ALBERTA ASSOCIATION ON GERONTOLOGY

Vision 2030 for Seniors Services Symposium:

Literature Review

TABLE OF CONTENTS

1 Introduction 4

1.1 Purpose 4

1.2 Methodology 4

1.3 Limitations of the Literature Review 5

1.4 Organization of the Literature Review 6

2 Demographic Profile of Alberta's Seniors 7

2.1 Seniors Population 7

2.2 Gender and Marital Status 7

2.3 Residence Type 7

2.4 Income and Financial Situation 8

2.5 Indigenous Seniors 8

2.6 Immigrant Seniors 9

3 Seniors Aging-In-Community and Community Needs 10

3.1 Alberta Context 10

3.2 Community Services and Supports 11

3.3 Social Isolation 19

3.4 Ageism 20

3.5 Access to Information and Resources 21

3.6 Transportation, Mobility, and Physical Access 23

3.7 Housing 25

3.8 Rural Seniors 27

4 Seniors Income and Financial Situations 30

5 Seniors Care 32

5.1 Informal Caregiving 32

5.2 Elder Abuse 32

5.3 Primary Care And Acute Care 33

5.4 Continuing Care 34

5.5 Medication Management 37

5.6 Medical Assistance in Dying (MAID) 38

6 Dementia 41

6.1 Alberta Dementia Strategy and Action Plan 41
6.2 A Dementia Strategy for Canada 44
6.3 The Brenda Stafford Foundation: Dementia Friendly Communities 45
7 Marginalized Seniors 48
7.1 Immigrant Seniors 48
7.2 Indigenous Seniors 52
7.3 LGBTQ2S+ Seniors 54
8 Technology 55
9 Human Resources 57
References 58

1 INTRODUCTION

1.1 PURPOSE

This literature review provides background information for the Alberta Association of Gerontology and delegates to their Symposium being held in November 2019. The symposium theme focuses on the 2030 Vision for Seniors in Alberta regarding the needs and challenges facing seniors as they grow older and the desired policies and services to meet those needs and challenges in 2030.

1.2 METHODOLOGY

Focus on Grey Literature

This literature review focused on an examination of the grey literature addressing Alberta seniors needs, issues and challenges and the recommendations made to address the findings. Grey literature refers to information produced outside of traditional publishing and distribution channels and can include reports, policy literature, working papers, newsletters, government documents, speeches, white papers, etc.

A review of grey literature was selected as a substitute for an online participant survey to minimize the duplication of findings and recommendations that have been made public through a range of governmental and non-governmental organizational research using a variety of study and consultation approaches. The literature review was also an adjunct to the pre-consultation sessions (focus groups) held with senior Albertans across the province. The findings of the focus groups have been published in a separate document.

The literature review is not an exhaustive review of all literature in all topic areas. The information is largely Alberta-based, easily accessible and is reflective of extensive collections of information from seniors and their families by a variety of organizations across the province. Academic literature was presented by content experts at the Symposium and is included in the Symposium Proceedings.

The literature review focused on finding information to answer the question: *What are the issues and challenges facing seniors in Alberta as they age, and what recommendations are being made to address them?*

Scope of and Approach to the Literature Review

The scope of the review was limited to sources that met the following criteria:

- Addressed the needs of seniors (aged 65 years or older) in Alberta
- Prioritized grey literature rather than academic papers
- Was readily available online or through hard copy documents
- Developed or published in 2015 or later

Seniors were defined as adults aged 65 and older, and priority was given to sources that identified specific needs, issues, and challenges and offered suggestions or recommendations to address these.

An Internet search, using Google, was conducted to identify pertinent grey literature produced by governmental organizations and non-governmental organizations representing and/or addressing seniors concerns.

Identifying relevant grey literature was an iterative process. Preliminary searches revealed a number of challenges:

- Information on topics relevant to seniors' needs is sometimes presented directly on organizational websites rather than in published reports or documents.
- Searches of a topic and the word 'Alberta' often produced only white literature or literature with a different geographic focus. While these may have contained useful insights, the resource and time limitations of the project required that often, they could not be included.
- Published grey literature that was readily available and in scope often took the form of an extensive document containing high-level overviews of many different topics related to seniors, not necessarily providing any specific identification of needs or recommendations to address them. Reviewing these to extract information on specific topics was time consuming and did not always produce the desired results.

A number of sources with a broad focus pointed to other organizations and documents, which broadened the review. Where gaps were found, another search for sources was conducted with a focus on newly identified organizations as well as the topics lacking information. This process was repeated as necessary in an attempt to create a complete set of information. Ultimately over 100 pieces of grey literature were found, including many from jurisdictions outside of Alberta and/or produced prior to 2015. From the full list of grey literature, the 54 that contributed to this report were selected based on the initial criteria, with exceptions made where there was a dearth of information and another source would help to fill a gap.

Relevant content was extracted and analyzed to identify common categories for both seniors' challenges and subsequent recommendations to address those challenges.

1.3 LIMITATIONS OF THE LITERATURE REVIEW

This review was subject to time and resource limitations, requiring a limit in the scope of the review and effort required in finding additional sources of information on topics where preliminary research produced minimal useful results. Therefore, lack of information presented on a topic may indicate that: a) no major needs have been identified on that topic in the grey literature; b) pertinent grey literature was not available or accessible in the public domain; or c) need for additional resources in order to conduct more in-depth investigation of that topic.

Readers should note that the information in this review serves as a starting point for discussions about the needs of seniors in Alberta and how to address them, rather than an exhaustive review of seniors' issues and associated recommendations.

1.4 ORGANIZATION OF THE LITERATURE REVIEW

This literature is organized into nine sections are follows:

1. **Introduction:** describes the purpose, methodology, and limitations of the review.
2. **Demographic Profile of Alberta's Seniors** provides a brief overview of various demographic characteristics of Alberta's seniors.
3. **Seniors Aging-in-Community and Community Needs:** discusses a range of challenges faced by senior Albertans in being able to stay living in the community, focusing on community supports and services, social isolation, ageism, access to information and resources, transportation, mobility and physical access, housing and rural seniors.
4. **Seniors Income and Financial Situations:** discusses financial constraints faced by many seniors in Alberta and ways in which the constraints can be addressed.
5. **Seniors Care:** discussed a range of challenges that have an impact on the care requirements of seniors as they grow older, focusing on informal caregiving, elder abuse, primary and acute care, continuing care, medication management and medical assistance in dying.
6. **Dementia:** describes the provincial Dementia Strategy and Action Plan, identifying some of the approaches being undertaken to improve dementia care in Alberta.
7. **Marginalized Seniors:** describes some of the needs and challenges faced by immigrant, indigenous and LGBTQ2S+ seniors and ways to address their needs
8. **Technology:** discusses the barriers to use of technology by seniors and ways in which technology can be used to enhance seniors' day-to-day lives
9. **Human Resources:** discusses the needs for an increased and diversified, well skilled and educated workforce to meet the growing demand for senior's care
10. **References:** provides a list of the sources used in preparing the literature review.

Report formatting notes:

1. **Citations in body of literature review**. Some adjustments were made to citing sources for the documents in the body of this review, given the number of times specific topics were addressed in multiple documents or multiple documents addressed several topics. The sources used in this literature review have been numbered and placed inside brackets with a full citation of the references at the end of the document.
2. **Highlighted recommendations**. Recommendations, suggestions, approaches, etc., to address identified seniors needs and challenges, were bolded and italicized in blue font as subheadings. This was done with a view to facilitating location of that information in the literature review.

2 DEMOGRAPHIC PROFILE OF ALBERTA'S SENIORS

2.1 SENIORS POPULATION

Alberta's senior population is over 605,000 ([13]), the majority of which are 65 to 85 years old ([1]), a subgroup sometimes considered 'young seniors. By 2035, the total number of seniors is expected to increase to 1 million and in the meantime the proportion of seniors who are older is also expected to increase steadily ([32]).

Roughly 78% of Alberta's seniors live in urban areas with 33% in Edmonton, 31% in Calgary, and the remainder in smaller urban areas. On average seniors represent 12.3% of the population in Alberta's urban areas, and the proportion of seniors in the two major urban centers of Edmonton and Calgary closely reflect this average. However, when looking at smaller urban areas the proportion of seniors is highly variable by location. In 2016 seniors represented approximately 20% of the populations in High River, Camrose, and Wetaskiwin respectively, 16% in Medicine Hat, and 15% in Lacombe. Conversely in Sylvan Lake, Grande Prairie, Cold Lake, and Wood Buffalo the proportion of seniors only ranges from 3-9%. While there will be an overall increase in the number of seniors across the province, and rural seniors only represent 22% of the total, the proportion of seniors in rural communities is expected to increase at a faster rate than the proportion of seniors in urban areas ([32]).

Some highlights:

- Currently Alberta has over 605,000 seniors; expected to grow to 1 million by 2035
- Majority of seniors are 65-85 years old
- 78% live in urban areas
- 12.3% of Alberta's urban population constitutes seniors
- More female seniors than male
- By 2038, at least 85% of seniors over 85 years will be female
- 76% male seniors are married compared to 51% of female seniors
- 91% of seniors live in private households; majority of which are houses
- 9% of seniors live in collective dwellings; majority of which are in health care and related facilities

2.2 GENDER AND MARITAL STATUS

Gender and marital status ([32]) reveal slightly more female seniors than male seniors and this is not expected to change. However, within the senior population, as they age from 65 years old to 90+ years old, the proportion of females increases. By 2038, it is expected that at least 58% of seniors over 85 years old will be female.

Approximately 76% of male seniors are married, 10% are widowed, 10% are separated or divorced, and 5% are never married. By comparison, about 51% of female seniors are married, 33% are widowed, 12% are separated or divorced, and 4% never married.

2.3 RESIDENCE TYPE

Seniors residence type ([32]) reveal just over 91% of seniors live in private households, the majority of which (72%) are in houses. The remaining in private households are in apartment buildings (16%) or moveable dwellings (3%). 1 in 7 Alberta seniors in private dwellings are renters, and one quarter of these have subsidized housing (which equates to about 3% of all

seniors living in private dwellings). Of the seniors who own their own homes, about one quarter have a mortgage.

About 9% of seniors live in collective dwellings, the majority of which are in health care and related facilities including nursing homes, hospitals, residential care, and senior citizens residences. Of those living in collective dwellings, about 53% are 80+ years old, and 37% are 80+ years old *and* female.

2.4 INCOME AND FINANCIAL SITUATION

Seniors income and financial situation ([32]) reveal approximately $73,000 for couples and $30,000 for individuals. Alberta seniors have higher average annual incomes than seniors across Canada. However, the income of both couple and individual seniors as a proportion of the median income of all ages in Alberta is low compared to the same measures in the rest of Canada. For example, in Alberta a senior couple's median income is only 68% of the median income of all ages, while in the rest of Canada that figure is 73%. In 2015, the prevalence of low-income in Alberta was 9.3%, and for seniors there was a gender disparity with low-income rates of 10% for females and 7% for males.

- Approximately $73,000 average annual income for couples and $30,000 for individuals
- 62% senior couples receive employment income; 29% for single seniors
- Senior participation in labour force increased from 10% to 20% (1997 to 2017)

Well over 90% of Alberta seniors receive income from old-age security, net federal supplements and Canada Pension Plan. 50-70% of seniors receive income from investment income and private pensions. 7-12% of seniors receive income from Registered Retirement Savings Plans, and 70-88% of seniors have 'other' sources of income.

62% of senior couples receive employment income, while for single seniors this figure is only 29%. Senior participation in the labour force has increased over the last 20 years from approximately 10% to 20% between 1997 and 2017, and the senior's unemployment rate in 2017 was just over 7%.

Alberta seniors have higher consumption rates and expenses than others across Canada, spending approximately 21% on income tax, 21% on shelter, 14% on transportation, 10% on food, 8% on household operations and furnishings, 5% on clothing and personal care, 5% on recreation, and 5% on health care.

2.5 INDIGENOUS SENIORS

In 2016 there were an estimated 13,000 Indigenous seniors in Alberta, which represented roughly 3% of all seniors provincially ([1]). However, there is some notable variance by location, with Indigenous people representing 16% of seniors in Wood Buffalo, 4.8% of seniors in Cold Lake, 4.1% of seniors in Lloydminster, 3.8% of seniors in Grande Prairie, 2.6% of seniors in Edmonton, under 2% of the seniors in Brooks, Red Deer, Camrose, Medicine Hat, Lethbridge, Okotoks, Calgary, and High River respectively, and 0% of the seniors in Canmore([32]).

13,000 Indigenous seniors in Alberta, or 3% of total Alberta seniors

Indigenous seniors in Alberta are younger than non-indigenous seniors, with 72% being 65-72 years old (compared to 62% of non-indigenous seniors in that age range). The majority live off-reserve, and there are approximately 10% more female indigenous seniors than male ([32]).

2.6 IMMIGRANT SENIORS

Immigrant seniors ([32]) account for an increasing proportion of the Alberta senior's population. As of 2016, the proportion of immigrants in Alberta's senior population was approximately 29% (145,000 people), which is higher than the total proportion of immigrants in the province (approximately 21%). Of the seniors who had immigrated to Alberta, 91% had been in Canada 10 years or more. Immigrant seniors were predominantly of European origin (48%) or Asian origin (36%). However, a shift is occurring, as it is projected that by 2070, 61% of immigrants will be of Asian origin, and 14% will be of European origin ([32]), which will also impact the demographics of seniors in the province.

- Proportion of immigrant seniors was 29%, about 145,000 (2016)
- 48% of immigrant seniors predominantly European
- By 2070, 61% expected to be of Asian origin and 14% of European origin

3 SENIORS AGING-IN-COMMUNITY AND COMMUNITY NEEDS

3.1 ALBERTA CONTEXT

Age-Friendly Communities and Aging-in-Place: a growing concept in Alberta. For over a decade Alberta has promoted the concepts of Age-Friendly Communities and Aging-in-Place to meet the needs of its aging population. The province set the stage in the 2008 *Aging Population Policy Framework* which prioritized "enabling seniors to remain in their own homes", "providing services to seniors in the community", and policies to support "housing and aging in the right place" ([44]). Aging-in-place requires "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level." ([41]). Public policy has shifted towards programming and related funding that supports aging-in-place; however, work remains to be done. Seniors in Canada overwhelmingly express a desire to stay in their own homes as they age, but aspects of how their communities and dwellings are set up can often prevent this from being possible ([5]).

In 2012 Alberta joined the broader Age-Friendly movement led by the World Health Organization (WHO) by producing resources to help communities across the province become age-friendly (58). Since then, a number of communities, including Edmonton, Calgary, Lethbridge, and the County of Strathcona ([3]) ([16]) ([12]) ([37]) have undertaken Age-Friendly research in their communities and developed Age-Friendly strategies. Each community approaches creating Age-Friendly strategies differently based on their unique requirements. While there are some common broad themes in the approaches developed across Alberta, and while many specific needs and recommendations have been named, there is variation among the strategies in terms of what has been prioritized, what issues have been included or excluded, and how the information is organized.

Meeting seniors' community needs are key to aging-in-place and age-friendly communities. Various levels of government and other organizations who work with and serve the senior population have highlighted specific needs in advancing the ongoing process of creating Age-Friendly Communities. Regardless of the source, many suggestions to facilitate aging-in-place can be broadly categorized as Community Needs. Community Needs can be thought of as a system of interconnected and interdependent elements that collectively contribute to a senior's ability to age-in-place. The associated needs identified in the literature are organized and presented in this section under the following sub-categories:

- Community Services and Supports
- Social Isolation
- Ageism
- Access to Information and Resources
- Transportation, Mobility, and Physical Access
- Housing
- Rural Seniors

3.2 COMMUNITY SERVICES AND SUPPORTS

3.2.1 The Role of Seniors Centres of the Future

A comprehensive report on the needs of seniors was commissioned by the City of Edmonton ([5]), with the purpose of informing the future of seniors centres in Edmonton. An extensive multi-jurisdictional literature review and public consultation were conducted, the results of which provide valuable insights into the needs of seniors in general. Below is a summary of relevant highlights from that report.

Significant opportunity for seniors centres to play a critical role in supporting aging-in-place in the community. Seniors centres are well-positioned to act as hubs where older adults and caregivers alike can access information and services and make social connections, and where other members of the community and businesses can engage with and support older adults.

Key areas where seniors centres need to shift. However, because the needs of seniors are changing along with the changes in the group demographics, there are some key areas where seniors centres need to shift to be able to serve the aging population effectively:

- **Increase capacity for services provided**. The demand for services will increase as the population of seniors increases. This will mean overall need for increased capacity in services provided by seniors centres, as well as the staff/outreach workers required to deliver them.
- **Integrate services with other community organizations through partnerships and collaborations.** Given the multifaceted nature of a seniors centre as a community hub, meeting the increased capacity needs will necessitate service integration with seniors centres and other organizations in the community by fostering collaborations and partnerships. Seniors centres will need to coordinate with groups that can help meet the transportation, housing, education, and health needs of seniors. A related need is that seniors centres will need to address a general lack of capacity and operational governance quality in order to effectively and efficiently manage this increased demand for services and complexity.
  - Examples of this working well include Edmonton where PEGASIS and the ESCC have a strong formal partnership, and also where the coordinators of senior centre outreach programs meet informally to share strategic tools and experiences. These examples could be modeled and expanded more broadly throughout the province.
- **Consider availability of different types of volunteer activities** in seniors centres. Most centres rely heavily on volunteerism to function, which is known to increase the sense of wellbeing of the volunteer, but the incoming or younger seniors do not have the same interests as previous cohorts. For example, many current opportunities are administrative or kitchen roles, but younger seniors generally do not wish to participate this way. Rather, they are more likely to want to be able to use their skills in mentorship roles or social coordination.

- **Consider additional programming to serve the needs of an increasingly diverse population** (e.g. multiple languages and cultures, non-binary sexual identities and orientations, etc.)
- **Address branding issue/stigma related to ageism**. Currently most seniors centre users are between 75 and 84 years old, and Baby Boomers in particular view them as 'places where old people' go and resist self-identifying as such. Marketing is needed to counteract this. This also points to a need to refocus programming from being deficit-based (i.e. meeting seniors needs) to asset-based (i.e. fostering physical and emotional wellbeing and promoting autonomy and active engagement).
- **Be sensitive to and accommodate the realities of aging.** A cautionary note is that if seniors centres are to serve an aging population, there is still a need to recognize the reality that although baby boomers tend to live longer and more healthy lives than previous cohorts, the reality is still that they are expected to have decreased mobility, vision and hearing loss, and increased numbers of people with cognitive impairments. As such seniors centres need to be inviting and appealing to participation by older adults, it is important to avoid perpetuating ideas of 'the ageless self' which denies the reality of aging.
- **Consider role in supporting caregivers**. Leverage the opportunity for seniors centres to also support caregivers. A key gap is that even where these services are currently provided, caregivers don't tend to access them.
- **Expand specific programming and outreach to overcome the unique barriers to participation faced by immigrant and refugee seniors** such as language, isolation, and financial dependency and precariousness.
- **Make health and wellness central to their programming** in support of active and healthy aging in community. Centres do not need to become a part of the healthcare system but can play an important and active role in health promotion and illness prevention, and education.
    - Take the opportunity to employ a preventative model to support seniors in aging independently and in their communities. This can include:
        - Wellbeing programs for physical health
        - Access to information and resources re: government services, wills, power of attorney, health care, medical insurance, financial literacy.
        - Health screenings and assessments and education.
        - Partnerships with healthcare organizations to offer services (e.g. flu shot clinics)
    - Policy and funding increasingly need to support / recognize the connections between physical and mental and social and emotional health and wellbeing. Health conditions tend to become more complex as people age. Seniors centres straddle these and will become more integral to the continuing care spectrum as time goes on.

3.2.2 Shepherd's care Foundation – Kensington Village Campus of Wellness and Care Demonstration Project

In 2012, the Shepherd's Care Foundation undertook a Campus of Wellness and Care demonstration project at Kensington Village (KV), one of their senior's residences ([48]). Kensington Village is a large campus with 580 independent residents with an average age of 84 years, 75% of whom live with chronic illness and many believed to be low income. The five-year demonstration project operated from 2012 to 2017. The goal of the project was to develop and test ways to help residents age in the right place, stay well and independent for as long as possible. The project focused on prevention, health promotion as well as the social determinants of health and other individual factors. Two streams of activities were carried out:

1. **Care in Place**: focused on improving the resident quality of life by providing onsite, easily accessible health care and information.
2. **Village Wellness**: focused on activities to improve resident quality of life by providing opportunities to pursue physical activity, hobbies/interest, health education and social interaction.

Five themes underlying the project were:

- Engaging seniors in project development
- Supporting resident personal empowerment in maintaining and improving their health
- Understanding factors that influence health & functionality with this population
- Providing ability-appropriate activities to promote wellness
- Improving access (i.e. reduce barriers) to activities & support

The results of the project were shared in two Briefing Notes; one focused on Active Living: Longevity Worth Living ([49]) and the other on the Importance of Relationships in Independent Living ([50]). The following table gives an overview of the needs expressed, that activities undertaken to address the needs and the resident outcomes.

Highlights of Kensington Village Campus of Wellness and Care Demonstration Project (CWCDP)

Older Adult Needs	CWCDP/Resident Response	Resident Outcomes
Engaged and productive lives ([49])	Designed engaging activities	• 76% learned new things • 67% found health education enabled decisions and actions to improve health and wellbeing • Those engaged in activities for 6 months or longer noted improved health (65% general health; 62% cognitive health)
Healthy and active living ([49])	Supported individual needs and develop co-leaders	Residents reported that activities helped them: • Prevent falls 53% (↑ 11%) • Manage pain 34% (↑ 7%) • Be more mentally active 61% • Be more physically active 75%

Older Adult Needs	CWCDP/Resident Response	Resident Outcomes
Participation in decisions ([49])	Consulted with residents and designed a range of options; CWCDP Resident Wellness Advisory Committee guided planning and delivery.	• 82% or residents reported their feedback was encouraged (↑18%)
Security ([49])	Activities designed to help residents get to know each their neighbours and KV staff, help identify problems and facilitate solutions	• 83% of residents felt safe and secure • 81% felt a connection to the KV community (↑28%) • 79% felt a connection to staff (↑36%)
Independent, productive and engaged lives ([50])	• Resident advisory council established and supported • Surveys and opinions solicited, discussed and acted upon • Coffee parties to introduce new residents to each other, to long term residents and to the project • Targeted programming for at-risk populations (visual and mobility impairment and early dementia)	• 77% affirmed services improved their ability to live independently (↑ from 62%) • 79% had increased sense of well-being (↑ from 43%) • 80% stated an increased connection to their neighbours (↑ from 77%)
Healthy and active living ([50])	• Staff and resident encouragement to participate • Evidence-based programming to support physical and mental activities • Group activities to encourage social interaction	• 88% described their social health as fair to excellent
Participation ([50])	• Resident-led activities supported by provision of supplies, set-up and communications • Celebrated success • Recognized the importance of relationship-centred focus	• 90% reported being actively involved in social activities • Resident-led exercise group grew from 10-15 participants to over 30 during the course of the project • Residents reported going to coffee or other social activities • Excellent participation in health information sessions

Older Adult Needs	CWCDP/Resident Response	Resident Outcomes
Security ([50])	• Residents acknowledged the importance of a receptionist at the main entrance and the presence of CWCDP project staff and KV staff • Personal safety information sessions	• 81% reported greater connection to staff (↑ from 53%) • 86% or residents felt safe and secure • Presence of friendly, considerate and welcoming KV neighbours reported • Focus group evidence showed isolated, non-involved residents felt insecure in building whereas those involved in the project felt very safe and secure

3.2.3 Covenant Health: Innovator's Challenge: Going Beyond the Conversation

In 2013, Covenant Health launched The Covenant Health Network of Excellence in Seniors' Health and Wellness (the Network) to create capacity and expertise focused on enhanced and more sustainable models of senior's care ([54]). Over the years the Network has invested in over 18 Innovation Fund research projects and several strategic initiatives. In October 2018, the Network convened a one-day symposium titled "Innovators' Challenge: Going Beyond the Conversation". The aim of the Symposium was to identify the most important challenges in supporting the provinces' growing population of seniors and the increasing pressures in meeting the need for services ([54]). The question addressed was: *What are the Grand Challenges in seniors' health and wellness? How do we create a new energy and fresh thinking toward tackling these challenges through partnerships and collaboration?* Participants identified 58 challenges and grouped them initially into 12 themes and then into seven categories.

Some of the categories identified in the Network's symposium, are also discussed in other parts of this literature review, which reinforces the significance of the challenges. Rather than segment the Network's results to fit into other parts of this document, a decision was made to keep the results together for cohesiveness in representing the Network's work.

Seven Grand Challenges

Seven grand challenges ([54]) as shown in the Network's report, are given in the table below.

SEVEN GRAND CHALLENGES
1. Structural Ageism
• Harmful generalizations regarding homogeneity of aging leads to viewing all seniors the same.
• Low social capital of seniors leads to structural and systemic ageism and devaluation.
• Medicalization of aging leads to care systems that are paternalistic and hierarchal.
• Low health provider preparedness regrading aging leads to biases and stereotypes.

SEVEN GRAND CHALLENGES
2. Social Determinants of Health
• Health services do not address social determinants of health (SDH) and social/economic inequities.
• Multi-generational interactions are needed to sustain and leverage seniors' social capital.
• Community based organizations, not-for-profit organizations and municipalities deliver social care better than health systems.
3. Social Isolation
• Social isolation is multi-faceted (emotional, spiritual) and is defined by the individual.
• Isolation is socially constructed and reinforced by segregating seniors for service delivery purposes.
• Services to mitigate isolation must address the individual's subjective perception of loneliness rather the system's objective metrics.
4. Risk Tolerance: Outdated Policies/Regulations
• The health system's culture of low trust and risk aversion has led to over-regulation.
• Poor accountability distinctions and boundaries across public sector silos have led to misalignment and overlapping and jurisdictions.
• Performance metrics have been inappropriately reduced to tracking inputs, outputs and compliance measures at the service delivery level rather than assessing macro-level population outcomes.
• Individual quality of life cannot be measured by quality control measures or risk metrics.
5. Technology-augmented Health Care
• The power and potential of technology is untapped as an enabler of the system transformation.
• Excessive legal concerns are preventing the democratization of data, which results in data continuing to be tied to the site, sector or provider rather than the individual.
• Data integration is imperative to transitioning from a health/sickness care model to one of self-care and self-efficacy.
• We must unleash the power of predictive analytics to link health and social data and reduce the reliance on retrospective reporting and funding models.

SEVEN GRAND CHALLENGES
6. Community -based approaches to care
• Care in the home, accompanied by robust caregiver supports, needs to become the norm for care streams and provider groups.
• We must manage longevity and complexity in community settings through innovation and reduced reliance on institutional care.
• Fluid, flexible and recurring transitions between home, community and institutional care must be driven by new funding and care models.
• Urban planning and community development are critical factors in promoting community living and outreach to seniors.
• Intergenerational living and transportation are prerequisites to strong community-based care.
7. Inspire for Change: System Transformation
• Courage, innovation and change leadership are imperative to transform seniors' care.
• We must embrace prudent risk-taking, innovation and intentional change using predictive and proactive approaches.
• Equity, not equality, should be the driver in meeting individual needs.
• Seniors' care needs to invest in 'small' – families, housing, neighbourhoods, communities and zones – to drive innovation, break down silos and create flexible pods with the larger system.

A New Vision for Seniors' Health and Wellness. Participants in the Network's symposium also imagined a new vision for seniors' health and wellness. The key components of the vision ([54]) are:

- Recognize that **caring and caregiving are the backbone of senior's social care and health services**, and therefore our *system must be structured and funded to support flexibility, responsiveness, and innovation*.
- **Large institutions will be divested of extensive control** so that:
  - ***Smaller care environments can be fully accountable and nimble*** *in all aspects of service provision and innovation.*
  - ***Seniors, families, communities, providers, and regulators will be inspired to learn, trust, understand, and collaborate in ways that truly meet local needs***.
- **Hidden and single access points will be replaced** with:
  - ***An every-door-is-open principle*** *as the medical system relinquishes its exclusive role as gatekeeper and point of entry.*

- ***Care will be organized within community hubs***. ***Funding will be decentralized and unbundled*** – *following the senior/family rather than tied to the provider or care site.*
- ***Emergency departments and hospital admissions will be a last rather than a first resort****, and premature presentation to hospital will be interpreted as a failure of the community system.*

- **The legal environment will change to accept some degree of risk as an acceptable trade-off to achieve senior, resident and family autonomy:**
  - ***No longer assume seniors need protection from all possible harms and risks*** – *or that every senior needs or wants the same services and outcomes.*
  - *Instead, we* ***will have progressed from a paternalistic model to a partnership model****; from doing to seniors to doing with seniors and their caregiving team.*

Four Broad Courses of Action Identified ([54])

- **Emerging Seniors are the Change Leaders.** Today's generation of pre- and early seniors (55 – 75 years) will be the driving force behind transformational change. The first step is to help officials recognize that pervasive ageism is inherent in every part of the current seniors' care system.
- **Outdated Policies.** Rewriting outdated regulations and policies – many of which are predicated on risk management principles and medical-illness models of care – is central to paving the way for system change. Work should begin in targeted areas of focus and expand more broadly as partnerships and solutions are developed.
- **System Bottlenecks.** With a forward-thinking seniors' manifesto and an innovation-friendly regulatory environment in place, targeted bottlenecks in the system can be methodically addressed using evidence, best practice, and knowledge gleaned from other jurisdictions nationally and internationally
- **Client-facing Drivers**. As the regulatory and service delivery environment shifts in favour of a more modern and responsive seniors' care system, it will be easier for local communities to address client- facing drivers of wellness, such as social determinants of health, social isolation, community services and technology integration.

3.2.4 Additional Ways to Address Community Supports and Services

A number of additional ways to address needs for community supports and services were identified in other literature:

- **Support and increase awareness of the importance of gathering spaces** for older adults ([15]). For example:
  - Promote virtual and physical spaces for divorced, widowed, and/or single older adults to meet.
  - Promote space for LGTQ2S+ older adults to socialize in a welcoming environment.
  - Promote space for Indigenous older adults to express their unique experiences.

- **Recognize the role of community partnerships and support in combating elder abuse** ([21]), and work to create an age-positive culture shift ([3]).
- **Engage older adults in decisions about what types of programs and services and activities are offered** in local hubs and increase intergenerational programming (e.g. explore opportunities for mentorship activities) ([3]).
- **Promote the value of hiring and retraining older adults** and educate employers regarding how to create age-friendly workplaces ([3]).
- **Improve availability of respite support for caregivers**, and affordable health services in community (e.g. family doctors, dental services) ([12]).
- **Support community/ neighbourhood planning to include older adult-friendly design and amenities**, such as walkable and safe access to amenities and health services at close proximity to communities, accessible transportation. ([15])
- **Promote priority services and supports to help seniors stay in their homes**, such as home and yard maintenance ([15]).

3.3 SOCIAL ISOLATION

Social isolation can stem from multiple limiting factors in a senior's life, which together can compound the effects on wellbeing. Seniors who face financial, transportation and mobility, cultural, language, and/or cognitive and physical health barriers are more likely to be isolated because each of these can present challenges to social connection ([2]) ([3]) ([15]). As such, participation and inclusion in community, familiarity with community, and being close to family and friends were named as priority needs for creating Age-Friendly Communities in Edmonton, Calgary, and Lethbridge. ([15]) ([3]) ([12]).

Isolation is strongly correlated with living arrangement, marital status, being over 80 years old, having poor health or multiple health issues, not having family contact, low income, changing family structures, level of access to technology, and critical life transitions such as retirement, loss of a spouse, or loss of a driver's license ([3]) ([20]). Hence, addressing social isolation of seniors must include addressing these other limitations. However, it has also been recognized at the federal and municipal levels that further research is needed in order to better understand the needs of socially isolated seniors, and to validate practices for addressing it ([16]).

Considerations identified to address social isolation include:

- Explore opportunities for companionship programs ([27]), to address seniors' aversion to going places alone ([20]).
- Promote intergenerational connectedness through initiatives such as sports and socializing activities and mentorship programs. ([15])
- Address language barriers among older adults from ethnic communities ([15]) ([27]):
  - Offer affordable and accessible English classes focused on older adults;
  - Offer multi-language services in seniors' homes;
  - Enhance health care service offerings in multiple languages;
  - Provide mental health supports in different languages for individuals who feel lonely and who speak English as a second language.

- Distribute print material at seniors' hubs to connect isolated or vulnerable adults. ([3])
- Focus on improving social participation by addressing availability of services and opportunities to be active for seniors who have challenges with mobility or leaving their homes ([12])
- Promote ways to invite and involve vulnerable and isolated seniors in physical, social, and intellectual opportunities. ([3])

3.4 AGEISM

The World Health Organization describes ageism as:

> "the stereotyping and discrimination against individuals or groups on the basis of their age; ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs" ([42]).

Ageism can be separated into two connected ideas ([5]):

1. A way of thinking and making assumptions about older people based on negative attitudes and stereotypes about aging, and
2. A tendency to structure society based on the assumption that everyone is 'young' and failing to consider the needs of older people.

Ageism is broadly recognized as a priority issue in Alberta and federally in Canada ([5]) ([6]) ([7]) ([12]) ([15]) ([21]) ([25]). The National Seniors Council has named 'identifying measures to counteract ageism by shifting the public discourse' as one of the four priorities in their 2018-2021 workplan which includes research, convening expert panels, and consulting with seniors and representatives of organizations serving or advocating for seniors ([25]).

Ways to combat ageism:

- **Dispel hidden prejudices about older adults by younger people**, by increasing opportunities to connect older adults with youth. Examples to support this:
  - Increase programming that engages seniors in visiting schools and interacting with children to help them appreciate the knowledge and experience of older adults. ([15])
  - Increasing intergenerational programming and promoting opportunities for mentorship activities ([3]).
- **Create an age-friendly culture shift** ([3]), including dispelling the stigma attached to Seniors' Centres as 'places for older people' which prevents Boomers from participating ([5]).
- **Improve respect and social inclusion** so that issues that affect seniors are considered by everyone, and seniors should be valued by residents of all ages ([12]).
- **Increase awareness of the value and experience older adults bring to workplace and community** ([15]) and improve seniors' civic participation and employment ([12]). This can be encouraged through greater availability of employment opportunities, more flexible

workplaces ([12]), and education for employers about age-friendly workplaces to be able to hire and retain seniors ([3]).
- At both a government policy and cultural level, **reframe the process of aging to gear services towards supporting health, wellbeing, and participation** of older adults ([5]).

3.5 ACCESS TO INFORMATION AND RESOURCES

Access to information and resources is crucial to age-friendly communities because it's a precondition for achieving results in other areas. It contributes to the ability to age-in-community with respect to community support, access to health services, housing support, transportation, and more ([3]).

Identified needs/approaches for increasing access to information and resources include:

- **Provide accessible and easy to understand information** to:
  - Enhance seniors' ability to navigate the continuing care system ([27]).
  - Clarify the registration process for the Alberta Blue Cross Coverage for Seniors Program ([6]).
  - Clarify the Direct to Tenant Rent Supplement Program of the Ministry of Seniors and Housing ([6]).
  - Help seniors report concerns ([12]).
- **Provide print materials at seniors' hubs** with information on fire and fall safety ([15]), and transit ([3]).
- **Connect to isolated or vulnerable older adults through ethnic/cultural media** and indigenous and immigrant service providers ([3]) and improve availability of translation and interpretive services ([12]).
- **Increase awareness of resources and support for caregivers available in seniors' centers** ([5]) and promote and keeping local listings on caregiver peer support networks ([15]).
- **Increase or promote a home support coordinator role at the community level** (as in Edmonton community leagues) to help address challenges seniors face obtaining and receiving assistance and information or help. ([15])
- **Raise awareness of home modification grants** via the Province of Alberta and Canadian Mortgage and Housing Corporation, and offer programs to help older adults retrofit their homes through do-it-yourself tutorials, financial assistance, etc. ([15])
- **Promote civic engagement and literacy** among older adults. ([3])
- **Promote public and professional awareness** on how to identify, prevent, and respond to **elder abuse** ([28]) ([3]).
- **Offer social supports for conflict resolution** on legal issues ([6])([7]).
- **Develop and promote criteria for age-friendly communications** ([3]).
- **Provide and promote resources to help older drivers** as they age ([3]).

3.5.1 Advance Care Planning (ACP)

The Advance Care Planning Collaborative Research and Innovation Opportunities Program (ACP-CRIO) produced a report titled *How can we help Albertans learn about and participate in*

Advance Care Planning? ([26]). The following is information from the ACP-CRIO report that is relevant to this literature review.

> Advance Care Planning is "the process of reflection on and communication of a person's future healthcare preferences, to guide medical decision-making, including when a person becomes incapable of consenting to or refusing healthcare". ACP improves quality of life and end-of-life care, reduces decision-making burden, suffering, and bereavement distress of family members, and improves efficiency and cost shifting within the healthcare system. However, it has been identified that public participation and awareness with ACP remains quite limited. Community feedback suggests that access to information and resources is a key gap.
>
> ***Recommendations made to address advance care planning include:***
>
> - **Provide ACP education opportunities for secondary school students, and relevant post-secondary and continuing education** professional programs related to nursing, social work, financial planning, insurance, funeral planning, etc.
> - **Provide opportunities for community groups, healthcare providers, and business professionals to come together and learn about and initiate ACP**. This could include group facilitated sessions with stakeholders from Alberta Health Services ACP and Goals of Care Designations provincial team, Volunteer Services, Diversity Services, and Elder Brokers.
> - **Simplify language of resources** and include explanations of how personal directives, wills, power of attorney, goals of care designations and advance care planning conversations relate together.
> - **Increase support for physicians and primary care teams** to have ACP conversations. For example, there could be facilitated coaching for how to complete documentation that reflects a person's preferences or values.
> - **Increase marketing of ACP** to the public and use narratives and storytelling in resources to encourage personal reflection and interest.
> - **Encourage integration of ACP into major life events** and include appropriate business partners. For example, ACP information could be incorporated into the processes for obtaining a driver's license or marriage certificate, during will and estate planning, or as part of insurance packages.
> - **Standardize ACP terminology** across Canada.
>
> **Additional barriers and needs have also been identified** as follows. When promoting ACP through community organizations barriers include:
>
> - Healthcare provider time constraints
> - Complicated documentation
> - Lack of public understanding of ACP (complex terminology, health literacy)
> - Legal concerns (Document legality, jurisdiction, legal costs)
> - Process concerns (Inaccessible documents/agents, difficulty maintaining up-to-date info for complex or emotional health issues)
> - Lack of perceived need

- Role confusion
- Lack of access for isolated older adults

Other identified needs to promote ACP include:

- Cross-sector collaboration, possibly through establishment of a multi-stakeholder working group
- Mandating primary care networks to have conversations (Long-Term Care and Assisted Living facilities could require residents to have ACP)
- Providing incentives for professionals and the public to engage in ACP

3.6 TRANSPORTATION, MOBILITY, AND PHYSICAL ACCESS

Transportation, Mobility, and Physical Access to resources and services is widely recognized as a priority for seniors to combat isolation and to age-in-community ([2]) ([3]) ([12]) ([15]) ([21]) ([24]) ([27]). Challenges related to inadequate transportation options and barriers to mobility and physical access include:

- Impacts on driving ability
- Loss of independence
- Isolation
- Reluctance to dealing with the public transportation system
- Difficulty scheduling and attending appointments
- Imposition on caregivers
- Inability to access medical and other services (e.g. grocery store, doctor's office)
- Inability to engage in social and religious activities
- Costs associated with above.

Winter presents a particular challenge for seniors due to increased risk of falls and problems with accessibility in pedestrian environments ([2]) ([3]) ([18]). Design of outdoor spaces and public buildings is also an important factor in seniors' participation in community and should support seniors' mobility and access ([3]) ([12]) ([21]).

Needs and recommendations to address general barriers to transportation, mobility, and physical access include:

- The provincial government to **continue its review of how transportation for seniors can be improved** across the province to give equal access to services for seniors where they live. ([21])
- **Community and neighbourhood planning should include older adult-friendly design and amenities**, such as walkable and safe access to amenities and health services at close proximity to communities. ([15])
- In recognition that many seniors continue to drive as their primary mode of transportation, **resources to support older drivers as they age should be provided and promoted** ([3]).

- **Access to information on transit options should be facilitated**, and transit training should be provided. ([3]) This includes ensuring that convenient parking at publicly accessible buildings, parks, and other public places is available ([12]).
- **Address the need for affordable transportation** by promoting affordable taxis and working with transit partners on sliding scale fees ([3]).
- **Timely ice and snow control measures** should be ensured to improve physical access on sidewalks and pathways, especially to locations serving older adults ([3]) ([12]).
- **Availability of public washrooms** should be improved ([12]).
- **Recognize transportation is vital to seniors' wellbeing by prioritizing it in budgets** similar to healthcare and housing ([24]).

3.6.1 Alternative Transportation for Seniors (ATS)

Development and promotion of Alternative Transportation for Seniors (ATS) is an identified need to meet increasing demand for options aside from private vehicles and public transportation as Alberta's population ages. ATS needs differ for each community based on the resources available, existing relationships, skills and assets, and funding within a community ([2]).

Approaches identified to develop community-specific ATS:

- **Learn what the transportation needs of seniors in the community are**, as well as what are the transportation needs of those who serve seniors in the community (healthcare providers, caregivers, community services providers) and identify resources available in the community. ([2])
- **Foster collaboration and partnerships to obtain community engagement and leadership**, for potential funding, and to ensure organizational stability. Demonstrate commitment to serving the needs of the target populations by engaging stakeholders throughout the process ([2]).
- **Ensure that transit drop-off and pick-up locations are able to accommodate accessible vehicles** ([3]).
- **Consider what is needed to accommodating people with cognitive and mobility challenges**, as well as special sensory abilities (i.e. Issues with vision, hearing, motor, voice, cognition, and touch) ([24]) ([2]).
- **Consider seniors sensitivity training for individuals providing ATS services** ([2]).
- **Determine where sustainable funding will come from**. This could include fee for service, sponsorships, community partnerships, etc. ([2]). Funding also includes addressing the lack of dedicated operational core funding which compromises ATS sustainability and puts vulnerable users at risk of isolation and poor quality of life ([24]).
- **Promote the 5 A's of senior friendly transportation** outlined by the Beverly Foundation ([2]) ([3]):
  - **Availability** (refers to transportation services that are provided to seniors and those services are available when needed (e.g., days, evenings; weekdays, weekends).

- **Acceptability** (refers to transportation in which service quality is acceptable in terms of advance scheduling; vehicles are clean and well-maintained; service providers provide driver 'sensitivity to seniors' training.)
- **Accessibility** (refers to transportation in which the service provider provides 'door-to-door' and 'door-through-door' transportation; provides transportation to essential and non-essential activities.)
- **Adaptability** (refers to transportation that can accommodate riders wanting to make multiple stops (trip chaining); service providers allow for different types of routes (fixed vs. user response) and passenger service (single vs. group); service providers can accommodate wheelchairs and walkers; escorts can be provided.)
- **Affordability** (refers to transportation services being provided at the lowest possible cost; services provided are affordable to senior passengers and to the community; seniors are aware of the true cost of the transportation services they receive.)

Gaps were identified in a report produced by the Edmonton Seniors Coordinating Council on support for ATS ([24]):

- **Address capacity issues**. Demand for ATS is exceeding existing providers' ability to expand.
- **Clarify the licensing requirements** for ATS providers and volunteer drivers.
- **Address the gap between costs and low-income seniors' ability to pay**. Subsidies are needed.
- **Partnerships are needed** with providers of housing and other seniors' services who are positioned to assess seniors' transportation needs, and who can serve as hubs for information, referral, and access to subsidies.
- **Resources are needed** for facilitative support to enable collaborative efforts among partners serving seniors.
- **Address tendency for policymakers and senior-serving organizations to put low priority on seniors' access** to appropriate transportation.

Note: A number of technological solutions related to transportation and mobility are listed in the Technology section of this report.

3.7 HOUSING

Seniors' housing needs is a priority municipally ([3]) ([12]) ([15]) and provincially ([13]) ([6]) in Alberta, and at the federal level in support of Canada's National Housing Strategy ([25]) ([38]). Needs identified in this review that relate to seniors housing have been divided into two distinct groups:

1. **Housing Options Needs:** A range of options in types of housing is needed to accommodate the diversity of seniors in Alberta. Consideration also must be given to the fact that individual seniors' housing type needs will change as they age and experience health, income, and social transitions.
2. **Home Supports Needs:** Seniors who stay in their homes as they age often require support services related to maintenance of their home, which helps enable them to age-

in-community and retain independence as long as possible. This includes services such as home and property maintenance, assistance with financial tasks such as bill payments, and retrofitting homes for accessibility.

Note: While they are distinct categories, there is a connection between seniors' housing needs and seniors' income and financial needs. Financial needs and affordability are important factors that determine what housing options and home supports are available to seniors ([3]) ([12]).

3.7.1 Housing Options Needs

Despite a preference to age in one's current home, many seniors need to seek other housing options as their physical, mental, and financial situations change ([3]). The physical condition of housing facilities (including those not for seniors) has been in decline since 2014, and senior-led renter households in Core Housing Need[1] increased from 33% in 2001 to 45% in 2016 ([13]). While the provincial government is working to address this, multiple jurisdictions have identified a growing insufficiency of adequate and affordable housing options for seniors, and for services that allow them to age-in-place ([12]) ([13]) ([17]) ([19]). Home design and layout can also pose a challenge. Inability to access areas of the home such as an upstairs bathroom or an emergency escape route, and designs that don't accommodate wheelchairs, lifts and other aids, can put seniors at risk. ([18]) The literature contained a number of needs to address for seniors' Housing Options.

Suggestions for the role all housing providers could play (not only those who build purpose-built seniors housing) included:

- **Change policy to increase affordable housing supply** ([3]).
- **Facilitate and develop alternative or innovative housing options** (e.g. co-op, co-housing, home sharing, Abbeyfield, cottage housing, college students living in seniors' residences, daycares in seniors' facilities, repurposing unused buildings.) ([3]).
- **Support the development of legal secondary suites**. ([3]).
- **Increase the standards for building accessible units** from 10% to 15% of provincially funded affordable housing and incentivize accessible housing development for home builders ([3]).
- **Require subsidized seniors housing buildings, supportive living facilities, and long-term care centres to be located in the communities where older adults live**, and incentivize of building more assisted-living facilities in local communities as an alternative for older adults to age in their own homes, to help maintain social support and networks ([3]) ([15]).

[1] Core Housing Need: A household that is in housing that is unsuitable, inadequate, or unaffordable, and that can't pay the median rent of alternative local housing that meets all three criteria (Source #28).

Additional suggestions:

- **Enable service providers that work with seniors to educate older adults and home buyers with accessibility needs** about the options available. ([3])
- **Improve access to programs and services** that provide assistance for older adults for costs that affect housing affordability, including home maintenance, utilities, and property taxes. ([3])
- **Advocate for an increase in affordable housing** that meets the needs of immigrant and refugee seniors ([19]).

3.7.2 Home Supports Needs

Retaining and maintaining housing is one of the top issues Albertans contacted the Office of the Seniors Advocate about from 2016-18 ([6]). It is a key outcome of Alberta Seniors and Housing that seniors have access to programs, services, and supports that help them live safely and independently in their chosen communities, and exploring the role of accessible housing and community supports in facilitating aging at home and in community is a current priority for the FPT Ministers Responsible for Seniors Forum ([13]). The following was identified by Age-Friendly Edmonton as **top needs for seniors' Home Supports** ([15]):

- **Programs to help older adults retrofit their homes**, through do-it-yourself tutorials, and financial assistance. ([15])
- **Assistance in finding qualified help** to provide home supports ([15]).
- **Assistance with the cost of home supports services**. ([15])
- **Services and support home and yard maintenance** including mainly mowing, snow removal, everyday housework, going to appointments, grocery shopping, meal preparation or delivery, and errands. ([15]) The most common loans funded under Alberta's SHARP program were for essential home repairs and adaptations (i.e. home roof repairs, furnaces, etc.) ([13]).

3.8 RURAL SENIORS

A Rural Health Services Review was conducted by the Government of Alberta ([38]). Below is an overview of the review findings that are relevant to the needs of seniors, including recommendations made to address these **needs**.

- **Enabled to age-in-community**. Like their urban counterparts rural Albertans want to be able age-in-community, and seniors are rapidly becoming the largest segment of many rural communities. Distance is the main determinant in rural seniors' access to health care services. Addiction and mental health services are in high demand for the rural elderly, and in rural and remote locations, individuals with psychiatric illness often choose to forego treatment, relapse or become unstable, and ultimately need emergency care, which places increased demand on EMS services. Additionally, staff at many rural hospitals report variable levels of training to deal with mental health crisis episodes.

- **Need for reliable transportation and increased access to and use of telemedicine**, which involves linking patients to health professionals via audio, video, and/or patient monitoring technology, was discussed by most communities.
- **An infrastructure need for more supportive living**, home care, long-term care, and supports for rural seniors to age-in-place.

Recommendations to address infrastructure barriers to healthcare access for rural seniors:

- **Conduct a full inventory of existing facilities province-wide** and, in consultation with communities, evaluate their potential for re-purposing or optimized utilization to enhance health care service delivery for local residents.
- **Fully integrate long term facility usage plans** in cooperation with communities as part of community health service planning.

Recommendations to address the need for continuing care of rural seniors:

- **Increase resources dedicated to home care, respite care, and supports for caregivers**. Encourage caregivers to offer (where appropriate) the option of services or care to be provided in a home setting (e.g. dialysis, chemotherapy).
- **Acknowledge that family members often act as care providers and allow program eligibility/criteria to support this role both financially and emotionally**.
- **Establish future living facilities that have flexibility to allow residents to age in place as care needs change/increase.** Work with existing lodge/continuing care facilities to explore potential for offering additional capacity to care for patients at the SL3, SL4 and SL4D levels of care.
- **Encourage communities to share best practices to enhance non-medical social supports** to assist seniors to age in place.
- **Increase the coordination and availability of mobile services** in the community and primary care services being available on scheduled days within a facility.
- **Provide additional options for community-based end of life care** through increased palliative care and hospice capacity.

Recommendations to address transportation and telehealth barriers to healthcare access for rural seniors:

- **Develop an overarching patient-centered strategy focused on minimizing the need for patients to travel to receive specialty consultation**. Encourage patient care planning to include greater consideration of distance between caregiver and patient as well as the patient's ability to travel.
- **Re-evaluate currently utilized options for patients to travel back to their community** and actively discourage unnecessary use of ambulance transfers for this purpose.
- **Mandate that PCNs provide services closer to patients** as opposed to using a single centralized location to serve large geographic areas.
- **Examine various models in use for publicly accessible transportation** and consider support for regional or community-based public transportation systems.

- **Monitor, measure, and incent increased utilization of telemedicine technology**. Investigate developing technologies for in-home communication and monitoring. Remove current barriers preventing increased utilization of telemedicine as an option for linking rural residents with needed health care services.

In addition to the recommendations in the Rural Health Services Review summarized above ([38]), the Transportation Toolkit produced by the Medically At Risk Driver Centre of the University of Alberta ([2]) identifies that transportation modes outside traditional ones (i.e. private vehicles and/or public transportation) is a particularly important need in rural areas where other transportation is not available, and suggests the development of Assisted Transportation for Seniors (ATS) in these areas. ATS is discussed more in-depth in the Transportation, Mobility, and Physical Access section of this report.

4 SENIORS INCOME AND FINANCIAL SITUATIONS

Many issues faced by seniors and organizations who work with them are exacerbated by financial constraints. Financial limitations create many barriers to meeting needs such as access to housing and home supports ([3]) ([12]), ability to participate in community ([20]), access to transportation, and access to health care services ([3]) ([12]) ([24]).

Provincial resources currently put toward addressing seniors' financial needs include: Alberta Seniors Benefit, Special Needs Assistance, Aging Well in Community grant program, Housing Support, etc. ([13]). Also, large proportion of seniors' income comes from federal sources (followed by private pensions and employment income). An identified potential risk that could affect the incomes of seniors is changes to funding levels, eligibility requirements, or support by other orders of government, and/or the occurrence of natural disasters ([13]). Income and financial supports (primarily assistance with applications for Government Pension benefits) are one of the top four issues brought forward to the Office of the Seniors Advocate Alberta in recent years ([6]) ([7]).

C**hallenges related to senior's income and financial issues identified**:

- The Alberta Council on Aging 2019-2024 Strategy highlights that **current supports for seniors are often based on a means test which looks at income** but fails to consider other expenses ([21]).
- In 2016 it was identified that **dental fees in Alberta were unregulated and higher than most western Canadian provinces**. **Not all health services covered under the Alberta Health Care system are readily accessible and affordable to those on a fixed income** without supplementary insurance programs ([23]).
- In 2017 it was identified that the **Alberta pensioner's annual cost of living adjustment was based on only 60% of the Canadian consumer price index**. This has had a negative impact on pension benefits such as Cost of Living Adjustment, Spousal benefits and the pension calculation ([22]).
- **Financial abuse** is one of the top two most commonly reported forms of elder abuse in Canada ([3]) and identifying measures to reduce crimes and harms against seniors, with a particular focus on financial abuse, fraud and scams is a work priority set by the National Seniors Council ([25]).
- **Income and financial insecurity** are key challenges faced by immigrant and refugee seniors as they often experience low or unpredictable income ([19]).
- Among seniors, **women are less financially secure than men** ([15]).

Recommendations made to address income and financial needs for seniors:

- **Affordable dental, optical and auditory fee structures for retired seniors** in Alberta should be incorporated into the AHC system accessible to all seniors on fixed incomes to ensure maintenance of good health throughout their retirement. Full health benefit coverage outweighs incremental care over the long term. Better quality of life and health will result in lower total social cost ([23]).

- With respect to current supports for seniors, **needs-testing should be used to complement current means tests and relate to individual needs and circumstances**, rather than basing supports on a means test which looks at income but fails to consider other expenses ([21]).
- **Change the current Local Authorities Pension Plan Board plan to incorporate annual increases to 100% of CPI**, rather than the Alberta pensioner's annual cost of living adjustment being based on only 60% of the CPI ([22]).
- **Regulate dental fee maximums and set affordable comprehensive solutions** which are available to all retired seniors on fixed incomes ([23]).
  - Provide comprehensive dental, optical and hearing coverage for retired persons on government income programs at a preset maximum of total benefit similar to accommodation limits (30% of income).
  - Set regulated professional fee structures for all public and private care providers.
  - Provide supplemental graduated incomes for all retirees based on regional cost of living.
- **Increase support for financial literacy initiatives** focused on vulnerable older adults, including the Seniors Financial Empowerment Network ([15]).
- **Support policy changes to increase affordable housing supply** ([3]).
- **Improve access to programs and services for older adults that provide assistance for costs that affect housing affordability**, including home maintenance, utilities, and property taxes ([3]).
- **Address the issue that program funding is often age-specific**, which creates barriers for intergenerational programming ([5]).
- **Provide education on Advance Care Planning (ACP) for financial and insurance professionals** in order to promote ACP, which will improve efficiency and cost-shifting within the healthcare system ([26]).
- **Work with transportation partners to offer sliding-scale fees** or seniors' subsidies ([3]).
- **Expand existing seniors outreach programming to address specific barriers faced by immigrant and refugee seniors**, such as financial dependency and precariousness due to isolation and language barriers ([5]).
- **Advocate for the Alberta Seniors Benefit not to be linked to federal Old Age Security benefits** so that immigrant and refugee seniors can benefit from this program ([19]).

5 SENIORS CARE

5.1 INFORMAL CAREGIVING

Across the spectrum of care for seniors, community and family caregivers play an important role. In Canada unpaid or informal caregivers provide up to 75% of care services for older adults living at home ([10]). Caregivers are a key component enabling seniors to stay in their homes longer ([15]), and significantly support the increasing number of older adults with dementia ([8]). However, caregiving often comes at a physical, emotional, and financial cost to the caregiver, and many report high levels of distress ([43]). The burden on caregivers is growing, and there is a need to better recognize the work they do and to provide support they require and information on their rights ([15]) ([40]).

Suggestions to support caregivers include:

- **Create, promote, and maintain a current listing of caregiver peer support networks** ([3]).
- **Explore the opportunity for seniors centres to provide support and resources** to caregivers and promote awareness of these services ([5]).
- **Promote services for the daily needs of seniors who are aging at home**, such as home maintenance services, meal delivery, and physical and mental health services, to support caregiver efforts ([3]).
- **Provide support for family caregivers of older adults**, and older adults caregiving for younger family members ([3]).
- **Ensure adequate support for caregivers** with respect to the psychological, health, financial, and personal consequences they experience ([3]).

5.2 ELDER ABUSE

Preventing and addressing elder abuse is a named priority of the Alberta Ministry of Seniors and Housing ([13]), and of the National Seniors Council ([25]). Although many cases are thought to go unreported, the two most commonly reported types of elder abuse in Canada are emotional and financial, and it is often committed by a person in a position of trust. Older adults who experience isolation, language barriers, and cognitive impairment may be at greater risk and face additional challenges to reporting ([3]).

Identified ways to address elder abuse include:

- **Identifying measures to reduce crimes and harms against seniors**, with a particular focus on financial abuse, fraud, and scams ([25]).
- **Improving access to information and services to identify, prevent, and respond to elder abuse** ([3]).
- **Inter-agency/multi-sector approach**: Collaboration with adult service providers and building community partnerships to promote public and professional awareness. This could include a coordinator role, funding, reporting, and monitoring ([3]) ([21]) ([28]).
- **Influencing legislation for increased protections of older adults** ([21]).

The Alberta Elder Abuse Awareness Council whose mission is to increase awareness and support community response to elder abuse, has identified the following **specific goals** ([28]):

- **Strong Marketing and Communications Strategy**
  - Develop and implement communications plan about the work of the Council.
  - Develop and implement a marketing plan about the work of the Council, and about the social issue of Elder Abuse.
- **Be a knowledge broker** to inform, educate, and connect communities to better respond to elder abuse
  - Host a 2019/2020 Elder Abuse Conference
  - Be a leader with World Elder Abuse Awareness Day (WEAAD) in AB
  - Be the hub for provincial resources on elder abuse
- **Make Albertans equipped to recognize, refer, respond, and reconnect** when dealing with elder abuse issues
  - Maintain and grow NFF (Neighbours, Friends and Families of Older Adults)
- **Address staffing needs**, board development, membership and sustainability.
- **Work closely with government and/or strategic partners** to strategically address current and emerging elder abuse issues:
  - Link to family violence groups and build connections
  - Strengthen relationships with GoA and other levels of government
- **Develop relationships with other potential partners and corporate sponsors**.

With respect to elder abuse in rural areas, the Town of Hanna has developed an Elder Abuse Prevention and Response Service Guide ([29]) which may be instructive to other rural communities where senior isolation and access to information and services is known to be a challenge. The guide builds off of resources provided in Alberta's Screening Guide for Service Providers on Elder Abuse ([36]), with expanded resources and contacts local to the Hanna area, tips on prevention, and education on risk factors.

5.3 PRIMARY CARE AND ACUTE CARE

Having transportation or being close to a physician and medical services is a need for seniors to age-in-community ([2]) ([15]). Additional areas for improvement that have been identified include affordable dental services, affordable general health services, and available family practitioners ([12]).

Specific to acute care, the Seniors Strategic Clinical Network is focusing on promoting elder-friendly care. In support of this: 12 acute care sites have implemented strategies to enhance the inpatient care of older Albertans; a provincial Delirium Toolkit was developed; an Elder-Friendly Care strategy is currently being developed, and three Partnership for Research and Innovation in Health Systems Grants have been awarded ([35]).

5.4 CONTINUING CARE

Alberta has an extensive continuing care system with the following levels of care ([45]) available to Alberta seniors based on assessed needs:

- **Home Care**: provides personal and health services for clients of all ages living in their homes or other private residential settings
- **Supportive Living**: type of continuing care accommodation where people remain as independent as possible in a homelike setting while they have access to services that meet their changing needs
- **Designated Supportive Living**: a type of supportive living that requires individuals to be assessed by a health professional to assess their unmet care needs. Professional health care services and personal care assistance are publicly funded, and facilities are operated either directly by Alberta Health Services (AHS) or by contracted care providers.
- **Long Term Care**: type of continuing care accommodation for people with complex medical needs who are unable to remain safely at home or in a supportive living accommodation. Long term care is provided in nursing homes and auxiliary hospitals. Long term care services are publicly funded, and facilities are operated either directly by Alberta Health Services or by contracted care providers.

5.4.1 Community-Based Continuing Care

Over the years, a number of studies have been conducted to examine and innovate in the field of continuing care for seniors. One of the major initiatives has been to prioritize community-based care options for seniors. Alberta Health Services in their 2018-19 Annual Report ([46]), reported on their progress in placing people in continuing care within 30 days, a measure that monitors the percentage of people who are quickly moved from hospitals and communities into community-based continuing care. In 2018-19, at the provincial level, 58% of people were moved from hospitals and communities into community-based continuing care.

Other statistics in the 2018-19 annual report provided the following statistics:

- **127,214 unique/individual clients received home care in 2018-19**, an increase of 4.3 % (121,929) from 2017-18
- **6,711 respite home care clients were served in 2018-19**, up from 6,372 (2017-18)
- **4,591 adult day program clients were served in 2018-19**, up from 4,287 (2017-18)

The AHS annual report states “To keep pace with population growth and aging, AHS needs to target increasing community capacity by 800-1,000 designated spaces annually.”

5.4.2 Long Term Care Living

The Health Quality Council of Alberta ([47]) conducted a survey in 2017 with family members of residents in long-term care about their experiences with the quality of care and services. 7,562 family members of residents living in 172 long-term care facilities were surveyed, with a response rate of 64%.

The “fast facts” were documented as follows:

- Family members rated overall care at their facilities at an average of 8.4 out of 10. Individual facility scores ranged from 6.6 to 9.7 out of 10.
- The majority of facilities did not show any significant improvement or decline in each of the key measures of care and services since the 2014 survey.
- On average, 93 per cent of family members would recommend their facility to others.
- Family members’ top recommendation for improvement was to ensure enough staff are available to meet residents’ care needs and their job responsibilities. Only 18 per cent of families said there were always enough nurses and aides.
- On average, smaller facilities have more positive family member experiences than at larger facilities.
- Individual facilities receive detailed facility-level reports to learn about areas they are doing well, and areas for improvement.
- Over the past 10 years, there have been no significant changes between each survey cycle.

The areas measured and the provincial results were based on a score out of a possible 100; the higher the score, the more positive the family experience. The following table shows the scores:

Areas of Care and Services	Provincial Score (out of 100)
Staffing, care of belonging and environment	**75** (range 59-91)
Kindness and respect	**85** (range 68-99)
Food rating	**72** (range 47-88)
Providing information and encouraging family involvement	**84** (range 65-97)
Meeting basic needs	**90** (range 67-100)

The findings showed no statistically differences in family experiences with the overall care rating across operator types (AHS, private and voluntary).

The National Institute on Ageing (NIA) ([51]) is a public policy and research centre based at Ryerson University in Toronto, dedicated to enhancing successful ageing across the life course. The NIA published a report, Enabling the Future Provision of Long-Term Care in Canada as the inaugural report in a three-part 2019 policy series addressing the future of long-term care in Canada.

The NIA defines long-term care as a range of preventive and responsive care and supports, primarily for older adults, that may include assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) provided by either not-for-profit and for-profit

providers, unpaid caregivers in settings that are not location specific and thus include designated buildings, or in home and community-based settings. In its report, the NIA described some of the current realities facing Canada as it deals with the rapidly growing needs of the Canadian ageing population:

- **Unmet home care needs and waitlists for nursing home.** Over 430,000 adult Canadians were recently estimated to have unmet home care needs (Gilmour, 2018b), while over 40,000 Canadians are currently on waitlists for nursing homes, in part, due to a lack of available home and community-based care.
- **Right service mix to address diverse needs.** Finding the right mix of publicly desired, clinically appropriate, and cost-effective services delivered across a variety of settings to a population with an increasing diversity of needs, abilities and challenges.
- **Strained health budgets and increasing complexity of older adults**. Dealing with the growing demand and necessity to provide more long-term care to Canadians within the confines of increasingly strained health care budgets and limited household means, exacerbated as Canadians are living longer with more complex health, social, and functional issues than any previous generation.
- **Long-term care spending challenges**. While long-term care spending is increasing, it has not kept pace with most of the nations in the Organization for Economic Co-operation and Development (OECD). Related to this is the lack of clarity on where the private and public provision of services being and end and what amount and types of long-term care can and will be publicly-supported.
- **System access and financial and caregiving limitations**. Older Canadians, their families and caregivers find it challenging to access the right care and supports when they need it, with a majority reporting their families are not in a good situation, financially or otherwise, to care for their older family members if they were to need long-term care.
- **Lack of a commonly accepted definition of long-term care** across Canada.

Current challenges articulated by the NIA were summarized as:

- **Expectations, system navigation challenges and preparation.** Canadians' struggle in understanding what to expect from and how to navigate publicly supported long-term care services and how best to prepare for their own needs.
- **Inadequate flexibility and choice in current care**. Current care is not seen as offering the level of flexibility and choice that is needed to meet the needs of an increasingly diverse population.
- **Caregiver and unpaid caregiver needs.** Care providers and unpaid caregivers have unique needs that need to be better recognized to attract these individuals to meet the growing and evolving care needs of the ageing population.
- **Unmet needs for long-term care**. Delivery of long-term care across Canada remains inadequate and challenging with unmet home care needs, waitlists for nursing homes, resulting in thousands of Canadians waiting in expensive hospital settings as Alternate Level of Care (ALC).

- **Lack of federal standards for long-term care.** No established federal standards for long-term care across Canada, resulting in a range of programs and variations in services, public funding levels, eligibility criteria and out-of-pocket costs for clients and residents.

The NIA noted that despite the challenges, a host of new innovative policies, models of care and approaches are being implemented in the provision of long-term care, based on regional priorities.

Emerging Enablers and Opportunities. The NIA also described four emerging enablers and opportunities:

- **Enabling evidence-informed integrated person-centred systems of long-term care**, accounting for the expressed needs and desires of Canadians.
- **Supporting system sustainability and stewardship** through improved financing arrangements, a strong health care workforce, and enabling technologies.
- **Promoting the further adoption of standardized assessments and common metrics** to ensure the provision of consistent and high-quality care no matter where Canadians need it.
- **Using policy to enable care** by presenting governments with an evidence-informed path towards needed reforms.

5.4.3 Role of Healthcare Supports in Continuing Care

Healthcare supports, primarily related to Continuing Care was one of the top four issues seniors referred to the Office of the Senior Advocate Alberta between 2016 and 2018 ([6]).

Support to live safely at home, close to friends and family, while receiving appropriate care and support services is a priority of the Seniors and Continuing Care Provincial Advisory Council 2018-2020 Work Plan ([27]).

5.5 MEDICATION MANAGEMENT

A key focus of Alberta Health Services Seniors' Strategic Clinical Network (SSCN) in recent years has been appropriate prescribing of medications for older adults ([35]). Long-term use of antipsychotics in older people with dementia is known to be harmful, and Appropriate use of Antipsychotics (AUA) began to be addressed by SSCN in 2013 ([33]). Today, a significant reduction in the use of antipsychotics has been achieved in Long-Term Care as well as Supportive Living Facilities ([35]). As of June 2019, the SSCN has struck a committee to begin addressing the need for an Appropriate Prescribing and Medication Use Strategy Among Older Albertans ([35]).

Between 2014 and 2018, the College of Physicians and Surgeons of Alberta, in a joint communication with the Alberta Medical Association, produced a series of articles written by physicians on issues related to prescribing medication for older patients ([34]). While these are not necessarily representative of the most pressing or high priority topics regarding medication management for older adults, they may provide some indication of areas of interest. The following are the article titles:

- Deprescribing PPIs: Do I still need the acid-reducing pill? (2018)
- Use and misuse of benzodiazepine in the elderly (2018)

- Managing Osteoporosis in the Very Old and/or Those living in Long-Term Care (2018)
- Is there a role for antipsychotic use in dementia? (2017)
- "Doctor, I'm taking too many pills": Tackling therapeutic competition in the elderly (2017)
- Is it an asymptomatic bacteriuria or a urinary tract infection? (2017)
- Management of Chronic Non-cancer Pain in Older Adults (2017)
- Pharmacological treatment of urinary incontinence in the elderly (2017)
- Statins in the Elderly (2017)
- Anti-depressant use in later life depression (2016)
- Hypertension in the elderly: Balance known benefits of treatment against the risks (2016)
- The DOACs: Look at individual patient characteristics (2016)
- "I can't sleep": Managing insomnia in the older adult (2016)
- Using Medication Reconciliation (MedRec) to optimize medications for seniors in the family physician's clinic. (2016)
- The association between medications and fall risk (2016)
- Polypharmacy: Appropriate and Problematic (2015)
- The flu vaccine: Why its efficacy outweighs its risks (2015)
- Pharmacological factors and falls in the elderly (2015)
- Medication management: Recognizing anticholinergic effects (2015)
- Tackling GERD (common and atypical symptoms) in older patients (2015)
- HgA1c targets and use of agents for diabetes in older adults (2015)
- Medication reviews in long-term and supportive care living: A physician's perspective (2014)
- Sedatives hypnotics and risk for adverse events (2014)
- When to stop medications in the care of older patients (2014)
- What does the evidence say about the risks and benefits of the atypical antipsychotics in dementia? (2014)

5.6 MEDICAL ASSISTANCE IN DYING (MAID)

Medical Assistance in Dying (MAID) is a recent occurrence in Canada. In February 2016 court orders made MAID possible, and in June 2016 federal legislation removed the need to attain a court order prior to undergoing MAID ([11]). MAID is pertinent to the discussion of seniors' needs because the average ages of people receiving MAID across the health zones in Alberta ranges from 68 to 72 years old ([11]).

Initially there was variation in the monitoring and reporting requirements nationally, which resulted in inconsistent collection of data. However, regulations for a new federal monitoring and reporting system for MAID were published in August 2018, and practitioners are now working to bring policies in alignment ([31]). Alberta Health Services immediately revised their MAID policy, likely in response to the new requirements (117).

Since 2016, available data on MAID from Alberta Health Services ([11]):

- 775 total MAID activities occurred in Alberta ([11]):
  - 279 in Calgary Health Zone
  - 283 in Edmonton Health Zone
  - 87 in the South Health Zone
  - 77 in the Central Health Zone
  - 50 in the North Health Zone
- Cancer is the most commonly reported underlying medical conditions of MAID recipients
- Most MAIDs occur in hospitals and health-care facilities, followed by the patient's home, then Long-term Care Facilities/Nursing Homes
- 106 people have been transferred from faith-based or non-participating sites to either a participating facility or the patient's home to receive MAID

In November 2018, the College of Physicians and Surgeons of Alberta produced advice to the profession regarding MAID ([30]), which stated the following:

> "Physicians have a Charter right to freedom of conscience and religion, as do all Canadians. A physician's conscientious objections must not impede the right of patients to receive unbiased information about and access to legally permissible and available health services. Refer to the Conscientious Objection standard of practice.
>
> - Physicians' communication and behaviour must be respectful of their patient's beliefs, lifestyle choices and values.
> - Physicians have an obligation not to abandon their patients.
> - Physicians who decline to provide a legally available medical service or information about that service due to conscientious objection are expected to offer the patient timely access to another physician or resource that will provide information about all available medical options.
> - Physicians must not provide false, misleading, intentionally confusing, coercive or materially incomplete information."

In 2019 the Canadian Association of MAID Assessors produced a white paper on the complications with MAID in the community ([39]).

Recommendations made to manage MAID:

- All patients undergoing MAID in the community should have documentation outlining their request and consent for the provision available at the time of the provision. Patients should also have an up-to-date provincial Do Not Resuscitate form available, or equivalent order signed by them and their physician or nurse practitioner, to prevent attempts at resuscitation should attendance or transport by emergency medical services (EMS) be required.
- Discussion of potential complications should be a routine part of the consent process when discussing the MAID provision with patients.
- Clinicians should obtain consent from patients prior to the initiation of MAID for any therapies that may be required should a complication occur (e.g. conversion from oral

self-administration to IV in the setting of delay, or the need for an unexpected transfer to hospital).

- For MAID provisions in the community, physicians and nurse practitioners who do not insert IVs as part of their regular practice should be accompanied by another clinician experienced in inserting IVs, in the absence of a peripherally inserted central catheter (PICC). The need for a functional PICC should be considered based on physical examination prior to the provision. Port-a-cath devices can be considered for access by experienced clinicians. Midline catheters are less secure than PICC's, and their function should be confirmed before use. Intraosseous infusion (IO) requires technical expertise and regular experience and is not recommended electively for MAID.
- For oral self-administered MAID, clinician presence at the provision is recommended to intervene with IV medications to complete the MAID provision in case of delay or complications with the oral preparation.
- Clinicians should know their contingency plan for failed vascular access or administration of medications prior to starting any provision. This plan will vary depending on local context. If clinicians are unable to establish IV access prior to the administration of medication, provision should be deferred until such time when non-emergent help can be obtained.
- If a complication occurs with either IV or oral self-administration, and clinicians are unable to obtain subsequent IV access, clinicians should decide whether the patient's condition allows for another clinician to be called to the scene to aid in obtaining access. Technical proficiency from regular practice and routine use is mandatory before considering intraosseous infusion emergently for a MAID complication.
- If a patient's condition does not allow for another clinician to come to the scene and it is decided that the patient requires immediate IV access, the clinician may have to call EMS (i.e. 911).
- If 911 is called, the clinician should request EMS to insert an IV and release the patient on scene, and/or ask them to call their online medical director for a similar order.
- If EMS are unable to insert an IV or to release the patient on scene (or refuse to do so), the clinician providing MAID should accompany the patient to hospital to help direct further care.
- Should a patient present to an emergency department as a result of complications of MAID in the community, and the validity of the MAID process can be confirmed to the satisfaction of the care team, it is appropriate to provide supportive and symptomatic care without attempts at resuscitation or overdose reversal. Further administration of medications to hasten death should only be considered by the clinician who assessed and obtained the consent for MAID."

6 DEMENTIA

6.1 ALBERTA DEMENTIA STRATEGY AND ACTION PLAN

In 2002 Alberta Health produced a provincial strategy primarily focused on providing advice to key stakeholders in the planning of continuing care services for people with Alzheimer's. In 2017 the approach evolved into a new strategy ([8]) to address the broader need of the new realities of dementia that dementia's impact on society as a whole has become more evident, the number of Albertans with dementia has increased, and the desire to receive care and support in a patient's community has increased. The new strategy also highlights that there are gaps in services and program delivery across both health and social systems ([8]).

Identified needs related to seniors and dementia include:

- **Advancing dementia diagnosis and management**, identified by the Health Strategic Clinical Network ([35]).
- **Providing assistance to those seeking support**, identified by the Office of the Senior Advocate of Alberta ([7])
- **Recognition that the challenges of dementia are compounded for marginalized groups**, including. ([8])
  - Members of Indigenous populations;
  - Albertans for whom English is a second language and those who don't speak English;
  - Lesbian, gay, bisexual and transgender Albertans;
  - Those who live in rural and remote areas;
  - Albertans living in poverty or experiencing homelessness; and
  - Those who have mental illnesses and/or developmental disabilities.

The provincial **Dementia Strategy and Action Plan identified four 'outcomes' or goals** ([8]).

1. **That Albertans understand the impact of dementia and actively work towards optimal brain health**. Examples of actions to support this are:
   - Develop and implement public awareness activities
   - Develop awareness program for Albertan employers
2. **That Albertans living with dementia and their caregivers are supported in communities**. Examples of actions to support this are:
   - Enhance and expand the variety of health and social supports available, including respite
   - Promote age- and dementia-friendly Alberta
   - Ensure available mental health and behavioural supports
   - Review provincial policies affecting persons with dementia and caregivers re: financial impact and needs.

Note: Caregivers did an estimated 18 million hours of unpaid care to Albertans with dementia in 2018. Community support to be more inclusive and welcoming of individuals with dementia and their caregivers is vital.

3. **That Albertans living with dementia and their caregivers receive timely recognition, diagnosis and clinical management through primary healthcare, supported by specialized services**. Examples of actions to support this are:
    - Engage with primary care teams, specifically physicians, to review needs for enhancing recognition, diagnosis, and management across the continuing care continuum (incl. end-of-life)
    - Promote Advance-Care Planning
    - Implement best practices in primary care, acute care, and continuing care settings
    - Expand availability of specialist consultation services, especially to rural communities
4. **That Albertans living with dementia and their caregivers experience timely, accessible, integrated and high-quality care and services**. Examples of actions to support this are:
    - Ensure Albertans have access to knowledge and a key contact to help them navigate the health and social system continuums
    - Improve transitions between community and care systems
    - Improve access to restorative and rehabilitative care across the community, acute and continuing care systems
    - Promote evidence-informed care and service planning that emphasizes living well with dementia
    - Encourage the appropriate use of medication for seniors, including appropriate use of anti-psychotic's initiative.

The **Dementia Strategy and Action Plan also named three 'enablers'** which address the system changes that are needed to ensure high quality dementia care and services ([8]).

1. **Research, Technology, and Knowledge Transfer**. This would involve developing and implementing a dementia research framework for Alberta and implementing promising innovations in care.
2. **A Trained and Supported Workforce**. This would involve working with stakeholders to develop core competencies in dementia care and embed these into educational programs, expanding access to education and training programs for all members of the workforce, and better understanding Alberta's workforce, considering the current and future needs of persons living with dementia.
3. **Monitoring and Reporting**. This would involve implementing the Alberta Dementia Action Plan, which details process for achieving the recommendations of the Alberta Dementia Strategy.

In 2019 the province issued a progress report on the Dementia Strategy and Action Plan and outlined the following next steps to addressing dementia in Alberta ([14]).

1. **Reduce stigma and creating supportive communities by:**

- Supporting community partners to raise public awareness on the importance of brain health.
- Enhancing respite and support services for caregivers, including the creation of more adult day program spaces.
- Supporting the completion of a Dementia Friendly Toolkit for Alberta communities interested in becoming dementia friendly.

2. **Providing more timely recognition, diagnosis, care and support by:**
   - Increasing the availability of dementia information and resources for health-care providers.
   - Releasing a provincial strategy and work plan for appropriate prescribing and medication use for older adults, including those living with dementia.
3. **Providing accessible high-quality care by:**
   - Continuing to work with designated supportive living and long-term care partners to sustain the progress already made on the appropriate use of antipsychotic medications.
4. **Supporting research and workforce by:**
   - Finalizing and beginning to implement the dementia research framework to guide and inform dementia research in Alberta.
   - Updating the health care aide provincial curriculum to align with the new health care aide competency profile, in consultation with experts and stakeholders.
5. **Continuing to monitor and report:**
   - Develop and share information on new, emerging and innovative activities around the Alberta Dementia Strategy and Action Plan.
   - Continue to work with the dementia strategy's implementation and monitoring committee to ensure oversight and support.

With respect to advancing dementia diagnosis and management in Alberta, the Seniors Health Strategic Clinical Network is pursuing the following activities:

- Completed the Primary Health Care Integrated Geriatric Services Initiative (PHC IGSI) in 2018, having engaged 6 primary care networks and 9 communities (109).
- Alberta Dementia Research Futures (Nearly complete as of April 2019 ([35]).
- Made dementia resources available for primary healthcare providers and the public by setting up a dementia advice line and posting dementia resources online for public and clinicians ([35]).
- Supported innovation in dementia care through community grants. Eight grants have been awarded for people impacted by dementia. ([35]). A new $1 million grant is in-place. The call for proposals had not been issued as of June 2019 (109).
- Began the Pain and Depressive Mood Quality Improvement Project; as of June 2019 ([35]):
  - Early adopter sites being identified via expression of interest
  - Content being identified for presentation at Learning Workshops planned for fall 2019
  - Data Working Group reviewing depressive moods quality indicator to better understand the trends and triggers

– Project evaluation framework being developed.

6.2 A DEMENTIA STRATEGY FOR CANADA

In 2019, the Government of Canada published the first national dementia strategy for Canada ([52]). The strategy sets out a vision for the future and identifies common principles and national objectives to help guide actions by all levels of government, non-government organizations, communities, families and individuals. The following table adapted from an exhibit in the report, provides an overview of the key components of the strategy.

VISION	PRINCIPLES
A Canada in which all people living with dementia and caregivers are valued and supported, quality of life is optimized, and dementia is prevented, well understood, and effectively treated.	• **Prioritizing quality of life** • **Respect and value diversity** • **Respect human rights** • **Evidence-informed** • **Results-focused**

NATIONAL OBJECTIVES	AREAS OF FOCUS
Prevent dementia	1. Advance research to identify and assess modifiable risk and protective factors 2. Build the evidence base to inform and promote the adoption of effective interventions 3. Expand awareness of modifiable risk and protective factors and effective interventions 4. Support measure that increase the contribution of social and built environments to healthy living and adoption of healthy living behaviours
Advance therapies and find a cure	1. Establish and review strategic dementia research priorities for Canada 2. Increase dementia research 3. Develop innovative and effective therapeutic approaches 4. Engage people living with dementia and caregivers in the development of therapies 5. Increase adoption of research findings that support the strategy, linking clinical practice and through community supports
Improve quality of life of people living with dementia and caregivers	1. Eliminate stigma and promote measures that create supportive and safe dementia-inclusive communities 2. Promote and enable early diagnosis to support planning and action that maximizes quality of life 3. Address the importance of access to quality care, from diagnosis through to end of life 4. Build the capacity of care providers, including through improved access

	to and adoption of evidence-based and culturally appropriate guidelines for standards of care 5. Improve support for family/friend caregivers, including through access to resources and supports

Five pillars were identified for effective implementation of the strategy ([52]):

1. **Collaboration**: The implementation of the strategy depends on continued collaboration on dementia, including with people living with dementia, caregivers and communities. All governments in Canada and many stakeholders, including care providers, community and social service organizations, researchers and advocacy groups, have a role to play in contributing to the achievement of the strategy's objectives.
2. **Research and innovation**: Canada remains committed to supporting research focused on prevention, therapies, quality of life of those living with dementia and caregivers and, ultimately, a cure. Canada will continue to conduct research, develop innovations, evaluate research findings and promote adoption of the most effective approaches as best practices across the country.
3. **Surveillance and data**: Optimizing dementia surveillance will provide a more accurate picture of the impact of dementia in Canada… and give greater insight into groups within the general population that are more impacted and more at risk and will support better identification of their health needs and those of caregivers.
4. **Information sources**: Valuable information and best practices on dementia exist in Canada and around the world. Efforts to improve access and enhance information resources will broaden awareness and understanding of dementia and support greater health equity. Innovative ways to improve access to information resources will be explored.
5. **Skilled workforce**: Canada's workforce is diverse including researchers who are seeking to understand the causes of dementia, exploring the development of therapies and seeking a cure, as well as health professionals and other care providers who interact with people living with dementia and caregivers. Having a workforce that is well trained and equipped to pursue dementia research and provide quality dementia care is essential.

6.3 THE BRENDA STAFFORD FOUNDATION: DEMENTIA FRIENDLY COMMUNITIES

The Brenda Strafford Foundation in Calgary led a Dementia Friendly Community demonstration project in two pilot locations, Calgary Westhills neighbourhood and the Town of Okotoks ([53]). A Dementia Friendly Community (DFC) provides community-based supports and services through local action for those living with (or affected by) dementia. By being a supportive, inclusive and responsive community, the whole community can benefit, including citizens living with dementia and their caregivers, as well local businesses and service providers in the community.

This two-and-a-half-year project had three goals:

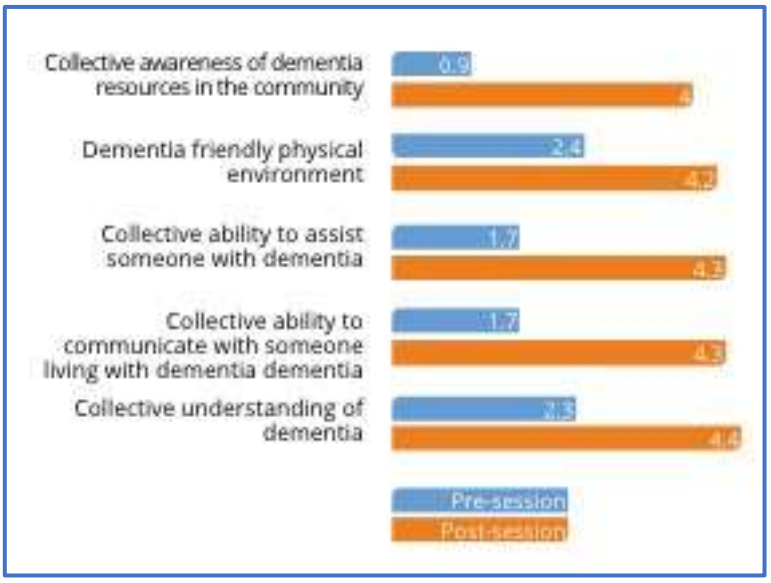
1. **Build community capacity to support individuals living with dementia and their caregivers** to feel included and supported enabling individuals to age- in-place safely in the community for as long as possible
2. **Raise awareness about dementia and reduce stigma** associated with the disorder through education and understanding
3. **Create a toolkit to enable the growth and sustainability of Dementia Friendly Communities** throughout Alberta

The project had a comprehensive implementation plan with several key accomplishments being realized after one year of operation. The following activities and their impact are taken from the Year One Impact Report 2018; the data effective as of April 1, 2018:

- **Community mapping**: to determine existing resources and supports available in the community
- **Partnership development**: partnerships were developed with a diverse range of expert and community stakeholders including individuals, businesses, organizations and service providers to collaborate and provide leadership, skills and resources to drive the initiative forward. **After one-year impact:** Industry sectors reached:
  - Schools
  - Banks
  - Pharmacies
  - Coffee shops
  - Faith centres
  - Recreation Centres
  - Municipal staff
- **Training in community sectors**: Training programs and materials were established, and local businesses and organizations received education to help them understand more about dementia and learn how to respond to situations when they encountered someone with dementia in the community. **After one-year impact**: Sixty-five (65) employees in businesses were trained.
- **First responder engagement and training**: first responders played an important role in keeping those living with dementia safe in the community. **After one-year impact**: 1,482 first responders trained.
- **Public awareness/community events**: community outreach events were held to engage the local community and increase awareness of both dementia and the DFC project and provide information about resources and supports. **After one-year impact**: 30 public awareness/community outreach events with 1,831 attendees
- **Intergenerational work**: Partnerships were built with schools to ensure youth were educated about dementia and equipped with knowledge and understanding at a young age, which helps to promote empathy and reduce stigma in younger generations. **After one-year impact**: 147 students trained

- **Caregiver support**: Building community capacity in a Dementia Friendly Community also included increasing access to resources and services (such as respite care) that support caregivers whose lives are impacted caring for a loved one with dementia.

An example of significant changes in knowledge levels demonstrated through the "Before and After" Evaluation surveys completed at the training sessions are shown in the following exhibit taken from the Year One Impact Report 2018.



7 MARGINALIZED SENIORS

Throughout the literature, specific mention is made about issues faced by seniors are compounded for those in marginalized communities due to the added language, cultural, social, and financial barriers. Mental health can also be impacted, as the added barriers lead to increased feelings of isolation, dependency and lack of agency, and overwhelm ([15]) ([19]). While many seniors experience common challenges, being Indigenous, immigrant, LGBTQ2S+, low-income, and female adds to the complexity of these challenges. Policy, priorities, and funding for seniors is generally informed by a normative view that they are English-speaking, non-immigrant, non-indigenous, straight, and from a stable socio-economic background. This is problematic as the diversity of the senior population is increasing, and services such as seniors centres tend to lack the capacity to address their needs ([5]).

7.1 IMMIGRANT SENIORS

The unique challenges faced by immigrant seniors commonly relate to income insecurity, lack of housing access and stability, transportation, mental health, and social isolation ([15]) ([19]).

Suggestions to address the needs of immigrant seniors:

- **Promote ways to invite and involve vulnerable and isolated seniors** in physical, social, and intellectual opportunities ([3]).
- **Offer affordable and accessible English classes** focused on older adults ([27]).
- **Offer multi-language services** in seniors' homes ([27]).
- **Enhance care service offerings** in multiple languages ([27]).
- **Distribute information through ethnic/cultural media**, and Indigenous and immigrant service providers ([3]).
- **Community support staff** who work within specific cultural communities ([5]).
- **Develop seniors-helping-senior's programs** for specific cultural and linguistic communities. ([5])
- **Provide culturally diverse staff** in seniors centres ([5])
- **Strong leadership and development of culturally sensitive programming**. Be aware that there may be some resistance in existing seniors' spaces to welcoming culturally diverse seniors and programming. That the traditional members of the centre may feel alienated. ([5])
- **Address unique challenges to self-sufficiency faced by immigrant seniors** in sponsorship breakdown; specifically mentioned as a need to be addressed by the Alberta Ministry of Seniors and Housing. ([6])
- **Assist newcomers and ESL older adults to access technology** to help them engage more in social and recreational activities ([15]).
- **Improve access to programs and services for immigrant and refugee seniors** by ([19]):
  - Provision of linguistically appropriate and culturally sensitive programs
  - Increased and better promotion of programs for immigrants and refugees
  - Intersectional understanding of the issues

  - Coordinated approaches amongst service providers
  - Improving government policies on immigrant seniors
  - Education and training
  - Building social/political community
  - Additional research
- **Increase the availability of free programs for immigrants and refugees** whenever possible. For low-income seniors, even a small fee to participate in a program can be prohibitive, and more free programs would ensure equitable access for all immigrants and refugees. ([19])
- **Ensure that facilities, housing programs and services for immigrants and refugees are easily accessible** and on a transit route, preferably very close to a transit stop. ([19])
- **Establish guidelines for collecting demographic information** on member and participant profiles (e.g. country of birth, language spoken, and ethnicity) as well as information about program needs and interests. Consistent data across service provider organizations can be used to assess specific needs and to determine how these needs might be met. ([19])
- **Within each facility, create a welcoming, respectful and inclusive culture**. This can be created by: ([19])
  - Hiring staff and volunteers who can speak languages other than English, depending on the profile of the membership
  - Ensuring that staff have the skills to create a respectful and inviting environment.
  - Requesting and encouraging non-immigrant seniors to be inclusive and respectful, and to help create a welcoming environment.
  - Ensuring that staff have the skills to create a respectful and inviting environment.
  - Requesting and encouraging non-immigrant seniors to be inclusive and respectful, and to help create a welcoming environment.
- **Support the provision of more senior-friendly English language programs** that are appropriate for seniors' learning pace, recognize literacy challenges in the seniors' first language, and include an opportunity to socialize and engage in conversational English.
- **Focus on providing recreational and other programs that do not require English language skills** and that will minimize language barriers to participation (e.g. fitness and dance classes). ([19])
- **Offer more programs targeted to specific immigrants and refugees'** ethnocultural /linguistic communities. Immigrants and refugees are most likely to attend programs that mitigate language barriers and provide a means of connecting with others in their own community. ([19])
- **Start by offering a program that is targeted to a specific cultural and/or linguistic group** to draw them to a facility they are not familiar with. ([19])
  - Consider the specific needs and challenges faced by the target group in both the delivery approach and program content.
  - Engage community support workers and cultural brokers who are connected to and have relationships with immigrants and refugees to assist with program design.

- **Provide more educational programs that address the day-to-day challenges of immigrants and refugees** (e.g. financial literacy, how to use transportation systems, information on seniors' benefits, housing and so forth). These needs may shift and change as new communities of immigrants and refugees arrive in Edmonton, and ongoing formal and informal needs assessments could be used to determine the most current and significant challenges faced by immigrants and refugees. Consider offering a series of short-term programs that meet the immediate needs of immigrants and refugees in addition to long term program offerings to ensure that emergent needs are being met. ([19])
- **Offer a mix of structured and unstructured programs to respond to immigrants and refugees' varying interests and abilities**. Food and the opportunity for social time should be available as a separate activity and also as a part of structured programs. Purposefully incorporate relationship-building activities into programs to facilitate the building of social networks between seniors and to help to reduce social isolation. ([19])
- **To promote and market programs, allocate resources to cultivate and maintain connections with formal and informal leaders** within community spaces such as places of worship and cultural gathering spaces. immigrants and refugees (like other seniors) value and are more likely to act upon information received from trusted sources. ([19])
- **Review promotional materials** such as newsletters and program guides for appropriate language. Avoid terminology that might be confusing for those with limited English language skills and use images and pictures to supplement written text. When possible, translate promotional material into the language of the target community. ([19])

Recommendations ([19]) were identified for organizational and policy level changes for funders and service providers that would benefit immigrants and refugees and address the findings that emerged in this project.

Recommendations for organizational and policy level changes for funders and service providers:

- **Income**
  - Advocate for the Alberta Seniors Benefit not to be linked to federal Old Age Security benefits so that immigrants and refugees can benefit from this program.
- **Transportation**
  - Advocate for subsidies for low-cost transportation options for immigrants and refugees.
- **Language**
  - Support the creation of translated materials that provide information to seniors, based on the major non-English languages spoken in Edmonton.
  - Support and Increase availability of interpreters that service providers can access at low/no cost.
- **Housing**
  - Advocate for an increase in affordable housing that meets the needs of immigrants and refugees. Ensure that housing options are linked to services for social support that facilitate independent and dignified living.

- **Research**
  - Implement a collaborative baseline study that provides demographic data to determine the scope of issues faced by immigrants and refugees in Edmonton. Baseline data would facilitate future evaluation processes to assess the effectiveness of programs and services for immigrants and refugees.
- **Recruitment and education**
  - Consider developing staff recruitment and hiring strategies to reach out to different ethnocultural and immigrant communities.
  - Strengthen staff capacity to work with immigrants and refugees with ongoing training for staff and service providers to better understand the needs and challenges faced by immigrants and refugees and promising practices for addressing these needs.
  - Develop a repository of resources (e.g. toolkits, education modules) for service providers that include guidelines for design and delivery of programs and services for immigrants and refugees.
- **Seniors' advocacy**
  - Support the development of an immigrants and refugee's advocacy group and other mechanisms that immigrants and refugees can participate in, to empower and equip them to advocate for policy change and more effective service provision.
  - Consult with and include the voices of immigrants and refugees in policy-making processes that affect them.

Recommendations for funders ([19]):

- **Funding for immigrants and refugees**
  - Increase the availability of funding for programs and services specifically for immigrants and refugees.
- **Funding models**
  - Advocate and fund research and action to develop new and sustainable funding models. Allocate more funding for organizations that provide services for specific ethnocultural and linguistic communities.
- **Mandated targets**
  - Include mandated targets for service provision to immigrants and refugees as a condition of funding to drive organizational commitment.
- **Housing**
  - Fund development of affordable housing that meets the needs of immigrants and refugees.
- **Research**
  - Support projects that build on current research and provide further insight into the specific needs of immigrants and refugees. Ensure that marginalized and vulnerable seniors are included, rather than only communities that have a large population of immigrants and refugees. Focus on key challenges such as income,

housing, and transportation, and the systemic changes required to address issues in these sectors.

7.2 INDIGENOUS SENIORS

The unique challenges faced by Indigenous seniors commonly relate to increased instances of trauma, family separation, premature death, social isolation, and poverty. More specifically, there is a need for those working with and influencing program, policy, and funding decisions to recognize the unique aspects of the experience of Indigenous seniors ([4]):

- **Excessive trauma is common** due to residential schools, 60s scoop, and the continuous impacts of its violent effects.
- **Interaction with grandchildren is often considered healing** and vital to quality of life. This involves activities such as passing on language and teachings.
- **At a higher risk of poor health** than the general senior population.
- **May avoid important activities that necessitate interaction with authority figures** (medical checkups, engaging with financial institutions, voting) due to a lack of trust.
- **More likely to have low-income**.
- **More likely to feel unsafe in their neighbourhoods** and not want to leave their homes.
- **Institutional environments may trigger memories of abuse suffered** in residential schools, which elicit avoidant behaviors. ([4])
- **Cultural activities are often experienced as a way to reconnect with their history** and sense of self in adulthood. However, there can be disconnect as some Indigenous seniors have not practiced for many years and feel that they have grown away from it. ([4])
- **A one-size-fits all approach for Indigenous seniors may be inappropriate** given the diversity within the Indigenous community, and. Needs may vary according to being Status or Non-Status, and First Nations, Métis, or Inuk. ([4])
- **Public transit services are a main mode of transportation** for Indigenous seniors. ([4])
- **Navigating access to resources both at the community and governmental level can be extremely challenging** due to the required paperwork and language barriers. This is often exacerbated by being on- or off-reserve, being registered with the Indian Act, and confusion about provincial versus federal jurisdiction. This may result in Indigenous seniors not accessing the critical aid they are entitled to, such as health funding and government benefits. ([4])
- **Lateral violence existing within the community may actively discourage Indigenous representation** within organizations. ([4])
- **Mistreatment of Indigenous people by staff of social agencies or healthcare practitioners** is not uncommon due to staff lack of cultural awareness, causing Indigenous peoples to become avoidant or mistrustful. ([4])

Suggestions to address Indigenous seniors needs:

- **Continue to implement an affordable provincial housing program** to provide affordable housing options for off-reserve Indigenous populations. (The Indigenous Housing Capital

Program started accepting applications for planning and construction funding in 2018) ([13])

- **Address a lack of available research and information on indigenous seniors needs** ([5]).
- **Support and increase awareness of gathering spaces for Indigenous older adults** to express their unique experiences. ([15])
- **Recognition by the community that there is an urgent need to respect and promote the inherent rights of Indigenous peoples** to live without facing discrimination, governments need to engage the broader senior population in cultural awareness and anti-racism movements ([4]).
- **Increase transportation options** for Indigenous seniors to access social events, including those outside of the city or on-reserve that are accessible, affordable, and appropriate ([4]).
- **Increase historical and cultural awareness among frontline health and social service providers** about the impacts of colonial violence experienced by Indigenous seniors and how it influences the present day. ([4]).
- **Establish culturally appropriate long-term care and permanent supportive housing facilities** that are Indigenous-lead and are equipped to provide opportunities for cultural practices ([4]).
- **Policy Makers need to** ([4]):
  - **Honor the right of Indigenous peoples to self-determination**, Indigenous seniors and the community should be engaged in the decision-making and design of available programs and services. Indigenous people have the right to determine and develop their own priorities when developing health, housing, and other programs. As much as possible, Indigenous organizations should be looked to as leaders for reducing social isolation in Indigenous seniors and supported as much as possible by the community-at-large.
  - **Improve infrastructure for seniors as a whole and ensure that these are accessible to Indigenous seniors r**elated to service directories, help lines, and access to mental health supports. Exploration must be done as to why low-income rates for Indigenous seniors are higher as compared to the rest of the senior population.
  - **Promote and encourage Indigenous students within higher education**, with the ultimate goal of addressing lower graduation rates and increase representation of Indigenous peoples as healthcare practitioners and service providers.
  - **Recognize that strategies to address social isolation among Indigenous seniors must go beyond treating the symptoms** and focus on individuals, families, and communities reclaiming cultures, traditions, ways of life, languages, worldviews, and ceremonies that were threatened during the colonial era and that continue to be threatened today.
- **Increase representation of Indigenous peoples as frontline workers** including social work, healthcare, and community agencies to generate more trust and understanding ([4]).
- **Develop a regular dialog with participants in services and cultural programming** ([4]).

- **Address need for trauma-informed practice** among programs targeted towards social integration or community building ([4]).
- **Address shortage of flexible and affordable transportation** for seniors to and from social events. Taxi cabs are an option but are not financially sustainable. Transportation is a key barrier for seniors wanting to access cultural activities, especially those that are not in rural areas ([4]).

7.3 LGBTQ2S+ SENIORS

The unique challenges faced by LGBTQ2S+ seniors relate to high degrees of social isolation, and a need for respect and acceptance in gathering spaces and housing options ([15]) ([9]).

Suggestions to address LGBTQ2S+ seniors needs:

- **Address lack of specific gathering places** for them to create contacts and decrease loneliness. ([15])
- **Recognition that LGBTQ2S+ older adults came out in a generation with much stronger gender and sexual orientation discrimination**, and therefore interaction with other seniors may feel like repeatedly "coming out". ([15])
- **Housing options** needs ([9]):
  - The environment must be inclusive, which requires intentional strategy.
  - Preference to age in home with services such as homecare.
  - Nearby amenities such as parks and recreation facilities, arts and culture venues, etc.
- **Supportive living needs** ([9]):
  - Partners must be respected and accepted as their main caregiver and allowed to share the room/suite.
  - Must have anti-discrimination measures are in place (bold is important to over 90% of respondents):
    - Policies against discrimination based on sexual orientation and gender identity,
    - Relationship status and shows of affection are respected,
    - Staff diversity training, social activities that make LGBTQ2S feel included
  - Support groups for LGBTQ2S,
  - Non-assumption of heterosexuality
  - Need a person on staff to approach re: disrespect/discrimination.
  - There is a need to explore the possibility of discrimination in seniors' housing because it has not been directly reported but there may be reasons people don't report or talk about it.

Note: There may be a general lack of readily available information on the needs of LGBTQ2S+. The literature reviewed made suggestions based on surveys where respondents were primarily under 70 years old, healthy, white, and middle class. It may be difficult to find LGBTQ2S+ seniors who are non-white, lower financial stability, health-compromised, with different gender identities, or who are 'street-involved'. Further research into the literature may be required, or this may point to limitation in the information. ([9])

8 TECHNOLOGY

Technology supports the personal needs of seniors in a wide range of ways by providing entertainment, helping them to stay connected with family and friends, supporting work-related opportunities, and providing access to information and services.

Barriers to personal uptake of technology use by seniors include:

- Affordability
- Lack of confidence
- Patience to learn
- Lack of support to learn
- Distrust

***Suggestions to address technological barriers ([15]) include*:**

- **Providing learning platforms** that are easily available and accessible with phone support
- **Providing screen-sharing capabilities and trained staff** to teach and troubleshoot
- **Offering affordable and accessible technology classes** that can be co-located at public libraries, recreation centers, or other seniors centres

Technology also has a role in helping to meet the needs of seniors with respect to transportation, ambulation, mobility, cognition, and activities of daily living, as outlined below ([18]).

Transportation solutions could include: Self-driving personal vehicles for non-urgent transportation, pre-programmed with the assistance of family or professional caregivers; Self-driving public transport vehicles; Technology that helps seniors plan for and confirm transportation options in a simple and affordable way; and Self-driving wheelchairs that use the bicycle lanes or pathways.

Mobility solutions could include: Position tracking to assess mobility decline for early intervention; Scooters, wheelchairs, and bed supports; Technology to aid in entering into the home due to steps; Exoskeleton to assist people with motion disability; Next generation robotic "Power Walkers" to help reduce falls; and Adding GPS and verbal and visual navigation aids to walker and scooters.

Cognition solutions could include: Autonomous robotics applications that monitor medications; Next generation voice-activated computer software or smart phone apps; A portal service that can be accessed to provide education/information/navigation community agencies and societies to provide aids to assist with hearing/vision etc.; More non-invasive monitoring systems that are not dependent on the direct output of the senior to define their needs.

Activities of Daily Living solutions could include: Remote monitoring able to look at the senior in the environment, medication reminders; Technologies that alert elderly to obstacles, uneven surfaces, environmental factors that could pose a problem; Smart clothing, able to monitor a person's breathing, heart and skin temperature; Video-based interaction for safety, social

support, monitoring, physician/clinician assessment; Mandatory changes to building codes; creating incentives to build barrier-free homes. ([18])

High Speed Internet in rural areas. In rural areas, it is suggested that everyone should have the right to high-speed data given the role services like Skype and telemedicine can play in reducing the need for seniors to travel long distances for medical care. Alternately, mobile telehealth services could be set up in a seniors centre.

9 HUMAN RESOURCES

An educated, trained, and well-supported workforce is needed to meet the variety of needs of Alberta's growing senior population.

Gaps in human services. A number of gaps were identified throughout the literature including:

- Need more culturally diverse community support and outreach staff who work within specific cultural and linguistic communities ([5]).
- Need more culturally diverse front-line workers including in healthcare and social work. ([4]).
- Staff in senior-serving organizations need to have the skills to create a respectful and welcoming environment for immigrant seniors ([19]).
- Staff in senior-serving organizations need to be able to work with seniors to teach and troubleshoot technology issues such as phone support, screen-sharing, etc. ([15])
- Need increased geriatric training for professionals, students, and caregivers ([3]).
- Need incorporation of Advance Care Planning into the curricula for medical, nursing, social work, legal, financial planning, insurance, and funeral planning professionals. ([26])
- Seniors centres need to have strong organizational governance with skilled staff, and more outreach workers, especially those who can support mental health and special needs. ([5]) ([17]).
- Adult service providers need to promote public and professional awareness of elder abuse. There could be a community coordinator role, in part to manage a process for funding, reporting, and monitoring ([3]).
- There is a capacity issue as demand for Alternative Transit for Seniors is outstripping capacity, and existing providers don't see a way to expand ([24]).
- Development of transportation options for seniors need to include:
  - Education for individuals designing and operating transit options regarding seniors' special issues related to sensory, motor and cognitive abilities. ([2])
  - Seniors sensitivity training for workers delivering transportation services. ([2])
  - Addressing the transportation needs of those who serve seniors in addition to seniors themselves. This includes healthcare providers, caregivers, community service providers, etc. ([2]).
- Need additional more consistent levels of training for staff at rural hospitals to deal with mental health crisis episodes. ([38])

REFERENCES

1. Statistics Canada. (2016). *Census of Population, Statistics Canada Catalogue no. 98-400-X2016001.* Accessed https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GID=0&GK=0&GRP=1&PID=109523&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2016&THEME=115&VID=0&VNAMEE=&VNAMEF= on July 29, 2019.
2. The Medically At-Risk Driver Centre (MARD), Department of Family Medicine. (2016). *Transportation Toolkit: For the implementation of alternative transportation for seniors in Alberta*. University of Alberta. Retrieved from https://cloudfront.ualberta.ca/-/media/mard/transportation-toolkit/transportationtoolkit_2016.pdf on July 29, 2019.
3. Age-Friendly Calgary. (2014). *Seniors Age-Friendly Strategy and Implementation Plan 2015-2018*. Retrieved from https://www.calgary.ca/CSPS/CNS/Pages/Seniors/Age-Friendly-Calgary-background.aspx on July 25, 2019.
4. Age-Friendly Edmonton. (2019). *Social Isolation of Indigenous Seniors*. Retrieved from https://edmontonsocialplanning.ca/index.php/resources/digital-resources/a-espc-documents/a06-newsletters/a06g-reports/1063-social-isolation-of-indigenous-seniors-age-friendly-edmonton on August 5, 2019.
5. Citizen Services, Community Inclusion and Investment, Edmonton Social Planning Council. (2017). *Seniors Centres of the Future Final Report*. Retrieved from https://www.edmonton.ca/programs_services/documents/PDF/scs-engagement-final-report.pdf on August 5, 2019.
6. Office of the Seniors Advocate. (2018). *Office of the Seniors Advocate Alberta Annual Report*. Retrieved from https://www.seniorsadvocateab.ca/images/OSA_annual_report_2017_2018.pdf on July 24, 2019.
7. Office of the Seniors Advocate. (2017). *Building a Strong Foundation: Office of the Senior Advocate Alberta Annual Report*. Retrieved from https://www.seniorsadvocateab.ca/images/pdf/SeniorsAdvocate_2016-2017_AR_Report.pdf on July 25, 2019.
8. Alberta Health. (2017). *Alberta Dementia Strategy and Action Plan*. Retrieved from https://open.alberta.ca/publications/9781460136898 on August 5, 2019.
9. Pride Seniors Project, Edmonton Seniors Coordinating Council, SAGE. (2015). *Into the Closet Again? An Assessment of Housing Needs and Preferences among LGBTQ2S Seniors and Soon-to-be Seniors in Edmonton*. Retrieved from https://www.mysage.ca/public/download/documents/11793 on August 15, 2019.

10. Stall, N. (2019, March). We should care more about caregivers. *CMAJ* 191(9), E245-E246. Retrieved from http://www.cmaj.ca/content/191/9/E245 on Sept 4, 2019.

11. Alberta Health Services. (2019). Medical Assistance in Dying Stats. Accessed https://www.albertahealthservices.ca/info/Page14930.aspx on July 29, 2019.

12. Age-Friendly Lethbridge. (2018). *Age-Friendly Lethbridge Survey Executive Summary*. (Information on results shared in personal communication with Rob Miyashiro, Executive Director, Lethbridge Senior Citizens Organization. Final Age-Friendly Lethbridge Plan is expected at the end of November 2019.)

13. Alberta Seniors and Housing. (2019). *Seniors and Housing Annual Report*. Retrieved from https://open.alberta.ca/dataset/5e26add6-8c5c-4404-9ae8-c65bd7985038/resource/3e08aa3a-3ab4-4be1-811f-103650c96f78/download/seniors-and-housing-annual-report-2018-2019-web.pdf on July 29, 2019.

14. Alberta Health. *Alberta Dementia Strategy and Action Plan: Progress Report*. (2019). Retrieved from https://open.alberta.ca/dataset/2262e7c9-8b18-4d52-91b1-fb1ed7761ac1/resource/c188d6d8-62f9-4716-8519-2eb2dfa1e926/download/adsap-progress-report-2019-03-06.pdf on August 5, 2019.

15. Age-Friendly Edmonton. (2019). *Older Adults Needs Assessment – Highlight Report 2019*. Retrieved from https://www.edmonton.ca/city_government/documents/PDF/2019-AgeFriendlyEdmonton-HighlightReport.pdf on August 5, 2019.

16. Edmonton Seniors Coordinating Council. (2011). *Vision for an Age-Friendly Edmonton: Action Plan*. Retrieved from https://www.edmonton.ca/city_government/documents/PDF/Final-Final_Seniors_council_plan_May26.pdf on August 5, 2019.

17. Age-Friendly Edmonton. (2015). *Older Adults Needs Assessment - Final Report 2015*. City of Edmonton. Retrieved from https://www.edmonton.ca/city_government/documents/PDF/AFEAdultNeedsReport.pdf on August 5, 2019.

18. Colton, B. (2016). *Aging in Place Stakeholder Consultation Results*. Presented at National Research Council of Canada Aging in Place Workshop. Retrieved from https://www.ascha.com/assets/publications_external/F.iii.AginginPlace-StakeholderConsultationResultsNov202016.pdf on July 29, 2019.

19. Age-Friendly Edmonton. (2015). *The Age of Wisdom: Giving Voice to Edmonton's Immigrant Seniors and Identifying their Needs*. Retrieved from http://www.seniorscouncil.net/uploads/files/AgeOfWisdomSummaryReport2015.pdf on August 5, 2019.

20. PAGASIS. (2017). *Population Baseline Survey Summary*. Retrieved from https://connectingedmontonseniors.ca/wp-content/uploads/2018/02/pegasis-populationbaselinesurvey-nov2017.pdf on August 15, 2019.

21. Alberta Council on Aging. (2019). *Alberta Council on Aging 2018-19 Annual Report*. Retrieved from https://acaging.ca/wp-content/uploads/2019/07/Annual-Report-2018-web.pdf on August 19, 2019.

22. Seniors United Now. (2017) *Pension Position Paper*. Retrieved from http://www.seniorsunitednow.com/cms/uploads/files/147281234fa049cc489dc0ba528acf5f.pdf on August 12, 2019.

23. Seniors United Now. (2016) *Position Paper on Affordable Dental, Optical and Auditory Fees*. Retrieved from http://www.seniorsunitednow.com/cms/uploads/files/938fa0cfdda50aebc60eb03984280602.pdf on August 12, 2019.

24. Edmonton Seniors Coordinating Council. (2018). *Building a Sustainable Assisted Transportation Service: A Collaborative Approach. Introducing the Assisted Transportation Network of Alberta (ATNA)*. Retrieved from https://www.seniorscouncil.net/uploads/files/Building-a-Sustainable-Assisted-Transportation-Service-ESCC2018.pdf on August 29, 2019.

25. The National Seniors Council. (2019). *National Seniors Council Work priorities*. Accessed https://www.canada.ca/en/national-seniors-council/corporate/priorities.html on August 26, 2019.

26. Advance Care Planning Collaborative Research and Innovation Opportunities Program. (2016). *How can we help Albertans learn about and participate in Advance Care Planning?* Retrieved from https://acpcrio.org/files/acpcrio/world-cafe-report-19sept2016-final.pdf on August 26, 2019.

27. Advisory Council for Seniors and Continuing Care. (2018). *Seniors and Continuing Care Provincial Advisory Council Work Plan 2018/19, 2019/20*. Retrieved from https://www.albertahealthservices.ca/assets/about/ac/ahs-pac-scc-2018-20-workplan.pdf on September 5, 2019.

28. Alberta Elder Abuse Awareness Council. (2018). *Alberta Elder Abuse Awareness Council Strategic Plan*. Retrieved from https://www.albertaelderabuse.ca/images/Strat_Plan_2018.pdf on August 14, 2019.

29. Hanna and Area Service Provider Referral Resources. (2018). *Taking a Stand Against Elder Abuse*. Retrieved from https://www.albertaelderabuse.ca/doc/68-hanna-and-area-service-provider-referral-resource/file on August 14, 2019.

30. College of Physicians and Surgeons of Alberta. *Medical Assistance in Dying - Advice to the Profession*. (2018). Retrieved at http://www.cpsa.ca/wp-content/uploads/2016/06/AP_Medical-Assistance-in-Dying.pdf on July 29, 2019.

31. Medical Assisted Dying in Canada, Health Canada. *Interim Reports 1, 2, 3, & 4*. Accessed at https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html on July 29, 2019.

32. Alberta Seniors Strategic Planning Branch. (2018). Insights on Alberta Seniors, What Statistics Canada Data can tell us. Retrieved from https://www.greymatters2018.com/presentation/82-insights-on-ab-seniors-speaking-notes-final/file on August 15, 2019.

33. Seniors' Health Strategic Clinical Network in collaboration with Addiction and Mental Health Strategic Clinical Network, Alberta Health Services. (2017). *Appropriate Use of Antipsychotics Quick Facts*. Retrieved from https://www.albertahealthservices.ca/assets/about/scn/ahs-scn-srs-aua-infographic.pdf on August 15, 2019.

34. *Optimized Prescribing with Seniors website*. (2014-2018). Accessed http://www.cpsa.ca/messenger/optimized-prescribing-seniors/ on August 15, 2019.

35. Seniors Health Strategic Clinical Network, Alberta Health Services. (2019). *2017-2020 Transformational Roadmap At a Glance*. Retrieved from https://www.albertahealthservices.ca/assets/about/scn/ahs-scn-srs-roadmap-summary.pdf on September 5, 2019.

36. Alberta Seniors and Housing. (2017). *Alberta Seniors and Housing: Service Provider Screening Guide for Elder Abuse*. Retrieved from https://www.seniors-housing.alberta.ca/documents/ElderAbuse-Screening-Guide.pdf on September 5, 2019.

37. Grey Matters Conference. (2016). *Age-Friendly Cities and Communities - Three Alberta Experiences.* Retrieved from https://greymatters2016.com/presentation/24-age-friendly-cities-and-communities-three-alberta-experiences/file on September 5, 2019.

38. Rural Health Services Review Committee, Government of Alberta. (2015). *Rural Health Services Review Final Report.* Retrieved from https://alberta.cmha.ca/wp-content/uploads/2017/01/Rural-Health-Services-Review-2015.pdf on September 18, 2019.

39. Canadian Association of MAID Assessors and Providers. (2019). *Complications with MAID in the Community in Canada*. Retrieved from https://camapcanada.ca/wp-content/uploads/2019/05/Failed-MAID-in-Community-FINAL-CAMAP-Revised.pdf on September 18, 2019.

40. Network of Excellence in Seniors Health and Wellness, Covenant Health. (2016). *Resources and Support for Caregivers in Alberta*. Retrieved from http://seniorsnetworkcovenant.ca/wp-content/uploads/2017/01/Resources-Caregivers-Inventories-of-Resources-and-Supports-for-Caregivers-in-AB-Doc-20160721-1.pdf on August 15, 2019.

41. Center for Disease Control Health Places website. (2014). Accessed http://www.cdc.gov/healthyplaces/terminology.htm on August 19, 2019.

42. World Health Organization website. (2019). Accessed https://www.who.int/ageing/ageism/en/ on September 5, 2019.

43. Dumont et. al. and Health Council of Canada cited in *Resources and Support for Caregivers in Alberta*. Covenant Health. (2016). Retrieved from http://seniorsnetworkcovenant.ca/wp-content/uploads/2017/01/Resources-Caregivers-Inventories-of-Resources-and-Supports-for-Caregivers-in-AB-Doc-20160721-1.pdf on August 15, 2019.

44. Seniors and Community Supports. (2010). *Aging Population Policy Framework: Executive Summary*. Government of Alberta. Retrieved from https://open.alberta.ca/dataset/501732e4-ae05-41c7-b1a4-c6e1cee4f152/resource/31b8f58b-d99c-4174-8e07-f0f18333539a/download/aging-population-framework-2010-summary.pdf on August 18, 2019.

45. Alberta Health. About Continuing Care. (description on website). Accessed at https://www.alberta.ca/about-continuing-care.aspx on October 3 2019

46. Alberta Health Services. Annual Report 2018-19. Accessed at https://www.albertahealthservices.ca/assets/about/publications/2018-19-annual-report-web-version.pdf on October 23 2019

47. Health Quality Council of Alberta. (2017). Long Term Care Family Experience Survey. Accessed at https://www.hqca.ca/surveys/continuing-care-experience/ on October 3 2019.

48. Shepherd's Care Foundation – Kensington Village. *Highlights 1 - Toward a Campus of Wellness & Care: Data-Informed Health Promotion with our Oldest Seniors*. Report on Campus of Care Demonstration Project. Phase 1: September 2013 to June 2015.

49. Shepherd's Care Foundation – Kensington Village. *Briefing Note #2: Active Aging: Longevity Worth Living*. Report on Campus of Wellness and Care Demonstration Project. Data gathered from 2013-2016.

50. Shepherd's Care Foundation – Kensington Village. *Briefing Note #3: The Importance of Relationships in Independent Living*. Report on Campus of Wellness and Care Demonstration Project.

51. National Institute on Ageing. (2019). *Enabling the Future Provision of Long-Term care in Canada*. Toronto, ON: National Institute on Ageing White Paper.

52. Public Health Agency of Canada. (2019). *A Dementia Strategy for Canada*. Ottawa, ON.

53. The Brenda Stafford Foundation. *Dementia Friendly Communities. Year One Impact Report*. (2018). Calgary, AB.

54. Covenant Health Network of Excellence in Seniors' Health and Wellness. (2019). *Innovator's Challenge: Going Beyond the Conversation. Summary Report*. Edmonton, AB. More information available at ShapeSeniorsCare@covenanthealth.ca or www.Seniorsnetworkcovenant.ca