Genetics
    - Physical or mental health conditions/diagnoses
    - Physical or cognitive disabilities
16. In general, what do you feel contributes to the good care of older adults?

Section Three: Formal Health Services, Formal Social Services & Informal Supports

These questions help me to understand a little bit more about the services and people in the local community that the older adult you support can turn to if they need assistance. There are no right or wrong answers.

17. What local health services support the health of the older adult you support?
18. Do you feel that the health services in the local community adequately support older adult? Why or why not?
19. What kinds of community groups or social services support the health of the older adult you support?
20. Do you feel that the local community groups or social services adequately support older adult health? Why or why not?
21. What role do you play in supporting the older adult patient?
22. Are there other people in the older adult's life such as family, neighbours or friends that help them? If yes, how do these people support them? If no, what will they do if over time they need more assistance?
23. What type of health service, community service, community group, informal support or resource is needed in the community to support older adult health?

Section Four: The Rural Community

These questions help me to understand a little bit more about the community in which the older adult you support lives as well as gives me an idea of how the community supports the health of older adults. There are no right or wrong answers.

24. How do you feel the local community impacts the health of the older adult you support?
25. What do you feel is missing in the community to support the health of the older adult?
26. What do you think is the most important thing to know about living in this rural community? Does this impact the health of the older adult you support?
27. What assumptions do people in the community make about older adults? Does this impact the health of the older adult you support?

28. Is there any important history or events that shape life in this community? Do you feel that it impacts the health of the older adult you support?
29. How do people get along in this community? Do you feel this impacts the health of the older adult you support?
30. How does the community support social activities for older adults? Do you think this impacts the health of the older adult you support?
31. Is there any transportation available in the local community? Do you think this impacts the health of the older adult you support?
32. Are there any prominent people in the community that help older adults? Do they impact the health of the older adult you support?
33. How do you feel that the government (municipal, provincial or federal) supports or hinders the health of the older adult you support?

Section Five: Wrap up

34. Is there anything that we haven't talked about today that you would like the researchers to understand about the person you support, their health or the transfer of older adults between health care settings?
35. Is there anyone you think I should talk to that would have insight on older adult health or the transitional care of older adults?

"Thank you so much for taking the time to speak with me today. I really appreciate you participating in this study and I hope that the rest of your day is pleasant."

Interview Guide for Frontline Health Care Providers

Just a reminder that this interview is completely voluntary so we can skip any questions you do not feel comfortable with and stop at any time.

Section One: Older Adult Transitional Care

We are going to start today by talking a little bit about the transitional care of older adults. There are no right or wrong answers.

1. What are some of the processes, tools or factors that enhance the transitional care of older adults?
2. What are some of the barriers to providing effective transitional care of older adults?

Sending Unit/Hospital

3. How do you prepare older adult patients for transfers to long-term care/home?
4. How do you prepare their families, friends and informal caregivers for the transfer?
5. How do you support both the patient and informal supports during the transfer?
6. How do you think older adults and informal supports feel during transfers?
7. Do you follow up on older adults after they leave the hospital?
8. Are you ever contacted by prior patients or people who care for prior patients after they have been discharged?
9. Can you describe the relationship/interactions you have with long-term care staff/home care staff/community staff related to the transfer of older adult patients?
10. From your perspective what is working well when you transfer an older adult patient?
11. What frustrates you the most about transferring older adult patients?
12. What would making transferring a patient easier?
13. Is there anything that we haven't talked about today that you would like the researchers to understand about you, your family member or the transfer of older adults between health care settings?

Receiving Unit/Long-Term Care Home

1. Do you feel adequately prepared to continue older adult care when patients are transferred to you from hospital? (e.g. Did you know what time they would arrive? Di you have enough information to provide quality care?)
2. What information either verbal/written do you receive from sending hospital?
3. What information do you not get, but would be helpful to receive?
4. How do you think older adults feel when they are transferred?
5. How do you think informal supports feel during transfers?
6. How do you support both the patient and informal supports during transfers?
7. Describe the interactions/relationship you have with the sending hospital regarding older adult transfers?
8. Do you contact the prior hospital to get more information on the older adult?
9. What frustrates you the most about getting transferred older adult patients?
10. What would make getting a transferred patient easier?

Section Two: Older Adult Health

These questions help me to understand a little bit more about what information you collect on patients as well as gives me an idea of what things you feel influence older adult health. There are no right or wrong answers.

1. What do you feel influences the health of older adults?
    - Education level
    - Employment/Previous Employment
    - Income level
    - Relationship Status
    - Personal life experiences or events
    - Being a caregiver or not being a caregiver to a dependent
    - Exercise frequency
    - Nutrition
2. Is this type of information gathered? If so, how is it used to provide care for older adults?

3. What aspects of identity influence the health of older adults?
    - The way you identify in terms of gender
    - The way you identify in terms of ethnicity
    - Sexuality
4. Is this type of information gathered? If so, how is it used to provide care for older adults?
5. How do an older adult's values or choices influence their health?
    - Religion versus no religion
    - Values or morals
    - Smoker/Non-smoker
6. Is this type of information gathered? If so how is it used to provide care for older adults?
7. What influences the health of older adults that is out of the patient's control?
    - Genetics
    - Physical or mental health conditions/diagnoses
    - Physical or cognitive disabilities
8. In general, what do you feel contributes to the good care of older adults?

Section Three: Formal Health Services, Formal Social Services & Informal Supports

These questions help me to understand a little bit more about what types of formal and informal supports you ask older adults about as well as the types of services and people in your community that support older adult health. There are no right or wrong answers.

9. Do you feel that the health services in the local community adequately support older adult health? Why or why not?
10. Do you ask what health services older adult patient's access? If yes, how is it used to provide care for older adults?
11. Do you feel that local community groups or social services adequately support older adult health in the community? Why or why not?
12. Do you ask what community groups or social services older adult's access? If yes, how is it used to provide care for older adults?

13. Do you feel that informal supports influence older adult health? If yes, how do these people support older adult health? If no, what has a larger impact on older adult health in the community?
14. Do you ask about an older adult's informal supports? If yes, how is it used to provide care for older adults?
15. What type of health service, community service, community group, informal support or resource is most needed in the community to support older adult health?

Section Four: The Rural Community

These questions help me to understand a little bit more about the community in which you provide care as well as gives me an idea of how the community influences older adult health. There are no right or wrong answers.

1. How do you feel the local community impacts the health of older adults?
2. What do you feel is missing in the community to support the health of older adults?
3. What do you think is the most important thing to know about living in the rural community and how does it impact the health of older adults?
4. What assumptions do people in the community make about older adults? Does this impact the health of older adults?
5. Is there any important history or events that shape life in this community? Do you feel that it impacts the health of older adults?
6. How do people get along in this community? Do you feel that this impacts the health of older adults?
7. How does the community support social activities for older adults? Do you think this impacts the health of older adults?
8. Is there any transportation available in the local community? Do you think this impacts the health of older adults?
9. Are there any prominent people in the community that help older adults? Does this impact older adult health?

10. How do you feel that the government (municipal, provincial or federal) supports or hinders the health of the older adults?

Section Five: Wrap up

11. Is there anything that we haven't talked about today that you would like the researchers to understand about older adults, their health or their transfer between health care settings?
12. Is there anyone you think I should talk to that would have insight on older adult health or the transitional care of older adults?

"Thank you so much for taking the time to speak with me today. I really appreciate you participating in this study and I hope that the rest of your day is pleasant."

Interview Guide for Managerial/Administrative Staff

Just a reminder that this interview is completely voluntary so we can skip any questions you do not feel comfortable with and stop at any time.

Section One: Older Adult Transitional Care

We are going to start by talking about older adult transitional care. There are no right or wrong answers.

1. What are some of the processes, tools or factors, specific to your hospital/long-term care home/community service that enhance the transitional care of older adults?
2. What do you feel are the barriers to providing effective transitional care of older adults?
3. How do you feel that the transitional care of older adults can be improved?
4. How do you support both the patient and family members during the transition and how can this support be improved?
5. What is one resource that would help you enhance the transitional care experience of older adults?
6. Can you comment on the interactions staff have with other health providers from different organizations/services?
7. How do you feel that the health system, including community and social care, can be reorganized to better support the transitional care of older adults?

Section Two: Older Adult Health

These questions help me to understand what you feel influences older adult health and what information your organization collects on older adults to deliver care. There are no right or wrong answers.

8. What do you feel contributes to the good care of older adults?
9. What do you feel are the main factors that enhance or inhibit older adult health in your community?

10. What over-arching strategies or policies do you have to support older adult health? How well are these being implemented in the frontline care of older adults?
11. Do you think the social determinants of health (such as income, education level, employment status, nutrition etc.) impact older adult health in your community? Explain.
12. Do your assessments, tools and processes reflect the social determinants of health? Why or why not?
13. Do you feel that unique identities (such as religion, identification in terms of gender, sexuality), impact older adult health in your community? Explain.
14. Do your assessments, tools and processes reflect on the unique identity of older adults? Why or why not?

Section Three: Formal Health Services, Formal Social Services & Informal Supports

These questions help me to understand a little bit more about the services and people in your community that support older adult health. There are no right or wrong answers.

15. Do you feel that the health services in the local community adequately support older adult health? Why or why not?
16. Do you feel that local community groups or social services adequately support older adult health in the community? Why or why not?
17. Do you have partnerships with other local organizations, groups or services?
18. What are the barriers to making or maintaining ongoing partnerships with other local organizations, groups or services? How can these relationships be improved?
19. Do you feel that informal supports influence older adult health? Explain.
20. What are the barriers to making or maintaining relationships with informal caregivers? How can these relationships be improved?
21. What type of health service, community service, community group, informal support or resource is most needed in the community to support older adult health?

Section Four: The Rural Community

These questions help me to understand a little bit more about the community in which you work as well as gives me an idea of how the community influences older adult health. There are no right or wrong answers.

22. How do you feel the local community impacts the health of older adults?
23. What do you feel is missing in the community to support the health of older adults?
24. What do you think is the most important thing to know about living in the rural community and how does it impact the health of older adults?
25. What assumptions do people in this community make about older adults and do you feel that this impacts older adult health?
26. Is there any important history or events that has shaped life in this community? Does this impact older adult health?
27. How do people get along in this community? Do you feel that this impacts the health of older adults?
28. How do you feel that community support for social activities supports or hinders older adult health?
29. How do you feel that transportation access impacts older adult health?
30. How do you feel that prominent people in the community support older adult health?
31. How do you feel that the government (municipal, provincial or federal) supports or hinders older adult health?

Section Five: Wrap up

32. Is there anything that we haven't talked about today that you would like the researchers to understand about older adults, their health or their transfer between health care settings?
33. Is there anyone you think I should talk to that would have insight on older adult health or the transitional care of older adults?

"Thank you so much for taking the time to speak with me today. I really appreciate you participating in this study and I hope that the rest of your day is pleasant."

9.6 Appendix F: Ethics Approval - Trent University, HHHS & SCN

TRENT UNIVERSITY

Laura Poulin
Canadian Studies
Kerr House

Office of
Research & Innovation

September 19, 2019

File #: 25863
Title: Transitional Care of Rural Older Adults: Understanding Older Adult Health Construction and the Influence of Multidimensional Contexts on the Transitional Care of Older Adults in Rural Communities

Dear Mrs. Poulin,

The Research Ethics Board (REB) has given approval to your proposal entitled "Transitional Care of Rural Older Adults: Understanding Older Adult Health Construction and the Influence of Multidimensional Contexts on the Transitional Care of Older Adults in Rural Communities".

The committee strongly suggests and encourages you to encrypt any data that is being collected that contains any personal or identifying information. Please add a statement to your consent form concerning this. For help with encryption services, please contact Trent's IT Department.

Please add a running footer to your consent form, with the date of Trent REB approval and consent revisions number (e.g., 01-Jan-12, Version 2), so that the consent form used can be easily identified in future.

When a project is approved by the REB, it is an institutional approval. It does not undermine or replace any other community ethics process. Full approval depends upon the approval of all other bodies who are named as stakeholders in this research.

In accordance with the Tri-Council Guidelines (article D.1.6) your project has been approved for one year. If this research is ongoing past that time, submit a Research Ethics Annual Update form available online under the Research Office website. If the project is completed on or before that time, please email Karen Mauro in the Research office so the project can be recorded as completed.

Please note that you are reminded of your obligation to advise the REB before implementing any amendments or changes to the procedures of your study that might affect the human participants. You are also advised that any adverse events must be reported to the REB.

On behalf of the Trent Research Ethics Board, I wish you success with your research.

With best wishes,

Peri Ballantyne.

Dr. Peri Ballantyne
REB Chair
Phone: (705) 748-1011 ext. 7813, Fax: (705) 748-1587
Email: periballantyne@trentu.ca

c.c.: Alex Lawrie
Acting Compliance Officer

HALIBURTON HIGHLANDS HEALTH SERVICES
Leaders in Innovative Rural Health Care

Haliburton Highlands Health Services
Administration Office
7199 Gelert Rd., P.O. Box 115
Haliburton, ON K0M 1S0
(705) 457-1392
www.hhhs.ca

July 12, 2019

Ms. Laura Poulin
PhD Student
Trent University
1600 West Bank Drive
Peterborough, ON Canada, K9L 0G2

Re: Trent University REB File #25863: *Transitional Care of Rural Older Adults* Research Study

Dear Ms. Poulin,

We have reviewed the above noted study, including the research protocol, information and consent forms, and the information and feedback provided to you by the Trent University Research Ethics Board (REB). The review of this study was informed by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, and the Ontario Personal Health Information Protection Act, 2004.

On behalf of Haliburton Highlands Health Services (HHHS), I am pleased to grant approval for this study to take place at HHHS, as outlined in the research protocol approved conditionally by the Trent University REB. Please note that you will be required to sign the enclosed HHHS Confidentiality Agreement prior to initiating any research activities at HHHS.

During the course of this study, any significant deviations from the approved protocol and/or unanticipated developments or significant adverse events should immediately be brought to the attention of the HHHS CEO (or delegate, in the absence of the CEO).

Please contact me if you have any questions or if you require any further information from HHHS.

Sincerely,

Carolyn Plummer

Carolyn Plummer, RN; MHSc
President and Chief Executive Officer
Haliburton Highlands Health Services
Email: cplummer@hhhs.ca
Tel: 705.457.2527
Fax: 705.457.1071
Web Site: http://www.hhhs.ca

CC: Dr. Peri Ballantyne
Dr. Mark Skinner
Karen Mauro

EXTENDICARE

August 30th, 2019.

Re: Trent University REB File #25863: Transitional Care of Rural Older Adults Research Study

Dear Ms. Poulin & the Trent Ethics Board,

I have reviewed the above noted study, including the research protocol, information and consent forms, and the information and feedback provided to you by the Trent University Research Ethics Board (REB). The review of this study was informed by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, and the Ontario Personal Health Information Protection Act, 2004.

On behalf of Haliburton Extendicare I am pleased to grant approval for this study to take place at Haliburton Extendicare, as outlined in the research protocol approved conditionally by the Trent University REB. Please note that you will be required to sign a Confidentiality Agreement prior to initiating any research activities at Haliburton Extendicare.

During the course of this study, any significant deviations from the approved protocol and/or unanticipated developments or significant adverse events should immediately be brought to the attention of myself the Administrator of Haliburton Extendicare (or delegate, in my absence).

Please contact me if you have any questions or if you require any further information.

Sincerely,

Jane Rosenberg

Administrator/DOC

Haliburton Extendicare

Extendicare Haliburton, 167 Park Street, Box 780, Haliburton, Ontario K0M 1S0
Tel: (705) 457-1722 Fax: (705) 457-3914
www.extendicare.com

9.7 Appendix G: Barriers to the Transitional Care Rural Older Adults

Barriers to Transitions		
Identified Barrier	**Impact on Older Adults' Transitional Care Experiences**	**Participant Quotation**
Family Tensions (Informal Care Context)	➢ Longer wait in hospital ➢ Frequent readmissions	"A non-supportive family or a family who are just there to give you grief, antagonists, trouble makers." (Front-Line Staff-Acute Care 20)
Caregiver Burn-Out (Informal Care Context)	➢ Longer wait in hospital ➢ Frequent readmissions ➢ Moving out-of-county to obtain adequate levels of care ➢ Accepting long-term care earlier than needed	"Family factors are also a huge barrier to discharges. Caregivers are often burnt out and push for their loved ones to stay in hospital because they feel they can't manage them at home. They worry about taking them home and we have to provide a lot of support for them to take them home." (Front-Line Staff-Acute Care 10)
Limited Home Care Services (Formal Care Context)	➢ Longer wait in hospital ➢ Frequent readmissions ➢ Accepting long-term care earlier than needed ➢ Moving out-of-county to obtain adequate levels of care ➢ Complacency in just accepting the home care services available	"Staffing shortages in the community is delaying discharges because they need home care and we don't have the hours in the community on a consistent basis. Often this means that older adults have to come back to hospital and keep coming back to the hospital because of the lack of home care." (Front-Line Staff-Acute Care 19) "They don't have the staff to fulfill the hours, it's a strain on the families and then they put them on the list for long-term care when maybe if they had more support at home they wouldn't have to." (Front-Line Staff-Long-Term Care 65)

Not Maintaining a Holistic Patient-Centred Focus (Formal Care Context)	➢ Longer wait in hospital ➢ Frequent readmissions ➢ Moving out-of-county to obtain adequate levels of care ➢ Accepting long-term care earlier than needed ➢ Complacency in just accepting the home care services available	"If they don't have a lot of support, transportation, limitations in financing or an understanding of their meds they'll often come back." (Front-Line Staff-Acute Care 44)
Biomedical/Episodic Focus of Care (Formal Care Context)	➢ Frequent readmissions ➢ Moving out-of-county to obtain adequate levels of care ➢ Accepting long-term care earlier than needed ➢ Complacency in just accepting the home care services available	"Usually in acute care they're just trying to get them out quickly and get the next person into the bed and this means we aren't able to take into account all the aspects of a persons' home life that is not helping this person thrive." (Front-Line Staff-Acute Care 5)
Lack of Insight & Individualized Health Experiences (Individualized Context of Health)	➢ Frequent readmissions ➢ Complacency in just accepting the home care services available	"They don't accept that they need long-term care even though they are in hospital often. Revolving door in and out." (Front-Line Staff-Acute Care 16)

Aversions to Long-Term Care (Individualized Context of Health)	➢ Longer wait in hospital ➢ Complacency in just accepting the home care services available	"We have had a few patients live in hospital, but it's because patients and caregivers have refused to go home or take a bed in long-term care and that's why they stay in hospital." (Front-Line Staff-Acute Care 10)
Cognitive Impairments/ Responsive Behaviours (Individualized Context of Health)	➢ Longer wait in hospital ➢ Frequent readmissions ➢ Moving out-of-county to obtain adequate levels of care ➢ Accepting long-term care earlier than needed ➢ Complacency in just accepting the home care services available	➢ "I have become a little more selective in my acceptance process, especially if there are behaviours. I have done some rejections and then I get challenged. I need to make sure I am saying something and reject them due to behaviours. I don't think it is on staff or administration, but there is this underlying pressure knowing that patients are not getting the appropriate care they need because of behaviours, that they will just live in hospital and not get the supports they need." (Administrator/Manager 78)

9.8 Appendix H: Health Professional and Housing/Service Limitations

Health Professional Limitations		
Position Identified	**Types of Participants who Identified this Concern**	**Rationale**
Home Care Staff	· All of the participants	➢ Staff burn-out ➢ Working conditions and staff turnover ➢ Older adults do not qualify for enough home care hours ➢ There is no flexibility in the services provided ➢ Home care is scheduled but then no one comes to provide it ➢ Staff do not complete tasks they say they will
Social Workers	· Front-Line Staff - C*ommunity, Long-Term Care & Acute Care* · Administrators/managers	➢ Provide support for families in conflict ➢ Manage care expectations of patients and informal supports ➢ Establish Power of Attorney/Substitute Decision Maker or fill in Public Guardian & Trustee applications ➢ Attend to the social determinants of health ➢ Support the logistics of patient transfers ➢ Assist patients with complex needs and patients with mental health concerns
Geriatric Expertise	· Front-Line Staff - C*ommunity, Long-Term Care & Acute Care* · Administrators/managers · Informal Supports-*Long-Term Care & Community*	➢ Assess geriatric conditions ➢ Manage chronic conditions and co-morbidities ➢ Perform medication adjustments and medication reconciliations ➢ Attend to older adults in all care settings ➢ Ensure home environments of older adults are safe

Physicians	· Front-Line Staff - C*ommunity, Long-Term Care & Acute Care* · Administrators/managers · Informal Supports-*Community*	➢ Many residents do not have family Doctors ➢ Many residents have Doctors out-of-county ➢ Walk-in clinics are scarce and typically seasonal ➢ There is a lack of primary care, which strains the emergency care system
Long-Term Care Staff	· Front-Line Staff - C*ommunity, Long-Term Care & Acute Care* · Administrators/managers · Informal Supports-*Long-Term Care* · Older Adults-*Long-Term Care*	➢ Funding cuts have contributed to staff shortages ➢ Residents in long-term care have higher acuity and are exhibiting more responsive behaviours and cognitive challenges
Rehabilitation Staff	· Front-Line Staff - A*cute Care* · Administrators/managers · Older Adults-*Community*	➢ There are limited community services available ➢ Assist with transitions back to the community ➢ Support safe exercise practices of older adults ➢ Address wait-times of current services

Housing/Service Limitations		
Need Identified	**Types of Participants who Identified this Need**	**Rationale**
No Specialized Services in the County	· All Participants	➢ Long travel distances to receive treatment ➢ The time allocated to arrange transportation ➢ Transportation access deters older adults from receiving treatment ➢ Older adults move out-of-county to ensure access to treatment
There is limited Supportive Housing for Specialized Populations	· All Participants	➢ No shelters for homeless populations ➢ Few supportive housing options for older adults, which contributes to them moving out-of-county ➢ Housing available for older adults is expensive and not affordable for most residents within the county which creates tension between residents who have lived in the county their whole lives and those who moved to the county upon retirement. ➢ The quality of older adult housing in the county is considered undesirable by many due to poor locations or conditions of the buildings ➢ Long wait-lists for supportive housing mean many do not ever get into supportive housing
Shortage of long-term care beds	· Front-Line Staff - C*ommunity, Long-Term Care & Acute Care* · Administrators/managers · Informal Supports-*Long-Term Care & Community*	➢ Older adults are not receiving appropriate levels of care ➢ There is a higher population of older adults in Haliburton and many are waiting a long time to access care ➢ A lack of long-term care beds leads to bed flow issues in hospital ➢ Many older adults move out-of-county to ensure access to long-term care

Limited Supports for Individuals with Mental Health or Addiction Concerns	· Front-Line Staff - C*ommunity* · Administrators/managers	➢ Alcoholism and addiction concerns are prominent in the county ➢ Mental health and addictions education is needed for all residents to address community stigma and learn ways to improve the supports available