THE NEED FOR SOCIAL INFRASTRUCTURE TO SUPPORT QUALITY OF LIFE AND WELLBEING FOR OLDER ADULTS

"Growing old is not a disease, it is a triumph."
– Maggie Kuhn

SENIORS FOR SOCIAL ACTION ONTARIO (SSAO)

September 2025

BRIEF TO THE PARLIAMENTARY COMMITTEE ON QUALITY OF LIFE AND WELLBEING

THE NEED FOR SOCIAL INFRASTRUCTURE TO SUPPORT QUALITY OF LIFE AND WELLBEING FOR OLDER ADULTS

EXECUTIVE SUMMARY

A STATEMENT OF THE PROBLEM

Canada's population is aging, but as a country and province we are underprepared for it.

On the surface, older adults appear to be doing fine – they contribute significantly to charities and to their families and communities. But all is not well with older adults, many of whom hide their health issues, financial challenges, loneliness, feelings of abandonment, and despair.

The lack of social infrastructure – personal and other supports that could be provided by non-profit organizations - has led to older adults risking their life savings and home equity to enter expensive private retirement homes rather than face their worst fear – institutionalization in long-term care facilities.

The lack of affordable, accessible housing with necessary supports built in prevents elders from downsizing and avoiding institutionalization, and is leaving some at risk of homelessness.

Ageist public policies and societal attitudes, including those promoting institutionalization of elders, contribute to the problem leaving older adults, including those advocating for change, feeling ignored and dismissed.

Ageism in research has also contributed to a lack of emphasis on ways to help elders to age and has not included them in the design of research questions and topics, in the research process, or in the analysis of results. This has led to government spending a considerable amount on research that is largely irrelevant to older adults. With Baby Boomers being the most educated generation in history it is time to incorporate their input into the research process.

Rather than investing in funding support to Naturally Occurring Retirement Community (NORC) programs and integrated care PACE-type in-home and residential assisted living programs (Program of All Inclusive Care of the Elderly) that have proven to support elders aging in place, the Ontario government has instead invested in mass institutionalization of frail older adults. This is in direct contradiction to their stated wishes not to be segregated and to age in their own homes and communities. It is also the least cost effective strategy for government in that institutionalization is by far the most expensive option.

THE SOLUTIONS

NORC-based programs employ the four pillars of healthy aging – nutrition, physical activity, social engagement and sense of purpose - and operate on the principle that these are recipes for health and longevity. Across Canada NORC-based programs, organized by older adults themselves are growing. They provide an excellent opportunity for government, in partnership with non-profit community organizations and older adults, to support independent, autonomous living for older adults that are highly cost effective.

NORCs can provide the foundation for three levels of support and planning:

- Level One: Older adults who enjoy reasonably good health but require some programs to maintain their health. This represents the majority of elders, and the resources required are a paid coordinator and meeting space. Programs can be delivered in partnership with a non-profit community agency.
- Level Two: Older adults requiring support for activities of daily living in their own homes to the end of their lives if that is their wish.
- Level Three: Older adults who require 24/7 care and supervision that can be effectively offered in non-profit residential assisted living or small, neighborhood homes operated by non-profit organizations.

Examples of successful NORC-based programs are found in the full report.

Seniors for Social Action Ontario (SSAO)) supports very basic programs like Oasis Communities for Aging Well which, through a research team at Queen's University in Kingston, is developing sites across Canada in order to advance understanding of programming that encourages older adults to continue to live independently and requires minimal program investment.

SSAO also supports very basic programs like Connections 400 that support older adults to live independently and maintain health with minimal program investment.

SSAO supports **enhanced home care programs** like CAPABLE which builds on older adults' strengths, is evidence-based,

and time limited. Developed at Johns Hopkins University, it is a person-directed program already operating successfully in Nova Scotia.

SSAO strongly supports **integrated care programs** that are also evidence-based and have been shown to maintain individuals requiring nursing home level care in their own homes and communities. PACE Burlington, OneConnect Durham Region, Peel Senior Link's Hub and Spoke Program, and the University Health Network's Integrated Care Program are examples provided in the report of programs that can maintain frail older adults in their own homes and communities to the end of their lives.

SSAO also supports **deeply affordable housing programs that are accessible and build in personal and medical support services**. These include intergenerational housing like the project being proposed by Village Canada in Ottawa, Co-operative and Co-housing that can incorporate home care support, non-profit assisted living residences, and small, non-profit, staffed neighborhood homes. All are described in more detail in the report.

Community-based applied behavioral interventions for older adults present an opportunity to enhance quality of life, maintain independence, and address problematic behaviors in aging populations. At the current time individuals with dementia in Ontario are housed in expensive specialized behavioral units in institutions – the worst possible places for this population. SSAO supports behavioral interventions that include trauma-informed care where individuals live in the community and in small, non-profit neighborhood homes because trauma-informed care, in particular, cannot be delivered safely in institutions. This report details how community-based behavioral interventions would work and why these would be a more ethical, less expensive, and more humane way to assist individuals with dementia and their families.

SSAO also supports **end of life care in the community using a health promotion approach.** End of life care in the community includes the five action areas of the Ottawa Charter:

- Incorporating policy related to providing housing and economic wellbeing, and community action supporting social wellbeing right to the end of life;
- Creating supportive environments to foster safe and enjoyable living that incorporates environmental and social determinants of health, including affordable, accessible, and safe housing options with space to incorporate medical equipment if required.
- Strengthening community action by supporting and empowering communities to create compassionate community initiatives that include recruiting and

training community connectors who link older adults with health and social services and organize neighborhood networks to provide practical care – driving, visiting, shopping etc.

- Funding community education on end of life issues to assist the public on how to remain healthy to the end of their lives, and prepare themselves and loved ones to navigate end of life.

- Reorient services away from hospital and institutional care to provide care at home in a way that can be scaled up nationally through integrated care, NORC-based programs and flexible funding.

The federal government has an important role to play in building community capacity and developing social infrastructure for aging and dying in the community.

RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

Seniors for Social Action Ontario is recommending:

1. That Oasis Communities for Aging Well be promoted and funded across Canada as an evidence-based approach to support older adults to continue to enjoy independent living and community involvement.

2. That NORC-based programs like Connections 400 that are highly effective be promoted and funded in established and developing vertical and horizontal NORCs for older adults requiring some minimal support to maintain health.

3. That the CAPABLE program be promoted and funded across Canada as a strengths and evidence based approach to maintaining individuals in their own homes and communities.

4. Funding PACE-like integrated care programs in community housing, seniors' buildings, vertical and horizontal NORCs, and within other deeply affordable housing initiatives would help to address the quality of life and wellbeing needs of older adults and provide the equitable social infrastructure within housing initiatives required to help them to age in place.

5. When providing transfer payment funding to the provinces, require that there be a range of deeply affordable housing options that are accessible, and that meet the needs of an aging population. Funding a variety of housing options that support aging in place will be a vital part of a deeply affordable housing continuum that takes into account quality of life and wellbeing of older adults and individuals with disabilities. This could be accomplished by redirecting funding currently used for mass institutionalization of older adults towards non-profit residential assisted living and non-profit, community-based, integrated care programs where older adults are living.

6. When funding research on aging, require that older adults act as advisors to researchers and help determine research questions, processes, and analyses of findings.

7. Launch a federal public education campaign promoting the contributions of older adults to Canadian society and one that defines ageism and its impact, encouraging conversations between the generations, especially concerning end-of-life decisions.

8. That the Federal government consider attaching a requirement to health funding transfers to be directed towards in-home, and community-based residential dementia care employing behavioral supports rather than locked wards in institutions.

9. That the Federal government fund compassionate community initiatives that include training for community connectors and public education to support individuals being able to die in their own homes and communities rather than in hospital or institutional settings.

A REPORT TO THE PARLIAMENTARY COMMITTEE ON QUALITY OF LIFE AND WELLBEING

September 2025

PREAMBLE

This report outlines issues that negatively affect older adult's quality of life and wellbeing and how these can be addressed more cost effectively by employing preventive alternatives to expensive and inhumane long-term care institutions.

The things that create a good quality of life and promote wellbeing for all ages are well documented - having enough money to address basic needs; feeling connected to family and friends; having good health; being independent and autonomous; having feelings and opinions respected, and living purposeful lives.

How Are Older Adults Really Doing?

On the surface it appears that older adults in Canada are doing all right. They tend to be well educated and have had long and prosperous careers. Many are managing fine financially. But that is not the whole story.

Many older adults today are financially stressed and feel abandoned by their families and society. They live with failing health, are often dismissed and disregarded, no longer feel needed, and have lost the ability to act on their own behalves.

Many also live their lives terrified at the prospect of being institutionalized in long term care facilities – a fate they consider to be worse than death. Some older adults are "choosing" MAID as an option once their level of frailty puts them at risk of institutionalization. Feedback to Seniors for Social Action Ontario (SSAO) from our members reveals that some would rather die than end up in "one of those human warehouses". Having no options but being "put away" or dying is having no options at all. Being institutionalized to facilitate their children obtaining their inheritances before the older person is gone is devastating for older adults. Feeling like society does not care what happens to them doubles the pain. Many hide their deteriorating health, loneliness, and declining functional abilities from family members and health care providers to avoid being institutionalized.

The lack of a community-based, caring social infrastructure – personal and other supports that could be provided by non-profit organizations - has led to older adults risking their life savings and home equity to

enter retirement homes. If they outlive their equity they worry that they will end up in the street, especially since affordable rental accommodation is so hard to find.

It is a terrible way to live. And many are ashamed to tell anyone that this is what they are experiencing or worrying about.

> ***Joan expressed that her mother's care costs are bankrupting her and she felt distraught not knowing how her mother and the family were going to manage once the income from sale of her condo ran out.***
>
> ***Marie was extremely worried about where she might live. Her retirement home costs had eaten up much of her savings from the sale of her house, and now the retirement "home" had been sold and conditions were deteriorating. She wanted out, but where could she go?***
>
> ***Sandra raised her children and did not work for many years. Last year her husband died without life insurance. She is now in difficult financial straits looking for an affordable apartment to rent in Toronto. She is not having any luck and has considered sharing with another woman. Even then she is likely to spend over 60% of what little income she has on housing.***

Fear of institutionalization, abandonment, ageist attitudes, and lack of affordable rental accommodation are quality of life and wellbeing issues that need to be addressed.

Seniors for Social Action Ontario believes it is time to talk about these hidden issues that negatively affect millions of older adults in Canada.

THE BIG PICTURE

As of 2024, there were 7,820,121 people over 65 living in Canada with 11,672 being centenarians. At age 65 men can expect to live 19.33 more years, women 22.10 more years (Statistics Canada, 2025). By 2030 older adults will comprise between 21 and 23% of Canada's population (StatsCan+, 2024).

Canada's population is aging, but there appears to be no strategy for addressing this demographic fact.

CARE RELATED AND HOUSING CHALLENGES

Many older adults have saved throughout their lifetimes and are managing financially, but a significant number are not. 28% or over a quarter of older adults reported that rising prices greatly affected their ability to meet day to day expenses in 2024 (StatsCan+, 2024).

Worry about making ends meet is affecting older adults' quality of life and sense of wellbeing. It is also affecting family member's quality of life.

More women are now at risk of going into long-term care institutions – joining the tens of thousands there, 69% of whom have no significant disabilities according to Ontario's Ministry of Health 2021 data. Or

they will end up poor and possibly homeless. Older adults – many with complex health needs are now turning up in shelters (Bowden, 2024).

An absence of non-profit personal support services in their homes and communities is placing them at risk of institutionalization as is an absence of affordable, accessible housing.

Costs of Rental Housing is Unaffordable

The head of Senior Women Living Together (SWLT, 2025) reports "currently none of my low income members (under $30,000 per year) can find anything affordable even when they are sharing the cost with 2, 3, or 4 others. They are having to pay more than 60% of their income even when sharing!" For many older adult renters finding accessible, affordable housing is a major challenge, especially in urban areas. This is leading to an increase in the elderly homeless population in Canada (Canadian Press, 2025).

THE NEGATIVE IMPACT OF AGEISM

Many older people seem well adjusted, having a much higher level of trust in others than their much younger counterparts. Over 60% seem highly satisfied with their lives. Over one third give to charitable causes – much higher than the general population. "For every $100 donated in 2022, $48 was given by those aged 65 and older. At $590, the median donation of older adults was the highest of any age group" (StatsCan+, 2024). Baby Boomers volunteer millions of hours of their time every year to help make society a better place. More of them are working after the pandemic than before it – some out of financial necessity.

Older adults are continuing to contribute significantly to society – and that is not counting the "softer support" they provide in caring for ailing spouses, babysitting grandchildren, providing advice and support to younger family and community members every day.

But how does society see and treat older adults?

Seniors for Social Action Ontario has identified state-sponsored and systemic societal ageism as significant issues that are doing serious harm to older adults. Cruel comments like "shut up you old bag" on social media; younger people active in political parties believing that Canada should not be wasting resources on old people and should instead be putting all of its resources into younger people's issues; old people being blamed for not moving out of their homes, even though accessible housing is not being built in much of Canada so they have nowhere to go except expensive retirement homes and institutions; having their pain and disabilities dismissed by health care

professionals as "you're just getting old"; being abandoned to loneliness by their families and the loss of friends; having governments invest over double the public funding in institutionalizing them than in helping them to age in place with necessary support services; their social support systems shrinking with no alternative emotional support available.

These and many more examples of ageism are harming older adults – although many don't speak of it. We are a generation that has learned to keep our problems to ourselves and soldier on.

This Preamble has outlined some of the issues reported to Seniors for Social Action Ontario that negatively impact older adults' quality of life and wellbeing.

The next section will provide viable, cost-effective, evidence-based alternatives to address these issues. Interventions, such as non-profit, community-based programs to address social isolation and loneliness can lead to significant cost savings for government when more costly interventions such as institutional long-term care are deferred or not needed at all.

Maria is 85 years old. After her husband died, Maria became very lonely, withdrew from social life and skipped meals and in her doctor's opinion was heading for a fall and hospitalization. Maria is now living in a Naturally Occurring Retirement Community where she joins other neighbours for meals, plays bridge once a week, and facilitates a Book Group. Maria has severe arthritis and needs help with daily living and now has access to community-based health services and a PSW who helps her with daily tasks. Maria wants to age in place and with the right supports she can die in the comfort of her own home.

THE SOLUTIONS

NATURALLY OCCURRING RETIREMENT COMMUNITIES (NORCs) PROGRAMS TO SUPPORT AGING IN PLACE AND ADDRESS QUALITY OF LIFE AND WELLBEING

The number of Canadians aged 85 years and older is expected to triple over the next 25 years (Statistics Canada, 2022e, 2022). If you ask people in this rapidly ageing population, they will tell you that they want to age in place. 96% of respondents of a 2021 National Institute on Ageing (NIA) and Canadian Mental Health Association (CMA) survey reported they "would do everything they can "to avoid moving into an institutional setting" (NIA, 2021).

Elders are living longer and deserve an optimal quality of life and wellbeing like all other Canadians. This goal is doable and will require new thinking and a reimagined social infrastructure to effectively support quality of life and wellbeing for older adults. Because institutional care is both costly and dehumanizing in the eyes of older adults,

the focus should be on the often less costly alternatives for aging in place that are more likely to promote increased wellbeing.

Nutrition, Physical Activity, Social Engagement, and a Sense of Purpose, the four pillars of health promotion, are foundational for healthy aging. Both the General Healthy Ageing (WHO Initiative) (WHO, 2020) and the UN Decade of Healthy Ageing Plan of Action (2022) provide strong evidence and support for the benefits of these pillars.

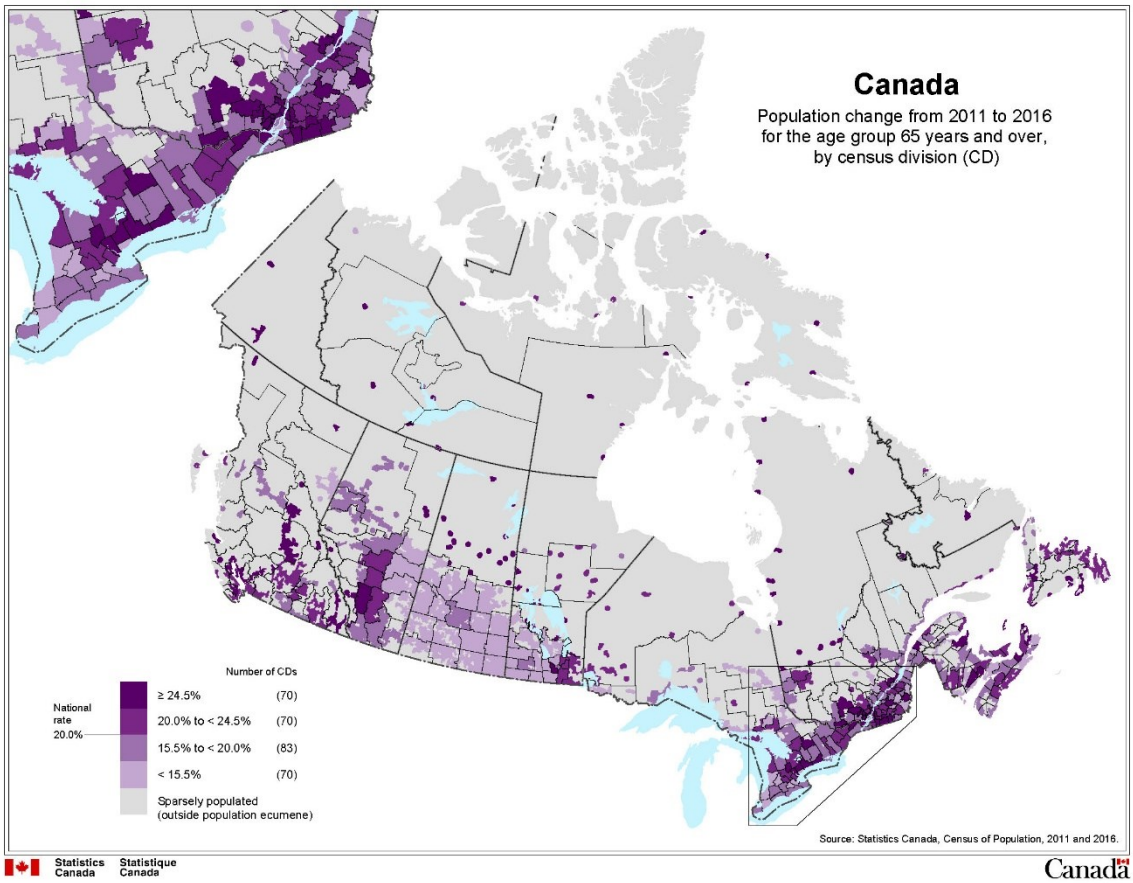
The Harvard Study of Adult Development conducted for more than 80 years, has shown unequivocally, that older adults are more likely to live healthier lives if these lives are lived with meaning, connection, and purpose (Harvard, 2015).

Throughout Canada older adults are taking the initiative to organize with the support of innovative community-based organizations to strengthen and sustain healthy communities of older adults. These communities are addressing important determinants of healthy aging such as social connection, nutrition, physical fitness, and sense of purpose which are the Oasis program's Pillars of Healthy Aging (Oasis, 2025).

Called Naturally Occurring Retirement Communities (NORCs) they have come, over time, to naturally house a high density of older adults (Hunt & Gunter-Hunt, 1985). These include communities that were designed to house a large concentration of older adults, but were not purpose-built for them.

NORCs can be vertical communities (e.g. multigenerational buildings, condos or co-ops) or horizontal communities with single-family homes in a particular geographical area.

Because NORC-based programs leverage the naturally occurring density of communities in which older adults live, the concentration of NORC-based programs continues to increase as the older adult population increases. As of 2022, there were 489 NORCs in the City of Toronto alone (University Health Network, 2022:8).


Canada
Population change from 2011 to 2016 for the age group 65 years and over, by census division (CD)
Number of CDs
National rate 20.0%
≥ 24.5% (70)
20.0% to < 24.5% (70)
15.5% to < 20.0% (83)
< 15.5% (70)
Sparsely populated (outside population ecumene)
Source: Statistics Canada, Census of Population, 2011 and 2016.
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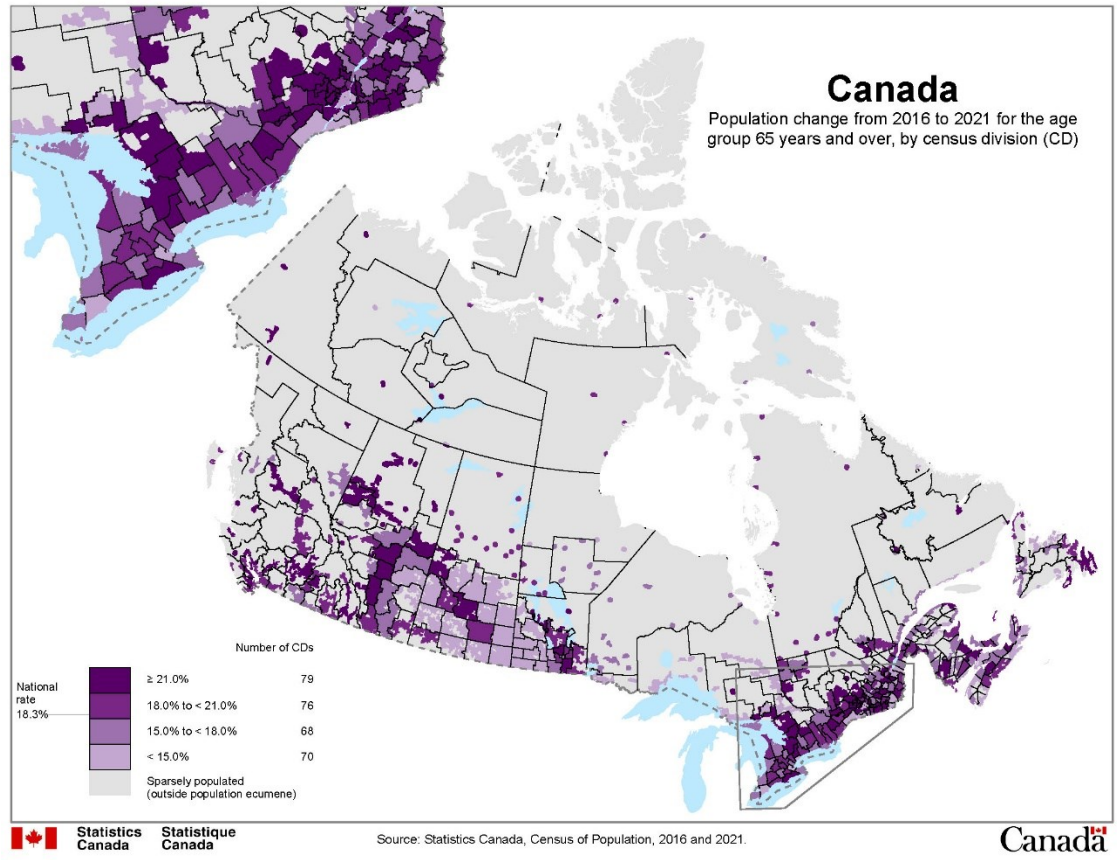
Canada
Population change from 2016 to 2021 for the age group 65 years and over, by census division (CD)
Number of CDs
National rate 18.3%
≥ 21.0% 79
18.0% to < 21.0% 76
15.0% to < 18.0% 68
< 15.0% 70
Sparsely populated (outside population ecumene)
Statistics Canada Statistique Canada
Source: Statistics Canada, Census of Population, 2016 and 2021.
Canada

The fact that NORCs are increasing dramatically as the population ages gives government, in partnership with community social services agencies, an excellent opportunity to support older adults to live as independently as possible in a place of their choosing.

A diverse range of programs to support older adult wellbeing has naturally developed (Parniak et al., 2022; Xia et al., 2022). Despite the diversity and range of programs, all NORC-based Programs share common goals to:

- Reduce social isolation by providing opportunities for social relationships;
- Increase access to community social and health services, information and resources;
- Provide opportunities for community and civic engagement;
- Offer common and designated shared space that is accessible and provides activities that foster social networks and interactions and a sense of purpose.

Activities within NORC-based programs operate on the principle of design and leadership by older adult residents themselves.

There is a broad range of program possibilities depending on the preferences and specific needs of the residents of individual NORCs:

- The first level is suited to those older adults who enjoy relatively good health but need some programming to maintain that health – both mental and physical - by addressing socialization, nutrition, physical exercise and sense of purpose. This is the largest group of older adults. Programs at this level usually require some resources to offer continuity and sustainability. This may include an allowance to pay a coordinator as well as reliance on a landlord or condominium board to provide meeting space. Programs may also be run by the residents themselves with the support of a community service organization with no funding at all for a coordinator. This second example tends not to be sustainable over time.
- The second level addresses the needs of older adults who require support for essential activities of daily living to continue to live independently in their homes and enjoy participation in a variety of community-based activities, while receiving care to the end of their lives if that is their wish.
- The third level addresses those adults who require 24/7 supportive care which can be offered effectively in non-profit residential assisted living or in a group home setting.

Examples of NORC-based Programs

Oasis Communities for Aging Well

Oasis (Oasis National, n.d.) is an innovative model that offers programming for older adults living within a NORC. Oasis is unique as it seeks to empower older adults to identify their needs and determine the services and activities which best meet those needs (Donnelly et a.l, 2019). Oasis includes programming - developed by members – designed to foster movement, healthy nutrition, and socialization to support older adults to age within their communities. The basic requirement for an Oasis program to function is a partner community social services agency to provide human resource and accounting services.

Most Oasis sites can be found in apartment and condominium buildings where the landlord/condo board has provided dedicated meeting space free of charge. One neighbourhood Oasis site in Toronto uses space in a decommissioned high school for its gatherings. The essential ingredient for sustainability and continuity is the provision of a paid coordinator at each site to facilitate the programming requested by the members.

A research team in the School of Rehabilitation Therapy at Queen's University has been studying the effects of Oasis for several years and has been responsible for expanding the Oasis program beyond the original site in Kingston, Ontario to 20+ sites across Canada. Except for the original Oasis site which is funded by the Ontario government, all Oasis sites are financially supported by time-limited research grants.

Connections 400 *(Formerly Oasis 400)*

Connections 400 is an incorporated non-profit organization of older adults living in two Toronto rental towers with 160 members. The Connections 400 model is based on Oasis Supportive Living Inc. It does not have a paid resource coordinator and no ongoing financial support for a resource coordinator. Resident older adults offer a wide range of activities designed by them in a dedicated seniors' lounge provided by property owners and management and with the support of a staff person designated by a local seniors' organization that provides guidance regarding activities on health and wellbeing and issues of concern to members. Resident older adult volunteers facilitate social drop-ins three times a week, a book group, a people and politics group, a French conversation group and weekly cards and games activities to reduce social isolation and increase social engagement. Resident older adult volunteers also organize wellbeing presentations on topics such as fall prevention and older adult nutrition.

In 2004 there were over 2,000 individual visits to the seniors' lounge. A newsletter provides older adults with wellbeing information in the lounge and online (exercise classes and webinars) in the community.

Connections 400 thrives on the motivation and capacity of older adults to age in place. Volunteer hours of members and a modest ongoing financial investment would make programs like this sustainable and successful over time.

STRENGTHS AND EVIDENCE-BASED ENHANCED HOME CARE

Quality of life and wellbeing are not advanced when older individuals and their family caregivers have to jump through numerous hoops to try to obtain care. Many have no idea where to start. Once they receive care it may be unreliable (stressed caregivers may not show up), inadequate (caregivers may not be trained to provide needed care), and it may not be enough or needs-based (Seniors for Social Action Ontario Home Care Report, 2023).

Too often, in Ontario, home care has been geared towards older adults' deficits rather than being based on their strengths. It is a model where older adults are expected to be passive recipients of care - creating dependency and lack of confidence.

The CAPABLE program developed by Johns Hopkins (2025) currently being piloted in the province of Nova Scotia in a partnership with Victorian Order of Nurses (VON Canada) offers a potential solution. By providing the services of a nurse, specially trained occupational therapist, and a handyperson, older adults have felt empowered to remain in their own homes and communities (VON Canada, 2024; Government of Nova Scotia, 2023).

The person-directed CAPABLE program's emphasis on older individuals' strengths has helped to improve their quality of life, confidence, and sense of wellbeing.

INTEGRATED CARE IS A VIABLE ALTERNATIVE TO INSTITUTIONS

Integrated care is "an organising principle for care delivery that aims to improve patient care and experience through improved coordination with integration being a combined set of methods, processes and models that bring it about" (Shaw & Rosen, 2011).

At the present time home care in Ontario is offered in a piecemeal, fragmented fashion that can result in elder care needs going unmet, several PSW's attending different clients in the same building, and older adults having difficulty finding support and navigating the system.

Support services are not offered in ways that target geographic areas of highest need, where the majority of elders living with frailty and people with disabilities live.

Services required by individuals with more complex needs are not bundled with personal support services, requiring that they and their loved ones navigate a complex, siloed health care system.

Integrated Care options address this problem. Below are three examples of integrated care in the community delivered by non-profit organizations.

PACE Burlington

Programs like PACE (Program of All Inclusive Care for the Elderly, n.d.) have been operating in the U.S. since it originated in San Francisco in the early 1970's. It has been highly successful in America with considerable research support. PACE provides "comprehensive medical and social services to frail, community dwelling elderly individuals….an interdisciplinary team of health professionals provides PACE participants with coordinated care…for most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home" (Medicaid.gov, n.d.).

Ontario currently has only one PACE program in Burlington. Comprised of service partners who voluntarily came together, it is showing early positive results similar to results described by PACE programs in the U.S.

OneConnect Durham Region

A proposal for a OneConnect PACE Program has been submitted to Ontario Health for funding in Durham Region by the non-profit Community Care Durham. This is a wrap-around service for older adults providing home and social care, health care, mental wellbeing, caregiver respite, and activation.

Peel Senior Link Hub and Spoke Model

Peel Senior Link's PACE type program – the Hub and Spoke model – that serves older adults in apartment buildings and the areas immediately surrounding them using a service coordination model has also been successful in maintaining older adults at home (Peel Senior Link, n.d.).

With many older adults requiring only some assistance to remain in their own homes and others having more complex care needs, PACE is an excellent solution since it provides care for older adults enrolled in the program that can be scaled up based on need.

University Health Network Integrated Care Program

The University Health Network (UHN) in Toronto supports an integrated care program that is client-directed, meaning that it is led by patients with services provided according to their identified needs. It provides wrap-around care for its patients through one point of contact, one patient record, and 24/7 support. An integrated care lead (system navigator and coordinator) brings all care providers together to ensure the individual receives continuity of care. This results in increased client education and self-management, delivery of more advanced care at home, decreased length of hospital stays and avoidance of unnecessary readmissions. The immediate impact on the health care system is that this integrated care approach "frees up beds, clinician time, and keeps patients, as much as possible, at home and in their communities" (UHN, 2025).

RESEARCH SUPPORT FOR PACE

PACE is the Gold Standard

In the U.S. PACE is described as "this innovative, accessible, and effective care model that successfully promotes independence for individuals with significant healthcare needs and is largely accepted as the gold standard for community-based integrated care"(McNabney et al., 2022).

"PACE provides comprehensive health services, including primary care, specialty medical care (audiology, dentistry, optometry, podiatry, etc), nursing, therapies (occupational, physical, recreational, speech, etc), pharmaceuticals, nutritional support, meals, behavioral health services, social services, day health center, home care, respite care, health-related transportation, and disability services. In addition to the breadth of care provided, the PACE model can expand its services to encompass other medically necessary services that would improve the participants' health" (McNabney et al., 2022; Williams & Chandrasekaran, 2023).

PACE Supports People Requiring Nursing Home Level Care

Sanford et al. (2020) found that "the average PACE participant is indistinguishable from a nursing home resident. The typical PACE participant is an older individual with 8 medical conditions and limitations or dependencies in 3 activities of daily living (ADLs). Nearly half of PACE participants have been diagnosed with dementia".

Wieland et al. (2020) found "despite high care needs, over 90 percent of PACE participants can continue to live in their

community with a good quality of life for up to 4 years".

PACE Successfully Addressed Elder Needs During the Pandemic

The pandemic hit older adults hard in Canada with thousands dying in long-term care facilities and many others struggling to find support in their own homes. "Between March 1, 2020, and August 15, 2021, over 56,000 residents and 22,000 staff in Canada's LTC and retirement homes were infected with COVID-19, resulting in more than 14,000 deaths among staff and residents (CIHI, 2021).

With Canada having among the highest death rates in the developed world in these facilities, it should have been a wake-up call that institutionalization is a dangerous option for frail older adults. Instead, rather than investing heavily in models that kept people at home and in their own communities - with proven success rates during the pandemic, Ontario doubled down on building even more costly institutions.

In sharp contrast to Canada and Ontario, research has shown that "PACE organizations responded rapidly to the COVID-19 pandemic, implementing a range of adaptations that shifted the PACE model from primarily center-based to a home-based model of care. Most PACE organizations reported an increase in the in-home services they provided, often accomplishing this through the redeployment of center-based staff. PACE organizations likewise leveraged telehealth and remote monitoring to increase support to beneficiaries in their home, implemented various COVID-19 vaccine and infection prevention efforts, increased food and nutrition services provided in the home, and took steps to address social isolation and boredom, among other initiatives" (Perry et al., 2023).

Funders Support PACE

The Centers for Medicare & Medicaid Services (CMS) consider the PACE provider-sponsored health plan model to be "the archetype for the future of older adult care in the United States because it integrates medical, behavioral, and social care for older adults with chronic illness (Gyurmey & Kwiatkowski, 2019).

Nevertheless, Ontario and Canada have not widely adopted this proven approach to maintaining individuals with complex needs in their own homes and communities. This has contributed to many older adults' fears of being institutionalized and undermined their quality of life and sense of wellbeing. It has also contributed to older adults lining the halls of hospitals, and lengthy wait lists for the most restrictive and costly option where older adults do not want to end up and where fewer professionals wish to work – long term care institutions.

HOUSING THAT SUPPORTS QUALITY OF LIFE AND WELLBEING

There is little thought currently given to home design that would support advanced old age and those living with frailty – an increasing demographic in Canada. Thought will need to be given about how to ensure that new housing builds are affordable, accessible, have space for integrated services and supports, and support technological innovations in care of older adults (Forsyth et al., 2019).

Naturally Occurring Retirement Communities and Programs

The NORC programs described earlier provide the first level of support for older adults to age in place.

Intergenerational Housing with Supports Built in for Aging Adults

Village Canada plans to build a large Canadian-built, non-profit, intergenerational, mixed income, and inclusive community at 875 Heron Road in Ottawa. The village will include all services required for older adults to age in place irrespective of their level of care requirements. There are currently fourteen service agencies, community associations and older adults' organizations coming together to develop this inclusive, intergenerational village. The Village will offer fitness, healthcare, and community support for older adults, and will be located close to a local mall, transit lines, and a footbridge across the Rideau River connecting with Carleton University to give students access to intergenerational housing, restaurants, cafeterias and recreational supports at the RA Centre.

This is exactly the kind of housing development that Seniors for Social Action (Ontario) has been advocating to assist older adults to age in place with dignity and support. It is a project that would support both younger and older people, and it could be built on unused federal government land through a land lease arrangement.

Cooperative Housing for Older Adults (Toronto)

The City of Toronto has several cooperative housing options that provide welcoming communities to support healthy aging in place in a maintenance free environment. In cooperative housing older adults pay a monthly fee for their homes but do not own them. "Becoming a resident and shareholder requires a one-time share cost and a monthly fee" (NICE, 2025).

Coop housing is affordable, encourages community and connection, promoting a sense of belonging and independence, while giving older adults a voice in managing their environments (Senior Care Services, 2025).

If coop housing is built according to universal design standards, it also becomes a more viable housing model for delivery of integrated personal and medical support services.

Co-Housing Options for Elders

Co-housing is essentially home sharing with others. Individuals have their own space but also share common spaces with other residents. These kinds of communities promote healthy aging and often include amenities such as enhanced accessibility and a suite for caregivers. Some co-housing communities in Canada are intergenerational encouraging interaction between residents of all ages thereby supporting interaction and connection – both of which address social isolation and loneliness (Canadian Cohousing Network, 2025).

If co-housing is built to universal design standards, it also provides an excellent venue for the addition of personal and medical support services.

Non-Profit Assisted Living Residences

Today older adults have few options but to live in for-profit retirement homes when they require some assistance given the absence of non-profit assisted living housing options. Retirement homes are extremely expensive and can quickly devour equity from the sale of individuals' homes, Non-profit assisted living residences can help to address this problem.

There are several advantages to this option being considered when deeply affordable housing is being funded and delivered. The non-profit advantage is that non-profits are directly accountable to the public for funding, include a strong volunteer based to provide additional support to residents, and they can offer a spectrum of services tied to individuals' needs rather than piecemeal home care approaches (AdvantAge Ontario, 2025). They are also governed by community boards often comprised of residents themselves.

When consideration is given to funding housing, emphasizing non-profit residences with assisted living services for older adults will be a vital part of the housing continuum.

Small, Non-Profit, Fully Staffed Neighborhood Homes

Individuals with physical and/or developmental disabilities, and mental health challenges already have access to small community residences, staffed 24/7 operated by non-profit organizations like Participation Houses, associations for community living, and mental health agencies.

This option is currently largely unavailable to older adults in Ontario and elsewhere in Canada.

It is an option that would be especially helpful for individuals with dementia (memory care homes) allowing them to remain in their familiar home communities. Small homes of six or fewer people would also be appropriate for the delivery of trauma-informed care – mind body therapies, music and art therapy, mindfulness and breathing exercises, and emotion-focused interventions. All of these are more appropriately delivered in small homes that are safe, where collaborative care is the norm, where staff and volunteers are trustworthy, and where residents are empowered and live in a culturally sensitive environment (Canadian Medical Association, 2025).

Trauma-informed care is critical for older adults with dementia because of the link between earlier traumatic life events and the development of dementia later in life (Severs et al., 2023).

Small homes of this nature delivered by non-profit, community-based agencies are also much more appropriate for cultural and Indigenous communities and for members of the LGBTQ+ community.

Small, neighborhood based homes will be a critical component of a housing strategy for Canada to support those with cognitive disabilities who also deserve a focus on their quality of life and wellbeing (Seniors for Social Action Ontario, 2025).

AGEISM – ONE OF THE LAST SOCIALLY ACCEPTABLE PREJUDICES

The World Health Organization (WHO) has defined ageism as "the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age (World Health Organization, 2020).

Stereotypical views of older adults abound in Canada, and little has been accomplished in combating these even though the psychological and health effects are now well documented (Weir, 2023). With ageist attitudes and behavior so prevalent but unacknowledged, internalized ageism appears to now also be a concern.

When older adults accept the discrimination, they start to go silent and stop talking about the things that concern them, fearing that they will be dismissed or humiliated. They begin to avoid social situations fearing that they will be put down or ignored. When even those with extensive successful professional and academic backgrounds are patronized and talked down to, it can have a very harmful impact on their self-esteem. Negative self-talk takes over, as SSAO members have reported, questioning "why am I even still here?" Depression and anxiety are not far behind when older adults are demeaned

and excluded from continued purposeful involvement in their communities.

Ageism in Canada - whether it be in the form of government policy and funding support for institutionalization of old people, or the general public that holds the view that spending taxpayer funding on old people is a waste, that old people should vacate their homes for younger people, or that old people's feelings don't count when it comes to end of life care - all of it has an extremely negative impact on older adults and interferes with their quality of life and wellbeing.

Ageism in Research

The considerable amount of federal spending on research on aging has not come with the requirement that older adults be involved in the choice of research topics and questions, research design, or interpretations of research results. Older adults' call for "nothing about us without us" has not been reflected in much research on aging conducted in Canada and this needs to change.

Researchers are often choosing topics that most older adults consider irrelevant with federal funding not being directed to research that would hold the most importance for them – such as research on the effectiveness of innovative alternatives to institutionalization.

Instead, research has often covered how to improve institutions and addressed staff and training issues, implying that staff issues are the same as resident issues (CIHI, 2025). Judging by reports to Seniors for Social Action Ontario, that is not the case.

It is time for a change. Baby Boomers are the most educated generation to date with considerable life and professional experience. To be ignored by researchers, public policy makers, and members of the general public – often those with far less knowledge, skills, or experience - has a devastating psychological impact. Researchers who do collaborate with older adults have found the experience to be helpful and to promote insight into what older adults need and how they feel.

Most Canadians do not realize that they are being ageist. From the young receptionist who talks down to an older adult on the phone aggressively asserting "if you'll let me finish!" while ignoring the older person's concerns, to elected officials who completely ignore older adults' wishes to age in place in their own homes and communities, instead directing billions in funding to institutions, ageism is pervasive and damaging. Apparently Canadians are largely unaware of just how damaging it is (IPSOS, 2024).

Ageism is a pervasive issue in Canada that demands immediate attention if older adults' quality of life and sense of wellbeing are to improve.

Through raising public awareness of ageism, promoting positive aging and the significant contributions to society made by older

people, implementing policy and program changes to support aging in place and inclusivity, and conducting further research that involves older adults, we can strive toward a more inclusive and equitable society for all Canadians. Ageism needs, finally, to be addressed at the federal government level.

APPLIED BEHAVIOR ANALYSIS AND COMMUNITY-BASED INTERVENTIONS FOR OLDER ADULTS

This section of the report will outline the importance of providing behavioral support at home and in non-profit, staffed small homes and assisted living residences where it can be more effectively and humanely employed than in institutional settings that fail to provide the safety, peer support, collaboration and mutuality, voice and choice (empowerment), and cultural sensitivity required for behavioral and trauma-informed approaches.

Applied Behaviour Analysis (ABA) is a scientific approach grounded in the principles of behaviourism, emphasizing the assessment and systematic modification of socially significant behaviours (Cooper, Heron, & Heward, 2020). While ABA has traditionally been applied to developmental disabilities and educational settings, its relevance to gerontology—particularly in community-based contexts—has gained scholarly and clinical attention. Community-based ABA interventions for older adults present an opportunity to enhance quality of life, maintain independence, and address problem behaviours in aging populations.

Behavioural Challenges in Older Adults

Aging is associated with a range of behavioural and cognitive challenges, including declines in memory, mobility, and social engagement. Additionally, older adults may exhibit problem behaviours such as aggression, wandering, or withdrawal, particularly in the context of dementia or acquired brain injuries (Trahan et al, 2011). These behaviours often lead to institutionalization, reduced autonomy, and caregiver burden.

Functional behaviour assessments (FBAs) are critical tools within ABA for identifying the antecedents, behaviours, and consequences (ABCs) that maintain such problem behaviours (Iwata et al, 1994). Problem behaviours have been demonstrated to serve specific functions (e.g., attention, escape, access to tangibles, sensory or automatic reinforcement). Interventions are designed to address the function of a problem behaviour. By applying FBAs in community settings, practitioners can design individualized interventions that are both ethical and effective.

Rehabilitation and Dementia

Progressive dementia can result in the deterioration of a variety of abilities such as short-term memory, language, reasoning, and self-care. Though cure is not a possibility now, stabilization through rehabilitation is a worthy goal (Buchanan et al, 2011). Buchanan et al. describe the Baltes and Baltes (1990) selective optimization with compensation model. The model proposes a process where the person with dementia and their caregivers select relevant repertoires for rehabilitation, efforts to optimize those repertoires, and strategies to help individuals compensate for lost abilities (p. 10).

Buchanan et al., describe interventions based on behavioural principles in the following areas of rehabilitation: cognitive rehabilitation and memory enhancement, altering social contingencies and communication styles, improving self-care skills, modification of physical environments, and increasing physical exercise and activity. The techniques suggested include external memory aids (e.g., shopping lists, calendars); the listener restating their understanding of what the person said; verbal and nonverbal prompting, modeling, and reinforcement; displaying emergency contact information in prominent locations; and structured exercise programs.

Trauma-Informed Care

Traditional care models, particularly those that do not account for an individual's trauma history, may inadvertently re-traumatize older adults. This can happen when care practices are perceived as coercive, unpredictable, or disempowering, leading to client resistance, poor engagement with services, and ultimately, worsened health outcomes.

As previously mentioned, Applied Behaviour Analysis (ABA) offers a structured, evidence-based, and data-driven approach to understanding and modifying behaviour. It operates by systematically assessing environmental influences on behaviour, implementing targeted interventions, and making decisions based on observed data. A specialized area within ABA, known as Behavioural Gerontology, specifically applies these principles to address age-related issues and enhance the quality of life for older adults.

The integration of Trauma-Informed Care (TIC) principles into ABA practice holds significant promise for creating a more compassionate, safe, and effective therapeutic environment for older adults. This integrated approach fundamentally shifts the focus from merely managing or suppressing "problem behaviours" to understanding their underlying causes, which are often rooted in past or re-triggered trauma. By combining these two frameworks, a synergistic care model

emerges. While ABA traditionally emphasizes observable behaviours and environmental contingencies, integrating TIC provides the crucial context of "why" certain challenging behaviours manifest. This allows for interventions that are not only effective in modifying behaviour but also profoundly healing and dignity-preserving. This convergence moves beyond simple symptom management to address the root causes of distress, fostering genuine growth and well-being.

Community-Based Settings and Delivery Models

Community-based ABA interventions for elderly adults typically occur in various settings including adult day care centers, assisted living facilities, home environments, and community centers. Function-based interventions have demonstrated effectiveness in addressing challenging behaviours (Baker et al.., 2005; Beavers et al.., 2013). These community settings offer several advantages over institutional care, including maintenance of familiar environments, preservation of social connections, and increased opportunities for naturalistic learning and behaviour change.

The implementation of community-based ABA programs typically involves several key components. First, comprehensive behavioural assessments are conducted to identify target behaviours, environmental factors, and potential reinforcers. Second, individualized behaviour intervention plans are developed based on functional analysis results. Third, training is provided to caregivers, family members, and community staff to ensure consistent implementation of interventions. Fourth, ongoing data collection and analysis guide treatment modifications and measure progress toward behavioural goals.

Community-based interventions emphasize accessibility and integration within the individual's natural environment—such as their home, community centers, or assisted living facilities—rather than in clinical or institutional settings. This ecological approach aligns with person-centered planning and supports aging-in-place, a priority in modern geriatric care (Mahoney et al.., 2003).

Community-based ABA interventions may involve:

- Caregiver training to manage problem behaviours using reinforcement strategies.
- Activity scheduling to promote engagement and reduce passive or depressive behaviours.
- Environmental modifications to prevent elopement or falls.
- Prompting and fading techniques to support skill acquisition and independence in daily living tasks.

Challenges and Considerations

Implementing community-based ABA interventions with elderly adults presents several unique challenges that require careful consideration. Cognitive impairments associated with aging and dementia can affect learning capacity, memory retention, and generalization of behavioural changes. Interventions must be adapted to accommodate these limitations while maintaining effectiveness and dignity.

Physical health considerations also play a significant role in intervention design. Age-related changes in mobility, sensory abilities, and overall health status may impact the feasibility of certain behavioural interventions. Additionally, medication effects and medical treatments can influence behaviour and response to interventions, requiring close collaboration with medical professionals.

Social and cultural factors represent additional important considerations. Elderly individuals often have well-established behavioural patterns, personal preferences, and cultural values that must be respected during intervention planning. Family dynamics and caregiver stress can also significantly impact intervention success, necessitating comprehensive support systems for all involved parties.

Ethical Considerations

The application of ABA interventions with elderly adults raises important ethical considerations that must be carefully addressed. Informed consent processes must be adapted for individuals with cognitive impairments, potentially involving family members or legal guardians while still respecting individual autonomy to the greatest extent possible Behaviour Analyst Certification Board's (BACB) Professional and Ethical Compliance Code (BACB, 2020).

Dignity and person-centered approaches must guide all intervention decisions. Behavioral goals should align with individual preferences and values rather than simply conforming to institutional or caregiver convenience. The use of restrictive procedures should be minimized, with emphasis placed on positive reinforcement and environmental modifications.

Cultural sensitivity becomes particularly important when working with elderly individuals who may have strong cultural traditions and values. Interventions must be designed to respect cultural backgrounds while addressing behavioral concerns effectively.

Conclusion

Community-based Applied Behavior Analysis represents a promising and evidence-based approach for addressing behavioral challenges in elderly adults. The systematic application of behavioral

principles, combined with person-directed approaches and comprehensive support systems, can significantly improve quality of life for aging individuals while supporting their continued community participation. As populations continue to age globally, the development and refinement of community-based ABA interventions will become increasingly important for promoting successful aging and reducing the burden on healthcare systems.

The success of these interventions depends on careful attention to the unique needs and characteristics of elderly populations, comprehensive training for all stakeholders, and ongoing research to refine and improve intervention strategies. With continued development and research, community-based ABA has the potential to play a crucial role in supporting the growing population of elderly adults in maintaining independence, dignity, and quality of life

PROMOTING QUALITY OF LIFE AND WELLBEING AT THE END OF LIFE

Older Canadian adults want to live their lives to the fullest until their last days. For most, this means they want to age at home in the community (National Institute on Aging, 2022). In a 2020 survey, as many as 96% of Canadians aged 65 and older reported they would do anything they could to avoid going into a long-term care facility (National Seniors Council, 2024). Living in the community also achieves greater health equity for older adults as they remain connected to their culture, language, and lifestyle.

In a recent study, Canadians reported a preference to die at home if required home-based services are available, their symptoms can be managed, and their family and community caregivers are well supported (Funk et al, 2022). Despite these preferences, most Canadians still die in institutions (hospital and long-term care homes), with less than 20% dying at home in the community (Statistics Canada, 2025;Canadian Institute of Health Information, 2022) Why is this?

The fundamental reason is that the Canadian government does not take a health promoting approach to older adults' end-of-life care that considers their quality of life and wellbeing. There is insufficient support for older adults to live well in the community right to the end of life. A health promoting approach aims to support people in achieving their fullest potential at all stages of their lives and it also includes accepting death as an inevitable life transition. It requires proactively supporting citizens at this vulnerable time of life as a social obligation. The 1986 Ottawa Charter for Health Promotion (World Health Organization, 1986) offers us a blueprint for achieving this.

The Ottawa Charter for Health Promotion identified five key action areas that the Canadian government can implement to support older adults living well in the community until end of life. These five action areas are interconnected and reinforce the importance of providing more social infrastructure to support older adults to age and die at home.

The five action areas of the Ottawa Charter are:

1. Build healthy public policy that integrates health (for all ages) into all policy areas, not only into health care. For older adults, this should include policy related to providing housing and economic wellbeing and creating policy to support community action that provides social wellbeing right to the end of life.

2. Create supportive environments that foster safe and enjoyable living and address all the environmental and social determinants of health. For older adults, this should include development of affordable and safe community housing options with barrier free environments and space to accommodate medical equipment if needed. Supportive social environments should include creating programs in Naturally Occurring Retirement Communities, called NORCs (University Health Network, n.d.) such as the OASIS program (OASIS national, n.d.).

3. Strengthen community action by supporting and empowering communities to set priorities, make decision, and take action to improve their health. This should include providing support to create compassionate community initiatives in which local community connectors provide social support, information on health and social services, and to develop neighbourhood networks that provide practical care (e.g. shopping, driving, visiting) for people who are experiencing illness or disability, and their caregivers (Tompkins, 2018; B.C. Center for Palliative Care, n.d.; Kellehear, 2005; Kellehear, 2013). While this would benefit people of all ages, it would benefit older adults most.

4. Developing personal skills to live well right to the end of life. This should include funding community education on end-of-life issues to help citizens gain the knowledge and skills necessary to remain healthy in later life and prepare themselves and their loved ones to navigate end of life (Kellehear, 2005; Kellehear, 2013). This would benefit people of all ages, but especially older adults and caregivers.

5. Reorienting health services away from hospital and institutional care (including long term care) to provide care at home in the community. This will benefit people of all ages who are seriously ill, dying and grieving. Innovative models for re-orientating health services being piloted or implemented in Canada and these can be scaled up nationally. Some examples include PACE (Program of All Inclusive Care for the Elderly-Burlington, Ontario) (PACE Burlington, n.d.), CAPABLE (The Community Aging in Place, Advancing Better Living for Elders Program-Nova Scotia) (Government of Nova Scotia, 2023) and the Extra-Mural Program (Hospital at Home-New Brunswick) (Extra Mural Program New Brunswick, n.d.). Existing home and community care programs across Canada can also provide enhanced services for older adults living in NORCs, rural areas and other geographies with a concentration of older adults if they have flexible funding models that facilitate assigning home care staff to serve a geography rather than individual clients.

Compassionate Communities as a Critical Social Infrastructure to Promote Quality of Life and Wellbeing for Older Adults

A Compassionate Community is a community of people, everyday citizens, who are passionate and committed to improving the experiences of those living with a serious illness, caregiving, dying, and grieving. Citizens of all ages take an active role in supporting people affected by these experiences. They do this by raising awareness about end-of-life issues, connecting individuals to care and services, and building supportive networks around people in need (Tomkins, 2018; BC Centre for Palliative Care, n.d.). Nurturing and supporting Canadian communities to implement Compassionate Community initiatives is fundamental to implementing a health promoting approach to end of life for older adults living in the community.

A Health Promoting Approach to End-of-Life Care views supporting people who are seriously ill, caregiving, dying, and grieving as a community responsibility, not solely the job of health care professionals. In fact, research has demonstrated that 95% of a seriously ill or dying person's time is not spent with professionals. Rather, 95% of the time is spent with family, friends, alone,

with animal companions or engaged in community activity (Kellehear, 2013; Kellehear, 2022). Although professionals do play an essential role in both home care and a home death, creating a Compassionate Community is primarily about building the capacity of community members (friends, neighbours, work mates, play mates etc.) to support one another at end of life.

Developing compassionate communities for end-of-life support has gained international momentum since the 2005 publication of the book “Compassionate Cities: Public Health and End of Life Care (Kellehear, 2005). The International Public Health Palliative Care Association (IPHPC) formed in 2013 to help promote Compassionate Communities as a social movement. IPHPC currently has a membership of 86 countries including Canada. Canada hosted the IPHPC Conference in Ottawa in 2017.

Key strategies in nurturing compassionate communities are community development, public education about end-of-life issues and implementing community connector programs. Community connectors are members of the community who receive coaching and support to connect people with needed information and resources and facilitate developing supportive networks of community members (Abel, 2018; Abel & Clarke, 2020).

Research conducted in Frome, England, demonstrated that implementing Community Connector programs for people with chronic or serious illnesses increased people’s wellbeing, reduced their visits to the hospital emergency by 14% and cut overall health care costs by 20% (Abel & Clarke, 2020).

Different countries have taken different approaches to compassionate community development. Some implement large-scale public education programs such as Last Aid (23 counties involved with the Canadian Hospice Palliative Care Association beginning 2025) or PalliLearn Courses (SW Australia and Alberta, Canada). Public Awareness Campaigns are common, for example, the annual Dying to Know Day (Australia) and in Canada, Advance Care Planning Day and National Grief and Bereavement Day (Canadian Hospice Palliative Care Association). Community Connector Training Programs have been developed in England (Compassionate Communities UK) and Australia (SW WA and Perth). Compassionate Ottawa is initiating a community connector program with ethnocultural older adults groups in 2026. Kerala, India, has mobilized and trained community networks to support people in their own homes, an approach now being replicated widely in Africa. The BC Centre for Palliative Care (Canada) has provided education, seed grants and toolkits that support community-based organizations support people who are caregiving, dying and grieving using compassionate community models.

Compassionate Community initiatives that have been most successful and impactful have received sustained funding from

governments. Internationally, sustained funding has come from various sources such as health departments, health authorities, public health systems or national palliative care strategies, depending on country and jurisdiction. Lack of sustained funding government has made achieving spread and momentum for compassionate community initiatives a challenge in Canada.

The Compassionate Community movement in Canada has been growing in the last 20 years. This is a testament to passion and commitment. Most Compassionate Community initiatives operate with volunteers and are funded by donations and sporadic and short-term grants from foundations and government. The provincial governments of Quebec, Alberta and British Columbia support Centres for Palliative Care which include significant Compassionate Community work. However, the federal government has provided little support for Compassionate Communities beyond some project funding from Health Canada.

The federal government in Canada has an important role to play in building community capacity and developing social infrastructure for aging and dying in the community. This includes Compassionate Communities, NORCs and older adults' community housing. Together they will provide the social infrastructure to support older adults to live well in the community right until the end of their lives.

RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

Seniors for Social Action Ontario is recommending:

1. That Oasis Communities for Aging Well be promoted and funded across Canada as an evidence-based approach to support older adults to continue to enjoy independent living and community involvement.

2. That NORC-based programs like Connections 400 that are highly effective be promoted and funded in established and developing vertical and horizontal NORCs for older adults requiring some minimal support to maintain health.

3. That the CAPABLE program be promoted and funded across Canada as a strengths and evidence based approach to maintaining individuals in their own homes and communities.

4. Funding PACE-like integrated care programs in community housing, seniors' buildings, vertical and horizontal NORCs, and within other deeply affordable housing initiatives would help to address the quality of life and wellbeing needs of older adults and provide the equitable

social infrastructure within housing initiatives required to help them to age in place.

5. When providing transfer payment funding to the provinces, require that there be a range of deeply affordable housing options that are accessible, and that meet the needs of an aging population. Funding a variety of housing options that support aging in place will be a vital part of a deeply affordable housing continuum that takes into account quality of life and wellbeing of older adults and individuals with disabilities. This could be accomplished by redirecting funding currently used for mass institutionalization of older adults towards non-profit residential assisted living and non-profit, community-based, integrated care programs where older adults are living.

6. When funding research on aging, require that older adults act as advisors to researchers and help determine research questions, processes, and analyses of findings.

7. Launch a federal public education campaign promoting the contributions of older adults to Canadian society and one that defines ageism and its impact, encouraging conversations between the generations, especially concerning end-of-life decisions.

8. That the Federal government consider attaching a requirement to health funding transfers to be directed towards in-home, and community-based residential dementia care employing behavioral supports rather than locked wards in institutions.

9. That the Federal government fund compassionate community initiatives that include training for community connectors and public education to support individuals being able to die in their own homes and communities rather than in hospital or institutional settings.

CONTRIBUTORS TO THIS REPORT

Helen Cooper has an academic background in Chemistry, Mathematics B.Sc. and Economics and Statistics M.Sc. She served as a municipal councillor, then as mayor of Kingston, Ontario, followed by a term as Chair of the Ontario Municipal Board. She was President of the Association of Municipalities of Ontario and a member of the Premier's Council on Health Strategy, as well as the Board of Cancer Care Ontario and the Advisory Council of the Nuclear Waste Management Organization. She was a charter board member of the Ontario Non-profit Housing Association. She is a recipient of the Queen Elizabeth Golden Jubilee Medal, a Distinguished Fellow at the Queen's School of Policy Studies and Past President of Oasis Senior Supportive Living Inc.

Patricia Spindel Ed.D. is the Chair of Seniors for Social Action Ontario, a co-founder of the Advocacy Centre for the Elderly, and a former President of Concerned Friends of Ontario Citizens in Care Facilities. She is also a recipient of a Government of Canada medal for service to her community. In her professional life she was a full time professor at the University of Guelph-Humber, Associate Dean of Health Sciences at Humber College, and Coordinator of the Social Services Worker Program. She served on the Council of the College of Social Workers and Social Services Workers and has authored three textbooks for Canadian Scholars Press.

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Mary Lou Kelley MSW, PhD has been engaged in practice, teaching and research in gerontology and palliative care since 1972. Her research used participatory action and community capacity development approaches to empower and support community members and front-line workers and create changes that improved the end of life for people, their families and communities. She was founding Director of the Centre for Education and Research on Aging and Health (CERAH) at Lakehead University. Mary Lou was the recipient of the Canadian Hospice Palliative Care Association's 2011 Award of Excellence, the

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Lynne Slotek, MSW, worked in the following fields: child welfare, early learning, mental health, criminal justice, prevention of homelessness and the prevention of violence against women. She was a field instructor for the graduate social work program at the University of Toronto and York University. She held executive director and senior management positions at Sistering (Toronto), the John Howard Society of Toronto, the Children's Aid Foundation (Toronto) and the Atkinson Charitable Foundation. Lynne served on two boards - one delivering advocacy and education to prevent violence against women and one developing housing for low-income senior women. She was the National Director of, and foundational leader for the Canadian Index of Wellbeing (CIW), an index developed to measure the wellbeing of Canada (with the Honourable Roy J. Romanow, the late Honourable Monique Begin and the Honourable David Johnston.) In 2015 she moved to a Naturally Occurring Retirement Community (NORC) in Toronto where she was a founding member of, and currently Board President of Connections 400 (formerly known as Oasis 400), an aging in place incorporated not for profit organization. In 2022 Connections 400 received a Community Hero Award from the Provincial Government for making life better in Toronto-St. Paul's.

REFERENCES

Abel, J. (2018). Compassionate communities and end-of-life care. *Clinical Medicine, 18*(1), 6–8. https://doi.org/10.7861/clinmedicine

Abel, J., & Clarke, L. (2020). The compassion project: A case for hope and human kindness from the town that beat loneliness. U.K: Aster.

Abel, J., & Kellehear, A. (2022). Oxford textbook of public health and palliative care. England: Oxford University Press. https://doi.org/10.1093/med/9780198862994.001.0001

AdvantAge Ontario. (2025). The not-for-profit difference in senior care. https://www.advantageontario.ca/AAO/Content/Resources/Consumers/The_Not_For_Profit_Difference_in_Senior_Care

Aoun, S. M., Richmond, R., Gunton, K., Noonan, K., Abel, J., & Rumbold, B. (2022). The Compassionate Communities Connectors model for end-of-life care: Implementation and evaluation. *Palliative Care and Social Practice*, 16. https://doi.org/10.1177/26323524221139655

Baker, J. C., Hanley, G. P., & Mathews, R. M. (2006). Staff-administered functional analysis and treatment of aggression by an elder with dementia. *Journal of Applied Behavior Analysis, 39*(4), 469-474. https://pmc.ncbi.nlm.nih.gov/articles/PMC1702326/

Baltes, M. M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. In P. B. Baltes & M. M. Baltes (Eds.), *Successful aging: Perspectives from the behavioral sciences*. New York: Cambridge University Press.

BC Centre for Palliative Care. (n.d.). Compassionate communities. https://www.bc-cpc.ca/all-resources/community-organizations/compassionate-communities-2/

Beavers, G.A., Iwata, B.A., and Lerman, D. (2013). Thirty years of research on the functional analysis of problem behaviour. *Journal of Applied Behavior Analysis,* 46(1), 1 – 21. https://pubmed.ncbi.nlm.nih.gov/24114081/

Behavior Analyst Certification Board. (2020). *Ethics Code for Behavior Analysts*. https://www.bacb.com/ethics/

Bowden, O. (May 29, 2024). Housing crisis is forcing more seniors into shelters, doctors say. https://www.cbc.ca/news/canada/toronto/toronto-seniors-homeless-shelter-1.7217059

Buchanan, J. A., & Fisher, J. E. (2002). Functional assessment and intervention for disruptive behavior in a nursing home. *Behavior Modification, 26*(4), 472–490. https://doi.org/10.1177/0145445502026004004

Buchanan, J.A., Christensen, A., Houlihan, D., and Ostrom, C. (2011). The role of behavior analysis in the rehabilitation of persons with dementia. *Behavior Therapy, 42*, 9 – 21. https://pubmed.ncbi.nlm.nih.gov/21292047/

Canadian Cohousing Network. (2025). Senior cohousing. https://cohousing.ca/senior-cohousing/

CIHI. (December 9, 2021). COVID's impact on long term care. https://www.cihi.ca/en/covid-19-resources/impact-of-covid-19-on-canadas-health-care-systems/long-term-care

Canadian Institute of Health Information. (2022). Death at home or in the community. https://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en#!/indicators/096/death-at-home-or-in-community/;mapC1;mapLevel2;/

Canadian Medical Association. (2025). Trauma-informed care: Better care for everyone. https://www.cma.ca/physician-wellness-hub/resources/policies-standards-and-best-practices/trauma-informed-care-better-care-everyone

Canadian Press. (June 6, 2025). Elderly homeless population increasing in Canada: 'I really don't know where to even begin'. https://www.ctvnews.ca/canada/article/were-people-too-canadas-homeless-population-is-aging-changing-how-shelters-run/

CIHI. (May 22, 2025). Recent staffing and quality indicator trends in long term care. Recent staffing and quality indicator trends in Canadian long-term care | CIHI

CNA. (October 27, 2022). What you need to know about the new assisted living HDB blats in Queenstown for seniors. https://www.channelnewsasia.com/singapore/community-care-apartments-hdb-flats-bto-queenstown-seniors-faq-3028446

Cooper, J. O., Heron, T. E., & Heward, W. L. (2020). Applied behavior analysis (3rd ed.). Toronto: Pearson.

Donnelly, C., Mahoney, J., Hay, M., Parniak, S., Goes, S., DePaul. (2019). Oasis Seniors Supportive Living: A model of active aging. OT Now.

Extra-Mural Program New Brunswick. (n.d.). EXTRAMURAL. https://extramuralnb.ca/

Forsyth, A., Molinsky, J., Kan, H.Y. (January 18, 2019). Improving housing and neighborhoods for the vulnerable: older people, small households, urban design and planning. https://link.springer.com/article/10.1057/s41289-019-00081-x

Funk, L. M., Mackenzie, C. S., Cherba, M., Del Rosario, N., Krawczyk, M., Rounce, A., Stajduhar, K., & Cohen, S. R. (2022). Where would Canadians prefer to die? Variation by situational severity, support for family obligations, and age in a national study. *BMC Palliative Care, 21*(1), 139. https://pubmed.ncbi.nlm.nih.gov/35909120/

Government of Nova Scotia. (2023). Supports to help seniors stay in their homes. https://news.novascotia.ca/en/2023/12/18/supports-help-seniors-stay-their-homes

Gyurmey, T., Kwiatkowski, J. (June 4, 2019). Program of All-Inclusive Care for the Elderly (PACE): Integrating Health and Social Care Since 1973. *Rhode Island Medical Journal*, 102(5), pgs. 30-32. http://www.rimed.org/rimedicaljournal/2019/06/2019-06-30-imsc-kwiatkowski.pdf

Harvard. (2025). Welcome to the Harvard Study of Adult Development. https://www.adultdevelopmentstudy.org/

How to ABA. (n.d.). How to ABA and Dr. Camille Kolu discuss core principles of trauma informed care in Applied Behavior Analysis. https://www.youtube.com/watch?v=1nPska8vuTM

Hunt, M.E. & Gunter-Hunt, G. (1985). Naturally occurring retirement communities. *Journal of Housing for the Elderly*, 3 (3-4). Haworth Press Inc. https://ogg.osu.edu/media/documents/sage/handouts/Naturally%20Occurring%20Retirement%20Communities.pdf

IPSOS. (December 3, 2024). Canadians' understanding of ageism varies widely, revealing a significant lack of awareness regarding its pervasiveness and detrimental consequences. https://www.ipsos.com/en-ca/public-opinion-on-awareness-of-ageism-in-Canada-2024

Iwata, B. A., Dorsey, M. F., Slifer, K. J., Bauman, K. E., & Richman, G. S. (1994). Toward a functional analysis of self-injury. *Journal of Applied Behavior Analysis, 27*(2), 197–209. (Original work published 1982). https://doi.org/10.1901/jaba.1994.27-197

Johns Hopkins. (2025). CAPABLE – Community Aging in Place – Advancing Better Living for Elders. https://nursing.jhu.edu/faculty-research/research/projects/capable/

Kellehear, A. (2005). Compassionate cities: Public health and end of life care. Oxfordshire, England: Routledge.

Kellehear, A. (2013). Compassionate communities: End-of-life care as everyone's responsibility. QJM: An International Journal of Medicine, 106(12), 1071–1075. https://pubmed.ncbi.nlm.nih.gov/24082152/

Lucock, Z. R., Williams, E. E. M., & Dillenburger, K. (2025). Behavioral gerontology at home: Retaining selfcare skills in an older adult with major neurocognitive disorder through stimulus control and subtle prompt hierarchies from spousal caregiver. *Behavior Analysis: Research and Practice. Advance online publication*. https://dx.doi.org/10.1037/bar0000310

Mahoney, D. F., Tarlow, B. J., & Jones, R. N. (2003). Effects of an automated telephone support system on caregiver burden and anxiety: Findings from the REACH for TLC intervention study. *The Gerontologist, 43*(4), 556–567. https://doi.org/10.1093/geront/43.4.556

Medicaid.gov. (n.d.). Program of All Inclusive Care for the Elderly. https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly

McNabney, M.K., Fitzgerald, P., Pedulla, J., Phifer M, Nash M, Kinosian B. (December, 2022). The Program of All-Inclusive Care for the Elderly: An Update after 25 Years of Permanent

National Institute on Ageing. (2022). Ageing in the right place: Supporting older Canadians to live where they want. https://www.niageing.ca/airp

National Seniors Council. (2024). Final report of the expert panel: Supporting Canadians aging at home: Ensuring quality of life as we age. https://www.canada.ca/content/dam/esdc-edsc/documents/national-seniors-council/programs/publications-reports/aging-home/NSC-ExpertPanel-AgingAtHome-FinalReport-EN-20240621.pdf

NICE. (2025). Housing options for older adults in Canada. https://www.nicenet.ca/articles/housing-options-for-older-adults#3a

Oasis. (2025). The three Oasis pillars. https://www.oasisagingwell.com/

Oasis National, Queen's University. (n.d.). OASIS Aging Well. https://www.oasisagingwell.com/

PACE Burlington, ON. (n.d.). *PACE program overview* [Video]. YouTube. https://www.youtube.com/watch?v=HN2wAaa7s0E Retrieved June 30, 2025

Program of All Inclusive Care for the Elderly. (2025). Program of All Inclusive Care for the Elderly. https://www.cms.gov/medicare/medicaid-coordination/about/pace

Provider Status .*Journal of the American Medical Directors Association,* 23(12). Pgs.1893-1899. https://www.sciencedirect.com/science/article/abs/pii/S1525861022007277

PACE Community Hub Burlington. (2025). PACE Community Hub. https://alzda.ca/pace-wellness-hub/

Parniak, S., DePaul, B.G., Frymire, C., DePaul, S., Donnelly, C. (April 14, 2022). Naturally occurring retirement communities: Scoping review. *JMIR Aging*, 14(3), 2. https://pubmed.ncbi.nlm.nih.gov/35436204/

Peel Senior Link. (n.d.). Assisted living services for high risk seniors. https://peelseniorlink.com/_content/uploads/2018/08/Board-Orientation-version.pdf

Perry, M., McCall, S., Nardone, M., Dorris, J. Obbin, S., Stanik, C. (February 25, 2023). Program of All-Inclusive Care for the Elderly (PACE) organizations flip the script in response to the COVID-19 pandemic. *Journal of the American Medical Director Association*. https://pubmed.ncbi.nlm.nih.gov/38163643/

Sanford, A.M., Morley, J.E., Berg-Weger, M., Lundy, J., Little, M.O., Leonard, K., Malmstrom, T.K. (2020). High prevalence of geriatric syndromes in older adults. PLoS One. 15(6). https://pubmed.ncbi.nlm.nih.gov/32502177/

Senior Care Services. (2025). Toronto Seniors Cooperative. https://retirementhomestoronto.ca/housing_options/seniors-co-operative

Senior Women Living Together. (2025). Welcome to Senior Women Living Together. https://swlt.ca/

Seniors for Social Action Ontario. (2023). Is home care working in Ontario? A Review of Home and Community Care Support Services. https://www.seniorsactionontario.com/_files/ugd/c73539_194912a643164a5f980b8b17a4650690.pdf

Seniors for Social Action Ontario. (July, 2025). Small not for profit neighborhood homes: The need and the potential in Ontario. https://mcusercontent.com/36363a028fc1d1a14890ff48e/files/610e4273-7631-c044-84e6-f551d8b65aa1/SSAO_Small_Neighbouhood_Homes_Project.pdf

Severs, E., James, T., Letrondo, P., Lovland, L., Marchant, N.L., & Mukadam, N. (September 22, 2023). Traumatic life events and risk for dementia: a systematic review and meta-analysis. *BMC Geriatrics*. https://pmc.ncbi.nlm.nih.gov/articles/PMC10517510/

Shaw S, Rosen R. & Rumbold B. (2011). What is integrated care? Nuffield Trust. https://www.nuffieldtrust.org.uk/research/what-is-integrated-care

Statistics Canada. (February 19, 2025). Deaths, by place of death (hospital or non-hospital) [Table 13-10-0715-01*]*. https://doi.org/10.25318/1310071501-eng

Statistics Canada. (April 23, 2025). Older adults and population aging. https://www.statcan.gc.ca/en/subjects-start/older_adults_and_population_aging

StatsCan+. (September 23, 2024). The older people are all right. https://www.statcan.gc.ca/o1/en/plus/7059-older-people-are-all-right

SWLT. (2025). Welcome to Senior Women Living Together. https://swlt.ca/

Tompkins, B. (2018). Compassionate communities in Canada: It is everyone's responsibility. *Annals of Palliative Medicine*. https://apm.amegroups.org/article/view/19240/pdf

Trahan, M. A., Kahng, S. W., Fisher, A. B., & Hausman, N. L. (2011). Behavior analytic research on older adults with dementia. *Journal of Applied Behavior Analysis*, 44, 687–691. http://dx.doi.org/10.1901/jaba.2011.44-687

U.N. Decade of Healthy Aging Plan. (2022). The Platform. https://www.decadeofhealthyageing.org/

University Health Network (UHN). (2025). Welcome to the integrated care program. https://www.uhn.ca/Integrated-Care

University Health Network (UHN). (n.d.). NORC Innovation Centre. https://norcinnovationcentre.ca/

VON Canada. (2024). CAPABLE. https://von.ca/en/capable

University Health Network. (2022). It's time to unleash the power of naturally occurring retirement communities in Canada. *UHN NORC Innovation Centre, National Institute on Aging*. https://norcinnovationcentre.ca/wp-content/uploads/NORC-Report-FINAL.pdf

Weir, K. (March 1, 2023). Ageism is one of the last socially acceptable prejudices. Psychologists are working to change that. https://www.apa.org/monitor/2023/03/cover-new-concept-of-aging

WHO. (October, 26, 2020). Healthy ageing and functional ability. https://www.who.int/news-room/questions-and-answers/item/healthy-ageing-and-functional-ability

Wieland, D., Boland, R., Baskins, J., & Kinosian, B. (July, 2010). Five-year survival in a Program of All-inclusive Care for Elderly compared with alternative institutional and home- and community-based care. *Journal of Gerontology and Biological Sciences*, 65(7), pgs. 721-6. https://academic.oup.com/biomedgerontology/article-abstract/65A/7/721/560137?redirectedFrom=fulltext

Williams, C.T. & Chandrasekaran, S. (October 28, 2023). Program of All Inclusive Care of the Elderly (PACE). https://www.ncbi.nlm.nih.gov/books/NBK597375/

World Health Organization. (2020), Global Report on Ageism. https://www.who.int/publications/i/item/9789240016866

World Health Organization. (1986). Ottawa charter for health promotion. https://www.canada.ca/content/dam/phac-aspc/documents/services/health-promotion/population-health/ottawa-charter-health-promotion-international-conference-on-health-promotion/charter.pdf

Xia, B., Jiaxuan, E. & Susilawati, C. (April, 2022). An overview of naturally occurring retirement communities (NORCs) for aging in place. https://www.researchgate.net/publication/360136732_An_Overview_of_Naturally_Occurring_Retirement_Communities_NORCs_for_Ageing_in_Place