Alberta Communities in Action:

Showcasing Grassroots Leadership and Impact

A CASE STUDY • DECEMBER 2025

ALBERTA ASSOCIATION ON GERONTOLOGY
Improving the Lives of Older Albertans

Healthy Aging Alberta

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Executive Summary

This project, Alberta *Communities in Action: Showcasing Grassroots Leadership and Impact,* explored how communities strengthen local collaboration to enhance the wellbeing of older adults.

The project engaged nine diverse communities through focus groups and dialogue to understand how relationships, leadership, and local assets contribute to shifting the focus of Alberta's health care system toward more community-based care and better outcomes for both people and the system.

Grounded in the Community Weaving Framework, the findings highlight that community ecosystems thrive and deliver new outcomes when:

- Driven by shared purpose ("The Fire")
- Interconnected relationships ("The Web")
- Consistent communication and coordination ("The Rhythm")
- Inclusive participation ("The Circles")
- Ongoing learning and adaptation ("The Spiral")

Community journeys varied according to the population profiles and local assets, but energy, ownership and new outcomes were evident in each community. Examples include new supports for individuals and family caregivers in support of aging in the right place (not hospital), improved working relationships among providers, and economic gains including new service capacity through partnerships.

Developing locally engaged networks of community, social, and health services, rooted in local knowledge and leadership and community assets, be they rural communities or focused areas within urban centres, can be anchors for refocusing Alberta's health system.

Action priorities include:

- **Leverage provincial health system change strategies to advance local connections.** Align provincial health reforms with local planning and funding to strengthen community-based services for older adults and caregivers.
- **Optimize infrastructure and processes for community development and impact measurement.** Invest in community hubs, navigators, and practical measurement tools to improve coordination, accountability, and results.
- **Promote a culture across local, regional, and provincial partners for community-based innovation.** Enable communities and partners to co-design, pilot, and grow new approaches through supportive policy, funding, and leadership.

The Time for Action is Now

The four-page summary graphic document found in **Appendix A: Summary Graphic: Alberta Communities in Action: Showcasing Grassroots Leadership and Impact,** is your guide to action.

Acknowledgements

This project was made possible through the generous participation and commitment of numerous individuals and organizations. We extend our sincere appreciation to the representatives of the nine communities who shared their time, experiences, and insights throughout the case study process. Their local knowledge and practical wisdom were essential to understanding how community ecosystems can be strengthened and activated.

We also acknowledge the valuable contributions of the Implementation Committee (HAA staff involved in program implementation and regional development and AHS Connecting People and Community for Living Well Initiative, and Advisory Committee, whose members brought a range of organizational and government perspectives to guide the work. Oversight and strategic direction were provided by the Alberta Association of Gerontology and Healthy Aging Alberta, whose leadership ensured alignment with provincial priorities for healthy aging and community-based support systems.

The project is grateful for financial support received from Alberta Health/ Continuing Care, Healthy Aging Alberta and in-kind support from the Alberta Association on Gerontology.

Introduction

Alberta's Context

A Refocused and Responsive Health System

Alberta is undertaking significant health system transformation grounded in a clear set of expectations for how care should be organized and delivered across the province. Central to these reforms is:

- **Commitment to local decision-making**, enabling communities and service providers to tailor solutions to local needs and population characteristics.
- **Delivering the right care in the right place at the right time**, shifting services closer to home and reducing reliance on institutional or emergency-based models of care.
- **Empowerment of both the health workforce** and **family caregivers,** recognizing them as essential partners in care planning, delivery, and continuity.
- **Focus on sustainability—ensuring Alberta maintains a publicly funded health system** that remains efficient, equitable, and capable of meeting the needs of an aging population.

Together, these expectations create an environment where integrated community ecosystems are not only possible but strategically aligned with provincial direction.

Renewed Emphasis on Rural Health

The Rural Healthcare Strategy reinforces Alberta's commitment to:

- **Strengthening access and service delivery in rural and remote communities.** This strategy acknowledges the unique challenges faced by rural residents, including geographic distance, workforce shortages, and limited availability of specialized services. It responds by promoting models of care that are locally anchored, flexible, and community-driven, ensuring rural populations receive timely and appropriate supports across the care continuum.
- **Highlighting importance of strong community partnerships and local leadership**—both central themes in the Local Community Ecosystems Activation Project. By emphasizing collaboration, shared responsibility, and culturally relevant approaches, the Rural Healthcare Strategy supports the activation of local ecosystems capable of addressing the needs of older adults in rural contexts.

Integrated Service Delivery and System Alignment

Alberta's transformation also involves reorganizing health services into clearer, more integrated areas of focus. This approach is intended to improve coordination, reduce fragmentation, and support smoother transitions for individuals and families.

The aligned service areas include:

- **Assisted Living Alberta**
  Supporting aging in place through coordinated housing, home care, and community living supports.
- **Primary Care Alberta and Preventative Health Services**
  Strengthening primary care networks, early intervention, and prevention so individuals receive timely, community-based support that reduces downstream demand on acute services.
- **Acute Care Alberta**
  Ensuring hospitals and acute facilities provide high-quality, efficient care while functioning in alignment with community and primary care services.
- **Recovery Alberta** (Mental Health and Addiction Services)
  Integrating mental health, addiction, and recovery supports across community and institutional settings, ensuring continuity of care.

These service groupings are designed to facilitate information sharing, cross-sector collaboration, and a more seamless experience for individuals navigating the system. For community ecosystems, this structure creates new opportunities to partner with health services, exchange data, and co-design solutions that keep older adults connected, supported, and well within their local environments.

The Project Context

The Local Community Ecosystems Activation Project was initiated to explore how local communities can build more cohesive and collaborative ecosystems, bringing together community organizations, health services, municipal services, and residents, to better support older adults' wellbeing.

As noted above, Alberta's health and social systems are undergoing significant transformation, with growing recognition of the importance of community-based supports in promoting the wellbeing of older adults. The community seniors serving sector plays a vital role in helping older Albertans remain active, connected, and supported within their local environments. However, fragmentation across health, social, and community systems limits the ability to deliver truly integrated and responsive services.

The project spanned eight months (March to September 2025, followed by presentations at the HAA Summit "The Tapestry of Aging" in October). The project Advisory Committee played a pivotal role in advising the Alberta Association on Gerontology and Healthy Aging Alberta by sharing their expertise and experience and guiding the process in the following areas:

- Synthesizing findings
- Defining key ecosystem components
- Considering policy implications for sustainability and implementation
- Helping develop a provincial "map" of community-focused initiatives (beyond case studies)
- Providing input through meetings culminating in a reflection session.

The Committee included leaders from Alberta Health, AHS (CPCLW, Connecting People and Community for Living Well Initiative), AAG, HAA, housing, FCSS, community-based seniors serving organizations, Indigenous-serving organizations, Caregivers Alberta and the Implementation Group. The project was overseen by a project manager representing AAG and supported by a Project Coordinator who also worked with the Implementation Committee.

Purpose of the Report

This report summarizes the process, in particular the case study approach, use of the Community Weaving Framework, key study findings, and lessons learned from the Local Community Ecosystems Activation Project. It aims to inform stakeholders, policymakers, and community leaders about effective approaches for fostering local integration and urges collective action to support healthy aging.

Organization of the Report

The remainder of this report is organized into four main sections:

- Overview of the Project's Methodology
- Presentation of Key Findings.
- Conclusions and Moving Forward
- Appendices

Throughout this report, **Stories from the Field,** are included to illustrate the leadership, spirit, and impact of connected community services.

Many stories were gathered during this project; this report presents only a sample. **Appendix F: More Stories from the Field** offers additional examples that further illustrate the powerful impact of connected services on the health and well-being of older adults. Together, these stories are numerous and diverse, demonstrating how both small actions and larger initiatives can profoundly improve lives, often restoring health stability, independence, social connection, and overall quality of life for older adults who did not expect to regain them after facing age-related challenges. Collectively, the stories provide heartwarming evidence of why connected community service networks, both within the case studies and in other communities doing similar work, are so meaningful and worthwhile.

Community Case Study Methodology

Community Case Study Approach

A case study approach offered a practical way to understand what is happening within communities by looking closely at real situations, experiences, and local assets. Instead of separating an issue from its surroundings, the approach recognizes that context matters and that community realities are interconnected. Case studies help reveal the "how" and "why" behind local actions, relationships, and outcomes. The method is flexible, adapts well to different situations, and generates insights that reflect lived experiences.

This approach was especially valuable for examining community ecosystems because it provided a well-rounded picture of each community and highlighted both unique circumstances and common patterns. It helped identify the conditions that supported collaboration, as well as the barriers that limited it. The resulting insights were grounded, practical, and relevant to policy development.

Community Selection and Profile Development

Numerous rural, urban and diverse communities in Alberta are doing exemplary work through connected community services that are contributing to the health and wellbeing of their older adults. In collaboration with the Implementation Committee, a detailed process was undertaken to identify and select communities to participate in the community case study. Using the criteria identified below, nine communities were identified and invited to participate in the case study.

Important criteria for selection of the nine communities included the following:

- Focus on rural communities that reflected a cross-section of Alberta, where vast geographic areas and long distances from major centres create barriers for older adults seeking social supports and health services. This focus also supported gathering insights and strategies to inform the implementation of Alberta's Rural Health Action Plan.
- Inclusion of an urban diverse community within a large urban centre, demonstrating strategies for serving diverse ethnic populations.

- Representation of communities `ranging from small to large populations demonstrating that connected-community approaches are feasible and impactful regardless of community size.
- Presence of an active community network serving older adults.
- Readiness and capacity to participate in the case study.

Contact information for each community participating in the case study is given in **Appendix B: Snapshot of Case Study Communities and Contact Information**.

Each community participated in the completion of a community profile to provide a foundational document for use in the focus groups. The profile captured basic community information; relationships, connections and supports; resources, investments and sustainability; outcomes and impact; future goals; and contact information. The type of information captured in each of these sections is shown in **Appendix C: Information Captured in Community Profiles**.

Using the profile information to shape the focus group questions minimized repetition and ensured that available discussion time centered on the community's most important experiences and stories.

Data Collection and Engagement Approach

Data were gathered through a series of focus groups and facilitated discussions, held both in-person and via Zoom, to ensure broad participation. Participants included community leaders and some service providers.

Once focus group dates and times were established, the communities' contact leaders were asked to identify and invite partner organizations to participate in the conversation. The focus group questions were sent in advance to facilitate preparation for the focus group conversations.

An overview of the key sections forming the focus group questions is shown in **Appendix D: Information Framing the Focus Group Questions**.

The focus groups spanned four months based on people's availability and were on average about 1.5 hours in duration. Some conversations were extended for another 30 to 45 minutes.

Application of the Community Weaving Framework

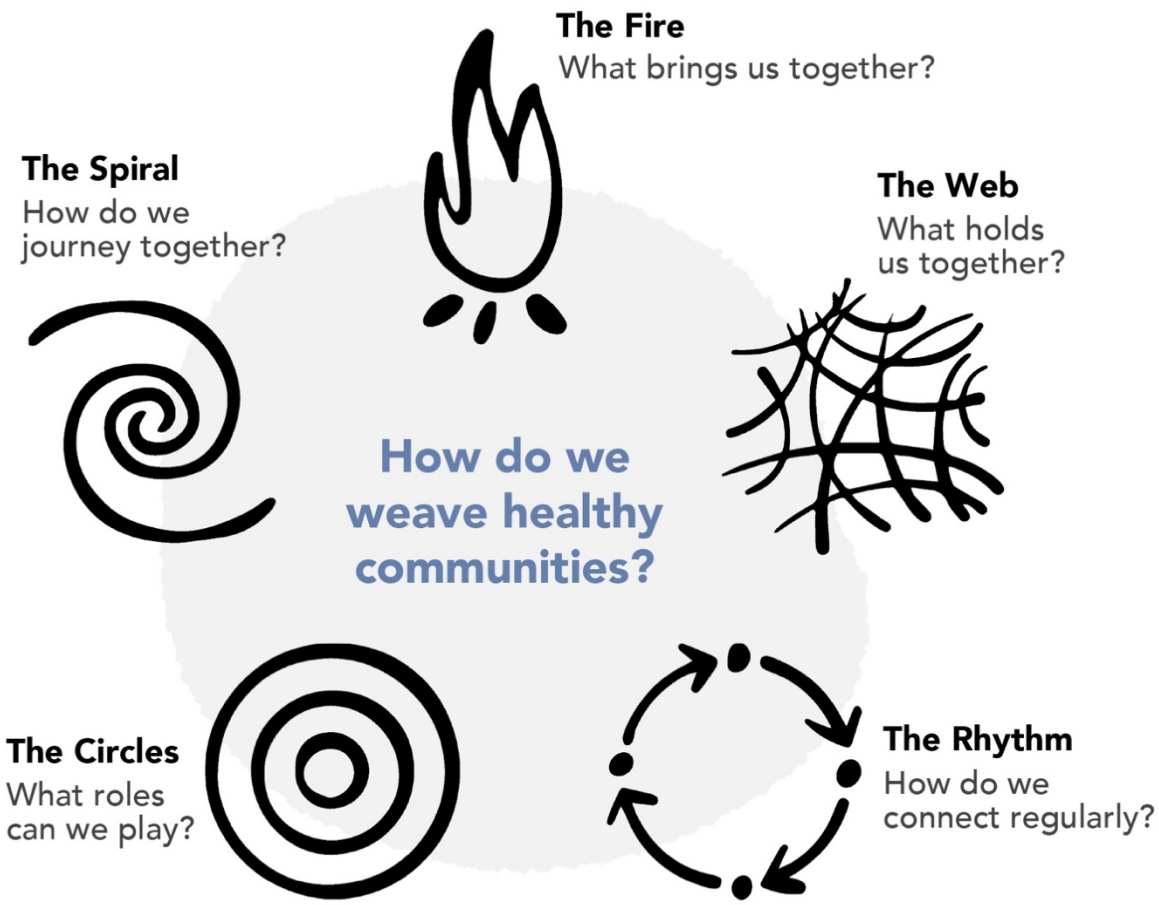
The Community Weaving Framework[1] served as the central analytical lens for understanding how communities organize and activate their ecosystems. The framework's five elements—*The Fire, The Web, The Rhythm, The Circles, and The Spiral*—were used to structure data collection, interpretation, and synthesis of findings across communities.

[1] Community Weaving. (n.d.). *Community Weaving Framework*. https://www.community-weaving.org

The community weaving framework is presented as a framework for weaving healthy communities. The co-creators of the framework describe community…

"…community as a web of mutual care around a shared possibility… The essence of community is relationships of care, held together by a sense of kinship and mutual support."

Five elements are viewed as essential in creating and building healthy communities as shown in the following graphic. Details on the specific components of each element are given in **Appendix E: Description of the Community Weaving Framework Elements.**



"The beauty of the community weaving framework is how it 'humanizes' the concept of building community networks"

Project Advisory Committee Member

Scan the QR codes below to watch two videos created by community networks in Bashaw and Drumheller. They demonstrate the 'humanizing effects' of the community weaving framework and bring to life the impact on the wellbeing of older adults.

Bashaw: **Drumheller:**

Key Findings

Summary of Major Themes by Each Framework Element

Findings are organized according to the five elements of the Community Weaving Framework, highlighting common themes and patterns across communities. Each element is followed by a sample of stories shared in the focus groups illustrating the underpinning of each element, while also reflecting the uniqueness and diversity of the communities and their connected community service networks.

The Fire – Bringing the Community Together

All communities identified a catalyst described as a key event that prompted a small group of people to act and set the stage for developing a range of connected services for older adults.

The community triggers or tipping points were described in the following ways:

- Repeated experiences of specific resident health incidents or unmet needs.
- Recognition that the same individuals were being served by multiple organizations without a formal referral or coordination process.
- Identification of common needs and service gaps, prompting one or two agencies to take initiative and bring a core group together.
- A strong mandate or commitment to serve a specific population (e.g., ethnic group, urban residents), leading to partnerships with organizations best positioned to meet a range of needs.
- Pilot projects or initiatives (e.g., Cancer Legacy Project, Age Friendly Initiative, Voices for Seniors) that revealed additional health and social needs and spurred the creation of a community network.

Stories from the Field

A crisis-driven spark leading to a regional wellness ecosystem

Bashaw's network grew out of an urgent problem focused on one man: a person with dementia, living alone, who kept walking on highways and through ditches, repeatedly triggering RCMP and community concern. The RCMP member refused a "lock him up" solution and instead pushed for dignity, safety, and shared responsibility. In working through his situation, local partners realized they were all involved with the same people but operating in silos, with no one holding the whole picture, and that insight led to the formation of the Bashaw Regional Wellness Team.

Enhancement of the wellbeing of Chinese Older Adults

The **Calgary Chinese Elderly Citizens' Association (CCECA)** was created in response to the profound isolation and barriers faced by older Chinese adults who arrived in Canada with limited English, unfamiliarity with local systems, and experiences of discrimination. Many felt invisible within mainstream services, struggling to access health care, benefits, housing supports, and community programs. CCECA emerged as a vital bridge—a culturally grounded hub that provides language-appropriate outreach, navigation support, interpretation, and social connection while partnering with health and community agencies. Over time, it has grown into a connected service network that links isolated seniors to one another and to broader community supports, helping them integrate into Canadian society while honouring their cultural identity and ensuring they feel seen, supported, and valued.

A clinician-led spark seeing unmet needs and "nothing to offer"

Drumheller's network began with a frontline nurse, who in 2017 kept encountering seniors newly diagnosed with dementia, people living in extreme isolation, overwhelmed caregivers, and older adults with no suitable programs or supports. Clinicians could identify the problems, but there was nowhere to refer people, and that gap pushed a group of like-minded, boundary-stretching practitioners to start imagining a community solution. After extensive mapping, conversations, and gap analysis, the coalition formally took shape around 2019 shaping a culture of pragmatism and

COVID as the catalyst for collaboration

Stettler's network began as a direct response to COVID, when agencies were overwhelmed by isolated seniors, soaring workloads, and major provincial supports systems shutting down or going remote. Staff described the phones "never stopping" and realizing they had to "gather the troops" because no single agency could cope alone, making the pandemic the catalyst that pushed them into true collaboration.

Community development rooted in public health and prevention

Vulcan's work emerged from the 2016 "Act4Health" initiative, which brought together partners from recreation, health, education, FCSS, the town, and community groups to ask what the community needed to be healthier. Four pillars were created—healthy eating, active living, reduced substance use and harm, and community connection, with connection quickly becoming the central focus. The entire approach is grounded in a strong public health lens that prioritizes social determinants of health, prevention, and early intervention rather than relying on acute or end-stage care.

The Web – Relationships Holding the Community Together

Strong community-agency relationships, built on trust, collaboration, and deep bonding, were a defining feature of the Web element.

Participants in the focus groups described their relationships as having:

- **A strong sense of community and a shared responsibility for caring for older residents**, reflected in the recurring question: "How can we help?"
- **A group of like-minded people who genuinely care about the wellbeing and quality of life of older adults**, working together to leverage all available resources.
- **A focus on the people who need support rather than on organizations or providers**, demonstrating person-centred care, community pride, and a community-driven approach.
- **A core set of shared values**, where everyone contributes to the network, no single organization "owns" it, and members think and act creatively, remain flexible and adaptable, and provide consistent support that builds community knowledge and trust.

The relationships and roles of the volunteers identified their value and resource management as:

- **A vital backbone of the community**, contributing significantly to its capacity and resilience.
- **Intentional engagement that recognizes volunteers' strengths** and balances them effectively with staff skills.
- **Strategic recruitment**, including thoughtful "handpicking" of volunteers suited to key roles.
- **Volunteer coordinators who provide essential added value** by supporting, organizing, and sustaining volunteer involvement.

The relationships and roles of the Link Workers / Navigators highlighted three crucial responsibilities:

- **Point of consistent contact for receiving and managing referrals** to ensure residents access appropriate services and supports.
- **Seamless coordination of needed services**, helping individuals navigate the system effectively.
- **Ongoing identification of service gaps and unmet needs**, informing broader community planning and improvements.

Stories from the Field

Deep community commitment with collaboration as a discipline, not a concept

In **Fort McMurray**, across all agencies, the unifying force was a deep commitment to community and a shared belief that seniors deserve dignity, belonging, and safety, with many partners viewing the work as a legacy they want to leave behind. Collaboration became a disciplined practice rather than a vague ideal: decision-makers stayed at the table, the focus remained on solving real gaps rather than chasing funding, partners trusted the process even when it felt uncomfortable, and no single agency became the "owner" of the network. Shared responsibility was deliberately cultivated.

Clear and consistent values driving their network

Cold Lake's network is grounded in clear, consistent values—being person-centred, compassionate, and deeply flexible—with participants describing a culture shaped by passion, integrity, patience, and genuine care. They emphasized a non-ego, non-territorial approach in which staff promote whatever program best fits the client, whether or not it's their own, and they intentionally use language that preserves dignity, such as saying "support" instead of "help." This values-driven mindset allows them to adapt easily, shift appointments, adjust services, and respond readily as people's needs evolve.

Strong volunteer backbone and well-organized fundraising

Bashaw relies on a strong volunteer backbone and a savvy, well-organized approach to fundraising. Volunteers take on everything from festival work and campsite cleanups to driving and short, family-friendly shifts that fit their schedules. Their annual event work can generate more than $60,000, money they describe as "free" not because it requires little effort, but because it isn't tied to restrictive grant conditions. These funds let the community fill service gaps, match other grants, and test new pilot ideas. They also work intentionally to match volunteers with roles that fit their motivation and capacity, and reducing burnout. They also adapt quickly when volunteer-based systems become too fragile; for example, bringing Meals on Wheels in-house when scheduling challenges began overwhelming volunteers.

Even amid disruption, trusted relationships and 'quiet navigators' make a difference

Westlock's seniors' network began around 2015–2016 as Voices for Seniors, created to give older adults a voice in community planning, identify service gaps, and improve coordination among agencies; it initially thrived with strong engagement and lively discussions about transportation, doctor access, and community needs, but participation later declined due to COVID-19 disruptions, administrative complexity, shifting expectations, and the withdrawal of medical partners such as the PCN. The network is now being revitalized as they work to rebuild purpose, trust, and momentum, drawing on one of Westlock's greatest strengths: deep, longstanding relationships built through consistent, face-to-face interaction. A Seniors Coordinator functioning as an informal navigator, enables seniors to access services through trusted referrals rather than formal systems, and this relational foundation allowed the community to continue achieving meaningful outcomes even when the formal network structure faltered.

The Rhythm – Ways of Connecting Regularly

Community networks use several complementary approaches to support clear communication and effective coordination, including:

- **Frequent communication through both informal and formal channels**, including phone calls, drop-in visits, and network newsletters.
- **Regularly scheduled meetings**, held as often as needed (e.g., monthly or quarterly).
- **A roundtable approach** that keeps the focus on the needs and services of older adults.
- **Monthly shared lunches** that strengthen relationships and encourage collaboration.
- **Daily huddles practiced by some agencies** to coordinate immediate needs and priorities.
- **Regional meetings or "communities of practice"** that support broader learning and alignment.

Participants also noted that co-location, particularly between primary care and community services, creates countless opportunities for timely, informal connections such as quick hallway conversations or office drop-ins that make communication and coordination easier and more effective.

Stories from the Field

Daily huddles integrate medical and social navigation

One of **Bashaw's** distinctive features is its daily 15-minute clinic huddles, where physicians, nursing staff, and the social-side navigation team meet to review the day. These brief check-ins allow real-time identification of patients whose needs are social, financial, or mental health–related rather than purely medical, creating rapid back-and-forth between home and clinic perspectives. The result is seamless warm handoffs to home support, transportation, mental health and addictions services, and income or benefits navigation, essentially social prescribing and care integration built directly into the daily rhythm of primary care.

A highly collaborative, referral-rich ecosystem

Cold Lake operates as a 'living network' rather than a formal structure, with continuous back-and-forth referrals among Age Friendly, FCSS, AHS, the hospital, long-term care, home care, the men's shed, churches, and transportation providers. Link workers and AHS meet monthly to jointly manage shared clients, and even contractors and volunteers, such as housekeeping staff, are treated as part of the team—trusted "eyes and ears" in people's homes. The network's strength lies in its relational culture grounded in mutual respect, low ego, and a shared purpose.

Shared ownership and processes

Stettler's network was intentionally designed so no single agency owns or leads it: the shared email can be used by anyone, meetings rotate between locations, and hosting responsibilities are spread across partners. This shared ownership creates an inclusive, low-ego culture and makes the network more sustainable than models dominated by one backbone organization. Participants noted that while the community once operated in silos, it now functions more like a "circle," where any point of entry leads seamlessly into the wider network; housekeepers, library staff, and Meals on Wheels drivers can quickly and confidently refer concerns onward, ensuring people are connected to the right supports without barriers.

Practical collaboration under one roof

Vulcan's network demonstrates the power of co-location and constant collaboration: FCSS, the Food Bank, the Rural Development Network housing project, and other supports share one building where many needs—taxes, benefits, food security, rental crises, navigation, and counselling referrals—are handled "in-house," while the clinic itself is embedded in the hospital with lab, x-ray, and even temporary post-surgery beds just steps away. Regular interagency tables, from general interagency to the elder abuse committee and the "Ask for Help" wellness group, keep partners tightly aligned and able to respond quickly and cohesively.

Primary care and community partnership in one building

Drumheller's primary care model is intertwined with community supports, with physicians and nurses routinely referring to local programs and beginning every clinical visit with questions about the home environment, food security, mobility, social needs, and isolation. The PCN has fully embraced social prescribing as part of its workflow, and the presence of a dedicated community coordinator within the health system—even at 0.5 FTE—has proven transformative. This creates a two-way partnership: medical providers identify and refer based on social need, while community partners relay back what they see in people's homes, allowing both sides to respond more effectively.

The Circles – Roles in the Community

Optimizing the roles of all partners, while recognizing the natural ebb and flow of changing mandates and priorities, was seen as essential. Flexibility, strategic positioning, shared workload, and advocacy across all levels of government were consistently highlighted as critical. Participants described their experiences in the following ways:

- **Leveraging the collective strengths and resources of all partners.**
- **Wearing different hats** to fill service gaps and ensuring that **egos are left at the door.**
- **Being strategic about who sits at the table**, ensuring that each person:
  - Is actively involved in serving seniors.
  - Has decision-making authority.
  - Brings an innovative approach to problem-solving.
  - Is reliable and trustworthy.
  - Demonstrates accountability and transparency.
- **Sharing the workload**, including tasks such as grant writing and administrative support.
- **Advocating with local and provincial governments** by building relationships, raising awareness of the network and its services, and demonstrating the community impact.

Stories from the Field

Community crises leading to trust building and shared values

Fort McMurray's history of fire, flood, and COVID has forged a culture of mutual reliance that participants believe accelerated collaboration, creating a nonprofit sector that is unusually tight-knit and grounded in trust, humility, and interdependence. This foundation is reinforced by strongly shared values—dignity, safety, freedom from abuse, diversity and inclusion, honesty, openness, and a person-centred approach that consistently takes precedence over agency interests.

Municipal ownership and governance foster a strong rural transportation service

In the **MD of Smoky River**, transportation is both a health service and a catalyst for social connection: medical trips remain the backbone of the program, but the bus also offers companionship, reasons to leave home, and a sense of belonging, even as younger seniors continue to see it as "not for them." The service is jointly owned by municipalities and governed through regular meetings, where leaders review detailed trip data to monitor outcomes and justify ongoing investment. This shared governance model is seen as unusual but highly effective for rural Alberta, reinforcing strong local ownership and accountability.

From Fairgrounds to Community Hub

In **Stettler,** a local agricultural society that once seemed destined to close found new life by stepping into an unexpected role in the community. Years earlier, the loss of skating, other events, and rentals had left the space isolated and narrowly focused but joining a broader community network changed everything. The ag society's space became a hub for cooking classes, inclusive programs for people with disabilities, dog-walking and indoor walking in winter, markets, and community gatherings. By opening itself to collaboration and reimagining its role, the society didn't just survive—it became a place where people could see themselves contributing to a healthier, more connected community.

Person-centered and flexible even in the 'grey areas"

Vulcan's network is deeply person-centred, flexible, and comfortable working in the "grey areas," with staff routinely meeting people wherever they are—homes, villages, restaurants, coffee shops—and adapting their approach to each person's capacity, fear, or readiness, sometimes making multiple reassurance calls before someone agrees to try a service. They push back against rigid rules when those rules undermine quality of life, avoid silos, and embrace the sometimes messy, interconnected nature of real problems. Their work is infused with compassion, respect, dignity, courage, and persistence, and grounded in viewing seniors as whole people with histories, identities, and roles they still want to contribute to.

The Spiral – Journeying Together

As communities move toward the future, they emphasized the importance of addressing a set of core barriers that affect their ability to sustain and strengthen their service and support networks. Several internal capacity challenges were identified:

- **Securing committed and stable funding**, given their heavy reliance on grants and the associated risks to staffing, service continuity, and the trust of older adults who depend on these supports.
- **Addressing critical unmet needs and service gaps for older adults**, including mental wellness (e.g., dementia, elder abuse, social isolation, depression), respite for caregivers, palliative care, home care limitations, and social work support.
- **Supporting additional social determinants of health**, such as transportation, housing, and food insecurity, by continuing to find and reinforce effective approaches.
- **Building strong operational foundations**, including adequate and secure office or service spaces, succession planning for retiring leaders, and consistent administrative support.

In addition to these internal needs, communities also reflected on broader contextual challenges they must navigate to sustain their efforts, expand their reach, and meet the growing needs of older adults—particularly in rural and remote areas:

- **Creating partnerships with Primary Care Networks and primary care**, which can be limited or inconsistent across communities.
- **Overcoming geographical barriers**, including long distances between communities within a region or county and the challenges of serving semi-isolated areas.
- **Influencing municipal policies**, where older adult needs and services may not be a priority; one strategy noted was framing the message as *"a healthy taxpayer is a healthy ratepayer."*
- **Building relationships with diverse ethnic communities**, where establishing trust and making meaningful inroads can take considerable time and sustained engagement.

Stories from the Field

Gaps and vulnerabilities

Despite its strengths, **Bashaw** is candid about its vulnerabilities: the future of its building is uncertain, and market-level rent would be unaffordable without new funding; most roles rely on short-term, piecemeal grants rather than stable core funding; rigid policies sometimes block common-sense solutions, such as home care declining to attend the lodge to coordinate care; and their evaluation system still depends on manual tracking without a simple cross-program reporting tool.

Staffing, program space and parking challenges

Calgary identified several significant barriers to sustaining and expanding its services. High staff turnover remains a persistent challenge, largely driven by competition from organizations that can offer higher salaries and better benefits, making retention difficult. As programs grow in popularity, the organization is also struggling with inadequate space and increasing competition for rooms shared with program partners. Costly parking further restricts access for older adults and their families, although public transit is accessible.

Sustainability barriers

Participants in **Fort McMurray** highlighted several sustainability risks: human capital challenges such as staff loss, burnout, and leadership transitions; organizational fragility among small nonprofits that could easily face closure; significant geographic barriers that make it difficult to serve distant Indigenous communities; and complex issues like hoarding that require specialized coordination and capacity many agencies do not currently have. Note: Fort McMurray has created a hoarding task force that will directly enhance housing stability for seniors.

Rural realities and constant funding struggles

Stettler's rural realities shape almost every aspect of its work, with major challenges around housing affordability, limited appropriate options for older adults, especially those with pets, significant transportation barriers for people living in small hamlets and villages, and persistent isolation among seniors whose families have moved away or who became disconnected during COVID. The network continually struggles with unstable, project-based funding that consumes staff time and rarely covers core operations, creating anxiety about burnout and the vulnerability of the system if even a few key people retire or leave, particularly without stable navigator funding or dedicated coordination support to keep the work from "fizzling out."

Funding, staffing, communication, and equity challenges

Vulcan faces several ongoing challenges, including unstable project-based funding that puts key roles such as the link worker, outreach staff, and RDN housing support at risk, raising concerns about turnover, sustainability, and the potential loss of trust if programs disappear. Communication gaps persist as traditional media weakens and digital platforms fail to reach many seniors and newcomers, requiring constant effort to keep physicians, paramedics, and residents informed about available services. Equity and access barriers further complicate the landscape, with language and cultural differences affecting newcomers, tech literacy gaps limiting older adults, and regional services meant to cover surrounding areas, often unable to show up due to travel and mileage constraints.

Clearer structure and stable funding for moving forward

Westlock's network needs a re-engaged advisory committee with a clear purpose, clarity about the roles of professionals versus community members, and a Terms of Reference that sets shared expectations. Progress will also depend on securing stable core funding rather than relying on project-based grants, as well as renewing partnerships with healthcare providers, especially the Primary Care Network, whose participation is essential to a functioning seniors' ecosystem.

Promising Practices

Across communities, participants reinforced several practical insights and mindsets that help communities move past barriers and sustain momentum in their work. These promising practices reflect both the urgency and creativity required to support older adults effectively.

1. Adopt a Bold, Action-Oriented Mindset

- **"Just do it and make it happen."** Don't wait for perfect conditions; act, adapt, and keep moving forward.
- **Find new paths around obstacles.** When one route is blocked, try another; creativity is often the fastest bridge.
- **Start with the "low-hanging fruit."** Early wins build confidence, trust, and community visibility.
- **Have a grand vision but begin small.** Dream big, but launch with manageable, achievable steps.

2. Lead with Collaboration, Not Ego

- **Leave egos at the door.** Shared ownership and shared leadership keep networks strong and unified.
- **Stay open to all potential partners.** Never discount what an unexpected ally might bring to the table.
- **Engage the "right" people from the "right" agencies.** Seek those with passion, commitment, and the courage to move the work forward.
- **Trust the process.** Let the work unfold naturally while staying aligned on purpose and values.

3. Cultivate Exceptional People and Organizational Qualities

- **Value the traits that make collaboration thrive:** proactive, open-minded, nonjudgmental, and visionary.
- **Be present and visible.** "Make noise," show up in the community, and ensure people know who you are and what you offer.
- **Keep conversations flowing.** Blend informal chats with structured discussions—both strengthen relationships.
- **Ensure consistency and stability.** Reliable staff and volunteers build trust, while flexibility keeps the work responsive to the needs of older adults and the overall community.

4. Innovate and Strengthen Operations

- **Step outside the box.** Encourage creative approaches that fit the local context and culture.
- **Adapt services to the community.** Tailor programs, training, and outreach to reflect cultural norms and community realities.
- **Find efficiencies without compromise.** Innovate ways to save time or resources while maintaining quality and dignity.

- **Invest in strong foundations.** Secure appropriate spaces, plan for leadership transitions, and maintain the operational supports that keep community networks strong.

Significant Learnings

The case study highlights the potential of community ecosystems as catalysts for local action and systems change. Significant learnings are summarized in the graphic, and described in more detail, following the graphic.

Significant Learnings and Implications for Sustainability

1. **Community engagement requires intentionality, support and infrastructure** to build connected relationships and service networks.
2. **Capacity development is the foundation for any community making a difference…**but requires sustained funding, changed practices & processes, and flexible policies, **including shared outcome measures that focus on the impact of community ecosystems.**
3. **Each community is unique**… local connected community networks evolve and vary depending on local assets, circumstances and history.

Community engagement requires intentionality, support and infrastructure to build connected relationships and service networks.

Meaningful engagement does not happen by accident; it requires deliberate strategies, dedicated roles, and spaces, both physical and relational, where people can come together. Communities need coordinators, outreach staff, link workers, and welcoming hubs that make it easy for older adults and other residents to participate and for agencies to collaborate. Engagement thrives when there is time for relationship-building, mechanisms for sharing information, and inclusive practices that ensure isolated or marginalized seniors are actively invited in. With the right infrastructure in place, communities can develop strong networks where service providers and residents feel connected, informed, and supported.

Capacity development is the foundation for any community making a difference… but requires sustained funding, changed practices and processes, and flexible policies.

Communities cannot deliver effective, older adult, person-centred supports without the capacity to do so. This means stable, multi-year funding for essential roles such as navigators, outreach workers, transportation coordinators, and community connectors. It also requires new ways of working such as shared planning tables, integrated referral pathways, cross-sector collaboration, and practices that emphasize prevention and early intervention. Policy flexibility is equally important; rigid rules often prevent communities from responding creatively to real-world needs. Building capacity is not a one-time investment but an ongoing commitment to equipping communities with the skills, resources, and authority they need to make lasting change.

Each community is unique in how its local connected community networks evolve and vary depending on local assets circumstances and history

No one template exists for building connected community services. Rural towns, hamlets, Indigenous communities, and regional centres each bring distinct histories, cultures, relationships, and assets that shape how their networks develop. Most communities rely on strong not for profit leadership and collaboration, while others rely on local champions, municipal leadership and support, and long-standing volunteer traditions. Geography, population size, available services, and past experiences with crisis or collaboration all influence what works. The most successful networks honour their local context, build on their strengths, and adapt models to fit their own realities rather than copying solutions from elsewhere.

The Creation and Evolution of Connected Community Services

Analyzing the case study findings by each element in the Community Weaving Framework laid the groundwork for articulating a five-step process required to create and, sometimes, recreate, connected community services.

The following graphic illustrates the flow in the creation process that correlates with the elements in the weaving framework.

Conclusions and Moving Forward

The Opportunity: Woven Networks of Services

The case study findings set the stage for defining the ultimate outcome: a woven network of services that functions as part of a much larger community ecosystem.

Connected Community Services to Health and Social Services

Connected community systems also need to be integrated to enhance the health and wellbeing of diverse populations. The three prominent sectors are:

- **Community Services**: Engaged and connected communities with natural supports and community-based services
- **Health Services**: Community based health services include the four pillars of Alberta's realigned health system: Primary Care (day to day health care), Acute Care Alberta (hospital, urgent care, emergency services), Recovery Alberta (mental health and addictions) and Assisted Living Alberta (continuing care, long term care, palliative and end-of-life care, support for older adults).
- **Social Services**: prevention, health promotion and non-medical services plus the Social Determinants of Health (SDOH)

Connected Community, Health and Social Services to a Larger Ecosystem

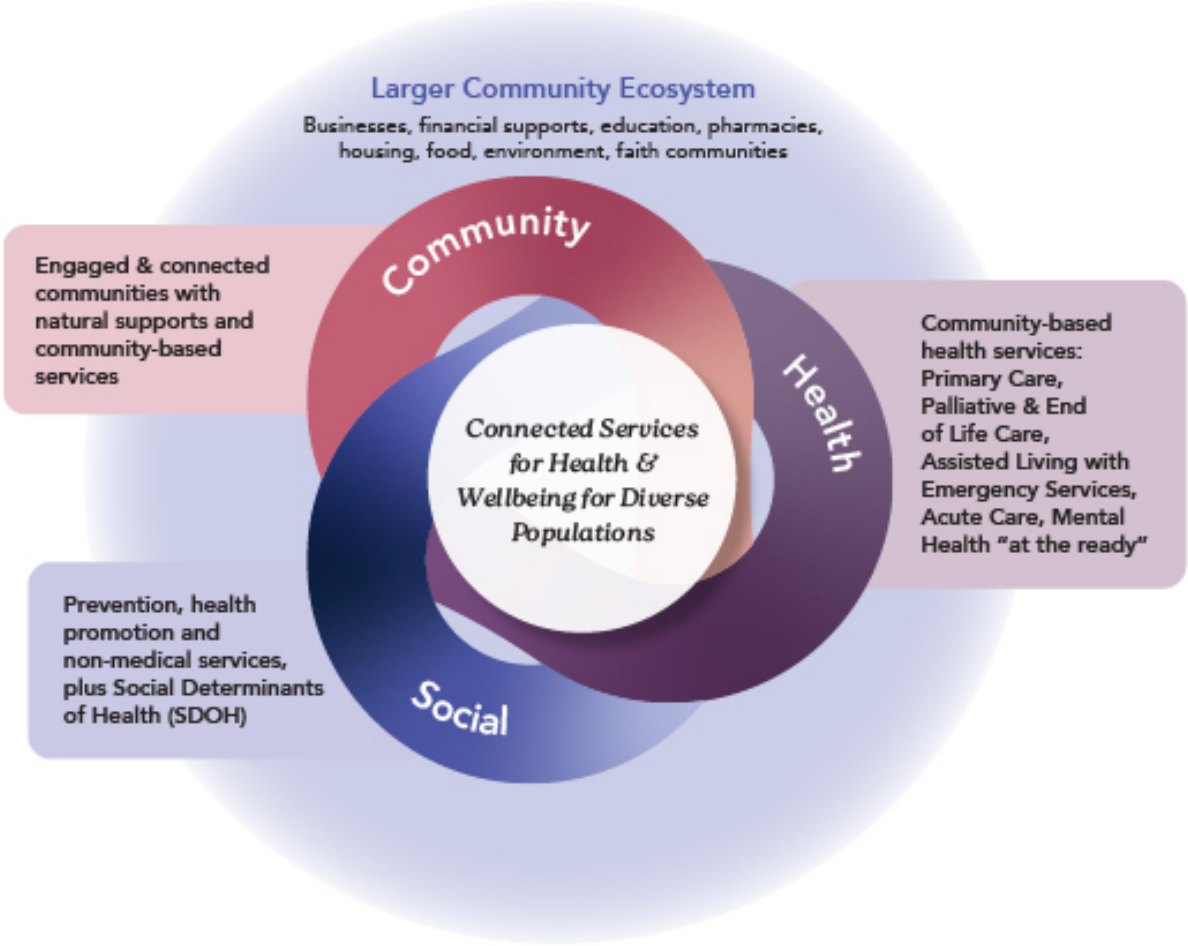
Connected community services do not stand alone. They gain strength, resilience, and impact when they are linked into a broader web of relationships and supports. This larger ecosystem includes not only community, health and social services, but also the businesses that sustain local economies, the financial supports that enable stability, the educational systems that build capacity, the housing and food-security structures that shape daily life, and the natural environment that underpins community wellbeing. When these sectors are woven together, they create the conditions for large-scale interconnected networks that can respond more effectively to the needs older adults and those of the community at large.

The Impact of Connected Community Services

Communities with connected services enhance:

- Quality of living and aging in the right place for older adults
- Supports for family caregivers
- Working relationships among providers
- Service capacity through partnerships
- Local economic gain

The following graphic illustrates the contributions of each sector and their interconnectedness within large ecosystems.



Recommendations to Sustain a Community-Focused System

Building a connected, person-centred ecosystem for seniors requires a coordinated effort across community, health, and social sectors. Based on the insights gathered from communities across Alberta, three overarching recommendations emerge, each essential for advancing the province's commitment to a refocused, prevention-oriented health system rooted in strong local capacity.

The key recommendations were strongly supported by the Project Advisory Committee, highlighting priority areas for future action.

Recommendation 1. Leverage provincial health system change strategies to advance local connections

Communities emphasized the need for stronger alignment between local priorities, regional structures, and provincial health system strategies. Alberta's ongoing health reforms create an important opportunity to bring these levels together through shared planning tables and coordinated governance, enabling clearer direction, better alignment of resources, and faster responses to community needs.

At the centre of this work is the expansion of community-based services to address long-standing gaps for older adults and caregivers, including dementia supports, elder-abuse prevention, mental health services, social isolation, respite, palliative care, and social work. Many seniors need help well before they reach hospital or long-term care, yet limitations in home care and pressures in the clinical system often leave these needs unmet. Stronger system alignment can shift attention and resources toward earlier, community-based supports and improve navigation so people can move smoothly between programs.

To support this shift, provincial policies and funding must enable local connection and flexibility. Multi-year, stable funding helps retain skilled staff and sustain partnerships, while flexible frameworks allow communities to adapt provincial strategies to local realities. Thoughtful use of technology can further support communication, data sharing, and coordination across the system.

By leveraging provincial health system change in these ways, Alberta can strengthen local service networks and build more connected, responsive community ecosystems for older adults and their caregivers.

Recommendation 2. Optimize infrastructure and processes for community development and impact measurement

Strong community ecosystems depend on having the right foundations in place—physical, organizational, and relational. Communities need shared and accessible spaces where health care, housing, FCSS, social supports, and community organizations can work side by side, making it easier for older adults and caregivers to find help and ensuring that "any door is the right door."

Just as important is human infrastructure. Community development roles such as navigators, link workers, service coordinators, and outreach teams are essential for reaching isolated seniors, coordinating supports, and strengthening relationships across organizations. Consistent investment in these roles enables communities to respond more quickly, prevent people from falling through the cracks, and make better use of limited resources through collaboration rather than fragmentation.

To sustain and grow these ecosystems, communities must also be able to demonstrate their impact. Simple, practical measurement tools are needed to track outcomes such as reduced isolation, improved safety, stronger partnerships, fewer emergency visits, delayed institutionalization, and more effective use of public resources. These data should be complemented by the lived stories of older adults, caregivers, and front-line workers, which show how community connections change lives in meaningful ways.

Together, strong infrastructure and meaningful impact measurement allow communities to continuously improve, build the case for ongoing investment, and support a health and social service system that values prevention, connection, and wrap-around care.

Recommendation 3. Promote a culture across local, regional, and provincial partners for community-based innovation

To achieve truly connected community services, Alberta must move beyond isolated pilots and program-by-program change and intentionally cultivate a culture of community-based innovation across all levels of the system. This means, together, creating the conditions for communities, service providers, funders, and government partners to experiment, learn, adapt, and scale what works.

Local communities are not just recipients of programs, but active partners in designing and improving solutions that reflect their unique strengths, challenges, and priorities. Community-based innovation recognizes that the most effective and sustainable approaches to care and wellbeing emerge when frontline providers, community organizations, older adults, families, and people with lived experience are empowered to co-create and test new ways of working. A culture of innovation encourages shared problem-solving, reduces risk aversion, and supports learning across the system rather than rewarding rigid compliance.

Deliberate action is needed at multiple levels to create safe spaces for experimentation, align funding and policy with innovation, support shared learning, invest in local capacity and embed innovation into leadership expectations.

Moving Forward to Mobilize Concepts and Opportunities

The case study findings, reinforced by the Project Advisory Committee, showed strong evidence of the tremendous gains possible in the health and wellbeing of older adults. These gains are achievable when the right services and supports are in place.

More older adults in both rural and urban Alberta can benefit from coordinated, connected community, health, and social services delivered within the broader ecosystem that shapes healthy living and healthy communities.

Now is the Time

Weaving local networks of community, social and health services, grounded in understanding people, community assets and natural supports, driven by local decision-making and action, contributes to refocusing Alberta's Health system.

Actions to keep this work moving in sync with Alberta's realigned health system, the Rural Health Action Plan and other upcoming strategies, include:

- **Secure collaborative action by the Ministries** of Assisted Living and Social Services, and Primary Care and Preventative Health Services with key champions like Assisted Living Alberta, Healthy Aging Alberta, Connecting People and Community for Living Well CORE group and its many partners.
- **Optimize infrastructure actions** by connecting Healthy Aging Alberta and its initiatives with Primary Care and Preventative Services, MAPS (Modernizing Alberta's Primary Health Care System) and Family and Community Support Services.
- **Strengthen the processes** through collaborative actions as noted in the recommendations.
- **Measure the impact of activated ecosystems** by building on initiatives already underway by the Health Quality Alberta, Imagine Citizens Network and Care Opinion Canada and other organizations.

Appendix A: Summary Graphic: Alberta Communities in Action: Showcasing Grassroots Leadership and Impact

ALBERTA ASSOCIATION ON GERONTOLOGY
Improving the Lives of Older Albertans

Healthy Aging Alberta

Alberta Communities in Action:

Showcasing Grassroots Leadership and Impact

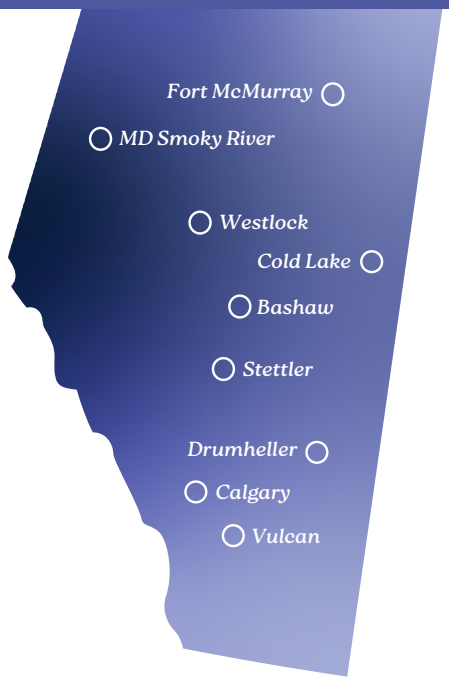
CASE STUDY OVERVIEW • DECEMBER 2025

Introduction

The Alberta Association on Gerontology (AAG) / Healthy Aging Alberta (HAA) Community Ecosystems Project conducted a case study of nine Alberta communities of varying sizes that have successfully built connected networks to support older adults.

Focus groups were conducted with diverse social support and health service leaders, to identify practices and implications that enable connected community networks (page 2 & 3).

Their success stories illustrate the promising practices that work now and demonstrate what will enable connected community networks to expand and be sustained over time, shifting the province from fragmented systems to woven networks—activated community ecosystems (page 4).



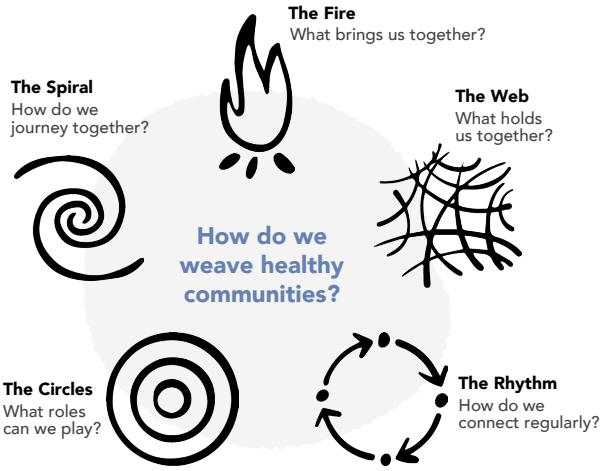
Case Study Resources:

1. The Community Weaving Framework. www.community-weaving.org
2. The full AAG/HAA Community Ecosystems Case Study Project Report will be available on the AAG website January 2026. https://albertaaging.ca

Listening to Communities

Introducing the Community Weaving Framework[1]

The findings from our focus groups were analyzed and categorized according to the elements of the *Healthy Communities Weaving Framework*—which defines five elements that help strengthen a community.



What is important

The main themes emerging from the focus groups were summarized using the Community Weaving Framework, with direct participant quotes included in quotation marks.

The Fire

Bringing the Community Together

- A spark ignites the community's need for change.
- Concerned organizations come together to respond to the need
- Community grassroots connect services and lead with intent
- External opportunities (e.g., new initiatives, government funding) are seized to support action.

The Web

Relationships that Hold the Community Together

- A strong sense of community builds, "how can we help" mentality
- "Like-minded" people who care about others come together, "think outside the box"
- Shared values focus on the people being served, not the organization, "egos left at the door"
- Collaborative partnerships rely on building trust
- Volunteers, the backbone of the community, thrive with "intentional engagement"
- Link workers/ navigators are critical for timely access to coordinated care

The Rhythm

Staying Connected

- Solid communication needs formal and informal approaches
- Regular meetings (e.g., scheduled meetings, daily huddles, regional or interagency meetings) are important to share updates, needs and problem solve
- Co-location of services, including PCNs, improves service coordination, communication and connection.

The Circles

Roles in the Community

- All partners share assets, expertise or resources, "who can fill the gaps"
- The "right" partners commit and contribute to addressing community needs and services
- Administrative resources are shared (time, funding, expertise)
- All orders of government (local, regional, provincial) are informed and invested.

The Spiral

Journeying Together

- Keys to future success:
  - » Stabilizing funding
  - » Closing significant gaps (mental health, respite) in older adult services and supports
  - » Addressing social needs impacting health (transport, housing, food)
  - » Reducing admin burden (grant writing, operations, effective info systems)
  - » Overcoming geographic challenges including stable internet
  - » Strengthening PCN/primary care partnerships
- Local governments understand and prioritize older adults needs
- Services to diverse communities grow when trusted
- "Just do it and make it happen", "Find a new path around the obstacles"
- Spark ideas, fuel their growth, and cheer the outcomes

Creating Connected Community Services

...an iterative journey

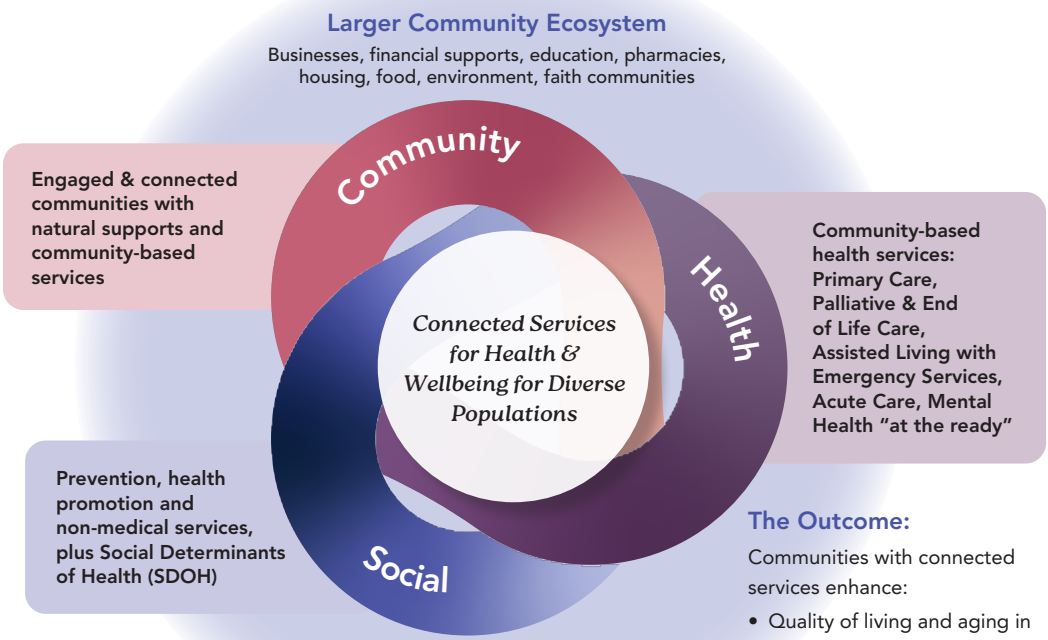
Significant Learnings and Implications for Sustainability

1. **Community engagement requires intentionality, support and infrastructure** to build connected relationships and service networks.
2. **Capacity development is the foundation for any community making a difference...**but requires sustained funding, changed practices & processes, and flexible policies, **including shared outcome measures that focus on the impact of community ecosystems.**
3. **Each community is unique**... local connected community networks evolve and vary depending on local assets, circumstances and history.

3

The Opportunity: Woven Networks of Services

...refocusing Alberta's health system



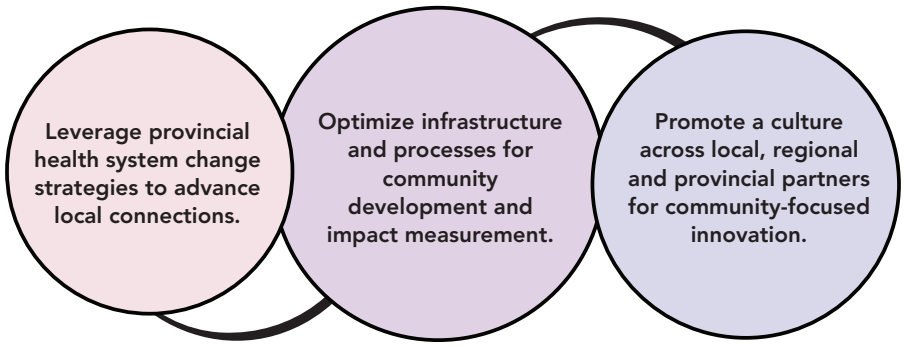
Scan to watch videos showing this in action: Bashaw: Drumheller:

The Outcome:

Communities with connected services enhance:

- Quality of living and aging in the right place for older adults
- Supports for family caregivers
- Working relationships among providers
- Service capacity through partnerships
- Local economic gain

Moving Forward: Sustaining a Community-Focused System



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Appendix B: Snapshot of Case Study Communities and Contact Information

AAG Case Study on Community Ecosystems

Snapshot of Communities Involved in the Case Study

RURAL COMMUNITIES

#	Community	Location/ Geographical Area	Total Population	Older Adult Population (65+)	Income	Connected Network	Contact
1	**Bashaw**	Central Alberta (200 kms south of Edm), County of Camrose	904	~33%	24% low income	Bashaw Wellness Team and Local Services, recent PCN established	https://bashawcrc.com/wellness-team
2	**Cold Lake**	NE Alberta (300 Kms from Edmonton)	15,661 (8% FN/ Inuit; 9% immigrants)	~11%	~6% low income	Age Friendly Cold Lake (11 programs/services) plus numerous community supports, clubs, organizations, etc. One PCN (24 physicians)	https://www.agefriendlycoldlake.ca
3	**Drumheller**	SE Alberta, (1.5 hours from Calgary), Starland County	8,092 (city) 11,753 (city & county)	~17%	~14% low income	Big Country PCN, Drumheller Seniors Coalition, other community and medical supports	https://bigcountrypcn.com/seniors-health/
4	**Fort McMurray**	NE Alberta, Regional Municipality of Wood Buffalo, 430 kms NE of Edmonton)	76,006 (7% Indigenous within the city; ~11% other ethnicities)	3095 (~4%)	11% (Fort McMurray & Wood Buffalo) (Receive Alberta Seniors Benefits. March 2020)	Seniors Subsector Collective Impact Initiative (St. Aidan's Society, Golden Years Society, YMCA of Northern AB, Nistawoyou Association Friendship Center, Multicultural Assoc (MCA) of Wood Buffalo)	https://staidanssociety.ca

#	Community	Location/ Geographical Area	Total Population	65+ Adult Population	Income	Connected Network	Participant Observations/Notes
5	**M.D. of Smokey River**	NW Alberta, in the Peace Region, five communities (Fahler, McLennan, Jean Cote, Girouxville, Donnelly, Guy)	1,895 (730, 36% speak French as mother tongue)	260 (~14%)	~16%, 305 (low-income status, in private households, 2020)	Smokey River FCSS and partners with a specific focus on rural transportation model	https://falher.ca/smoky-river-fcss/
6	**Stettler**	East Central AB, 190 kms from Edmonton), County of Stettler	Total 11,361 (5,695, town; 5,666, county	2,409 (town & county, 2019) (~9% town; ~17%, county)	38% (Receive Alberta Seniors Benefits. March 2020)	Stettler Connects Information & Referral Centre, numerous community supports and medical supports	https://stettlerconnects.com/programs-services/health-well-being
7	**Westlock**	Central Alberta, about 90 kms north of Edmonton, Westlock County	4,921	1,390, ~28%	~17%, 1,155 (low-income status in private households)	North Zone Health Neighbourhoods	https://www.westlock.ca/living-here/westlock-district-fcss/
8	**Vulcan**	Southern AB, County of Vulcan, 130 kms from Calgary and 95 km from Lethbridge	1,769	870, ~49%	~38%, 665 (low-income status in private households)	Act4Health Coalition	https://vulcanandregionfcss.com https://www.vchwfoundation.com/act-4-health/ https://www.vchwfoundation.com/social-prescribing-and-older-adults/

ETHNIC COMMUNITY WITHIN AN URBAN COMMUNITY

9	**CCECA (Calgary Chinese Elderly Citizen's Association)**	Downtown Calgary	N/A	Calgary Chinese population, ~6.4%, 93,510	All Calgary seniors, ~10%; Chinese NK	2024, launched Community Home Support Services (six initiatives; HAA funding); overall 30 programs and services provided.	https://www.cceca.ca

Appendix C: Information Captured in Community Profiles

The following tables gives an overview of the type of information captured in the community profiles.

Profile Section	What it Captured
Basic Community Information	Overview of the identity and context of each community, focusing on geography and older adult demographics.
Relationships, Connections and Supports	How each network started, the partnerships it sustains, the values and vision of the partnerships, social and medical supports woven into the community fabric.
Resources, Investments and Sustainability	Highlighted the assets and collaborative practices that enabled the community network's work along with the investments still needed.
Outcomes and Impact	Captured what has been achieved and how challenges have been managed, showing the network's contribution to the community well-being
Future Goals	Looked ahead to capacity: the building, expansion and partnership opportunities.
Contact Information	Provided points of connection for follow-up and ongoing engagement.

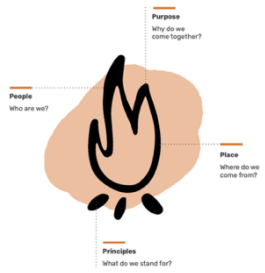
Appendix D: Information Framing the Focus Group Questions

FG Information Category	What it Captured
Formation of the Community Network	Understanding about why and when the network began, the community's shared identity and values, initial goals, and how the network has changed over time.
Relationships, Connections and Supports	Explored key relationships behind the network, what strengthened internal and external connections, available social/medical supports, roles of older adults, and how trust and engagement are fostered.
Resources, Investments and Sustainability	Examined the resources used to build the network, collaboration for acquiring resources, reliance on volunteers and in-kind supports, remaining investment needs, and methods of evaluating resource impact.
Outcomes and Impact	Identified major achievements, barriers and adaptations, the network's overall community impact, and how outcomes—particularly older adult wellbeing—are tracked or measured.
Future Goals and Development	Looked at plans for leadership continuity, potential expansion, desired improvements, opportunities for new or strengthened partnerships, and external supports needed going forward.
Success Stories	Gathered real examples of positive impacts on older adults, as well as meaningful stories involving volunteers, partners, or staff.
Promising Practices	Highlighted effective practices and innovations that contributed to the network's success, along with lessons valuable to other communities.
Reflections and Closing Thoughts	Invited final reflections, advice for others, and any additional insights not previously covered.

Appendix E: Description of the Community Weaving Framework Elements

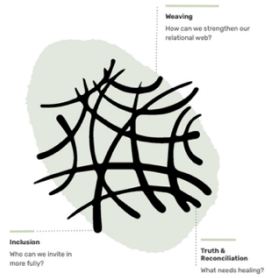
Note that the information in each text box is an excerpt from the Community Weaving Framework handbook.

The Fire



The Fire is the community's core source of energy and identity—its shared purpose, values, and sense of belonging. It begins as a small spark, nurtured through stories about who we are and why we gather. As the vision becomes clearer it naturally draws in those who resonate

The Web



The Web is the foundation underpinning every group, holding it all together. The web is strong when relationships are based on trust, respect and mutual care. When the web is fractured, relationships can be superficial, transactional or contentious, and as a result ideas, resources and energy cannot flow.

The Rhythm

The Rhythm involves numerous ways in which people come together regularly to share their gifts and support one another. Over time, healthy communities develop a set of core practices that stoke the fire and help manifest the shared purpose.

The Circles

The Circles represent a variety of roles. In every community, some people contribute a lot and some very little, with many people in between. These different layers of participation are natural and change over time. However, if we leave them unnamed, they can lead to feelings of guilt, frustration and burnout. In a healthy community we define clear roles and find ways to honor the different levels of engagement.

The Spiral

The Spiral looks to the future and sustainability. Communities are complex living organisms. Everything is in constant flow. People move in, around, and out of communities as commitments and contexts change. On a collective level, the community may need to regularly reinvent itself, coming into a conversation about what to keep or change as it continues to emerge and evolve.

Appendix F: More Stories from the Field

Bashaw

One client's trauma; one major system change

In Bashaw, things changed because of one woman's experience. She lived in the lodge and broke her arm, and staff did what they thought they had to, they called an ambulance. She ended up in the ER for nine long hours, scared, exhausted, and even becoming incontinent while she waited. The staff were devastated; the system had failed her. That experience triggered action by the Regional Wellness Team. They redesigned the whole approach, so the pharmacist now comes to the lodge every week, checking on residents and handling issues early so no one has to endure a trip like that again.

Transportation preserving identity and belonging

For many older adults in Bashaw, volunteer-driven transportation makes it possible to keep attending the Legion, church, and long-standing community groups, allowing them to stay connected even after they can no longer drive. One senior captured the heartfelt sentiment: ***"Being able to get to my meetings makes me feel like I'm still me."***

Calgary

Building Safety, Dignity, and Belonging for Chinese Older Adults

The Calgary Chinese Elderly Citizens' Association has achieved a remarkable record of leadership and innovation in supporting Chinese seniors. It created a unique caregiving program that trains Chinese-speaking caregivers; opening pathways for new immigrants while meeting culturally specific care needs. It launched the Emotional Health Carnival, now an annual community event, and produced the first elder-abuse awareness skits and multilingual resources used across Alberta. The Association has also led major collaborations, including the "Chinese Community Response to Family Violence," which has saved lives and supported many families, and the Immigrant Seniors Advocacy Committee, a long-standing voice for immigrant seniors' concerns. In times of crisis, CCECA has consistently mobilized quickly and effectively such as arranging escorted vaccination transportation and grocery delivery during COVID-19, providing emotional support to wildfire evacuees in 2016, and assisting flood-affected seniors in 2013 with relocation, re-entry services, and on-site emotional wellness support.

Cold Lake

Client Recovery from a Near Crisis

A couple in Cold Lake were living in severe dysfunction as both husband and wife had dementia, the home was unsafe, the husband wandered and crashed his vehicle, and he was heavily medicated. When the wife died suddenly after an injury, he was left frail, depressed, and completely alone. The network

stepped in, reconnecting him with family, supporting his move into lodge care, and surrounding him with social connection through the Friendship Luncheon and volunteer visits. Today, he is thriving—gaining weight, laughing, socializing, and even singing alongside a volunteer musician.

Drumheller

"About 24 hours to solve this problem"

The Drumheller team rallied around an older man living in a one-room shack with no running water, a single unsafe heater, extremely limited income, and signs of cognitive impairment; when they finally understood the full situation, they realized they had, in their words, *"about 24 hours to solve this problem."* In that time, they secured a donated bed, brought in Helping Hands for cleaning, laundry, and bathing support, replaced his soiled bedding with clean supplies, and approached him gently using the trust built through the Circle of Connection. He now attends programs more regularly and has even begun coming on his own to another group, sitting with an older man and chatting throughout—something staff describe as *"unbelievable"* given where he started.

A client who never had friends before

In Drumheller, an older woman who had lived her entire life without friends and spent nearly all her time alone was referred by the clinic to the Circle of Connection group at the library and later began attending Memory Café outings. At first, she needed encouragement and weekly reminder calls, but gradually she began to laugh, relax, and fully participate, eventually telling staff, *"I've never had friends before. I've never felt like I belong."* Months later, she arrived at a movie outing, introduced herself to another isolated senior, and afterward told staff she thought he might "be really good at being my friend." She now attends programs on her own, and when her son urged her to move to another community, she refused, explaining, *"I can't leave. I finally have friends. You call me every week. People care about me here."*

Fort McMurray

Reaching invisible older adults

For years, the Multicultural Association noticed older adults from newcomer families quietly trailing behind younger relatives at cultural events, present but unseen, smiling politely yet never speaking. Many spoke little English, faced immigration challenges, spent long days alone while family members, worked multiple jobs, experienced deep loneliness and in some cases were subjected to elder abuse and neglect. One staff member recalled watching a Filipino grandmother who *"stood pressed against the wall the whole time, smiling, but she didn't talk to anyone. She didn't know she was allowed to join the activities."* With growing capacity within the Multicultural Association, relieving pressure on St. Aidan's and other partners, these seniors are now being intentionally identified, invited, and welcomed. Families say they see real changes: more confidence, more conversation, and a new willingness to go out.

Supporting older adults' financial security

Fort McMurray created a Financial Security Education and Awareness Program, after finding that 76 percent of seniors were not accessing the financial supports available to them. With increased capacity, the team developed targeted responses, including a significant example from a remote Indigenous hamlet where a Link Worker helped an Elder who believed she owed $10,000 to the Canada Revenue Agency. After reviewing and correcting her tax return, staff resolved the supposed debt and connected her to additional benefits that increased her monthly income by more than $800. The intervention greatly improved her quality of life and demonstrated the real, measurable impact of focused financial support services.

MD of Smokey River

Transportation essential to keep medical appointments

An older adult living alone in the MD, with no family nearby and no ability to drive, began using the Wednesday bus to Peace River for recurring medical procedures after being referred by AHS. She stated, *"If the bus didn't come, I simply wouldn't go. There's no other way for me to get there*." Her appointments often took the entire day, and drivers learned her schedule, helped her manage transfers with her walker, and ensured someone was always there to pick her up. Since joining the service, she has not missed a single appointment, her chronic condition has stabilized, and she says she now feels *"looked after—not forgotten."*

Enabling transportation for wheelchair users

The transportation Coordinator described how several wheelchair users rely on the accessible bus, including a man newly transitioned to a wheelchair who told staff, *"I thought this was the end of me going anywhere. I didn't think a bus in a small town would take me."* Instead, the service has allowed him to attend medical appointments, run his own errands, and visit friends he hadn't seen in months. His growing independence has transformed him into a kind of "bus ambassador," encouraging other wheelchair users to sign up and reclaim their mobility as well.

Stettler

Rescue from a life-threatening living situation

An older man in a small village had been living in a camper-tent despite serious health issues. When a hospital referral brought him to the Navigator Project, staff first had to determine whether it was even safe for workers to enter his living situation. Through persistent, one-on-one support, regular visits, conversations, and help navigating housing options; he was successfully transitioned into lodge housing before winter. Participants emphasized that without the navigator and the broader network, he likely would have been discharged back into that unsafe environment and could easily have faced a life-threatening incident during the cold months.

Widowed, isolated, unable to manage serious health needs

A widowed man living alone on the third floor of an apartment building, on oxygen, without a vehicle, and physically unable to manage his belongings; had become so isolated that he wouldn't open his door, instead dropping his keys over the balcony so workers could enter. The navigator and local partners helped him imagine a new life by touring the lodge with him, arranged for a student volunteer to help him sort through his possessions each week, and coordinated moving unwanted items to thrift stores and community exchange sites. Step by step, they supported him in downsizing and eventually moving into lodge care, where he is now living safely, with proper health supports, and far less isolated.

Vulcan

Support and navigation when the unexpected happens

A man came into the Vulcan medical clinic for what he thought was a routine medical appointment and was unexpectedly diagnosed with blood cancer, with no family nearby, no ability to drive, and no idea how he would manage treatment or navigate the system. The physician walked him straight across the hall to the clinic's link worker, who sat with him, listened, and immediately began untangling his situation. Within days, transportation to cancer treatments was arranged, home support and check-ins were set up, benefits and paperwork were completed, food bank access was coordinated, and emotional support was put in place to help him cope with the shock. Reflecting on that moment, he said, *"I didn't know what I was going to do. Then she [link worker] just took my hand and said, 'We'll walk through this together.' That saved me."*

Helping with multiple needs, gain some independence

Vulcan's Home Support Outreach Worker supports seniors in their homes who would otherwise fall through every crack, including one senior in a rural hamlet who had no working stove, very limited housekeeping capacity, growing fear of accessing services, and early cognitive decline. Through weekly visits, the worker helped with light housekeeping, food support, benefit applications, mental health referrals, and the kind of regular check-ins that prevent isolation from turning into crisis. The senior later shared how profoundly this relationship mattered, saying, "*She's the only person who sees me. I clean before she comes because I want to make her proud."*

Westlock

In need, overwhelmed, anxious and lack of trust

A senior living alone in a rural area repeatedly refused help despite obvious need; overwhelmed and anxious, she didn't trust "programs," but she kept noticing the Seniors Coordinator showing up at every community dinner, flu clinic, and outreach event. One evening she quietly approached her and said, *"You're always here. Can you help me figure out what to do about my bills?"* That moment of trust

opened the door to income support navigation, a warm referral to home support, transportation assistance and reduced anxiety and feelings of isolation.

Community dinners are connectors

At one community dinner, a senior whom no one had met before quietly approached a staff member and said, *"I didn't want to come. But now I see there are people here who care."* That single moment illustrated why shared meals and face-to-face gatherings matter so deeply in Westlock: they reveal needs that would otherwise stay hidden, create trust, build a sense of belonging, and often become the first doorway into supports and services.