Canada's Drug Agency
L'Agence des médicaments du Canada

Health Technology Review

Aging in Place

Summary of Engagement Activities

Overview

Canada's Drug Agency actively involves patients, families, patient groups, and interested parties to enhance the quality and relevance of assessments, providing those affected by the assessments with an opportunity to contribute. The agency has adopted a Framework for Patient Engagement in Health Technology Assessment, including the Standards for Patient Involvement in Individual HTAs, to guide these activities.

For this project, Canada's Drug Agency sought a diverse range of perspectives to inform and validate the discovery and information gathering phase. This included 3 Community Engagement Sessions, 2 Decision maker roundtable sessions, and 1 Policy/Research session. The primary objectives were to gain a deep understanding of the issue, context, and population in Canada, as well as the priorities of individuals, caregivers, health professionals, clinicians, policy researchers, and health system leaders.

The Decision maker roundtable sessions with healthcare decision-makers aimed to understand their perspectives, observations, and experiences regarding interventions that support aging in place. We also sought to validate the focus of the work and identify other relevant issues, ensuring the evidence product is relevant, timely, and meets current decision-making needs.

In the Community Engagement Sessions, we involved individuals with direct personal experience related to aging in place, such as older adults, spouses, adult children, and caregivers. Healthcare professionals, including physicians, nurses, occupational therapists, physical therapists, psychologists, social workers, and administrators providing or supporting care for those aging in their own homes, in supportive care settings, and in long-term care, also participated. Findings from literature, real-world evidence, and data analyses were discussed to obtain feedback on initial findings, fill in gaps, and better understand the Canadian context.

The Policy/Research Engagement Session engaged individuals with extensive knowledge and expertise in policy and/or research on aging in place, including academic researchers, policy analysts, and implementation scientists. This session aimed to explore possible barriers to action in this area and gather insights into the challenges and success factors associated with implementing and sustaining aging in place initiatives.

CDA-AMC's engagement efforts demonstrate a commitment to ensuring that its assessments are relevant, informed, and responsive to the needs and priorities of those affected by its guidance, from health care decision-makers to those currently aging in place in Canada.

Decision Maker Roundtables

What Did We Do?

Virtual roundtable sessions were held with jurisdictional decision-makers on February 1 and 2, 2024. These sessions were intended to validate our approach to our aging in place work, and to obtain input to ensure that our evidence product is relevant and meets health system needs.

Sessions included an overview of our proposed approach to this work, followed by a facilitated discussion.

Question 1: What is your general reaction to what we have shared thus far? Are we on the right track?

Participants validated our proposed approach. Across the jurisdictions, participants commented on the timeliness of this work, expressing particular interest in exploring innovative models of care to enable services and programs to be delivered in the home. They noted that Canada's current acute care and long-term care (LTC) systems alone were unlikely to meet the needs of aging populations.

Question 2: What areas and/or outcomes would be most helpful for Canada's Drug Agency to focus on?

Balance of Care/Coordinating Across Care Settings

Prevention of premature LTC admissions, reducing the length of LTC stays, and decreasing avoidable emergency department (ED) visits were common priorities across jurisdictions. There was interest in upstream interventions to address challenges including LTC capacity, waitlists for supportive services, and high proportion of alternate levels of care.

Participants noted that inadequate access to care in the home and community may result in reliance on the ED, and they expressed interest in learning more about gaps within and between care settings and systems.

Hospitalized older adults may be unnecessarily discharged to LTC due to insufficient home care and/or community care support. Some jurisdictions stated that data suggests a significant proportion of their LTC admissions may be considered unnecessary; that is, seniors would be able to receive care at home if services and supports were available.

"It's about right-sizing, not rationing."

Robust home and community care systems were identified as prerequisites to aging in place, particularly in the context of aging populations with increased medical complexity. Participants expressed that home care must not be an "afterthought," nor must it rely on family members and caregivers to function.

While participants agreed on the importance of connecting home care, primary care, and LTC, they also acknowledged the complexities of coordinating care. Several participants noted that in some jurisdictions, Health and Long-Term Care are separate ministries. Addressing silos and improving communication between settings and services was seen as crucial to ensuring effective resource allocation, increased efficiencies, and process improvement.

The Role of Technology in Supporting Aging in Place

Participants expressed interest in the ways in which technologies might support aging in place. Specifically, participants felt that technology could offer a potential way to shift more care into the home through interventions such as:

- Remote patient monitoring,
- Artificial intelligence,
- Communication technologies to connect home care with other care settings and facilitate collaboration across the circle of care,
- Platforms to address social isolation,
- Language and translation support.

Interoperability was also highlighted as a key enabler to support aging in place.

However, participants also noted challenges in ensuring equitable access to technologies. In addition to concerns around consumer costs and digital literacy, they observed that many rural and remote communities continue to struggle with insufficient internet and cellular service.

Rural and Remote Populations

Overall, participants emphasized the need for rural-specific strategies and indicators. The differences in needs, priorities, and challenges between rural and urban populations was consistently highlighted.

Participants noted that rural communities generally have fewer resources and less access to services, presenting additional barriers to rural seniors seeking to age in place. Moreover, economies of scale that may facilitate implementation in urban areas may not have the same impact in rural ones.

It was also noted that rural populations are generally older. Rural patterns of supply, access, and demand may therefore present a unique challenge, particularly for isolated and remote communities.

Quality of Life/Quality of Aging

Social isolation, loneliness, and quality of life were prevalent discussion themes. Participants agreed that seniors' happiness is as important as their health. Moreover, participants observed that the risk of isolation increases as higher levels of care are required.

While some jurisdictions disseminate client experience surveys, there was strong interest in recommendations for indicators and qualitative measures for quality of life. There was also interest in comparing social isolation, loneliness, and happiness between seniors receiving home care and LTC.

Participants also noted that strategies to mitigate social isolation and loneliness may benefit from cross-sectoral collaborations beyond the health systems. Social prescribing and peer support were identified as topics potentially warranting further exploration.

"A community wraps around a population to support them to age in place."

Indigenous Health

With respect to considerations for Indigenous health and communities, participants highlighted that efforts to support older Indigenous adults to age in place occur within the context of unique cultural norms and practices. Participants identified considerations including:

- The need for culturally safe and relevant care,
- Broader systemic inequities, including inequitable access to services (particularly in rural and remote communities),
- Variability in community resources and capacity,
- Lack of coordination between services delivered and funded by different entities and levels of government,

The importance of Elders being able to age at home with the support of their families and communities was highlighted. Participants reported that Indigenous partners tend to prioritize direct in-person care in the home/community, rather than technologies to support aging in place initiatives. They also noted the need for language support/interpretation/translation.

Question 3: How might you use a report or recommendations from us?

Evidence-Informed Decision Making

Participants noted that many aging in place initiatives, solutions, and conversations are underway in Canada, with an influx of research in recent years. They expressed a desire for an evidence product to assist with:

- Understanding and evaluating this body of work,
- Guiding decision making within their jurisdiction,

- Bringing attention to new ideas.

It was observed that it can be challenging to collect data relating to outcomes and quality in home care settings, yet that data is critical to implementation. Participants suggested that they would find value in recommendations for indicators to measure and report on, and in common terminology/definitions to aid comparative analyses, particularly across jurisdictions.

Finally, they also expressed a desire to leverage learning and work done by other provinces and territories where possible. Evaluations of other projects and demonstration of outcomes were identified as being of particular interest. In particular, awareness of previous implementation challenges would enable jurisdictions to pre-emptively plan for them.

Cost-Benefit Analyses

The importance of economic evaluations was particularly noted for policy-makers and decision-makers. Participants shared that the ability to clearly articulate the value of an initiative or intervention is essential to decision-makers.

"We need to be able to show governments why this matters."

Community Engagement

What Did We Do?

We held three community engagement sessions to better understand the reasons why people are unable to age in their home or community for as long as they want to or are able to, from different perspectives and lived experiences. Participants included people who are aging in place, or who would like to; family members and caregivers to older adults; a variety of health care professionals; academics and researchers; and other interested community and sector leaders.

Each virtual session was two hours long and held on Zoom. Before the session, participants were provided with an agenda, their fellow participants' biographies, and a list of issues identified in published reports that may contribute to people being unable to age at home as long as they wish or are able to. Participants discussed the relevance of these issues based on their perspectives and experiences, and other reasons why people may not be able to age in place.

The sessions were observed by members of the CDA-AMC project team, and a note-taker from Canada's Drug Agency. CDA-AMC staff and the Health Technology Expert Review Panel will consider these discussions as they appraise the evidence and develop guidance on this topic for publication in July 2024.

The remainder of this document summarizes what we heard across the three sessions.

What Did We Hear?

Across different perspectives and experiences shared by the participants, a consistent key root cause of people being unable to age in place was health needs (including physical, mental, and cognitive health) that could not be safely managed in the home or community. Difficulty Preventing and Managing Chronic Conditions and Injuries

Inadequate supports for families and caregivers:

- Insufficiently addressed home and community care support needs: Participants emphasized that home and community care is not sufficiently resourced to meet the needs of adults seeking to age in place. The insufficient resourcing they referenced includes funding and health human resources. Home and community care are often difficult to access, with long wait times, or are not available in the quantity (e.g. hours, people) or quality (e.g., reliability, training, level of service) needed to safely and effectively manage care. We heard there is also significant variation within and between jurisdictions. Significant demands are placed on caregivers, including:
  - Financial: Caregivers may supplement public home and community care with private services; however, they reported that these costs may not be affordable or sustainable. Additional costs may be incurred (and may be partially or not reimbursed) through medical travel if care is not available in the community, medical supplies and supports (e.g., supplies to manage diabetes, walkers), and time away from work.
  - Time: Insufficient supports for caregivers may result in significant investments of caregiver time, both in providing care directly, and in navigating/coordinating care. Many caregivers must also balance this time with their own health needs, childcare and/or employment.
  - Level of care required: If providing care directly, caregivers may need to provide care beyond their personal comfort level or ability, and beyond what is most safe and/or effective for the older adult (for example, a caregiver unable to safely lift an older adult, or uncertain which clinical signs require follow-up).
  - Emotional costs: In addition to the stress which may result from high demands on time and resources, managing an older adult's care and safety can result in significant emotional strain, fatigue, and worry.
- Lack of resources for navigating and advocating with the health system: Participants reported that they were often unaware of the resources available to them (and conversely, those resources *not* available/covered within the public system), unsure where to find information about programs and services, and uncertain how to access resources even where they were known. Administrative requirements and burdens – for example, rigid application processes and complex forms –intensify navigation challenges. Families, caregivers, and older adults seeking to advocate for an individual or themselves feel they must "know the right words" to do so successfully. These barriers are exacerbated by insufficient accommodation for language, cultural, and cognitive differences.

Type, diversity, and appropriateness of care and supports:

- Disjointed care and poor transitions in care: The navigation challenges described above are worsened by complex, siloed health systems. Participants shared that health information does not readily follow individuals across the health system and clinicians cannot easily communicate between practices and settings, presenting a significant challenge when an individual is seeing multiple health care providers – as is often the case for older adults who may be managing multiple health conditions. This lack of coordination among and between health care providers may result in delayed care and safety concerns (e.g., medication reconciliation when multiple prescribers are involved). There may also be a lack of coordination between other health-related agencies and service providers (e.g., disease-specific associations).
- Non-optimized use of health care providers and allied health: While participants specifically referenced challenges in accessing primary care, they also noted that some health conditions could be managed with support from other health providers and/or allied health professionals: e.g., pharmacists, physiotherapists, occupational therapists, dieticians, social workers.
- Additionally, participants suggested that allied health professionals may be able to prevent decline or loss of function while the older adults await assessment or access to other services. However, even when it would be appropriate and/or preferable to do so, we heard that these health professionals are not always accessible or used to their full potential to provide interprofessional care.
    - Health promotion: Difficulties accessing continuous, integrated care also inhibits health promotion, health protection, and preventive care (including for mental/cognitive health). There may not be sufficient staff to run health promotion programs, programs may be limited for certain conditions (e.g., there may be a diabetes program, but not one for arthritis), and/or they may not be accessible to older adults (e.g., digital-only screening programs). We heard that challenges in "managing problems before they start" may lead in turn to development of more health conditions, greater acuity of conditions, and loss of function.
    - Remuneration: Participants noted misalignment between a fee-for-service remuneration model and the holistic health care needs of older adults seeking to age in place.
- The hospital as a "place of last resort": Due to insufficient community care services and supports, hospitals and emergency departments were described as places of last resort – used when caregivers are no longer able to manage an older adult's care themselves, or when a health event (e.g., a fall) suddenly necessitates care beyond what can be provided at home. Patients discussed how hospital stays are associated with decline and loss of function, which makes it harder to age at home. However, we heard that older adults sometimes remain in hospital longer than they and/or their caregivers want, due to a lack of supports to enable safe discharge.
- Unmet need for culturally safer and appropriate care: Culturally safer and appropriate care is not always available or accessible. Participants noted that there are diverse cultural needs, understandings, and relationships relating to aging and mortality, including the need for culturally safer and appropriate practices for First Nations, Inuit, and Métis Elders. We also heard that 2SLGBTQIA+ people may also face discrimination in housing and health care.

- Unmet need for person-centered, goals-based care: Participants shared that goals around aging in place vary between individuals; care providers do not always prioritize individual autonomy and decision-making, particularly when it involves "living with risk."
    - Certain groups may have additional considerations and/or face additional systemic barriers: For example, participants referenced people leaving correctional facilities or other secure environments may lack social supports to overcome system barriers such as obtaining a health card in their new place of residence; veterans leaving the Canadian Armed Forces health benefits; people with co-morbidities such as PTSD or substance use, for which stigma is a barrier to finding appropriate housing and/or care as they age.

Limited Housing Options and Built Environment Needs

- Appropriateness and availability of housing and built environment:
    - Appropriateness: We heard that housing and/or the built environment may not be appropriate to the needs of the older adult(s). For example, doorways may be too narrow to accommodate a wheelchair, there may be too many stairs to navigate safely or comfortably, and outdoor maintenance needs (e.g., lawn and garden maintenance, snow removal) may exceed their capacity to manage.
    - Availability: Even where current housing does not meet needs, participants noted that alternative housing may not be available. For example, zoning may not permit the construction of a secondary dwelling unit on a primary residence, or there may be long wait times for assisted living residences. Participants noted that some older adults may also be unhoused or underhoused.
- Insufficient support for home adaptations and modifications: We heard that risk assessments may not be carried out on the home/built environment to identify ways to make it safer; for example, through installing grab bars, raised toilet seats, or ramps. One participant reported requiring a physician's note to enable such an assessment but being unable to obtain one. Where adaptations and modifications are identified, they may not be affordable and/or there may be administrative barriers (e.g., building permits, zoning restrictions).
- Transportation challenges: Participants shared that transportation challenges result in increased risk of isolation, difficulty attending medical appointments or picking up medications, and difficulty accomplishing tasks such as grocery shopping.
    - Lack of driving alternatives: Where driving is not an option (e.g., the older adult has ceased driving, and/or their family and caregivers do not drive), we heard that there may be few other modes of transportation, particularly in rural areas. Public transit may not be available or easy for older adults, caregivers, or health workers to navigate, and taxis/rideshares may not always be practical or affordable.
    - Physically inaccessible transportation: Participants said that, particularly for older adults with mobility considerations, available transportation may not be physically accessible. Where wheelchair taxis are available, they may present additional costs and/or logistical barriers (e.g., inflexible pick-up times, specific hours of operation).

Social Isolation

- Lack of support to help older adults manage stage-of-life changes: According to participants, older adults are often unsupported in managing stage-of-life changes, such as no longer driving, death of life partner and/or close friends, and ambiguous losses (e.g., loss without closure, as in the feeling of loss when a loved one's physical/mental/cognitive health declines).
    - Death of life partner: Participants emphasized the death of a life partner as a significant stage-of-life change. In addition to bereavement, they described how the death of a life partner may have additional functional implications: for instance, they may have also been providing care, managing household tasks (cooking, paying bills), or been a key part of a social network.
- Difficulty accessing appropriate social programs: Social programs (e.g., adult day programs, recreational groups and classes) may not be available, or may not be appropriate for the individual's physical, mental, and/or cognitive health. From some participants' perspectives, investment in larger and/or additional long-term care facilities are often prioritized over community programs that support social participation.
- Ageism and stigma: Fewer opportunities for intergenerational interactions decrease knowledge and understanding of aging. In addition, stigma remains with respect to mental health and substance use.

Challenges Accessing and Engaging with Technological Devices Intended to Support Aging in Place

- Unavailable health records: While health records were discussed in the context of uncoordinated care that is partly attributable to a lack of interoperability, participants also observed that electronic health records do not permit seamless access to, or sharing of, health information, including by the individual and their family/caregiver.
    - Privacy barriers: Participants noted that in some cases, privacy requirements may restrict which care providers are able to access, receive, and share health information. However, privacy protections for personal health information also remain a concern.
- Limited and varied use of virtual care and remote monitoring: While these technologies can support delivery of care at home, their deployment within and across jurisdictions remains limited and variable.
- Inaccessible technologies:
    - Inaccessible design: Technologies may not have accessibility features; for example, supports for older adults with vision or hearing loss. Their design may not be accessible to older adults with cognitive health considerations.
    - Inaccessible modality: Older adults may not have access to the internet or be able to navigate online platforms and services, e.g., due to insufficient support to develop digital health literacy skills. Additionally, they may not have access to telephone and/or cell service.
    - Caregiver burden: Additional caregiver time and efforts may be required to maintain technology's usefulness and function: for example, ensuring the technology remains updated, maintaining a working knowledge of the technology and any new versions, and supporting the

older adult in using it (e.g., remembering passwords, assisting with set-up, serving as unofficial "tech support").

Policy Researcher Engagement

What Did We Do?

Following the Community Engagement Sessions, we held a Policy/Researcher Engagement session to better understand the policy, funding, and other systemic barriers challenging the implementation of promising aging in place strategies and initiatives in Canada, and how jurisdictions in Canada or internationally have overcome these barriers. We conducted outreach to relevant organizations and academic institutions that have a focus on policy research and aging in Canada. Participants of the session included people working in the field of Policy and Research in Canada with a focus on Aging populations.

The virtual session was one hour and thirty minutes long and held on Zoom. Participants were provided an agenda, biographies of all participants and a participant guide to help them prepare for the discussion. Members of the project team, including members from our Patient, Clinician and Industry Engagement team, a Qualitative Research Officer, a Scientific Advisor, an ethics lead, and a clinical Research Officer, collaborated to develop the questions and session materials. The participant guide contained a table with categories of strategies and initiatives supporting aging in place. We used the categories of strategies and initiatives created by the National Institute of Ageing as a starting point to create these categories. We are using these categories to inform our review of systematic review evidence on strategies and initiatives currently underway. The guide asked participants to choose one to three strategies or initiatives (or categories of strategies and initiatives) that you have experience with, and reflect on the following questions:

- If they were successfully implemented, why? If they were discontinued, delayed, or not expanded, why?
- What systemic challenges prevent older adults in Canada from having equitable opportunity to access, receive, use, and benefit from these strategies and initiatives? Who is left out and why?

What key considerations should health care decision-makers remember when seeking to support the implementation of aging in place strategies and initiatives?

It was emphasized to participants that the goal of this discussion is not to focus on specific initiatives and strategies, however examples are a starting point to think of systemic challenges and enablers to implementation. A Zoom whiteboard was used to illustrate the discussion and to allow participants to expand on the relationships between concepts, and making connections between certain challenges, enablers, context, and key equity considerations that impact successful implementation.

Participants were encouraged to contribute with the lens of their personal experience and professional point of view.

The session was facilitated by two Engagement Officers and observed by two members of the project team. Staff and our Health Technology Expert Review Panel will consider these discussions as they appraise the evidence and develop guidance on this topic for publication in July 2024.

What Did We Hear?

We heard that transforming the healthcare landscape demands a holistic approach, encompassing evaluation, knowledge mobilization, technology, equity and accessibility considerations, and innovative policy and funding mechanisms. Despite evidence supporting community-based health models, their implementation faces systemic resistance. The Canada Health Act's emphasis on traditional infrastructure may limit innovation for home care solutions. Addressing these challenges requires flexible, community-based solutions. Temporary funding, caregiver burden and constraints on healthcare professionals further complicate progress to successful implementation of new strategies or initiatives in Canada.

Technology and Digital Literacy

- Technology Training: Participants emphasized the need for ongoing training with respect to the use of technologies, highlighting a project that offered geolocation technologies for older adults, however its use was not effective in the settings it was implemented. This was attributed to the lack of training for staff members to use innovative technologies, and lead to a lack of use by patients. Implementation plans are crucial to align staff with the goals of the project or innovation.
- Digital Literacy: Technology supports can be an enabler; however, one participant underscored that digital literacy of older adults is a crucial aspect to consider and can often lead to more challenges in using supportive technologies for their health if they do not fully understand how to utilize the tools at their disposal.
- Socio-cultural considerations: The need to focus on the socio-cultural issues over the technical was also discussed as crucial to the success of implementing new innovative technologies. For example, one participant highlighted that Sweden has had Electronic Medical Records since 2003, unlike Canada who lacks consistent access to EMR. She highlighted that this is not a technical issue. The Canadian healthcare system does have the ability to implement an EMR, however it was described as a sociopolitical issue, and at the organizational level a socio-cultural issue.
- Consumers buy in for innovative technologies: One solution highlighted was to leverage technology to facilitate direct connections between care providers and recipients, which could streamline operations by eliminating intermediaries in scheduling and financial management. However, this model assumes that the end user is educated, has digital literacy and can manage risks related to the use of the technology. There is significant potential for AI, AI chatbots and blockchain technology to enhance and streamline Canadian's decision-making in healthcare and access to care, yet consumers need to buy into these technologies and technology support is crucial for

success. Training, resources, and dedicated support need to be planned at the onset to ensure successful technology implementation.

- Risk to privacy: Assessing how we are protecting people who use the innovative technologies is also an important aspect to consider, especially for older adults with less experience using apps, web portals and other technologies which underscores the need for knowledge mobilization.

Evaluation, and Knowledge Mobilization

- Evaluation: One contributor discussed the challenges faced in evaluating healthcare programs. Fully understanding and articulating the intervention and predicting its intended, and unintended consequences. One example provided was a program focused on reducing hospital admissions by increasing geriatric nurses' contact with patients, however contrary to its intended purpose, it led to higher admissions due to nurses noticing additional health concerns during these additional contacts. Data collection and measurement and assessing potential outcomes need to be embedded for any successful initiatives.
- Knowledge mobilization: We heard that knowledge mobilization is crucial for success. Knowledge mobilization needs to be addressed for both the decision maker as well as the end user. The decision maker needs to have a holistic understanding of end users' (health care professionals, older adults, and caregivers) needs, and the end user is less likely to utilize new innovations if they are not adequately supported to learn how to use them. One participant highlighted the potential assumption that end users know how to utilize new programs or innovative solutions, however this is not the case for all health care users. One participant asked, "What is the knowledge that is required for that solution to take effect?" as a key consideration when planning any new strategy or initiative.

Equity, Accessibility, and Inclusion

- Disability awareness: We heard there is a lack of understanding and awareness of disabilities in Canada and how it entrenches itself in poor design of buildings and services. Systemic agism and systemic ableism is a cause for concern when thinking about what is needed for successful implementation.
- Coordination and Enforcement: Lack of coordination on public policy was discussed as a challenge. Integrated and collaborative approaches are necessary between decision makers and the end user, to avoid fragmentation and multiple competing priorities. One participant provided an example of effective coordination from a Maritime province, where accessibility, disability and inclusion efforts happen in one central ministry that has oversight on other ministries, leading to more coordination and more effective enforcement for accessibility standards.
- Accessible and culturally appropriate environments: Efforts could be focused on solutions like the Age-Friendly Cities initiative, which is designed to involve citizens to enhance the social and built environments of municipalities to support the quality of life for all citizens, especially older adults. In these cities, mobility and activity is built into the infrastructure to support aging in place.
    - Social isolation: Canadians need to access community engagement activities and social supports, and the lack of access can exacerbate mental health issues and increase isolation,

especially when accessing healthcare requires you to move away from your community into accessible environments such as long-term care.

- Data and Evaluation: We heard that the Eurocentric nature of many existing programs might not align with the needs or values of all communities across Canada. Data driven methods may not work for certain populations, which underscored the importance of culturally appropriate approaches to implementation and the evaluation of innovative strategies. Readily available data can be limited in terms of what is consistently gathered, leading to further challenges to implementation of potentially effective initiatives. The voices and involvement of many equity deserving populations are not considered, leading to missed opportunities for appropriate and effective ways to address the needs of the populations who need the most support. Program evaluation needs to look beyond traditional data methods when creating an evaluation plan of new programs and initiatives, especially for communities consisting of equity deserving groups.
- Geographic Disparities: We heard that challenges related to geographic disparities in access to healthcare, particularly in Canada's rural and remote areas often face significant barriers such as limited access to care, insufficient transportation systems, and a lack of social support services like home care. This often leads to overburdening caregivers to fill in the gaps.
    - Intersectionality of inequities: Inequities are further exasperated by other challenges such as cultural and language barriers for French speaking populations as well as populations from different cultural backgrounds. A participant explained it as a layering of inequities when living remotely and having a language or cultural barrier.
    - Health human resources shortage: This was further emphasized as it continues to create challenges in accessing health care services, especially in rural and remote areas and this challenge will continue to grow without effective solutions. Technology may be useful to deliver more services in rural and remote communities, however digital literacy issues, internet access and affordability of data plans contribute to implementation challenges.
- Caregiver burden: Similarly to what was heard in the Community Engagement Sessions, we heard that caregiver burden is a significant challenge and there is a need for social care integration. The overburdening of caregiving on family members was described as an intergenerational issue, predominantly affecting women. Time spent trying to coordinate services for loved ones and taking time off work to bring family to appointments have significant impacts on the wellbeing of caregivers. Some employers are beginning to offer a broader suite of supports for workers who are family caregivers, such as coping and support tools as well as coverage for time away from work which can alleviate this challenge, however it is not broadly implemented by employers in Canada.
- Systemic harm and patient centred solutions: Prescribed solutions for communities was discussed as a barrier. Trauma associated with past interactions with the healthcare system need to be acknowledged. Mistrust with the health system due to systemic racism and mistreatment can lead to avoidance of utilizing health care services. Solutions need to address this mistrust by leveraging community resources, peer-led initiatives, and outreach models to provide stronger person-centred care. One participant highlighted an example of a northern Canadian community, who did not want to travel to receive care and don't wish to be placed in long term care away from their communities. Community-lead healthcare solutions tailored to specific needs of the local populations were noted as crucial to successful implementation. Solutions need to look beyond doctors, nurses and

regulated healthcare professionals and explore new ways to provide community-based care. Capacity building within communities was emphasized as an effective solution that ensures community members can age in their homes. Furthermore, participants highlighted that assessing a community's capacity before implementation is important, ensuring it has the resources and strengths necessary for success.

Policy and Funding

- Bridging evidence to action: We heard that the disconnect between the wealth of evidence supporting community-based health models and the actual changes implemented in funding and in policy is an important aspect to consider. Participants agreed that there are numerous reports and studies that show promise for cost savings and improved health outcomes, however change has not occurred.
    - One example shared, a model introduced in a maritime province demonstrated significant impacts, providing baths and foot care leading to reduced emergency department visits for older adults, however sustainable funding continues to be at the forefront of the discussions to spread the program more widely.
- Systemic resistance: Participants outlined that change within the healthcare system needs to overcome systemic resistance, despite widespread agreement on the need for innovation and transformation. Entrenched practices and siloed structures may prevent meaningful shifts in healthcare. One participant explained it as a Canadian paradigm, while another noted that this reluctance is not due to a lack of desire to improve by decision makers, but rather it's embedded in the "DNA" of the healthcare system since its inception.
    - A participant contrasted this occurrence to the Netherlands, where substantial policy changes have been successfully implemented and reallocated 50% of funds from facility-based care to primary care, leading to delivering effective health care in home for older adults. Defaulting back to previous practices and ways of doing is often the result when what's needed is a shift in system level thinking.
- The Canada Health Act: We heard from participants that the Canada Health Act, established 40 years ago can be a barrier to innovative solutions due it primarily funding hospitals and doctors, leading to heavily favouring traditional health care infrastructure. This legislation dictates the foundational structure of Canada's healthcare funding, leaving essential services like home care, nursing home care, pharmacare, and dental care as secondary considerations. Despite this, one participant noted that a significant portion of healthcare demands are for these essential services. Another participant estimated that a significant amount of all activity currently happening in facilities don't need to.
- Government responsibilities: One participant reflected on the disparity between local level community interventions and the broader national healthcare framework dictated by the Canada Health Act. There is a potential misalignment where federal and provincial structures may not adequately support grassroots initiatives. There is an opportunity for an increased role for municipalities and regional governments, which may have a clearer understanding of local needs and could better support geographic and community specific differences through legislative or funding changes. One example provided was the concept of neighbourhood networks, consisting of

older adults who self-organize and make connections with social services and support each other's needs. It was also acknowledged that municipal governments face limitations in terms of revenue generation and legislative authority. Shifting the language and paradigm of the health care system is needed for all to benefit, both from decision makers and the health care end users to build comfort around new and innovative solutions.
    - Temporary funding: It was further highlighted that despite funding for local health services, if the funding does not continue, the program will end regardless of its effectiveness. Funding cycles of the government impact the ability to assess the effectiveness and sustainability of new strategies and can lead to programs ending due to a lack of ongoing funding and long-term planning.
- Salaries and compensation: Salaries for home care workers and nurses were discussed as another barrier, highlighting the need to be paid on a salary, not "by the minute" to attract more workers in the field. Furthermore, participants echoed that funding should go towards front line workers, and one participant highlighted that increasing salaries for home care workers would incentivize more Canadians to work in this field.

Flexible and Community-Led Approaches

- Systems based approach: We heard that there is a need for a systems approach to health service delivery in communities, emphasizing the importance of assessing a community's capacity, strengths, and resources rather than merely focusing on specific programs. Communities and community leaders can be empowered to lead innovations with openness to understanding the factors of the system at large and less focused on the program itself. One participant suggested using different tools of assessment, ways of enabling and methods of incentivizing to accommodate varied community members. A shift from modifying existing programs to adopting a broader, more adaptable view that supports sustainable interventions within the community was further stressed.
- Flexible programs and services: One participant emphasized an approach to "flex everything", explaining that removing fixed infrastructures, care models, roles for care in the community and instead allowing highly adaptable, flexible, and configurable ways to help people age in place. When asked why flexibility of programs continues to be a challenge, one participant noted "They just kept wanting to do the future using today's infrastructure."
- Constraints of current health professionals: It was noted that care plans need to be in the hands of those closest to the patient, to design, plan and execute the care plan. However, another challenge highlighted is that physicians and health care professionals are already constrained by their demanding schedules. This limits the time they can dedicate to adopting new methods or approaches outside of established routines. More ways to facilitate connections or coordinate at the point of care are needed, to better integrate and shift supports closer to where patients interact with the health care system.

Appendix 1: Community Engagement Methods

Recruitment

Patient, clinician, and industry engagement officers promoted the call for statements of interest widely. The open call was shared with those who subscribe to CDA-AMC E-Alerts, which are time-sensitive alerts about Canada's Drug Agency, feedback opportunities, and corporate news. There are about 150 Canadian clinician groups and patient groups are subscribed.

In addition to CDA-AMC E-Alerts, invitations to complete or share the open call for statements of interest was shared with the following organizations:

- Closing the Gap Healthcare
- SE Health
- Ontario Homecare Association
- Sinai Health - Healthy Aging and Geriatrics
- CDA-AMC Patient and Community Advisory Committee (PCAC)
- Canadian Consortium on Neurodegeneration in Aging (CCNA)
- UHN NORC (Naturally Occurring Retirement Community) Innovation Centre
- Carers Canada
- Centre for Aging and Brain Innovation (CABHI) at Baycrest
- Ontario Caregiver Association
- Canadian Seniors Association
- Patient Voices Network – BC
- Canadian Centre for Caregiving Excellence
- Canadian Support Workers Association (CANSWA)
- Centre for Aging SMART
- Alzheimer's Society of Canada
- Canadian Gerontological Nursing Association
- Canadian Association of Occupational Therapists (CAOT)
- Canadian Geriatrics Society
- Canadian Association of Social Workers
- Can Age
- Canadian Frailty Network
- Canadian Coalition for Senior's Mental Health (CCSMH)
- Canadian Association on Gerontology (CAG)

- Canadian Association for Retired Persons (CARP)
- National Institute on Ageing (NIA)
- The Canadian Association for Long Term Care (CALTC)
- Ontario Community Support Association
- Canadian Home Care Association (CHCA)
- Canada Mortgage and Housing Corporation (CMHC)
- Alberta Seniors & Community Housing Association (ASCHA)
- BC Seniors Living Association
- Canada Safety Council
- AGE-WELL
- BrainXchange
- Active Aging Research Team (UBC)
- Healthy Aging CORE
- Western University – Canadian Centre for Activity and Aging
- Seniors Health Knowledge Network
- University of Manitoba's Centre on Aging
- Elder Abuse Prevention Ontario
- The Canadian Network for the Prevention of Elder Abuse (CNPEA)
- Canadian Centre for Elder Law (CCEL)
- Ontario Pharmacists Association
- Coalition of Pharmacists Caring for Aging Canadians
- Lakehead U - Centre for Education and Research on Aging & Health
- Canadian Indigenous Nurses Association
- National Collaborating Centre for Indigenous Health
- Healthcare Excellence Canada
- Age Safe Canada
- The Schlegel-UW Research Institute for Aging (RIA)
- Pinecrest-Queensway Community Health Centre's Multicultural Seniors Program
- University of Regina
- University of Alberta
- Alzheimer's Society of Nova Scotia
- Caregivers Nova Scotia
- Yee Hong Long-Term Care
- The Council on Aging of Ottawa

- Eva Marsden Centre for Social Justice and Aging
- 8 80 Cities
- The National Resource Centre on 2SLGBTQI Aging
- Ottawa Senior Pride Network
- University Health Network's Healthy Ageing and Geriatrics Program

Participant Selection

We sought to engage people with extensive personal and/or professional experience within a Canadian health system. Specifically, we wished to engage with health care professionals who are providing or supporting care for those aging in their own homes, in supportive care settings, and in long-term care (e.g., physicians, nurses, occupational therapists, physical therapists, psychologists, social workers, administrators, policy-makers) as well as people with direct, personal experience with the challenges and success factors of aging in place (e.g., older adults, spouses, adult children or other family members, and caregivers)

Interested parties were invited to complete a statement of interest and answer the following questions:

- What is your connection to aging in place?
- Describe how your personal or professional experience and knowledge of the wider issues is relevant to this topic. How will this add to the diversity of perspectives shared and help inform CDA-AMC's work in this area?
- Is there a specific technology or issue that should be considered in the project from your perspective?
- Is there anything you need to make your participation in the project easier?

The statements of interests were reviewed by two Engagement Officers, and participants were selected for the Community Engagement Sessions based on having a diversity of perspectives, geographic representation in Canada, and other dimensions of difference to ensure a wide range of views would be included and captured.

Selected participants were invited to complete a registration form to select their preferred date & time, to advise us of any accessibility needs to participate and to declare any conflicts of interest.

Meeting Format

Three sessions were held via Zoom on February 28, 2024 at 6:00 p.m. ET; February 29 2024 at 11:00 a.m. ET; and March 4, 2024 at 1:30 p.m. ET to accommodate participant times zones and ensure options are available for a wide variety of participants' schedules.

Each meeting was 2 hours of short presentations and whole group discussions.

One week prior to the meeting, materials were sent to all participants. The premeeting materials consisted of an agenda, participant biographies, and a participant guide summarizing a draft List of reasons people may be unable to age in place as long as they want to or are able to guide the discussion.

In the first twenty minutes of each meeting, a CDA-AMC staff member facilitated introductions of participants, provided a territorial acknowledgment, and conducted Zoom polls to gather insights from participants and establish the foundation of the discussion for the session. Following this, a facilitated discussion occurred on the 4 broad reasons why people cannot age in their home. After a break, further facilitated discussions focused on special considerations and how these reasons affect different groups from participants' perspectives.

All participants were required to comply with existing CDA-AMC policies regarding code of conduct and the disclosure and management of conflicts of interest. Honorariums were offered to all participants to compensate for their time spent reviewing meeting materials, attending the meeting, and reviewing the draft meeting summary.

An emotional support designate was present for the session to offer support if any of the participants became distressed during the meeting.

List of Co-Creators and Participants

Community Engagement Session Co-Creators

Mary Reeves, NB

Prachi Khanna, BC

Attendees

The session brought together a diverse group of participants, each contributing a unique perspective on aging in place. This included geriatric health care professionals like physicians, nurses, occupational therapists, physiotherapists, fall prevention professionals and psychiatrists, who provide or support care across various settings—from personal residences to long-term care facilities. Attendees also included administrators, managers, and primary care providers, offering insights from operational and implementation standpoints. Complementing these professional viewpoints were direct experiences shared by older adults, family members, and caregivers.

- Monique Lizon, ON
- Jim Closs, ON
- Randal McKnight, NB
- Richard Louis, NB

- Alexis McGill, NB
- Prachi Khanna, BC
- June Blau, SK
- Germaine Fisher, NL
- Edward Ting, BC
- Ruth Wells, NL
- Rebecca Tibbo, NL
- Joan Cranston, NL
- Allison Scott, AB
- Erica Burton, NL
- Cynthia Theberge, YUK
- Dorothy Mary Senior, NL
- Lyn Stuart, NS
- Karen MacCurdy Thompson, NB
- Susan Palijan, ON
- Lisa Droppo, ON
- Clara Bolster-Foucault, QC
- Cindy Grief, ON
- Joanna Evans, MB
- Nicole Allam, YUK
- Melinda Ovens, YUK
- Mike and Kathy Mason, ON
- Joanna Evans, MB
- Meryl Orth, MB
- Kerri Chomenchuk, SK
- Elizabeth Rhynold, SK
- Catherine Ann Kelly, NL
- Gregory Toews, MB
- Colette Pancoe, MB

Appendix 2: Policy Researcher Engagement Methods

Recruitment

Patient, clinician, and industry engagement officers promoted the call for statements of interest widely. The open call was shared with those who subscribe to CDA-AMC E-Alerts, which are time-sensitive alerts about Canada's Drug Agency, feedback opportunities, and corporate news. There are about 150 Canadian clinician groups and patient groups are subscribed.

In addition to CDA-AMC E-Alerts, invitations to complete or share the open call for statements of interest was shared with the following research groups:

- Healthcare Excellence Canada (HEC)
- National Institute on Ageing (NIA)
- NORC Innovation Centre at University Health Network (UHN)
- AGE-WELL
- C.D. HOWE Institute
- SE Health
- McMaster University, Aging, Community & Health Research Unit
- Canadian Standards Association
- Canadian Centre for Care Giving Excellence
- Centre for Aging + Brain Health Innovation (CABHI)
- University of Manitoba, SOARR: Supporting Older Adult Healthcare Reform through Research
- Nova Scotia Centre on Aging, Mount Saint Vincent University
- University of Toronto, Institute of Health Policy, Management and Evaluation
- Previous relevant CDA-AMC project participant

Participant Selection

We sought to engage people with extensive knowledge and expertise of policy and/or research on Aging in Place to explore possible barriers to action in this area. The goal was to gain an understanding of perspectives, observations and experiences about health system decision makers' understanding and awareness of the evidence for interventions that support aging in place.

Participants were carefully selected through a collaborative approach that involved consulting with key organizations and professionals deeply engaged in aging-related research. Additionally, the project team conducted extensive literature searches to help identify organizations to invite participation.

Selected participants were invited to complete a registration form to select their preferred date & time, to advise us of any accessibility needs to participate and to declare any conflicts of interest.

Meeting Format

The engagement session was held via Zoom on April 22, 2024, at 3:00 p.m. ET until 4:30 p.m. ET. One week prior to the meeting, materials were sent to all stakeholders. The premeeting materials consisted of an agenda, participant biographies, and a participant guide summarizing categories of strategies and initiatives supporting aging in place. We used the categories of strategies and initiatives created by the National Institute of Ageing as a starting point to create these categories to guide the discussion.

In the first ten minutes of the meeting, a CDA-AMC staff member facilitated introductions of participants and provided a territorial acknowledgment. Following this, a facilitated discussion occurred on the systemic challenges and enablers to implementing strategies and initiatives.

The second half of the session focused on equity and other key considerations. A whiteboard was utilized to add a visual element to the discussion, and to explore the intersectionality of different concepts discussed.

Additional details and examples of the categories of strategies and initiatives supporting aging in place can be found in Appendix 2.

All stakeholders were required to comply with existing CDA-AMC policies regarding code of conduct and the disclosure and management of conflicts of interest. Honorariums were offered to all participants to compensate for their time spent reviewing meeting materials, attending the meeting, and reviewing the draft meeting summary.

Attendees

The session brought together a diverse group of participants, each contributing a unique perspective on aging in place. This included policy researchers, analysts, and implementations scientists.

- Tanya McDonald, Healthcare Excellence Canada (HEC)
- Zayna Khayat, Adjunct faculty, Rotman School of Management, University of Toronto
- Susan Bronskill, ICES
- Jordann Thirgood, Canadian Standards Association
- Bianca Stern, The Centre for Aging + Brain Health Innovation (CABHI)
- Josephine McMurray, AGE WELL