Title

Aging all over the place: a multidisciplinary framework, that considers place and life trajectories of older adults within their communities

Abstract

Purpose

This conceptual paper describes *Aging All Over the Place* (AAOP), a federative framework for action, research and policy that considers older adults' diverse experiences of place and life trajectories, along with person-centered care.

Design/methodology/approach

The framework was developed through group discussions, followed by an appraisal of aging models and validation during workshops with experts, including older adults.

Findings

Every residential setting and location where older adults go should be considered a 'place', flexible and adaptable enough so that aging *in place* becomes aging *all over the place.* Healthcare professionals, policymakers and researchers are encouraged to collaborate around four axes: 1) biopsychosocial health and empowerment; 2) welcoming, caring, mobilized, and supportive community; 3) spatiotemporal life and care trajectories; and 4) out-of-home care and services. When consulted, a Seniors Committee showed appreciation for flexible person-centered care, recognition of life transitions and care trajectories, and meaningfulness of the name.

Originality

Building on the introduction of an ecological experience of aging, AAOP broadens the concept of care as well as the political and research agenda by greater integration of community and clinical actions. AAOP also endeavors to avoid patronizing older adults and engage society in strengthening circles of benevolence surrounding older adults, regardless of their residential setting. AAOP's applicability is evidenced by existing projects that shared its approach.

Social implications

Population aging and the pandemic call for intersectoral actions and for stakeholders beyond healthcare to act as community leaders. AAOP proposes opportunities to connect environmental determinants of health and person-centered care.

Keywords

Aging model; Reciprocity; Healthy aging; Community; Self-care

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Authors and affiliations (for the *Université de Sherbrooke* Population Aging unifying theme)

Mélanie Levasseur [a,b], Melanie.Levasseur@USherbrooke.ca (Corresponding author)

Daniel Naud [a], Daniel.Naud2@USherbrooke.ca

Nancy Presse [a,e], Nancy.Presse@USherbrooke.ca

Nathalie Delli-Colli [a,c], Nathalie.Delli-Colli@USherbrooke.ca

Patrick Boissy [a,d], Patrick.Boissy@USherbrooke.ca

Benoît Cossette [a,e], Benoit.Cossette@USherbrooke.ca

Yves Couturier [c], Yves.Couturier@USherbrooke.ca

Julien Cadieux Genesse [a], Julien.Cadieux.Genesse@USherbrooke.ca

[a] Research center on aging, CIUSSS de l'Estrie, 1036 Belvédère Sud, Sherbrooke, QC, Canada, J1H 4C4

[b] School of rehabilitation, Université de Sherbrooke, 300 King Est, Bureau 200, Sherbrooke, QC, Canada, J1G 1B1

[c] School of social work, Université de Sherbrooke, 2500 boulevard de l'Université, Sherbrooke, QC, Canada, J1K 2R1

[d] Department of surgery, Faculty of medicine and health sciences, Université de Sherbrooke, 3001 12e avenue Nord, Sherbrooke, QC, Canada, J1H 5N4

[e] Department of community health, Faculty of medicine and health sciences, Université de Sherbrooke, 3001 12e Avenue Nord, Sherbrooke, QC, Canada, J1H 5N4

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Introduction

In western countries, one person in four will be aged 65 or over by 2050 and life expectancy has risen by over four years since 1990 (United Nations, 2019). Longer life expectancy increases the heterogeneity of aging trajectories (Nguyen *et al*., 2021) and the demand for home and long-term care (Canadian Medical Association & Deloitte, 2021). This affects how and where older adults live as well as their quality of life. Conceptual models of active and healthy aging emphasize how and where older adults "should" age, which can stigmatize and marginalize those with disabilities or different trajectories. Described as a "gerocide" (Servello & Ettorre, 2020), the COVID-19 pandemic not only amplified older adults' physiological, psychological and social challenges, but also opened a 'policy window' (Kingdon & Stano, 1984) to target underlying deficiencies in public healthcare and maintain quality of life for all. To optimize healthcare systems (Lehoux *et al*., 2018), facilitate partnerships and rebuild community cohesion (Robinette *et al*., 2021), it is essential to be supported by an inclusive yet farsighted heuristic framework that emphasizes the adaptation of communities and institutions to welcome, recognize and empower older adults better. Such a framework must also highlight the conditions that allow older adults to age in accordance with their interests and capacities and the ecological determinants of health, along with person-centered care interventions. For better healthcare, communities and the well-being of all, it is important to federate unite researchers, stakeholders and older adults around a common, clear, inclusive mission. This conceptual paper describes the development and applicability of *Aging All Over the Place* (AAOP), a federative framework for action, research and policy.

Conceptualizing place and time in the aging process

In gerontology, concepts and models defining and explaining the lives of older adults have evolved: *health*, for example, shifted from the absence of disease to physical, mental, and social well-being (Svalastog *et al*., 2017). Also, the active aging model of the World Health Organization (WHO; 2002) was developed to be more inclusive than the successful aging model of Rowe and Kahn (Foster & Walker, 2015). Considering the intertwining within gerontology of advanced knowledge in the psychological, biological and social sciences, as well as shifts in demography and large-scale events (*e.g.*, COVID-19; Panel on New Directions in Social Demography *et al*., 2013), this evolution is normal and desirable. Frameworks are important to provide the structure to guide actions that promote important values such as healthy lifestyles and to lower healthcare costs. As argued by Raymond and colleagues (2020), however, models are not neutral and can marginalize, blame and stigmatize older adults when they do not fit the values associated with the aging process being promoted.

To help older adults navigate through their evolving social identities, roles and participation, as well as their living situations and places including care, commercial and community resources, frameworks must be built on holistic, inclusive models and guide action, research and policy to reduce risks of marginalization and vulnerability. The *ecological model of aging* (EMA; Lawton & Nahemow, 1973) examined the person-environment fit, *i.e.*, optimal interactions between the person's competences and the environment. Environmental factors facilitate or hinder competences and trigger adaptive behaviors and emotions. The EMA has fostered various actions and policies (Scheidt & Norris-Baker, 2003), but has been criticized for overlooking changes over time and the social and cultural aspects of place. For example, structural changes within the ecosystem can undermine a precarious person-environment fit, such as gentrification, *i.e.*, when wealthier residents move into a neighborhood, increasing the cost of rent and ultimately displacing older residents (Burns *et al*., 2012). This EMA did not consider attachment to place, such as the home or community, where the person stays in place even if the fit is not optimal (Smith, 2009). Fostering aging in

place initiatives, the EMA encourages older adults to remain in their current dwelling until the end of life, even when their need for support increases (Alley *et al.*, 2007). Promoted internationally (WHO, 2007), aging in place encompasses physical accessibility, service proximity, security, recreational resources, housing and transportation. Although aging in place aims to improve the well-being and health of older residents and their communities and is desired by most older adults, it may not be suitable in situations of vulnerability, such as precarious housing (Means, 2007). Even in the absence of functional decline, older adults can improve their well-being by relocating to a home that requires less maintenance and is closer to family, friends and meaningful resources (Golant, 2003). Demographic transitions, however, call for a more comprehensive idea of aging that encompasses the concept of *place* alongside a person-centered approach, that encourages healthcare providers to co-design and personalize care with older adults, and that recognizes heterogeneous late life and health trajectories (Santana *et al*., 2018).

In response to the limitations of previous models, the *ecological framework of place* (EFP; Diaz Moore, 2014) incorporated time and the environmental experience: places are not only where resources and leisure are located, they are also where actions, feelings, and memories are experienced. Additionally, the environmental context is reshaped by historical and periodic transformations (demographic changes or day/night transitions; Cutchin *et al.*, 2003), and by the ways people use places in their everyday lives, which is constantly negotiated. Because older adults are more susceptible to being impacted by changes at the local level, especially when their mobility declines, this negotiation is fundamental. Transformations of neighborhoods can challenge older citizens' sense of belonging, impact their quality of life and even marginalize them (Burns *et al*., 2012). Lastly, the EFP stresses the importance of positioning older adults, not using dichotomous concepts such as healthy vs. unhealthy, but as actual citizens wihnth agency, displaying contradictions and aspirations about life projects, and as observers of and contributors to their own life. However, although the EFP draws attention to the ecological experience of aging, it is not precise enough to demonstrate the operationalization of its concepts, especially with regard to home and clinical care (Diaz Moore, 2014). To continue to improve actions, research and policies that reflect the contemporary context, this conceptual paper aims to describe a framework federating action, research and policy that considers the diverse experiences of place and life trajectories, along with person-centered care.
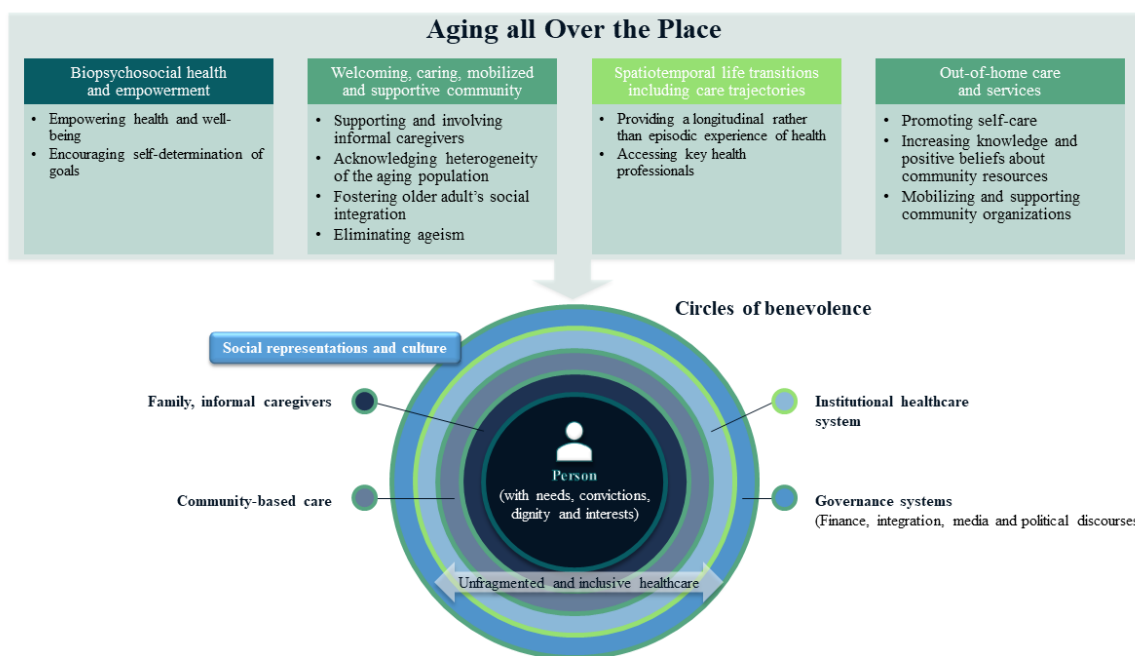
Development of a heuristic, federative framework: the method

To foster a wide range of collaborations within the community and encourage the creation of conditions that allow older adults to age in their own way, *i.e.*, in accordance with their interests and capacities, intersectoral experts in the field of aging (*e.g.*, social sciences, medicine, engineering) from *Université de Sherbrooke* (Canada) developed a heuristic framework through a rigorous process involving experts. These experts are intersectoral researchers in the field of aging, stakeholders, including older adults, a living lab coordinator, representatives of community healthcare, and university administrators and coordinators. This work began with group discussions, followed by an appraisal of aging models to improve aging in place guidelines, that consider life and health trajectories and the person's experiences. The framework was validated during a one-day retreat and two final workshops, one with experts and the other with members of the Research Centre on Aging Seniors Committee. Based on the literature, EFP and priorities discussed in the groups, the framework was then drafted along with its broad axes. Finally, the validation process involved consultation regarding the framework's relevance and implications.

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Proposed framework

The *Aging All Over the Place* (AAOP) framework is an EFP-based person-centered approach in which place is flexible and adaptable enough so that aging *in place* becomes *all over the place.* This framework defines health holistically, *i.e.*, including life satisfaction, social engagement, empathy towards older adults, community support, and diverse life and care trajectories (Figure 1). AAOP combines the concepts of life trajectories and evolvability of living environments. These environments include not only where the person lives but all the places the person goes to (parks, friends' homes, public places, healthcare centers, stores, *etc*.). In spite of a large body of evidence-based articles stressing the dynamics of agency, connectedness and experience of place (Rosenwohl-Mack *et al*., 2020), aging in place is often defined by physical and functional aspects (Pani-Harreman *et al*., 2020). AAOP aligns with international best practice guidelines. For example, the framework highlights the importance of the rights-based approach in the WHO's Global report on ageism (2021) and Active aging policy framework (2002). The aim is to foster equal opportunity and treatment in all aspects of life (social, economic, cultural, spiritual and civic) as individuals grow older and to develop a new narrative around age and aging. Another example is AAOP's alignment with the WHO's World report on ageing and health (2015), which defined healthy aging as the process of developing and maintaining the functional ability that enables well-being in older age, and introduced the diversity of late life trajectories. Given the combination of both active and healthy aging in AAOP, even if intrinsic capacities decline, people living in a supportive environment may still be able to accomplish activities that matter. Highlighting these issues is timely, as baby boomers are now turning 75 years old and, given their diverse lifestyles and interests, older adults may require a wide variety of care and housing opportunities (Wright *et al*., 2014). In addition, the health challenges amplified by the pandemic and the recent Declaration of Astana (WHO, 2019) call upon stakeholders beyond the health sector to collaborate and act to empower local communities and individuals to develop health policies for all. As it includes all residential settings and places where older adults go, the AAOP framework guides healthcare professionals, policymakers and researchers to collaborate around four axes: 1) biopsychosocial health and empowerment; 2) welcoming, caring, mobilized and supportive community; 3) spatiotemporal life transitions including care trajectories; and 4) out-of-home care and services (Figure 1).

Aging all Over the Place

Biopsychosocial health and empowerment	Welcoming, caring, mobilized and supportive community	Spatiotemporal life transitions including care trajectories	Out-of-home care and services
• Empowering health and well-being • Encouraging self-determination of goals	• Supporting and involving informal caregivers • Acknowledging heterogeneity of the aging population • Fostering older adult's social integration • Eliminating ageism	• Providing a longitudinal rather than episodic experience of health • Accessing key health professionals	• Promoting self-care • Increasing knowledge and positive beliefs about community resources • Mobilizing and supporting community organizations

Circles of benevolence

Social representations and culture

Family, informal caregivers

Community-based care

Person (with needs, convictions, dignity and interests)

Institutional healthcare system

Governance systems (Finance, integration, media and political discourses)

Unfragmented and inclusive healthcare

The axes' titles are color-matched with the most relevant actor or system in the circles of benevolence

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Figure 1. Aging All Over the Place model

Axis 1. Biopsychosocial health and empowerment

The development of models in gerontology show that aging is a complex, evolutive process. Considering people's physical, psychological and social characteristics, a multidimensional vision of health, *i.e.*, a biopsychosocial (BPS) approach (Lindstrom & Eriksson, 2010), is preferable. The dimensions of place and time in the BPS model of health are flexible in providing the person with support and proximity resources to develop resilience and maximize problem-solving and coping skills during negative events (such as worsening health, rent increase, death of someone close; Meléndez *et al.*, 2015).

Moreover, the BPS model helps to assess the determinants of people's health, facilitates their empowerment and limits their risk of marginalization (Nordgren & Fridlund, 2001). By co-determining older adults' healthcare plan with them and considering their life and health trajectories, the person-centered approach supports healthcare professionals and caregivers in determining interventions and activities according to the person's interests and capabilities (Santana *et al.*, 2018; . Person-centered care and empowerment also mean that older adults are allowed to make sub-optimal decisions regarding services, treatment or living situation, without being stigmatized. In a safe and flexible environment that provides adequate support and resources, older adults share responsibility for their health and receive help to cope with stressors and disabilities.

Axis 2. Welcoming, caring, mobilized, and supportive community

Caregivers are often the community members closest to older adults (Figure 1) and, if involved in their care, should also be involved in decision-making. Collaboration between older adults, caregivers and health professionals is a determinant of the quality of care and helps to postpone institutionalization (Ris *et al.*, 2019). Family members and close friends of all ages can be caregivers who are helped to develop knowledge (*e.g.*, monitor symptoms, provide emotional support) and skills (*e.g.*, self-care, transferring from chair to bed; Given *et al.*, 2008). To support caregivers, communities can provide self-help resources and events, such as dementia discussion groups, to share experiences with other caregivers (Capus, 2005).

Older adults must feel welcome in the community. A caring and mobilized community must foster social integration, such as with intergenerational programs that build sustained familiarity and overcome ageism (Hagestad & Uhlenberg, 2005). A caring community is a network of partners able to reach out to vulnerable older adults, support them in improving their well-being, assist them in obtaining appropriate services and promote their independence and social participation at all stages of aging (Djouini *et al.*, 2021). Rather than agents of change, older adults are seen as victims to be protected and ignored when planning urban regeneration projects, regardless of their life experiences (Riseborough & Sribjlanin, 2000). When planning actions, projects or policies, professionals, researchers and policymakers are encouraged to foster empathy towards older adults who may have seemingly unpredictable interactions with the environment (Golant, 2003).

Axis 3. Spatiotemporal life transitions including care trajectories

Aging in place is an adaptive process, ideally with flexible living environments, such as 'lifelong' homes that are functional for everyone, including intergenerational families and people with disabilities (*e.g.*, wider doors, utilities at a convenient height; Andrews, 2008), and neighborhoods (*e.g.*, accessory dwelling units, opening elementary schools in the evenings for services for older adults, innovative intergenerational destinations). With the support of professionals and carers, older adults could regularly assess whether

theirhome and neighborhood meet their present and future needs, which increases their sense of control and well-being (Kahana *et al*., 2012). Such reassessments increased the likelihood of implementing home adaptations (Yuen & Carter, 2006) while no reassessment increased anxiety and often diminished autonomy (Shippee, 2009).

A longitudinal rather than episodic experience of health should also be supported. Time accounts for the short- and long-term impacts of environmental events and transitions in a person's trajectory (Merçon-Vargas *et al*., 2020). For example, the COVID-19 pandemic and public health measures may have lasting consequences for older adults, especially those in a vulnerable situation (*e.g.*, in a long-term care center, with pre-existing health conditions, being socially isolated, from a visible minority or a member of LGBTQ2+ communities; Wister, 2021). As major decisions are made during transitions but are not noticed by healthcare professionals until an acute event occurs, early detection could be improved through regular follow-ups (Löfqvist *et al*., 2011). Another recommendation is to involve older adults' caregivers during healthcare visits since care trajectories, such as relocation, home adaptations, or even smaller income, can have major implications for them (Wiles, 2005). In addition, giving a central role to advanced practice nurses or social workers throughout the healthcare trajectory facilitates decision-making (Imhof *et al*., 2012). Two in five older adults reported problems with coordinating their care (Osborn *et al*., 2014), resulting in inadequate care, avoidable expenses and longer wait times (Heckman *et al*., 2013). Grouping healthcare services together in a "one-stop shop" (*i.e.*, first contact care, treatment for disease, technical procedures and prevention) was viewed by older adults as improving accessibility, continuity and comprehensiveness of care; they also felt empowered through decision-making (Schäfer *et al*., 2018).

Axis 4. Out-of-home care and services

According to the EMA (Lawton & Nahemow, 1973), the interaction between person and environment generates facilitators and barriers for older adults. On the one hand, enabling older adults' skills and control facilitates their self-care (Beckingham & Watt, 1995), especially when healthcare professionals allocate sufficient time to partner and consider their needs and potential solutions (Paterson, 2001). Resource referrals can facilitate self-care by increasing knowledge and positive beliefs about community resources (*e.g.*, smoking cessation, healthy eating; Tung *et al*., 2019). Although referrals can be computer-generated, the involvement of practitioners improved physicians' care competency (Lathren *et al*., 2013) and older adults' adherence to their care plan (Hayes, 2007).

On the other hand, when aging at home, older adults should receive inclusive community-based care, with a well-organized set of multidimensional community services (Williams *et al*., 2009). Aging all over the place, regardless of life and health trajectory, requires continuous accessibility throughout the neighborhood: starting in the home and continuing on the street and sidewalks, in shops, parks, community health and specialized centers, and so on. Shared indoor and outdoor spaces in low-income apartment complexes, especially when proximity resources are lacking, can provide on-site opportunities for social interaction and wellness programming (*e.g.*, blood pressure clinics; education on practical life skills, fraud and scams, staying active, financial planning; Atlanta Regional Commission, 2009). Outside the home, inaccessible pathways, distant leisure and commercial resources or heavy road traffic can fragment a neighborhood. This may force older adults to compromise and limit out-of-home care, services and social participation to accessible places. Underserved neighborhoods, *i.e.*, those that lack the necessary care and transportation resources for older adults, may contribute to their being stuck in one place, which may have a negative impact on their health, well-being and sense of belonging (Woolrych *et al*., 2020). For example, services such as Wheels-to-Meals that complement prepared meal services like Meals-on-Wheels could welcome older adults with and without disabilities, foster empowerment and self-esteem, as well as lessen

social isolation. However, this type of approach can only be effective if community organizations are mobilized (Westwood & Daly, 2016). When local legislators are receptive to health promotion initiatives and community organizations believe they have a positive impact and participate in decision-making, health promotion is strengthened (Simonsen-Rehn *et al*., 2006).

Older adults' appraisal of the AAOP model

The AAOP model was presented to the Research Centre on Aging Seniors Committee, which has eleven members who represent communities (*e.g.*, neighborhood) or associations (*e.g.*, education and cultural communities) and advocate for older adults. Launched in 2018, the Seniors Committee is occasionally consulted by researchers and asked for their input and recommendations. Following a short presentation of AAOP, the Seniors Committee members shared their appraisal of the model. Concerning the name, they found that Aging in place – generally familiar to a larger audience – conveyed a comfortable and clear ideal but was restrictive and could be confused with "staying in place". Because it recognizes the diversity of life and health trajectories, which affect aspects of life related to social interactions, household finance, self-care and housing, the Seniors Committee thought that AAOP was more likely than Aging in place to transform the aging experience positively. Flexible person-centered care was also considered to be more effective in integrating older adults in their community and was seen as less restrictive for marginalized persons. Finally, committee members found that AAOP was consistent with age-friendly communities' planning ideas, which is relevant for policy making, as decision-makers could be more aware of existing research and interventions.

Applicability of AAOP for communities

AAOP can foster multidisciplinary collaborations and guide actions, research and policies to have a greater impact on society in line with its axes. One example is the *Benevolent community* (Levasseur *et al*., 2021), a rural project that encompasses central concepts of AAOP, including a BPS approach to health, empowerment, a mobilized and supportive community, and out-of-home services. Relying on a community development approach to foster social participation, the *Benevolent community* was started by community members, including older adults, caregivers, healthcare and community organizers, as well as community stakeholders. Following twelve public consultations, the community members identified their needs and, in collaboration with a research team, adopted five initiatives to locate and assist isolated older adults, improve mobility and increase knowledge about social opportunities and chronic conditions (Levasseur *et al*., 2021). By empowering communities and older adults, including in decision-making, this study actively promoted support and a holistic vision by identifying social isolation as a factor in situations of vulnerability. Community development and the involvement of older residents as research partners are also aspects fundamental to Age-friendly cities (AFC), which are rooted in the recognition of life and health trajectories. As implemented in the province of Quebec (Canada), the AFC model was initiated by researchers in 2006 and is now used in over 1,000 cities (Garon *et al*., 2016). The AFC program in Quebec emphasizes participatory decision-making that includes older adults and stakeholders (elected officials, representatives from the voluntary sector, public health and social services) in clarifying older adults' needs and helping to define and carry out initiatives. Finally, another example designed to foster welcoming communities is a French-language interactive platform promoting interaction to combat ageism (Baillargeon & Levasseur, 2021) that was co-constructed by intersectoral researchers, older adults and students with the aim of

eliminating stereotypes, prejudices and discrimination against older adults. Using social media, this platform invites the general public to join a conversation around research results and actions to counter ageism, especially by valuing diverse life and health trajectories. Initiated by experts from the research network that originated AAOP, these projects are examples of current efforts to develop inclusive, holistic approaches. Other existing initiatives are aligned with AAOP and could be replicated to foster the well-being of all. For example, the *Volunteer friendly visitor program* in Ontario (Canada; MacIntyre *et al*., 1999) partnered undergraduate students with isolated older adults to do mutually chosen activities for about three hours per week, including short walks, talking or listening, assisting with care activities and reading aloud. This intergenerational program fostered the participants' self-worth, social support and life satisfaction. In the *Naturally occurring retirement communities supportive services program* in the USA (Bedney *et al*., 2010), housing that was not originally planned for older adults is adapted (apartment buildings, condominiums, even neighborhoods or small towns). Coordinating the efforts of voluntary support systems, building managers and community partners promotes social support and enhances the accessibility and affordability of existing services (Greenfield *et al*., 2013). This increases older residents' engagement in out-of-home activities and use of community services (Bedney *et al*., 2010). Lastly, a telehealth educational intervention in Northern Ontario (Canada; Cameron *et al*., 2018) enhanced older adults' self-efficacy in coping with chronic conditions by generating a group identity with the other program participants. Belonging to a social group fostered older adults' confidence and skills that enable adaptive responses to chronic pain, and also improved their sense of efficacy. Although built on a rigorous collaboration between multisectoral experts and stakeholders, including older adults, the present framework, like other work on concepts and models, is time- and context-sensitive and influenced by the particular participants involved. Nevertheless, AAOP could support projects in the near future by providing a clear vision for action, research and policy.

Conclusion

This conceptual paper describes the development of *Aging All Over the Place*, a framework that federates action, research and policy and considers older adults' diverse experiences of place and life trajectories, as well as person-centered care practices. Based on a partnership with older adults, an inclusive discourse with a BPS approach to health, and the mobilization of communities, the framework also promotes unfragmented healthcare that considers life transitions and provides a network of nearby services, which fosters self-care and mutual aid. By going beyond the healthcare system and mobilizing the broader community, the framework reaches out to an inclusive, caring society. In short, AAOP aims to avoid patronizing older adults and to engage society in reinforcing circles of caring surrounding older adults, regardless of their residential setting. AAOP's applicability was evidenced by projects that shared an inclusive, holistic approach and that a federative framework could structure by defining a clear scope of action. Global, national and local public authorities could embrace new challenges such as demographic changes and COVID-19 variants by advancing research and policy, redesigning healthcare, and developing mutual aid.

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