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The Lived Experiences of the Oldest-Old Using Community Support and Health Services: A Missing Piece in Age-Friendly City Development

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Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science

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THE LIVED EXPERIENCES OF THE OLDEST-OLD USING COMMUNITY
SUPPORT AND HEALTH SERVICES: A MISSING PIECE IN AGE-FRIENDLY
CITY DEVELOPMENT

(Thesis Format: Monograph)

by

Flora M. Vieira Zamora

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science

The School of Graduate and Postdoctoral Studies
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ABSTRACT

Increases in population ageing and urbanization have led to development of age-friendly cities to ensure that communities meet the needs of older adults. Community support and health services are particularly important in maintaining health and independence, especially for those in advanced age whose needs are often greater. While much has been done to integrate the needs of younger, healthier older adults, to date there has been little focus on the needs of frailer older adults. This phenomenological study explored the lived experience of community-dwelling individuals, 80 years of age and older, using community support and health services. In-depth interviews were conducted with a purposeful sample (n=10) of older individuals. Hermeneutic thematic analysis revealed three central themes related to the use of community support and health services in maintaining independence: *life experiences and circumstances*, *personal compensatory mechanisms*, and *community design and structure*. Implications for age-friendly development and further research are discussed.

Keywords: ageing, oldest-old, age-friendly cities, community support and health services, hermeneutic phenomenology.

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DEDICATION

For *Mom and Dad*,

The two most inspirational people in my life.
Your hard work, dedication, and faith are truly exemplary.
Thank you for always being there. I love you.

For *Paige*,

Your positivity, perseverance, and never-failing faith in the midst of challenges are absolutely remarkable. You are amazing.

For *Mikayla, Savannah, and Olivia*,

Thank you for your beautiful smiles and for bringing me so much joy.
May your lives be filled with the greatest adventures, the happiest moments, and a multitude of opportunities. Never stop learning and always remember to follow your dreams. I love you girls.

For *My Participants*,

May your experiences inspire positive change for an inclusive and age-friendly future.

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1. INTRODUCTION

1.1 Background and Significance

For decades, leading demographers, gerontologists, geriatricians, and other health professionals have discussed and predicted the impact of the rapidly-increasing global trend of population ageing (United Nations Population Fund (UNFPA), 2007; World Health Organization (WHO), 2007a). Population ageing has enticed many societies into finding ways to address the ‘grey wave’ (Steed, 2007), the ‘silver tsunami’ (Kennedy, 2010), and the ‘senior surge’ (Tompkins, 2008). Although population ageing may pose different implications for different sectors, most agree with concerns of future healthcare and economic sustainability (Béland & Viriot Durandal, 2012; Boecking, Klamar, Kitzmann, & Kirch, 2012; Caldwell, Saib, & Coleman, 2008; Dall et al., 2013; Feng, Liu, Guan, & Mor, 2012; Harvey & Thurnwald, 2009). Alongside population ageing, urbanization is also on the rise: people are relocating to cities, including older adults (UNFPA, 2007; WHO, 2007a). The urban environment has been found to be an essential determinant of health and quality of life for older adults (Beard & Petitot, 2010). Due to rapidly-growing urban communities with high concentrations of older individuals, many government and privately-led organizations are implementing policies and programs to ensure that communities become more age-friendly (Alley, Liebig, Pynoos, Banerjee, & Choi, 2007; Plouffe & Kalache, 2011).

Local senior-friendly initiatives have been around for many years (Austin, Des Camp, Flux, McClelland, & Sieppert, 2005; Feldman & Oberlink, 2003; Pollak, 2000). Although initiatives vary in their focus, by the age-friendly aspects they address (i.e., physical vs. social continuum) and by the way in which they carry out their goals (i.e.,

top-down vs. bottom-up approaches) (Lui, Everingham, Warburton, Cuthill, & Barlett, 2009), they all share the common vision of wanting to make the community a place where older adults feel respected, included, supported, and empowered (Austin et al., 2005). In 2007, the World Health Organization (WHO) released *Global Age-Friendly Cities: A Guide*, providing a framework to help communities create more accessible urban environments for older adults. This framework uses eight critical domains that have been identified as being most necessary to improve and maintain quality of life for older adults (WHO, 2007a; WHO, 2007b). This global initiative has been helpful to encourage cities to implement age-friendly strategies, with the aim of ensuring that older adults' needs are being considered as part of municipal planning initiatives (WHO, 2013).

Community support and health services, one of the eight domains and a priority focus of age-friendly initiatives, are essential in maintaining the health and independence of older adults (WHO, 2007a). The use of these services tends to increase with age, particularly in advanced old age (Sinha, 2012; Soldo & Manton, 1985; Wolinsky & Johnson, 1991). Although much has been done to integrate the voices and needs of younger, healthier older adults into the Age-Friendly City (AFC) framework, to date, there has been little focus on integrating the unique needs of the oldest-old: those 80 years of age and older who often exhibit multiple comorbidities that intensify their need for community support and health services (Baltes & Smith, 2003). Thus, it is imperative to conduct further research to identify the unique needs of the oldest-old and, in particular, their community support and health service needs as part of AFC development.

1.2 Study Purpose

The purpose of this study was to better understand the lived experiences of community-dwelling individuals, 80 years of age and older, and their use of community support and health services. Using the established AFC framework put forth by the WHO (2007a; 2007b), this study aimed to specifically focus on the oldest-old population and their community support and health service needs. The research question that was addressed is the following: What is the lived experience of community-dwelling individuals, 80 years of age and older, using community support and health services?

2. LITERATURE REVIEW

2.1 Introduction

The concurrent global trends of population ageing and urbanization have led to the development of age-friendly initiatives to ensure that cities and communities are equipped to deal with the varying needs of older adults (Beard & Petitot, 2010). Various domains are deemed important to enhance older adults' quality of life in urban centers (Lui et al., 2009). Among these, community support and health services have been identified as critical in the maintenance of independence and quality of life among older adults living within the community (WHO, 2007a). It is clear that older adults are a heterogeneous population with many differing needs, and that the needs of individuals 65 years of age differ significantly from the needs of individuals who are 80 years of age and older (Baltes & Smith, 2003). Actively engaging individuals in advanced age in community initiatives often presents a challenge; thus, their needs are frequently not fully represented within age-friendly city development. Ensuring that community support and health service needs of these individuals are being met is imperative to creating age-friendly cities that are inclusive for all older adults.

2.2 Concurrent Global Trends: Population Ageing and Urbanization

2.2.1 *Population Ageing*

With improvements in public health, life expectancy and overall physical and mental health have increased into later years (Baltes & Smith, 2003; Caldwell et al., 2008). Increased longevity at older ages alongside an overall decline in fertility rates across continents has led to a change in demographics, contributing to global population ageing (National Institute on Aging (NIA), 2007; Uhlenberg, 2013; United Nations (UN),

2001; UN, 2009). Population ageing occurs when there is an increase in the proportion of older adults (60 years and older) and simultaneous decreases in the proportions of children (less than 15 years) and working-age individuals (15-59 years) (UN, 2009). The UN (2009) describes current population ageing as *unprecedented*: having never occurred before in human history; *pervasive*: a global phenomenon affecting most countries around the world; *profound*: having significant implications in social, political, and economic realms; and lastly, *enduring*: a global trend that is expected to continue to rise in the years to come (Uhlenberg, 2013).

The global proportion of those aged 60 years and older will double from 11% in 2006 to 22% in 2050 (WHO, 2007a). Additionally, the global proportion of older adults is growing at a rate of 2.6% per year, far exceeding total population growth, which has a 1.2% increase annually (UN, 2009). Moreover, population ageing is occurring within the older population, with the 85 years and older cohort being the fastest growing portion of many national populations (NIA, 2007; Sinha, 2012; UN, 2009) including China, the United States, India, Japan, Germany, and Russia (NIA, 2007). According to the UN, in 2009, individuals aged 80 years and older made up 1.5% of the total world population, with this number expected to rise to 4.3% by the year 2050 (UN, 2009). In particular, those 80 years of age and older already comprise 5% of the total population in France, Italy, Germany, Japan, and Sweden (UN, 2009). In Canada, the proportion of older adults, 65 years and older, has increased from 13.7% of the population in 2006 to 14.8% at the last population census in 2011 (Statistics Canada, 2014). Furthermore, preliminary numbers show an increase to 15.3% in 2013 (Statistics Canada, 2013). More locally, in London, Ontario, a parallel increase has occurred in older adults 65 years and older, from

13% of the London population in 2006 to 14.7% in 2011 (Statistics Canada, 2014). Although population ageing may pose different implications for different societies, universally there seems to be ‘an alarm factor’ concerning the impact of this booming demographic on future healthcare and economic sustainability (Béland & Viriot Durandal, 2012; Boecking et al., 2012; Caldwell et al., 2008; Dall et al., 2013; Feng et al., 2012; Harvey & Thurnwald, 2009).

2.2.2 Urbanization

Alongside population ageing, global levels of urbanization are also on the rise; people are moving to cities, including older adults (WHO, 2007a). In 2008, 3.3 billion people, more than half of the world’s population, were found to be living in cities; this statistic is expected to rise to 5 billion by the year 2030 (UNFPA, 2007). This urbanization is also evident at a local level, in London, Ontario. In 2006, London’s population was estimated at 352,395 residents, increasing to 366,151 by the 2011 census (Statistics Canada, 2014). In particular, the population of older adults 65 years and older also increased in London, Ontario, from 48,365 in 2006 to 53,705 in 2011 (Statistics Canada, 2014). Urban environments can offer many advantages to their residents, such as accessible, efficient, and quality services (Harris, 2012; McIlwain, 2011). It is for these reasons Yoder (2013) says that millions of older adults are moving to cities (UNFPA, 2007; WHO, 2007a). The increase in urban populations is an inevitable trend; however, the way in which this urbanization is addressed can be an opportunity (UNFPA, 2007). This opportunity can allow for community design, supports, and services to be remodeled (Ball & Lawler, 2014) in a way to help ensure that cities are meeting the needs of growing older adult populations. Given that cities are already the central hub for

important economic, social, demographic, and environmental initiatives, it follows that cities are at the forefront for positive change, especially in a time of surging population ageing (UNFPA, 2007).

2.2.3 Implications of Population Ageing and Urbanization

With booming populations in urban centers and simultaneous global ageing, it follows that the number of older adults in these urban locations is also increasing (UNFPA, 2007; WHO, 2007a). With the current and rising numbers of city-dwelling older adults, municipalities, city planners, health professionals, and other community personnel express substantial concerns regarding the ability to successfully cope with the demands of this shifting demographic, such as the adequacy of available resources and the continued and future demand for resources and services (Isaacs, Miller, Harris, & Ferguson, 2007; Kennedy, 2010). Many sources predict that these changes may bring potential detrimental consequences (Caldwell et al., 2008; Lloyd-Sherlock et al., 2012; Waldbrook, Rosenburg, & Brual, 2013). Having a negative perception of the aged often stems from the idea that an ageing population will cause increasingly burdensome demands on society (Beard & Petitot, 2010). However, this way of thinking creates further challenges and hinders potential positive planning for ageing societies (Kwok & Tsang, 2012). Therefore, more emphasis needs to be placed on the positive aspects of population ageing, in particular the opportunities, resources, and wealth of experience that older adults can provide to society (Caldwell et al., 2008; Provencher, Keating, Warburton, & Roos, 2014; Sinha, 2012).

Although urban communities can be advantageous to older adults in many ways, such as through the availability of cultural, educational, and religious programs,

accessible healthcare services, and other public resources, they may also provide challenges in community design which may have an impact on function and independence (Barusch, 2013; Buffel, Phillipson, & Scharf, 2012). The ability to remain independent and actively engaged in the community is strongly influenced by the compatibility of one's physical and social environment with one's specific needs (Golant, 2014). Older adults consider neighbourhood design to be an important determinant of activity in later years (Michael, Green, & Farquhar, 2006). Furthermore, older adults' perceived accessibility to key resources has been identified as an important determinant of social participation (Richard, Gauvin, Gosselin, & Laforest, 2008). Since physical and social activity are important factors in maintaining independence in advancing age, it is critical that neighbourhood design be conducive to engaging in these activities. Kennedy (2010) suggests that most communities and cities were designed with the "American Dream" in mind, focusing on a younger demographic. Although our societies have changed, the focus on younger individuals has remained static, in many cases posing problems for an ageing population (Kennedy, 2010; Sinha, 2012).

Environmental design is particularly important with advancing age, as it can act as a facilitator or barrier to an older adult's activity patterns, daily routines, and overall independence (Chippendale & Boltz, 2015; Michael et al., 2006). For example, Chippendale and Boltz (2015) found that older adults living in urban communities perceive the features of their community as important factors in the risk of falls and attitudes regarding fear of falling, while Smee, Anson, Waddington, and Berry (2012) found that the oldest-old have an increased risk of falls compared to their younger old counterparts. The person-environment fit theory of ageing, derived from the ecological

theory of adaptation and ageing (Nahemow & Lawton, 1973), describes the importance of the relationship between older adults and their environment. As the needs, such as community support and health service needs, of the individual increase, the demands placed on environmental conditions also increase (Nahemow & Lawton, 1973). Congruence between the needs of the individual and the resources offered by the surrounding environment is determinant of positive outcomes (Golant, 2014; Wallace & Bergeman, 1997). Therefore, the urban environment is an essential determinant of health and quality of life for older adults, making ageing individuals particularly vulnerable to any deficiencies in their environments (Beard & Petitot, 2010; Beard & Warth, 2013; Golant, 2014; Menec, Means, Keating, Parkhurst, & Eales, 2011).

There are two key issues to consider in successful environmental design: (1) the physical design and layout of the community, and (2) the infrastructure of the community, that is how services and programs are delivered (Hunt, 2001). It has been suggested that community infrastructure is not always designed to best cater to the needs of older adults, in particular to the needs of those in advanced old age, who may have functional limitations and other health concerns (Alley et al., 2007; Caldwell et al., 2008). Thus, community design and service availability frequently fall short, failing to meet the needs of these individuals. Urban centers often have multiple layers and silos of planning and development that are not well integrated and often lack intercommunication (Drummond, 2012; Menec, Novek, Veselyuk, & McArthur, 2014). For example, Drummond (2012) discusses the challenges that exist between the different sectors of the Canadian healthcare system. He explains that since the healthcare system is divided into independent silos (i.e., family doctor, specialist, hospital, etc.), communication between

these silos is often hindered, resulting in an inefficient delivery of healthcare services. This poses a greater challenge for age-friendly initiatives to be implemented. Since services are being designed for older adults, it is important to include older adults in the development of these services (WHO, 2007a). It is also important to remember that older adults are not a homogenous group (WHO, 2002; WHO, 2007a), resulting in differing needs across communities depending on the mix of younger and older adults living within these communities (Baltes & Smith, 2003). It is important, therefore, to ensure that all age groups of older adults are being included. As individuals get older, they tend to spend more time in their immediate environments (Golant, 2014), making the effective design of their surroundings an even more critical issue.

2.2.4 Ageing in Place

Evidence suggests that older adults want to remain in their own homes as long as possible (Alley et al., 2007; Kennedy, 2010). In a study conducted by the American Association of Retired Persons (AARP), it was found that 88% of those who participated in the study and were over the age of 65 wanted to age in place (Keenan, 2010). Ageing in place is defined as “the ability to live in one’s own home and community safely, independently, and comfortably, regardless of age, income, or ability level” (CDC, n.d.). Remaining at home allows older adults to keep a connection with their past, maintain current familial and community bonds, maintain a sense of independence and privacy, and reduces admissions to care facilities (Hinck, 2004). To do this, however, we must first acknowledge the needs presented by older adults and ensure that cities and communities are conducive to enabling them to live healthy, happy, and independent lives in their own homes. Plouffe and Kalache (2010) state that older adults can provide

an abundance of potential for our communities; however, they also say that for older adults to enact these potentials, communities must be ready to make the changes that enable active engagement and provide full availability and accessibility of resources for older adults of all ages, even those in advanced old age. Instead of the many grim perceptions (e.g., that an ageing population will bring increased demands for society), these changes should be seen as opportunities to modify outdated policy models, urban priorities, and inefficient infrastructure (Lloyd-Sherlock et al., 2012). The need to ensure that rapidly-growing urban communities also become more age-friendly for the growing demographic of older adults is a critical issue, and one that various programs have begun to address (Beard & Petitot, 2010; Plouffe & Kalache, 2011; Sinha, 2012; WHO, 2007a).

2.3 Senior-Friendly Community Initiatives

Due to the overwhelming statistics and predictions for the ageing population, discussions of potential strategies and solutions on how to make cities and communities more age-friendly have been at the forefront for many years (Alley et al., 2007). Across continents, many local senior-friendly initiatives have been implemented to help communities help older adults age at home (Lui et al., 2009; Menec et al., 2011). For example, in 2000, the AARP published *Liveable Communities: An Evaluation Guide*, to help communities assess whether their environment was suitable to encourage independent living as people age (Alley et al., 2007; Kihl, Brennan, Gabhawala, List, & Mittal, 2005; Pollak, 2000). Also in 2000, the Elder Friendly Communities Program was developed through various collaborations in the city of Calgary, Alberta (Austin et al., 2005). This initiative implemented an extensive situational assessment phase followed by a development phase that engaged older adults in a community program to address the

needs identified in the first phase. The goal of this initiative was to empower older adults to collaborate with community organizations to ensure that their communities were supportive and indicative of their needs and the needs of future older adults (Austin et al., 2005).

Similarly, in 2001, the Village Model was established, with the first ‘village’ created in Boston, Massachusetts (Scharlach, Davitt, Lehning, Greenfield, & Graham, 2014). The village model is a consumer-based association that is organized and run by and for older adults. The goals of this program are to help facilitate social engagement, service provision, and ageing in place for older adults within the community (Scharlach et al., 2014). Additionally, in 2003, the AdvantAge Initiative was established in New York City (Feldman & Oberlink, 2003), a senior-friendly community model with specific priorities identified to assist communities in helping older adults achieve maximal wellbeing. These priorities included addressing basic needs, promotion of social and civic engagement, optimization of physical and mental health and wellbeing, and lastly, maximization of independence for frail and disabled older adults (Feldman & Oberlink, 2003). A more local initiative, Ontario’s Aging at Home Strategy, was implemented in 2007 by Ontario’s provincial government. It aims to help older adults successfully age at home through the expansion of community services in collaboration with the fourteen Ontario Local Health Integration Networks (LHINS) (Ministry of Health and Long-Term Care (MOHLTC), 2013).

Among the many initiatives created to help communities meet the various needs of their ageing individuals, a common goal is evident: to make the community a place where older adults feel respected, included, supported, and empowered (Austin et al.,

2005). Nevertheless, despite these many initiatives, professionals and researchers have not yet reached consensus on a single definition that explains what constitutes a senior-friendly community (Lui et al., 2009; Menec et al., 2011). Some studies have found that key features for a senior-friendly community include financial security, accessible and affordable transportation, appropriate housing, accessibility of health and community services, availability of community and educational participation programs, safety, and walkability (Alley et al., 2007; Black, 2008; Everingham, Petriwskyj, Warburton, Cuthill, & Barlett, 2009; Feldman & Oberlink, 2003; Kwok & Tsang, 2012; Lui et al., 2009).

Although most senior-friendly initiatives focus on the importance of the physical and social environments within communities, the emphasis along the physical-social continuum (i.e., the degree of physical vs. social features of the environment that are addressed) varies (Alley et al., 2007; Clark & Glicksman, 2012; Lui et al., 2009; Menec et al., 2011). These initiatives also vary in how they carry out their goals (i.e., top-down vs. bottom-up approaches) (Lui et al., 2009). A top-down approach begins with creation of policies and rules that are implemented by governments and other leading decision-makers (Meslin, 2010). In contrast, age-friendly initiatives that use bottom-up approaches focus on the individuals that are affected by the issues, and ensure that their participation and collaboration are used so that policies and practices reflect their specific needs (Lui et al., 2009; Meslin, 2010). Lui and colleagues (2009) suggest that having an integrative approach that incorporates both physical and social features, while having a collaborative relationship between individuals affected by issues and policy makers, is the best way to deliver a senior-friendly initiative. One of the most significant and recent senior-friendly

initiatives that incorporates all of these features and aims to promote change on a global scale is the Age-Friendly City (AFC) Movement (WHO, 2007a; WHO, 2007b).

2.4 The Age-Friendly City Movement

2.4.1 *Conceptualization and Origins of the Age-Friendly City Movement*

The idea for the AFC Movement was conceived in 2005 at the World Congress of Gerontology and Geriatrics in Rio de Janeiro, Brazil (Neal & DeLaTorre, 2009). In 2006, the WHO and the British Columbia Ministry of Health developed the Vancouver Protocol (WHO, 2007b) as a guide to help communities assess their age-friendliness and with that develop strategies for improvement (Neal & DeLaTorre, 2009; WHO, 2007a; WHO, 2007b). The AFC Movement was created upon the active ageing concept put forth by the WHO (WHO, 2002). The WHO describes active ageing as “the process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age” (WHO, 2002, p.12). In an age-friendly city, a term coined by the WHO, older adults are supported and enabled to actively age through understanding their different abilities and capacities; understanding their diverse needs and preferences; accepting their choices and lifestyles; protecting the most vulnerable; and encouraging their participation and inclusion in all aspects of community life (WHO, 2007a). Furthermore, active ageing is dependent on various interacting factors such as gender and culture, as well as economic, health, physical, personal, behavioural, and social determinants (WHO, 2007a).

The WHO identified eight domains, based upon previous senior-friendly community models and the active ageing concept, that are deemed most important for enhancement of quality of life in urban-dwelling older adults (Plouffe & Kalache, 2010;

WHO, 2007a; WHO, 2007b). These eight domains include: outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, and community support and health services (WHO, 2007a; WHO, 2007b). Using the Vancouver Protocol (WHO, 2007b), focus group research was conducted with 1,485 older adults, 250 caregivers, and 515 service providers in 33 global cities to discuss the eight domains (Plouffe & Kalache, 2010). The information and trends identified and confirmed through these focus groups were used to create the document *Global Age-friendly Cities: A Guide*, in 2007. With input and collaboration from 35 global cities, the guide aims to provide communities with a framework to create a better-suited and more accessible urban environment for older adults based on what older adults express that they need most (WHO, 2007a). This guide was created using a bottom-up approach, which enabled older adults to become involved in the age-friendly planning taking place in their communities, and empowered them to express their needs and wants to help ensure that all changes were conducive to their needs and wishes (WHO, 2007a; WHO, 2007b).

Due to the overwhelming interest in the AFC Movement, the WHO established the *Global Network of Age-friendly Cities* (Parry, 2010; Plouffe & Kalache, 2010). This network enables international cities to support each other in the implementation of local age-friendly initiatives and to be able to share experiences and information with one another (Parry, 2010). When a city joins the network, they commit to a five-year process. Years one and two are planning years, during which assessment of the age-friendliness of the city is completed, indicators are identified to monitor progress, strategies are set in place to ensure older adults are involved in all phases, and a three-year city plan is

developed based on assessment findings (WHO, 2009). After having received approval from the WHO for their city plan, the community moves on to the implementation process that takes place in years three, four, and five. At the end of year five, the city will evaluate its progress, after which cities continually improve their features by building upon their positive changes (WHO, 2009). As of 2013, the network consisted of 135 cities and communities across 21 different countries (WHO, 2013).

2.4.2 The Age-Friendly City Movement Internationally

The development of the AFC Movement has helped entice many cities and communities across numerous countries to jump on board with their own age-friendly initiatives. In the United States, the impact of the AFC Movement on the implementation of age-friendly initiatives has been significant. Some examples include the Age-Friendly Philadelphia Initiative (Clark & Glicksman, 2012; Glicksman, Clark, Kleban, Ring, & Hoffman, 2014) and the Age-Friendly Portland Initiative (Neal, DeLaTorre, & Carder, 2014). One of the biggest strengths exhibited by the Age-Friendly Portland initiative is the building of this initiative on existing collaborations and relationships with the local university, government agencies, and local city planning committees, helping to facilitate implementation (Neal et al., 2014).

Assessment of age-friendly initiatives across the United States has brought forth some valuable lessons. Ball and Lawler (2014) suggest that implementing age-friendly initiatives may be futile if underlying outdated policies, practices, and infrastructure are not first rethought and reinvented. Although they agree that age-friendly initiatives have made some great progress, Ball and Lawler (2014) suggest that future initiatives should also take into account the seminal factors that have made ageing in the community a

challenge in the first place. Therefore, it is encouraged to act locally, but think nationally when implementing these initiatives. Furthermore, it is important to understand how governmental roles are involved in the implementation of these strategies (Lehning, 2014). Understanding how the different layers of an age-friendly initiative work together is essential to its cohesion and ultimate success.

AFC initiatives have also emerged across Europe (Buffel et al., 2014; Green, 2012; McGarry, 2012; McGarry & Morris, 2011), Asia (Kadoya, 2013; Kim, 2013) and Australia (Ozanne, Biggs, & Kurowski, 2014). For example, in 2009, the Manchester Ageing Strategy was established with aims of developing lifetime communities that have good, affordable, accessible, and appropriate transportation, housing, and community environments (McGarry & Morris, 2011). Its goal was to help older adults become more engaged within their communities and experience better healthcare and community support, while creating effective intergenerational links and decreasing any inequalities that may be present within the community (McGarry & Morris, 2011). In Korea, the ‘Gangnam Senior Plaza’ was developed based upon the Korean ministry guidelines in conjunction with the active ageing concept from the WHO (Kim, 2013). This community center offers opportunities for continuous engagement, volunteerism, medical information, and continued educational development, while operating on the HAPI (healthy body, active mind, productive lifestyle, and integrative ageing) life model principle (Kim, 2013). These examples show the impact of the AFC movement and provide some valuable insights into how to implement and design future age-friendly initiatives.

2.4.3 *The Age-Friendly City Movement in Canada*

On a national level, the AFC movement has also been helpful in implementation of age-friendly initiatives. Between the years of 2007 and 2011, 560 communities in Canada became involved with age-friendly strategies (Plouffe & Kalache, 2011). Some of these initiatives include the establishment of the Age-Friendly Cities in Quebec (AFC-QC) (Garon, Paris, Beaulieu, Veil, & Laliberte, 2014), the implementation of the Age-Friendly Manitoba Initiative (Hallman, Menec, Keefe, & Gallagher, 2008; Menec et al., 2014) along with the publication of the Age-Friendly Rural and Remote Communities Guide (Federal/Provincial/Territorial Ministers Responsible for Seniors, 2007), and more locally the Age-Friendly London Initiative (Age Friendly London Task Force, 2012). Garon et al. (2014) discuss the importance of collaboration for the success of AFC initiatives. Having partnerships, collaborations, and constant communication with older adults, community members, stakeholders, seniors' associations, and governments is imperative to the successful implementation of age-friendly strategies (Garon et al., 2014).

When the progress of the Age-Friendly Manitoba initiative was evaluated, positive outcomes were found. For example, many of the different communities that had joined the initiative had been successful in improving their degree of age-friendliness, in developing partnerships with other organizations and communities, and in exhibiting continual age-friendly promotion (Menec et al., 2014). Recommendations for continuing and future age-friendly programs include the necessity of having strong governmental leadership at all levels, having continual community support in terms of funding and networks, taking opportunities to collaborate with more established community initiatives

to help advance the age-friendly initiative, and achieving sustainability through the perpetual promotion of age-friendliness (Hallman et al., 2008; Menec et al., 2014).

On a more local level, London, Ontario, was the first Canadian city to join the Global Network of Age-friendly Cities in 2010 (Age Friendly London Task Force, 2012). In 2011, the London city council established the Age Friendly London Task Force, a committee consisting of over 150 older adults, community members, caregivers and service providers. This committee worked and continues to work collaboratively to create and implement strategies to improve the lives of older adults in the community of London, Ontario using the AFC's eight critical domains (Age Friendly London Task Force, 2012). Additionally, between the years of 2008 and 2011, the City of London and the Seniors Community Association (P. Fleming, personal communication, July 2014) conducted a study, *Connecting London Seniors*, to better understand the needs of older adults living in London, Ontario.

Five City of London planning districts were included in the *Connecting London Seniors* study: Central London, Medway, Argyle, Glen Cairn, and Westmount. These neighbourhoods were chosen to represent older adults of all ages, abilities, and cultures, while representing all North, East, South, and West areas of London, Ontario. One of the biggest strengths of the *Connecting London Seniors* study was the successful implementation of Senior Neighbourhood Advisory Councils (SNACs) within all five communities, providing a direct reciprocal communication link between older adults within these communities and the City, and enabling 'bottom up' community identification of priorities in each neighbourhood. One of the limitations of this study, however, was the inability to successfully connect with the oldest-old in these

communities. Thus the unique needs of this sub-population continue to remain unknown (P. Fleming, personal communication, July 2014).

Although many age-friendly strategies are being implemented around the world, the sustainability of these initiatives requires further study (Golant, 2014; Ruza et al., 2012). While many studies have been published on the establishment of age-friendly strategies, fewer studies have been published on the sustainability and evaluation of these current initiatives (Ruza et al., 2012) to determine if their implementation is making a difference in the community and in the lives of older adults. Fewer still have examined the unique and differing needs of the different cohorts of older individuals, particularly those in advanced age striving to remain independent in their own homes. Further research is warranted on the effectiveness of current age-friendly strategies, to ensure that these initiatives form part of a long-term solution for the government's 'ageing at home' strategy (Golant, 2014). Golant (2014) noted that it is unrealistic to believe that an age-friendly strategy will ensure that all older adults of differing needs and wants will be satisfied; therefore, it is important to understand the resources of the community and the differing needs that are presented within it. For example, a healthy, recently-retired 65 year old will have very different needs than an 85 year old with multiple co-morbidities (Baltes & Smith, 2003). Thus, identifying the different community elements that are of priority and that are important to older adults, while keeping in mind that older adults are a heterogeneous population with differing needs, is the first step to developing a successful age-friendly initiative.

2.4.4 Community Support and Health Services

Within the eight domains provided by the World Health Organization (2007a; 2007b) (outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, and community support and health services), community support and health service issues were identified as critically important for older adults (WHO, 2007a; WHO, 2007b). The World Health Organization defines community support and health services as:

The blend of health and social services provided to an individual or family in his/her place of residence for the purpose of promoting, maintaining or restoring health or minimizing the effects of illness and disability. These services are usually designed to help older people remain independent and in their own homes. They can include senior centres, transportation, delivered meals or congregate meals sites, visiting nurses or home health aides, adult day care and homemaker services (WHO, 2004, p. 16).

For the purpose of this study, the WHO definition has been categorized into three distinct categories: health services, formal (traditional) community supports, and informal (social) community supports. Health services are defined as any medical or health services performed by health professionals. Formal (traditional) supports are defined as any formal support service that helps with activities of daily living, provided by a professional agent (excluding medical and health services and excluding care provided by family and friends) such as help with cleaning, personal emergency response systems, meal support, and transportation. Informal (social) supports are defined as any informal community-based program that may provide support to the individual (excluding medical

or health services and formal community supports), such as activity clubs, church membership, community organizations, and social clubs.

Discussion regarding community support and health services dominated focus group discussions during the creation of the AFC Movement (WHO, 2007a). The recurrent themes that were discussed included accessibility, affordability of care, the available range of health services, ageing well services, homecare opportunities, and the establishment of community resources (WHO, 2007a). The widespread concerns that were expressed with health and community resources during the establishment of the AFC Movement indicate that this area is of great importance for older adults. Inadequate knowledge or awareness of available health services was one of the identified barriers to accessibility of care (WHO, 2007a). This poses a great challenge because it decreases the potential of these services and leaves the individual without the needed care. Some recommendations given by the WHO (2007a) include raising awareness, more effective coordination of services, and the use of telephone information services. This barrier has been previously discussed in the literature with a potential solution being the implementation of regular friendly informative visits to homebound older adults (Keller, Flatten, & Wilhite, 1988).

Another prominent theme that was identified was the need for a wider range of health services including ageing-well services such as health promotion, screening, and prevention programs (WHO, 2007a). A study on self-perceived satisfaction of primary care for older adults in the Netherlands (Hoogendijk et al., 2013) found that although most of their physical and environmental needs were being met, mental health needs were not being addressed. This shows the importance of acknowledging all aspects of primary

care to enable older adults to successfully age at home. In addition, Jacobs, Rottenberg, Cohen, and Stessman (2013) found that continuing or commencing physical activity in advanced age was conducive to the reduction of health service use among older adults. Furthermore, Hinck (2004) found that health education is a necessity for older adults to know what to expect and to be able to understand what forms part of the normal ageing process, what does not, and when to seek help. Therefore, establishment of prevention and health promotion services to further aid older adults in their active ageing process is a critical component of health service provision in age-friendly cities.

The lack of coordination between community services was also an important theme brought forth by older adults (WHO, 2007a). This lack of coordination between services appeared to cause gaps in the available care system, often creating hindrances in accessing care, such as lengthy, repetitive, and complicated application processes (WHO, 2007a). In addition, insufficient knowledge of the availability, high cost, low quality, and inaccessible community services were all barriers that were discussed during the focus group sessions (WHO, 2007a). Muramatsu, Yin, and Hedeker (2010) found that accessibility and availability of supportive home and community-based services decreased stress levels in older adults with low or declining function in activities of daily living. Furthermore, Krause (2010) found that having close friendships within the church community was reflective of a positive perceived health status in older adults, particularly in the oldest-old. This shows the importance of maintaining quality and accessible community services to support older adults throughout the different transitions of advancing age (Service Ontario, 2013).

As is evidenced through the literature, community support and health services are essential for the continued maintenance of health and independence in community-dwelling older adults (Cantor, 1989; Muramatsu et al., 2010; Van Houtven & Norton, 2004; WHO, 2007a; Wolinsky & Johnson, 1991). Older adults are heavy users of the healthcare system and usage tends to increase with advancing age and emerging comorbidities (Sinha, 2012; Soldo & Manton, 1985; Wolinsky & Johnson, 1991). In Ontario, older adults make up 14.6% of the population; however, they are responsible for almost half of all healthcare spending (Sinha, 2012). On average, Canadians 80 years and older account for the largest amount of health care dollars per capita, per year, compared to all other cohorts (Canadian Institute for Health Information (CIHI), 2013). In general, more healthcare dollars are spent with increasing age (CIHI, 2013). For example, in 2011, it was found that Canadians 80 years of age and older accounted for \$20,387 per capita health dollars compared to \$6,431 per capita accounted for by younger older adults between the ages of 65 and 69 (CIHI, 2013). Gu, Zhang, and Zeng (2009) found that accessibility to healthcare services has a strong influence on longevity and overall health. Additionally, continuity of care with a family physician has been found to be associated with lower mortality, indicating that having consistent and accessible health services is of great importance for older adults and for the population in general (Wolinsky et al., 2010). Therefore, it is imperative to create adequate health networks that integrate and coordinate the different facets of the healthcare system to ensure that older adults of all ages are receiving the best and most appropriate care (Branca et al., 2009; Drummond, 2012; Sinha, 2012).

Similarly, advancing age also increases the likelihood of needing social and related care that encompasses both formal and informal services (Cantor, 1989). Previous studies have found that presence of community supports is strongly correlated with positive or improved perceived health status (Abolfathi Momtaz, Ibrahim, & Hamid, 2013; Glass & Vander Plaats, 2013; Potts, 1997). In addition, social and community support are integral factors in helping older adults with activities of daily living such as personal care, personal development, and socialization, which in turn helps older adults to remain independent members of the community (Cantor, 1989). Social connectedness was found to be the most important factor in maintaining independence and positive perceived health in old age (Callen & Wells, 2003; Krause, 2010). In particular, the positive association between social engagement and physical health can also be seen in the oldest-old (Cherry et al., 2013), indicating the importance of social support into advanced old age. Therefore, it is critical to ensure that access to social support and social engagement opportunities be maintained for those in advanced old age who may be frail, have mobility issues, or compounding comorbidities (Baltes & Smith, 2003). Community-based services can be very helpful and are imperative to enabling older adults to stay connected to their communities. Because of the great importance of community support and health services in the daily lives of older adults, particularly for those in advanced old age, this study will focus on this specific domain.

2.4.4.1 Barriers and Enablers in Using Community Support and Health Services

Since community support and health services are so important to ensuring well-being and independence in older adults, it is particularly warranted to discuss different factors that hinder and enable the access and use of these services. Allan, Funk, Reid, and

Cloutier-Fisher (2011) discuss personal and community factors that may act as barriers in the access and use of health and community services. Personal barriers include poor health, reduced mobility, higher number of chronic conditions, and lower income (Allan et al., 2011), all common characteristics associated with advanced age (Baltes & Smith, 2003). Community barriers include factors such as insufficient quantity and quality of services, insufficient or lack of transportation, unaffordability of services, and poor integration or organization of services (Allan et al., 2011), environmental factors of critical importance with advancing age.

Interaction with service providers (Dickinson et al., 2011; Prior, Bahret, Allen, & Pasupuleti, 2012) and the ethnicity (Lai and Chau, 2007) of the older adult can also influence health and community service access and usage. The relationship that an individual has with his or her health service provider can affect access to certain services, such fall prevention interventions, in a positive or negative manner (Dickinson et al., 2011). For example, in a study conducted by Prior et al. (2012), successful promotion of a senior's outreach program for critically-ill older adults was effective in enabling older adult participation, which in turn helped to reduce the rates of hospital readmission and emergency department use in these older adults. Ethnicity and culture can also act as barriers for older adults from different ethnic minorities, as they often experience even greater difficulties in accessing community support and health services (Lai and Chau, 2007). In a study investigating the health service barriers faced by older Chinese immigrants in Canada, Lai and Chau (2007) found the top three barriers included: language, long waitlists, and insufficient knowledge of existing services.

Geography is another factor that may also have an impact on accessibility and usage of health and community services (Goins, Williams, Carter, Spencer, & Solovieva, 2005). For example, in a study conducted by Goins et al. (2005) regarding self-perceived barriers in health care among rural older adults, it was found that older adults living in rural communities experience larger challenges in accessing services. These challenges include transportation difficulties, limitations on the abundance of services and the quality and appropriateness of services that are available, and financial hindrances in accessing these services (Goins et al., 2005). Although this study was based on information from rural older adults, the results obtained are useful and applicable for urban planning as well, as access to needed services can be a problem in both rural and urban settings (Schoenberg & Coward, 1998). In urban settings in particular, Schoenberg and Coward (1998) found that due to population ageing in cities and increased demands placed on available services, older adults are faced with increased wait times or denied access to certain social services. Kiyak and Reichmuth (2005) found many intertwining determinants affecting the access to and use of dental services in older adults. These included, for example, income, availability of medical and dental insurance, urban vs. rural residence, physical accessibility to dental services, overall health status, and psychosocial factors such as personal attitudes towards the use of dental care (Kiyak & Reichmuth, 2005). Moreover, a study performed to determine an understanding of perceived barriers to access and use of healthcare services among community-dwelling older adults found that improvements in health care accessibility are required for older adults living with functional disabilities or poor mental health status, or those living in rural communities (Thorpe, Thorpe, Kennelty, & Pandhi, 2011).

With the exponential increase of population ageing, more and more older adults want to remain independent and age in place, thereby intensifying the demands placed on health and community services. To ensure that community support and health services are accessible and their use enabled for older adults, different factors must be addressed. First and foremost, the health and community service system must be well organized and integration must exist along the service continuum (Drummond, 2012; Sinha, 2012). For example, technological improvements in assessment, service, and referral procedures could help to enable a better integration of services and ensure their accessibility (Sinha, 2012). Additionally, this also means that health and community service providers must be properly trained and highly skilled in their areas to deliver effective services (Sinha, 2012). Zagaria (2013) discusses the importance of ensuring that health and community service providers maintain effective communication with the public, and in particular with the individuals who will be accessing their services. It is also imperative to maintain sensitivity towards socioeconomic and socio-demographic factors (Allan et al., 2011; Zagaria, 2013) that quite often influence the degree of accessibility and usage older adults encounter with services. Furthermore, it is important to remember that because of multicultural societies, cultural sensitivity must be integrated within available health and community services to ensure that individuals of all cultures have the equal opportunity to access and use these services (Zagaria, 2013). It is through understanding the barriers and enablers that older adults face in the attainment and usage of community support and health services that we can ensure that future community and service planning capitalizes on the enablers and diminishes the barriers, thus improving accessibility of these services for all older adults.

2.4.5 Meeting the Needs of ALL Older Individuals

It is well known that the community support and health service needs of older individuals differ significantly depending upon an individual's level of independence, function, and age. Interestingly, WHO AFC documents use the generic term 'older adult' (defined as those 60 years and older) (WHO, 2002; WHO, 2007a; WHO, 2007b; WHO, 2011; WHO, 2012) throughout, without any distinction between the needs of variously aged individuals across the eight domains. Although the WHO recognizes that diversity increases with age (WHO, 2002; WHO, 2007a), this is not reflected in the development of the AFC Model (WHO, 2007a; WHO, 2007b). Furthermore, the age-friendly literature focuses on implementation and, on a smaller scale, the evaluation of age-friendly initiatives, but it does not explicitly address differing needs of older adults for whom these initiatives are being established. It is recognized that the AFC movement, while growing significantly, is still in its early stages with limited evaluation outcomes. It is also recognized that individuals in advanced age, who may be frail and socially isolated, are the hardest to reach and engage in AFC planning. Thus, it becomes even more imperative to ensure that the voices of these individuals who have the greatest community support and health service needs, are heard in the AFC planning process. Understanding the heterogeneity, and the diverse and dynamic needs that exist within the older adult population is imperative for the development of age-friendly communities (Caldwell et al., 2008; Kerr, Gordon, MacDonald, & Stalker, 2005).

2.4.6 A Missing Age-Friendly City Piece: The Oldest-Old

Baltes and Smith (2003) found that recommendations made for the general ageing population are not entirely reflective of the needs of the various demographics found

within the older adult cohort. Priorities in early old age often do not remain priorities in advanced old age (Gondo, 2012; Smith, Borchelt, Maier & Jopp, 2002). A valuable distinction is made between individuals in what Baltes and Smith (2003) term the ‘third’ and ‘fourth’ ages (Baltes & Smith, 2003; Laslett, 1991). The third age typically refers to individuals between the ages of 65 and 79 and is defined as a period of fulfillment in which there are increases in longevity and quality of life (Baltes & Smith, 2003; Green, 2012; Laslett, 1991). These individuals are usually recently retired and still possess the stamina and ability to remain active and engaged in their families and communities (Laslett, 1991). Baltes and Smith (2003) further describe the third age as a period in which there are increases in life expectancy, physical health, and mental health; cognitive reserves are still intact, including emotional health, intelligence, and wisdom; and lastly, self-plasticity is still at play. The fourth age starts around age 80 and is seen as a time of dependence and decline in which extraordinary needs and vulnerabilities may be exhibited (Baltes & Smith, 2003; Green, 2012; Laslett, 1991). Baltes and Smith (2003) describe this period as a time in which individuals may experience multimorbidity and decreases in physical and cognitive function. Increases are also seen in the prevalence of dementia and related disorders. Furthermore, demographic characteristics such as living arrangements and marital status have been found to vary substantially between the young-old and the oldest-old (Chi & Lubben, 1994). By making the distinction between these two phases of older age, it is clear that heterogeneity is present between the younger old and the oldest-old; this inevitably translates into differing needs across these populations, an important consideration for age-friendly city development.

Black (2008) found that when comparing the health needs of younger-old and oldest-old residents of a naturally occurring retirement community in Florida, the oldest-old residents exhibited greater health needs across physical, psychological, and social wellbeing domains. The oldest-old also experienced a greater number of chronic conditions and utilized more adaptive equipment than the younger-old (Black, 2008). Callen and Wells (2003) investigated the self-perceived health of the oldest-old and found that health problems including vision, gastrointestinal problems, and arthritis were strongly associated with reduced nutritional health maintenance of individuals in advanced old age. Given the additional obstacles introduced in the fourth age, the process of optimization of health for these individuals becomes much more challenging (Baltes & Smith, 2003). In addition, older adults who have poorer self-perceived health, physical limitations, or experience challenges with activities of daily living, are greater users of health services (Wolinsky & Johnson, 1991).

In particular, older adults use a significant number of health services, and this number is greatly increased in the oldest-old, who use a greater number of emergency room services (Vilpert et al., 2013) and have a greater number of hospital days and physician visits than their younger-old counterparts (Chi & Lubben, 1994; Soldo & Manton, 1985). In addition, Wallace and Hirst (1996) found that the oldest-old use fewer community-based services than the younger-old, especially activity-related community services. This discrepancy is possibly due to mobility or functionality issues that may be present in these oldest-old individuals (Wallace & Hirst, 1996). All of these examples reinforce that the needs of the oldest-old vary substantially from the needs of younger older adults. In addition, it is important to remember that, even within the oldest-old

group, there exists a significant amount of heterogeneity in terms of differing levels of capacity and dependency. To address the heterogeneity in this period of instability and unpredictability, known as the fourth age, innovative, creative, and effective health and social interventions must be developed (Gondo, 2012; Jagger et al., 2011) and should be incorporated into AFC planning and development.

2.5 Study Rationale and Objectives

Although much has been done to integrate the needs of younger, healthier older adults into the AFC framework, to date there has been little focus on integrating the needs of frailer, older individuals, the oldest-old, who often exhibit multiple comorbidities that intensify their need for community support and health services (Baltes & Smith, 2003). As described by Baltes and Smith (2003), the fourth age is often referred to as a time of greater dependence, unpredictability, functional limitations, and multimorbidities. Because of these potential issues, it is much more challenging to actively engage the oldest-old in AFC planning and development. Thus, the goal of this study was to better understand the day-to-day experiences of these individuals and their unique needs. Using the established AFC framework put forth by the WHO (WHO, 2007a; WHO, 2007b), this study aimed to focus specifically on the community support and health services domain as it relates to the oldest-old. The following research question was addressed: What is the lived experience of a community-dwelling individual, 80 years of age and older, using community support and health services?

2.6 Conclusion

Global population ageing and urbanization have led to the development of age-friendly initiatives to ensure that communities are accessible and conducive to the needs

of older adults (Beard & Petitot, 2010; WHO, 2007a). Understanding that older adults are not a homogeneous population is imperative to understanding the differing needs among older individuals (Caldwell et al., 2008; Kerr et al., 2005). Effective community support and health services are essential in maintaining health and independence for older adults, especially in the oldest-old, who are the most frequent users of these resources (Baltes & Smith, 2003; Lloyd-Sherlock et al., 2012; Sinha, 2012; WHO, 2007a; Wolinsky & Johnson, 1991).

It is hoped that the results of this study will help inform AFC development locally, regionally, nationally, and internationally. Older adults, even those in advanced age, have much to offer in helping to redesign and optimize their communities to enable independent living as long as possible.

3. METHODOLOGY

Hermeneutic phenomenology was used in this study to better understand the lived experience of community-dwelling individuals, 80 years of age and older, using community support and health services. Outlined below is a brief description of the origins and evolution of phenomenology as both a philosophical method of understanding phenomena and as a research methodology used to investigate and understand these phenomena (Dowling, 2007; van Manen, 1990; van Manen, 1997). Hermeneutic phenomenology is explained as a research methodology and the rationale for its use in this study is provided. Different measures of quality criteria in hermeneutic phenomenology are used and described. Study design, data analysis, and employed methods of study rigor are discussed. Consistent with wanting to be a transparent researcher (Tracy, 2010), a self-declaration is included.

3.1 Phenomenology

Phenomenology originated as a philosophical means of understanding phenomena in the 20th century (Dowling, 2007). Phenomenology aims to understand lived experiences or phenomena of everyday life (Dowling, 2007; van Manen, 1997). There are two primary branches of phenomenology: descriptive (eidetic) and interpretative (hermeneutic) (Flood, 2010). Although there are various schools of phenomenology, and thus a multitude of ways to conduct phenomenological research (Dowling, 2007; van Manen, 1997), seminal players in phenomenological philosophy are Husserl (1931), Heidegger (1996) and Gadamer (2004). Husserl (1931) developed and supported phenomenological reductionism or descriptive phenomenology. This method of phenomenology aims to understand the lived experience exactly as it appears, without

pre-reflections, bias, and interpretations (Dowling, 2007). Researchers are expected to identify and neutralize, through bracketing (Husserl, 1931), all prior knowledge and preconceptions to ensure that these do not influence study results (Flood, 2010).

On the other hand, Heidegger (1996) recognized the importance of describing phenomena, as they appear, but additionally supported a more hermeneutic or interpretative method of phenomenology, extending the study of the lived experience from description to understanding via an interpretative process (Dowling, 2007). Heidegger embraced inclusion of prior knowledge and preconceptions to aid in interpretation of the meaning of the lived experience (Dowling, 2007; Flood, 2010).

Gadamer (2004), a student of Heidegger, further advanced two important elements in phenomenological study: prejudgment and universality (Dowling, 2007). Prejudgment encourages the researcher to recognize and use his or her own prior knowledge (fore-structures) to aid in interpreting the data (Dowling, 2007; Gadamer, 2004). Furthermore, universality explains the importance of a co-constitutionality, in that meanings are understood through a joint interpretation between researcher and participants (Dowling, 2007; Flood, 2010). This enables understanding of the phenomenon through a 'fusion of horizons', or a blend of participant and researcher interpretations and meanings (Flood, 2010, p.10). The horizon is the complex and dynamic collection of assumptions, meanings, interpretations, and ideas expressed both by the participant and the researcher.

Informed by seminal philosophical phenomenologists like Husserl, Heidegger, and Gadamer; modern-day phenomenologists, like Max van Manen (1990), have been pivotal in evolving phenomenology to include both a philosophical means to

understanding phenomena, as well as a research methodology to investigate and understand these phenomena (Dowling, 2007; van Manen, 1990; van Manen, 1997). Van Manen (1990) combines Husserl's descriptive method and Heidegger's interpretative extension, reasoning that understanding a phenomenon or lived experience requires both description and interpretation (Dowling, 2007). In addition, he emphasizes reflection and study of the outside world prior to reflecting on the data (Dowling, 2007; van Manen, 1990). Like Heidegger and Gadamer, van Manen does not suggest bracketing (Husserl, 1931), or eliminating prior knowledge and fore-structures (Gadamer, 2004); instead, he suggests embracing this outside knowledge to aid in development of a holistic understanding of the phenomenon (Dowling, 2007; van Manen, 1990; van Manen, 1997).

Since the aim of this research study was to describe community-dwelling older adults' experiences with using community support and health services, and interpret meaning from these experiences, hermeneutic phenomenology was deemed the most appropriate methodology and chosen as the research approach.

3.2 Hermeneutic Phenomenology as a Methodology

The aim of hermeneutic phenomenology is to explore, describe, and interpret lived experiences, and from this, attribute meaning to these experiences (Anderson, 1991; Flood, 2010; Smythe, Ironside, Sims, Swenson, & Spence, 2008; Streubert & Carpenter, 2011, van Manen, 1990; van Manen, 1997). Understanding how individuals experience a given phenomenon drives phenomenological inquiry (Crist & Tanner, 2003). This research study incorporated the philosophical underpinnings of hermeneutic phenomenology put forth by Heidegger (1996) and Gadamer (2004), but also employed the tangible phenomenological practices described by hermeneutic phenomenologist Max

van Manen (1990). Although the foundational philosophical concepts put forth by Heidegger and Gadamer are essential in understanding hermeneutic phenomenology, this study is less philosophical in nature and aims to inform practice, which is a strength of van Manen's approach, as can be seen in nursing, educational, and various other human sciences research (Dowling, 2007).

Hermeneutic phenomenology aims to incorporate both description and interpretation of a given phenomenon or lived experience (Dowling, 2007) in order to attribute meaning to this experience (Flood, 2010). Meanings are constructed through dialectical interaction of participant experiences and interpretations of these experiences (Flood, 2010; van Manen, 1997). Understanding that people are influenced by their own values, life histories, and surrounding environment, and using and accepting fore-structures put forth by the researcher and the participants enabled the production of a holistic interpretation of the lived experiences of these participants (Koch, 1999). Following Heideggerian and Gadamerian hermeneutics, the interpretation of this phenomenon was made possible through the constant reflection, questioning, reading, re-reading, connecting, context positioning, and analyzing of ideas, themes, and implications that arose (Koch, 1999). By listening, questioning, discussing, hearing stories, and incorporating previous knowledge, an understanding of how the oldest-old use community support and health services was made possible. The goal is that these findings will help advance understanding of community care as experienced by the oldest-old.

3.2.1 *Why Hermeneutic Phenomenology?*

This study employed a hermeneutic phenomenological methodology within an interpretivist/constructivist paradigm to investigate and interpret the lived experiences of community-dwelling oldest-old with community support and health services, specifically in London, Ontario. The underlying constructivist ontology of relativism is congruent with the aim of the study as the goal is to hear each of the participant's voices; they are unique to the individual and dependent on social and personal contexts (Guba & Lincoln, 1994). This was achieved by understanding the multiple experiences and realities of the oldest-old in how they perceive and interpret their use of community support and health services within their communities. Furthermore, the epistemological approach that is both transactional and subjectivist coincides with the goal of interpretative phenomenology that aims to allow the researcher and participants to work together to increase understanding about the phenomenon (Guba & Lincoln, 1994; Koch, 1999). Lastly, as described by Guba and Lincoln (1994), a constructivist paradigm uses a methodology that is both hermeneutical and dialectical, stating that the knowledge derived from individual experiences will be best refined through interactive and open communication between the researcher and participants. This coincides with Koch's (1999) description of phenomenology and Gadamer's (2004) ideology of the 'fusion of horizons', that joins the knowledge of the participants and the researcher to create a final product. Understanding and interpreting the lived experiences of the oldest-old is essential to understanding how these individuals attain and use community support and health services, and thus, may enhance an understanding of how to best meet their community support and health service needs.

3.2.2 *Critical Components of Hermeneutic Phenomenology*

The key characteristics of a hermeneutic phenomenological study that were incorporated into this research include: i) 'being in the play', being open, allowing the experiences to tell their truths, and not fearing uncertainty; ii) accepting personal fore-structures and, through this, allowing the fusion of horizons; and lastly, iii) engaging in the hermeneutic circle (Koch, 1996; Koch, 1999; Smythe et al., 2008).

3.2.2.1 *Being in the Play*

Smythe et al. (2008) explain that the quest of a hermeneutic phenomenologist is to recognize that the goal is not to create nor discover truths that are generalizable, objective, or simplistic, but instead to ignite thinking, dialogue, and understanding about the human experience. The researcher must engage his/her whole self in the research process to allow for the emergence of the 'ah-ha' moment (Koch, 1999). The researcher must be open to minimal structure, as human experiences are often filled with layers of depth that can send the discussion in many different directions (Smythe et al., 2008). Gadamer (2004) describes hermeneutics as less of a method but more of an attempt to overcome traditional methods. Although it is recommended to have some prompts when going into a phenomenological interview, the researcher must be flexible and adaptable to what the discussion brings, to being in 'the moment', and to knowing that each conversation will be unique (Smythe et al., 2008). Using these ideas, a sense of openness was maintained when meeting with participants, to enable them to feel comfortable and thoroughly share their experiences. This was done by having minimal structure in the interview, allowing participants to share their stories in the order and form they wished to do so, and by allowing participants to take as much time as they saw fit. This openness

facilitated the discovery and exploration of their unique lived experiences with community support and health services.

3.2.2.2 *The Fusion of Horizons*

Gadamerian hermeneutics places its aim of inquiry in the fusion of horizons (Koch, 1999), “the coming together of different vantage points” (Koch, 1996, p.17). As described by Smythe et al. (2008), the researcher must engage completely in the research process, accepting that all previous knowledge and fore-structures will have influence on the interpretation of the experiences that are being investigated (Koch, 1999). Fore-structures refer to preconceived, pre-learned, or pre-understood information, which sets the foundation upon which understanding of the current phenomenon is possible (Koch, 1999). Everything from our past resides within us, influencing how we understand and interpret human experiences (Smythe et al., 2008). Both Heidegger, Gadamer, and van Manen recognized this and therefore indicated that instead of trying to bracket these past experiences, they be should embraced and fused with the new knowledge that is emerging from the current research (Hans, 1978; Koch, 1999; Smythe et al., 2008; van Manen, 1997). Hermeneutic phenomenology enables the fusion of ideas and experiences from both the participants and researchers to allow for a joint creation of the research product (Dowling, 2007; Koch, 1999). These phenomenological ideologies were fulfilled in the study by allowing immersion in the experiences that participants shared, through continual reflection with the data and emerging ideas, but at the same time using all past experiences and knowledge as tools to aid in interpretation of their personal stories, feelings, and ideas. For example, the researcher was able to use previous experience from working with older adults and knowledge from the literature to facilitate interpretations.

3.2.2.3 *The Hermeneutic Circle*

Koch (1996) describes the hermeneutic circle as a “metaphor taken from Heidegger to describe the experience of moving dialectically between the part and the whole” (Koch, 1996, p.176). The interpretation of the human experience comes from the continuous interaction between the participant, the researcher, the text, and past experiences and knowledge (Koch, 1999). It is only through reading, re-reading, connecting ideas, questioning, and reflecting that a shared understanding can be created (Koch, 1999). Hermeneutic phenomenology is a circular process: even after some meaning and understanding have emerged, the participant and the context in which the information was gathered are often revisited and re-questioned to aid in further understanding and interpretation (Crist & Tanner, 2003). Continuous engagement in the hermeneutic circle was maintained throughout the research process, through continual reflection with the data and emerging ideas, and by specifically, switching back and forth from the big picture to the different parts of participants’ experiences.

3.3 Quality Criteria in Hermeneutic Phenomenology

3.3.1 *Self-Reflexivity*

Tracy (2010) describes sincerity as an important quality criterion in qualitative research. Sincerity is achieved through self-reflexivity regarding the researcher’s values, biases, and understandings, as well as through transparency regarding the methods and challenges of the research process (Tracy, 2010). Reflexivity refers to a continuous self-awareness and conscious thinking that spans the duration of the research experience (Finlay, 2002). Self-reflexivity allows the researchers to determine how their own theories and pre-understandings are influential to the research and to the interpretation of

the phenomenon (Morrow, 2005). Lastly, self-reflexivity forms part of the hermeneutic circle, thereby being an essential component of phenomenological research. Consistent with Tracy's (2010) sincerity criteria, self-reflexivity and transparency were maintained throughout the research process through the use of self-reflexive notes, and regular debriefing of the research process with the research supervisor and advisory committee members.

3.3.2 *Trustworthiness*

Tracy (2010) identifies eight major criteria for a trustworthy qualitative research study. These criteria include: worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethical, and meaningful coherence (Tracy, 2010). Tracy (2010) describes a study with a worthy topic as one that is "relevant, timely, significant, interesting, or evocative" (p.840). A study that employs rich rigor is careful to include sound theoretical constructs, adequate sample numbers, appropriate contexts, and strong and conscientious data collection and data analysis processes (Tracy, 2010). The sincerity of a research study can be achieved through self-reflexivity, data audit trails, and transparency about the challenges and limitations of the study (Tracy, 2010). A credible research study includes thick, rich data, and employs quality-generating techniques such as audiotaping, verbatim transcription of interviews, and member checking to ensure accuracy and authenticity of the data (Lincoln & Guba, 1985; Tracy, 2010). Quality research resonates with the reader through evocative presentation of the findings or recommendations (Tracy, 2010). Furthermore, a trustworthy research study provides a significant contribution to the field of study, while ensuring that all ethical guidelines are closely followed. Finally, a quality research study ensures that the information presented

has a natural flow and is coherent, achieved by ensuring ontological and epistemological ideologies are in sync with the methodology and paradigm that are chosen and the goals that are stated (Tracy, 2010). This research study used these eight criteria to ensure that the results were of good quality so that they can be useful for age-friendly city development and for the health and ageing field in general.

3.4 Study Design

3.4.1 *Sampling and Recruitment*

London, Ontario, was selected as the location of study due to both its active participation in the WHO's AFC initiative (Age Friendly London Task Force, 2012) and to fill a gap identified by a previous study, the *Connecting London Seniors* project (P. Fleming, personal communication, July 2014). This research project was designed to address this gap by specifically focusing on individuals in advanced age, those 80 years of age and older, who have been shown to use more services than their younger-old counterparts (Sinha, 2012; Soldo & Manton, 1985; Wolinsky & Johnson, 1991).

Using the London, Ontario, planning district information (Appendix B) (City of London, 2013), which is based on the 2006 municipal census, and the neighbourhood selection criteria from the *Connecting London Seniors* study (P. Fleming, personal communication, July 2014), the Westmount planning district was chosen as the community of choice for this study (Appendix C). Of the five communities in the *Connecting London Seniors* project, Westmount had the highest proportion of older individuals. Westmount is also among the top ten planning districts in London, Ontario, with the highest proportion of resident older adults (City of London, 2013). According to the 2006 census, 15.8% of Westmount's residents were 65 years of age and older (City of

London, 2013). Prior to beginning the study, the researcher familiarized herself with the Westmount community and the community support and health services currently available within it (Appendix D) to determine any changes since the *Connecting London Seniors* project. Familiarization was facilitated, for example, by driving around the Westmount community to observe where supports and services were situated, walking through Westmount Mall and having a cup of coffee in the mall, all ways of trying to get better acquainted with the Westmount community.

Purposeful sampling (Palys, 2008; Patton, 2001) was used to identify 10 individuals, 80 years of age and older, living within the Westmount community. In-depth, semi-structured interviews were used to capture and describe common experiences of individuals using community support and health services. A sample size of 10 participants is consistent with the recommended sample size for phenomenological research (Creswell, 2007; Morse, 2000). In phenomenological research, sample size is considered adequate when theme saturation is reached, that is when interpretations are clear and additional participants do not reveal novel findings or meanings (Crist & Tanner, 2003; Morse, 1991). Theme saturation was reached with the 10 participants included in this study.

The Senior Neighbourhood Advisory Council (SNAC) in the Westmount community was used as the key informant in identifying eligible participants. Individuals were eligible to participate if they met the following inclusion criteria: i) residence within the Westmount community (or on the outskirts, but identifying Westmount as their home community), ii) 80 years of age and older, and iii) ability to speak fluent English. Contact was made with the Westmount SNAC to arrange a time to present the project to

Westmount community members. Interested and eligible individuals were provided with a letter of information and consent form (Appendix E). Once consent was obtained, the researcher arranged a day and time for the interview to take place.

It is well known that individuals in advanced old age are the hardest-to-reach individuals and because of this are often under-represented at community meetings. To help overcome this challenge, members of the Westmount SNAC were provided with recruitment posters (Appendix F) and specifically asked to talk with individuals within their communities who were less active and socially isolated, and to ask these individuals if they would agree to being approached by the researcher for a more complete explanation of the research purpose and procedures. In addition, members of the Westmount SNAC were encouraged to provide feedback and suggestions regarding other potential avenues to reach the more vulnerable and socially isolated members of their community.

Individuals who agreed to have their contact information provided to the researcher were subsequently contacted by the researcher to set up an introductory meeting, at a time convenient to them and in a location of their choice, to discuss the study and to answer any questions. At this initial meeting, individuals were provided with a letter of information and consent to participate (Appendix E). Anonymity and confidentiality procedures were discussed at the beginning of each interview, and participants were reassured that participation was voluntary and informed that they could withdraw at anytime, if they wished to do so. Ethics approval was obtained from The University of Western Ontario's Research Ethics Board prior to commencement of study (Appendix A).

3.4.2 Data Collection

In-depth, semi-structured interviews were used to obtain information about the lived experiences of individuals, 80 years of age and older, in using community support and health services. Consistent with guidelines for qualitative interviews (Creswell, 2007), interviews in this study were approximately 60-90 minutes in length.

In-depth interviews are a well-known and effective method for qualitative data collection (Morrow, 2005). Interviews were conducted in the study participant's home or in another location that the individual found more comfortable. If the participant wished to have his/her spouse present in the interview, consent was also obtained from the participant's spouse. Prior to commencement of the interview, participants also completed a short socio-demographic questionnaire (Appendix G). A semi-structured interview guide (Appendix H) was created and used to guide the interview. During the interview, participants were asked to reflect upon their day-to-day experiences using community support and health services and were encouraged to continue speaking until all desired information was shared. Five specific questions were asked:

1. What do community support and health services mean to you?
2. How do you experience community support and health services in your everyday life?
3. How do you feel about the community support and health services in Westmount?
4. How important are community support and health services to help you stay independent and living in your own home?
5. Do you have any other thoughts about community support and health services or experiences that you would like to share? Have we missed anything?

Probes were used to encourage participants to provide details that afforded a deeper understanding of their answers to the initial questions. Participant interviews were audio-recorded and transcribed verbatim, to ensure accurate representation of participant stories. No notes were taken during the interview. This enabled complete immersion and engagement in the stories and experiences that were being shared. However, a reflexive journal was kept, in which field notes were recorded before and after the interviews. This journal allowed reflection on the environment in which the interview took place, specific participant characteristics, the mood of the interview, documentation of non-verbal communication and subtle nuances, and reflection on interpretations that were beginning to arise. For example, one participant remained seated for the entire interview, and in particular, did not get up upon the researcher's arrival or departure. Furthermore, another participant's constant movement throughout the interview was similarly noted. These non-verbal actions were noted in conjunction with the participant's story to add another layer of understanding to the participants' daily experiences and how they remain active or struggle with mobility on a day-to-day basis.

3.5 Data Analysis

Consistent with hermeneutic phenomenological research, data analysis was simultaneous to data collection (Miles, Huberman, & Saldaña, 2014; Mills, Bonner, & Francis, 2006; Smythe et al., 2008; Streubert & Carpenter, 2011). Having data collection and analysis occur simultaneously enabled immersion with the data and gave the opportunity to ensure that subsequent data collection was improved and refined (Miles et al., 2014). As each of the 10 interviews was completed, the primary researcher transcribed them, and continuous reflection on emerging ideas and interpretations was

conducted, through journaling, self-reflexive notes, and regular debriefing with the study supervisor and advisory committee. Each narrative was read multiple times and reflected upon based on the researcher's own personal emotions, ideas, and feelings, with the aim of beginning to develop interpretations and thus begin the journey towards illumination of deeper understanding and meaning within the analysis process (Miles et al., 2014).

3.5.1 *Inductive Thematic Analysis*

Inductive thematic analysis was performed using the immersion and crystallization strategy (Lincoln & Guba, 1985; Ward-Griffin et al., 2004). Immersion consisted of listening and re-listening to the audio files, reading and re-reading the transcripts, and writing reflexive notes, until familiarity with the data was established. To facilitate the immersion phase of the analysis process, van Manen's (1997) thematic analysis approach consisting of wholistic, selective, and line-by-line analysis was used. During the crystallization phase, important ideas, patterns, and themes began to emerge (Lincoln & Guba, 1985; Patton, 2001).

3.5.1.1 *Wholistic Analysis*

During this phase of the analysis process, each transcript was read as a whole (van Manen, 1997) with the aim of understanding the participant as a holistic being – what characteristics are specific to this person? Do they regularly use community support and health services? Are they independent? What is important to them? Reflection using questions like these was conducted to get a 'story' or 'snapshot' of each participant. Field notes were also analyzed to help round out these participant snapshots. Appendix I provides examples of participant snapshots that were compiled in this phase of the analysis.

Throughout this process, meetings with the project supervisor and committee members were held to discuss general meanings and patterns that were beginning to emerge within and across individuals. This process provided a good foundation to conduct subsequent deeper analyzes of each transcript and helped to enrich subsequent data collection.

3.5.1.2 *Selective Analysis*

In this phase of the analysis, multiple complete read-throughs of each transcript were conducted and any significant words or phrases that were dominant in the text were highlighted, underlined, or circled. Notes were also made in the margins with specific questions, interpretations, or ideas that required revisiting (van Manen, 1997). Within this phase, first cycle coding and second cycle coding were completed (Miles et al., 2014; Saldaña, 2009). In first cycle coding, the goal is to assign specific codes to the data, whereas in second cycle coding, the aim is work with these identified codes to cluster them into categories and patterns for subsequent analyzes and emergence of themes (Miles et al., 2014; Saldaña, 2009). A combination of coding techniques including open (initial), *invivo*, values, emotions, and descriptive coding (Saldaña, 2009) were used for first cycle coding, and pattern and focused coding techniques for second cycle coding.

3.5.1.2.1 *First Cycle Coding*

To complete first cycle coding, a combination of coding techniques was used to code the transcripts by hand. Initial coding or open coding is an open-ended coding technique that allows the researcher to become familiarized with the data, with little stipulation on what should or should not be coded (Saldaña, 2009). This type of coding was used as it allowed the researcher to begin extracting ideas and topics from the

different parts of the text. For example, one participant on multiple occasions, indicated the importance of family, and therefore, one of the initial open codes was ‘Family is Important’. Invivo coding uses the participants’ words as the code itself, which allows the participants’ words and voices to be honoured in the coding process (Saldaña, 2009). This type of coding is in line with phenomenological research as it allows the voices of the participants to tell the story (Saldaña, 2009). For example, when one participant explained how he felt after the passing of his wife, his direct quote was used as a code as it perfectly illustrated his experiences and feelings. Values and emotion coding refer to codes that are made based on the participants’ beliefs and feelings about certain experiences and ideas (Saldaña, 2009). This type of coding was used to ensure that personal beliefs or feelings about the use of community support and health services were fully captured, such as positive feelings and experiences when using health services such as the pharmacy. Lastly, descriptive coding is used to summarize the main topic of a portion of qualitative data (Saldaña, 2009). This type of coding was used to ensure that the researcher was keeping track of the different topics that were arising throughout the interview. For example, if a participant spoke about recent medical tests and a variety of health services, this was coded as “Health Service Usage”.

Committee members performed simultaneous open coding for 2-3 interviews, to support intercoder agreement (Miles et al., 2014). This was done to guarantee that each participant narrative had been reviewed by at least two different people. This simultaneous first cycle coding helped to ensure study rigor (Tracy, 2010) and guaranteed that codes, patterns, and subsequent emerging themes were consistent across the research team.

3.5.1.2.2 *Second Cycle Coding*

When first cycle coding for each transcript was complete, all codes were entered into an Excel spreadsheet, after which all codes were categorized based on topic and patterns to begin understanding the separate parts of the interview. A combination of pattern coding and focused coding techniques was used to complete this phase of analysis (Miles et al., 2014; Saldaña, 2009). Pattern coding organizes and helps give meaning to the information by combining similarly coded data (Saldaña, 2009). For example, clustering all ideas that are pertinent to the importance of family support in a participant's life and trying to understand and interpret how and why this family support is important to the participant. Focused coding categorizes the first cycle codes and the data based on thematic similarity (Saldaña, 2009). For example, first cycle codes regarding the use of health services could be clustered under the category 'Health Service Use'. Appendix J shows an example of second cycle coding.

Coding feedback from committee members was used to refine the initial coding list. An iterative process was used with multiple rounds of refinement until a final coding list was established. This final coding list was then used to further analyze the data. (Appendix K).

3.5.1.3 *Line-by-line Analysis*

After the final coding list was established, codes from each transcript were entered into NVivo 10 Software©. Rereading the transcripts line-by-line enabled further understanding of how each sentence or sentence cluster was related to the use of community support and health services (van Manen, 1997). Throughout the process, analytical memos and annotations were used to help keep track of emerging themes,

questions, and ideas (Miles et al., 2014). After all the codes had been entered into NVivo 10 Software©, this program was used to facilitate a deeper analysis of each participant's narrative, known as within case analysis (Miles et al., 2014). NVivo 10 Software© enabled reflection of specific codes within each participant interview and enabled understanding of how the different parts of each participant's experience were interrelated and connected to the use of community support and health services. For example, one participant's indication of good health and mobility impacted her minimal use of traditional community supports and health services. NVivo 10 Software© also allowed a cross-case analysis between participants to be conducted (Miles et al., 2014). The researcher was able to look within a specific code and see how it had an impact on each participant and how it related to the overall experience of using services. For example, by looking within the code 'sense of community', the researcher was able to interpret and understand which elements of participants' lives contributed to this sense of community, such as meaningful community membership and social activities. The goal of this cross-case analysis was not to increase generalizability, which would violate phenomenology's aim (Symthe et al., 2008), but rather, it was done to create a deeper understanding and meaning of the experience of using community support and health services.

The combination of analyzes used in this study facilitated the emergence of themes and helped to deepen understanding of participants' experiences during the crystallization phase (Lincoln & Guba, 1985). Reflexive notes added another layer of depth to the analysis, as the researcher was able to keep track of thoughts, ideas, and questions throughout the process. Member checking was completed with nine of the ten

participants. Member checks were conducted in-person with six participants and via telephone as selected by the remaining three participants. The missing member check was due to an inability to contact the participant. The researcher attempted to call the participant multiple times during a two-week period. At the end of the two-week period the participant's number was out of service and there was no other way of contacting this participant. Member checks were conducted to ensure accurate portrayal of participant experiences and to establish study rigor (Guba & Lincoln, 1994; Koch, 1996; Tracy, 2010). During the member checks, the researcher summarized the main topics discussed during the initial interview, focusing on how each participant used and experienced community support and health services. The researcher asked participants if the summary was an accurate portrayal of their experiences and participants were encouraged to share anything that may have been missed or anything further they wanted to add. Notes from each member check were added to the original interview data and subsequently analyzed.

3.6. Study Rigor

3.6.1 *Credibility*

Authenticity was addressed by making every effort to capture the perspectives of participants in their own words (Patton, 1990). Member checking (Guba & Lincoln, 1994; Koch, 1996), having participants confirm that interpretation of the findings reflected their perceptions and experiences, was done to promote authenticity of data. Credibility of findings was ensured through audio-recording and verbatim transcription of each interview to ensure accuracy. Furthermore, consistency in interpretation of findings was strengthened through simultaneous coding and discussions with the project supervisor and advisory committee members (Miles et al., 2014).

3.6.2 *Transferability*

It is important to note that although the aim of this study was not to produce generalizable findings (Lincoln & Guba, 1985; Smythe et al., 2008), the information and understandings that have emerged will be useful to other older adults, health professionals, researchers of ageing, community developers, policy makers, and the ageing field as a whole. The insights and implications highlighted in this study may be useful to inform AFC development and future studies in the ageing field. Transferability is defined as the applicability of the findings to other similar individuals, situations, and places (Lincoln & Guba, 1985). Lincoln and Guba (1985) explain that by attaining rich descriptions of the human experience, this transferability is made possible. Therefore, it is expected that the results found from this study will, similarly, be transferable to wider contexts.

3.6.3 *Ethics*

Ethical practice is the end-goal of all qualitative research regardless of paradigm or methodology (Tracy, 2010). As stated previously, procedural ethics review (i.e., the general ethical steps that are required by ethics boards) (Tracy 2010; Guillemin & Gillam, 2004) took place at The University of Western Ontario before the study commenced (Appendix A). However, situational ethics that are specific to context of study (i.e., ethical steps that are taken throughout the research process that are specific to the research at hand) (Tracy, 2010) were also adhered to throughout the research process. This was ensured at all points of contact with participants, potential participants, and recruitment facilitators. It was recognized that this study involved a vulnerable population and therefore efforts were put into place to ensure participants felt comfortable, valued,

and respected. For example, transparency about the research study and its goals were made completely clear to participants, and they were encouraged to ask questions throughout or after the interview had concluded. Lastly, exiting ethics (i.e., ethical steps taken beyond the data collection phase, referring to how the study is concluded and how results are shared) are currently being adhered to (Tracy, 2010). Confidentiality and anonymity were and will continue to be maintained in accordance with the Tri-Council Policy for ethical conduct in research (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010).

3.6.4 Reporting

Results from this study will be shared with the City of London's AFC network in collaboration with a member of the advisory committee (P. Fleming) who is also Chair of the City's AFC Community Support and Health Service Task Force.

3.7 Declaration of Self

With the goal of being a self-reflexive and transparent researcher, discussing my interests and goals in the ageing field is an essential disclosure (Tracy, 2010). Ever since I was a little girl I was inspired by older adults and very much enjoyed the conversations and stories they had to share with me. Having lost my grandparents at a very young age, I may have been looking for individuals to fill that role for me. Throughout my adolescent years I enjoyed visiting retirement homes and volunteering at my church parish, all areas in which I engaged in substantial interaction with older adults. My interest continued (and continues) to grow during my university career through working in hospitals, retirement homes, and teaching basic computer skills to older adults. Having completed my

undergraduate program in Biology and Medical Sciences, I was never exposed to the issues of ageing apart from the physiological changes that are inherent. I had heard of the course: *Health Issues in Aging*, offered by the Health Studies department and remember that every time I tried to enroll in this course, it was full. In my final year of undergraduate studies, a spot opened up and I happily took this opportunity. It was through an assignment in this course that I was exposed to hearing about the challenges that older adults face in accessing and using the services they need to practice active ageing. When I heard about the Health and Aging Masters Program I was inspired to turn my natural interest of working with older adults into a project that could make a difference in the lives and community experiences of these individuals.

My previous volunteer experiences helped to enrich my interview process and afforded me familiarity and a sense of ease going into the interviews. Furthermore, my educational background in physiology and pathology facilitated a clear understanding of some of the issues that participants discussed in terms of health. Personal family experiences with caregiving and different issues related to ageing helped me to empathize with the experiences participants shared. Overall, I believe that my previous work and experiences were assets in helping me to conduct this research.

I am truly passionate about advocating for older adults. They provide such a wealth of knowledge and potential for our societies. These are the individuals who built our communities and brought us to where we are now. They are our grandparents, our parents, aunts, uncles, and friends. We must ensure that we create communities in which older adults can feel included, supported, valued and empowered. For all these reasons, I chose to complete this study.

3.8 Conclusion

This study aimed to understand and interpret the lived experiences of community-dwelling oldest-old in their use of community support and health services. The main goal was to ensure that the voices of the oldest-old were heard. Therefore, this study employed a hermeneutic phenomenological methodology that is grounded in an interpretivist/constructivist paradigm informed by the work of Heidegger (1996), Gadamer (2004), and van Manen (1990). The critical components of a hermeneutical phenomenological study that were incorporated into this research include: i) 'being in the play': practicing openness, complete engagement in the moment and not fearing uncertainty; ii) the fusion of horizons and incorporation of fore-structures: accepting and integrating past knowledge and experiences, allowing the joining of different vantage points; and lastly, iii) proper implementation of the hermeneutic circle (Koch, 1996; Koch, 1999; Smythe et al., 2008). The trustworthiness and quality of the research study was ensured through the use of Tracy's (2010) criteria for good qualitative research and Guba and Lincoln's (1994) criteria for credibility.

4. FINDINGS

The goal of this hermeneutic phenomenological study was to understand the lived experience of community-dwelling individuals, 80 years of age and older, using community support and health services. In-depth analysis of each participant's story and holistic analyzes of all findings were completed.

4.1 Participants

A total of ten individuals agreed to participate in the study and consented to interviews. During two of the interviews, participants chose to have their spouses present and included in the discussion. Eight participants were female and two were male. The average age of participants was 86 years (SD = 4.6), ranging from 80 – 95 years. Four participants were married. Of these, two lived exclusively with their spouses, one lived with his spouse and additional family, and one lived alone. The spouse of the participant who lived alone was in a long-term care facility. Six participants were widowed. Of these, five lived alone and one lived with her son and his wife. The average length of time participants lived in Westmount was 19 years, with a range of 6 – 48 years. Only two of the ten participants had a regular caregiver. Participants' self-rated health status ranged from fair to excellent, with the majority rating their health good to excellent (n=9). Self-rated independence ranged from very little independence to completely independent; half of the participants described themselves as being somewhat independent (n=4) or having very little independence (n=1), while the other half described themselves as being very independent (n=3) and completely independent (n=2). All participants reported leaving their homes at least weekly, with the majority (n=8) leaving their home multiple times per week. Of the ten participants, three were Veterans

of the Second World War. Participants' socio-demographic characteristics are described in more detail in Table 1.

Eight participants indicated that they turn to a family member or friend when in need of help, whereas only two indicated turning to formal figures such as a family doctor or Veterans Affairs Canada (VAC). All participants reported using community support and health services within the Westmount Community. Among this group of participants, community supports were used much more frequently than health services. Community supports used included traditional supports such as help with cleaning, personal emergency response systems (Connect Care), meal support, and transportation, as well as social supports including church membership and apartment building socials. Participants reported that their social supports provided opportunities for connection, engagement, and membership in their community. Health services used include visiting their family physician for routine checkups and preventative screenings, dental checkups, and the pharmacy for their medication needs. The majority of participants (n=8) reported being satisfied with the community supports available, while two reported being somewhat satisfied. All participants reported being satisfied with health services (Table 2).

Community support and health services identified by participants as being most important included the aforementioned community and health services, along with family and social support, as well as opportunities to meet new people and to be engaged in their community.

Table 1. Socio-Demographic Characteristics of Participants

Characteristic	Study Participants (n=10)
Mean Age (years)	86 (range: 80 – 95) (SD = 4.6)
Gender	Female (n=8) Male (n=2)
War Veteran	30% (n=3)
Marital Status	
Married	40% (n=4)
Widowed	60% (n=6)
Single	0% (n=0)
Separated	0% (n=0)
Divorced	0% (n=0)
Common-law	0% (n=0)
Mean years lived in Westmount Community*	19 (range: 6 – 48)
Living Arrangements	
Alone	60% (n=6)
With Spouse/Partner	20% (n=2)
With Other Family Members (e.g. child, etc.)	20% (n=2)
Currently have a caregiver/helper?	
Yes	20% (n=2)
No	80% (n=8)
Highest Level of Education	
Public School	10% (n=1)
High School	50% (n=5)
College (diploma)	20% (n=2)
University with a Bachelor's Degree	10% (n=1)
University with a Master's Degree	10% (n=1)
University with a PhD or MD	0% (n=0)
Other Education	0% (n=0)
Perceived Health Status	
Excellent	10% (n=1)
Very Good	30% (n=3)
Good	50% (n=5)
Fair	10% (n=1)
Poor	0% (n=0)
Extremely Bad	0% (n=0)
Perceived Independence Level	
Completely Independent	20% (n=2)
Very Independent	30% (n=3)
Somewhat Independent	40% (n=4)
Very Little Independence	10% (n=1)
Not At All Independent	0% (n=0)
Completely Dependent	0% (n=0)
How often leave home?	
Nearly Everyday	50% (n=5)
3-5 Days/Week	30% (n=3)
1-2 Days/Week	20% (n=2)
Mostly on Weekends	0% (n=0)
Once Every Two Weeks	0% (n=0)
Once/Month	0% (n=0)
Less than Once/Month	0% (n=0)
Almost Never	0% (n=0)

*Participants either lived directly within the Westmount Community, or on the outskirts, but considered Westmount their primary community.

Table 2. Community Support and Health Service Information

Characteristic	Study Participants (n=10)
Who do you turn to when you need help? Family/Friend Health Professional Other	80% (n=8) 10% (n=1) 10% (n=1)
Do you currently use community supports in Westmount? Yes No	100% (n=10) 0% (n=0)
How often do you use these community supports? Everyday A few times per week Once per week A few times per month Once per month Rarely	0% (n=0) 50% (n=5) 30% (n=3) 10% (n=1) 10% (n=1) 0% (n=0)
How satisfied are you with these community supports? Extremely Satisfied Usually Satisfied Somewhat Satisfied Somewhat Dissatisfied Usually Dissatisfied Extremely Dissatisfied	60% (n=6) 20% (n=2) 20% (n=2) 0% (n=0) 0% (n=0) 0% (n=0)
Do you currently use health services in Westmount? Yes No	100% (n=10) 0% (n=0)
How often do you use these health services? Everyday A few times per week Once per week A few times per month Once per month Rarely	0% (n=0) 0% (n=0) 0% (n=0) 40% (n=4) 40% (n=4) 20% (n=2)
How satisfied are you with these health services? Extremely Satisfied Usually Satisfied Somewhat Satisfied Somewhat Dissatisfied Usually Dissatisfied Extremely Dissatisfied	50% (n=5) 50% (n=5) 0% (n=0) 0% (n=0) 0% (n=0) 0% (n=0)
Accessibility of community support and health services Very easy to access Usually easy to access Somewhat easy to access Somewhat difficult to access Often difficult to access Not accessible	40% (n=4) 60% (n=6) 0% (n=0) 0% (n=0) 0% (n=0) 0% (n=0)
Are all community support and health service needs being met in your neighbourhood? Yes No	90% (n=9) 10% (n=1)

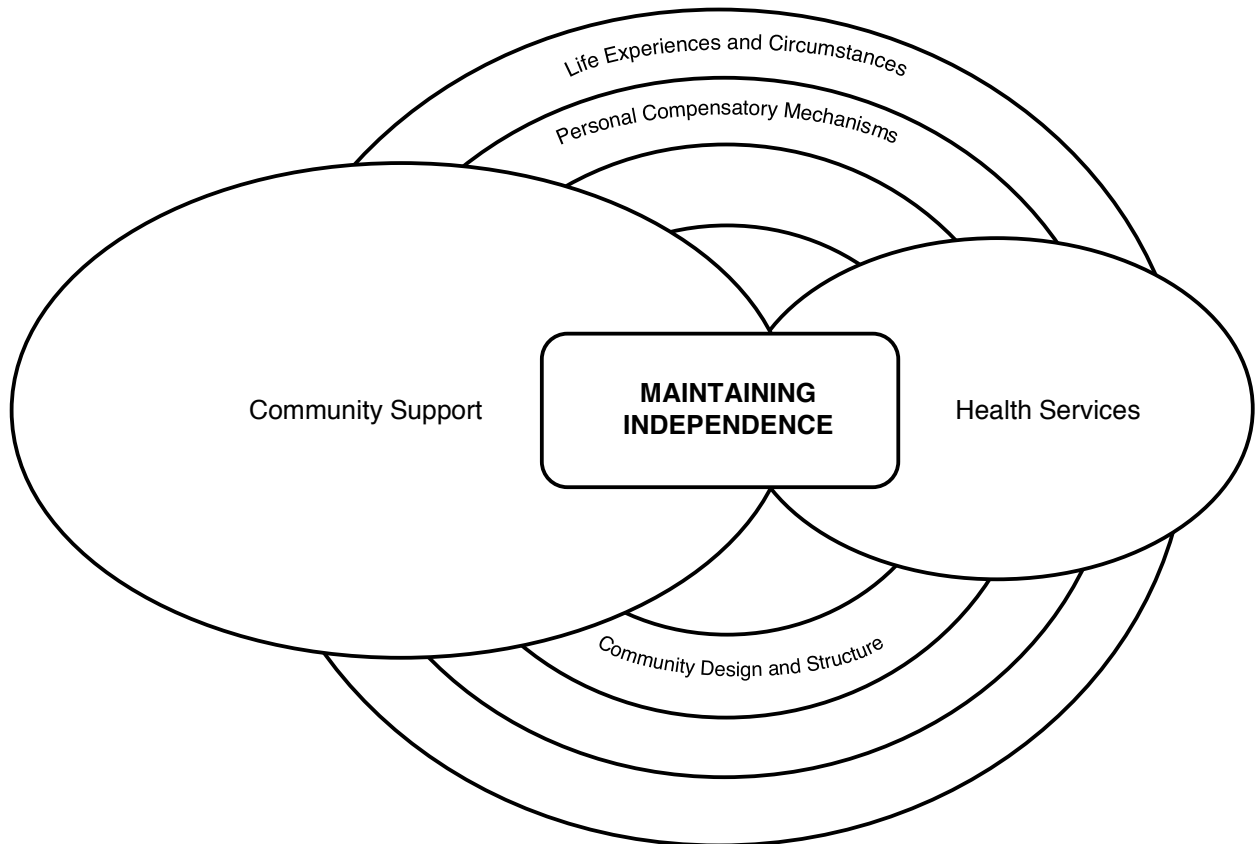
4.2 Emergent Themes

The findings of this study reflect the shared experiences of using community support and health services among the community-dwelling older adults, 80 years of age and older, in this study. Maintaining independence was key across all interviews. This was a goal for all participants, something they constantly strove to maintain and around which their use of community support and health services revolved. Three central themes emerged as to how study participants used community support and health services to maintain their independence: (1) life experiences and circumstances, (2) personal compensatory mechanisms, and (3) community design and structure (Figure 1). Each of these themes contained multiple subthemes.

4.3 Life Experiences and Circumstances

Life experiences and circumstances refer to interacting factors such as one's unique past experiences, unique characteristics, and past and current personal circumstances. In trying to understand the role of community support and health services in maintaining independence, it became clear that each participant's experiences and circumstances played a key role. For example, the life of Participant 6, whose husband was in a nursing home, revolved heavily around her husband and visiting her husband in the home. This particular circumstance influenced Participant 6's daily activities. In a similar example, Participant 10's husband was in a nursing home for a number of years prior to his death. The positive experience she witnessed in her husband's care may have influenced her attitude, as she was the only participant interviewed who felt less concerned about having to move to a long-term care facility in the future, should circumstances require it. Within the 'life experiences and circumstances' theme, four

Figure 1. The Experience of Using Community Support and Health Services to Maintain Independence



subthemes emerged: health and functional status, family and social support, driving ability, and significant life events. All of these were found to influence the need or the degree of need for community support and health services.

4.3.1 *Health and Functional Status*

The majority of participants in this study rated their health from good to excellent and, as might be expected with good health, reported their health service use was limited to routine medical and dental screenings and medication-related pharmacy use on a monthly basis: "...so far my health is pretty good...so I don't have a lot of needs yet" (Participant 10). Similarly, Participant 4 stated: "No, I can't use any of that yet...I'm hoping I can keep on going without it. Day comes, I'll have to give a call. But...so far so good!" [laughing]. However, if a chronic health condition existed or a previous health problem was exacerbated, as was the case with one participant who had experienced a heart attack and two strokes, more frequent monitoring was required:

...about once a month... And if your blood is off a bit, then they want you to go in a week's time. But most of the time you manage a month...you take Warfarin, a blood thinner, and you have to keep checking it...right now mine is a bit high (Participant 10).

Another participant reported similar circumstances:

I see my doctor on the 29th of this month. And she wants to see me now every month...I have an abdominal aorta that's expanding...Mine is just below the stage where they would operate but they don't want to operate on me because of my age. Everything is age, age, age now. And then I have a growth in my bowel that they were unable to remove and I'm having a lot of bowel problems because of the discharge from this growth...had C-scan every 6 months to follow the expanding aorta and the last one just a month or so ago... (Participant 8).

Not surprisingly, given the relatively good self-reported health of participants, they were minimal users of health services.

Functional status, as one would expect, influenced the use of formal (traditional) community supports. For example, Participant 4 expressed having many issues with mobility and therefore indicated having challenges with completing some everyday activities, such as cleaning her house. She described having to ask the VAC to increase support to twice a month instead of once: “They were coming once a month but then a while ago I said no because I had to have help [to] make the bed and do other things for me that I was unable to do myself...” (Participant 4).

Interestingly, despite the majority of participants rating their health as good, their perceived level of independence varied significantly. Half the participants described themselves as being somewhat independent, while the other half as very independent. While there seemed to be few differences between these two groups of participants in terms of health services and formal (traditional) community supports used, it seems that requiring an assistive device (walker), losing the ability to drive, and the type and degree of family support in place played a role in how participants perceived their independence levels.

Most participants (9 out of 10) in this study reported using a significant number of informal (social) community supports, again reflecting the relatively healthy nature of this group. Participants reported that these informal (social) community supports helped them create new friendships, enabled social connectedness, and enabled them to remain actively engaged within their community, all factors important in maintaining one’s independence.

4.3.2 *Family and Social Support*

Support provided by family and friends played a significant role in the lives of participants in this study. Eight of the 10 participants indicated that they turned to a family member or friend, when they needed help. All participants indicated having close family or friends on whom they relied, thus reducing their dependency on, and need for, formal community supports and health services. For example, Participant 4 explained that although transportation services might be available within the community, she has been able to get by with help from family and friends:

Well I guess there is some volunteers that do...will give rides...for people, but I've thankfully been able to manage without doing that, with friends and family, you know? (Participant 4)

Participant 9 had a similar experience, but expressed an increased dependency on family members for support:

As much as I can do, but most of it is done for me. Not through my choosing but he's [husband] the head cook and bottle washer. He does very well as well. He does all the cooking. And...you [looking at husband] do the laundry my daughter does the ironing. So I'm well looked after (Participant 9).

Participant 9 indicated minimal use of health services, stating that her health was good. However, she perceived her independence level to be very low. Despite this perception, she did not require any formal (traditional) community supports because her family provided all of the help she needed on daily basis. While this seems to be working well for Participant 9 at the moment, it does raise the question, what would happen if circumstances changed and her familial support was no longer available? Should this happen, her reliance on community supports would greatly change.

In addition to providing tangible support with everyday activities, having a family member or friend available also provided a sense of reassurance. Participant 5 lives with his wife, daughter, and son-in-law. Although expressing a high degree of independence, living with their daughter and son-in-law afforded a great deal of support:

But we've got the advantage also, if anything does go amiss, that our daughter is there as well. And security is another thing that we don't have to worry too much about, because either we're here, or she's here. Or her husband's here. So there's always someone here in case (Participant 5).

In a similar example, Participant 1 stated:

When you get older, you have to have one another...I have one friend and she barely can walk right now and she can't drive anymore, they took her driving license away. Whenever...she wants to play cards... I pick her up. Because you have to do that, you get older, you got to kind of help one another (Participant 1).

In addition to receiving help from family and friends, the previous quote demonstrates that participants also wanted to be there for others, indicating the presence of a reciprocal support system within their social circle. For participants who did require help with activities of daily living, the presence or absence of support from family and friends was a determining factor in their use of community supports. Since all participants indicated having a good support network from family and friends, most participants preferred to depend on family and friends for help instead of turning to formal (traditional) community supports and health services.

The relationships participants shared with family members, friends and neighbours not only provided tangible support with activities of daily living but also a sense of social connectedness. Of these social relationships, relationships with family members and friends were identified as the most supportive.

As the interviews progressed and immersion in each individual's story continued, a prominent commonality across all interviews emerged, and this was the emphasis that each participant placed on relationships with family members. This included immediate family such as spouse and children, and extended family, for example, siblings, grandchildren, great-grandchildren, nieces, and nephews. Participants described meaningful experiences and memories they shared with their loved ones. Furthermore, participants shared details about their loved ones' lives, such as where they work and what they enjoy doing. It became evident that participants cherished the connections they had with their family members and that these connections and relationships could often suffice and eliminate the perceived need to seek social connections elsewhere. For example, when Participant 9 was asked if she was engaged in community groups and activities, she responded:

Not very often. Because you know, we've got family and family is very important. So we tend to...like we're going out with our grandson tonight and his girlfriend and his mum and dad and her mum and dad. So we don't really need anything else at the moment (Participant 9).

It was also found that familial connections could directly dictate use of community supports, as in the case of Participant 6, who lived alone, but her husband, diagnosed with dementia, lived in a long-term care facility. For this participant it was clear that the spousal relationship was the central component of, not only her day, but also her life, leaving little time for other things:

I do feel guilty about him being in there, but I don't think I could look after him. No. After all, last Saturday he said to me, "How come you can escape from here and I can't?"...You know, so...how can he think that? (Participant 6).

Although Participant 6 did indicate that she engaged in her church community and in other social activities, the extent of her involvement was limited because of her visits to the nursing home: “I wouldn’t mind being able to use a computer...But then again...I could try to learn...[are there no classes available?]....There are, but...if it’s during the day or at night, doesn’t suit me” (Participant 6). Taken together, these examples indicate that familial social connectedness was important to these participants and had an impact on their use of other community supports.

Among participants, connections with friends were highly desired and often sought. Nine of the ten participants were involved in various community groups and expressed the importance of socialization and developing relationships. The desire to make new friends and develop new bonds was often an instigator in seeking social community supports. Participant 2 said: “I wish I had more friends”. Social community supports became much more important for Participant 2, who had recently lost his wife. He indicated engagement in many social activities, including local community clubs, apartment building gatherings, and involvement in different ministries and activities taking place at his church. He expressed feelings of loneliness, and thus his involvement in these social activities may have been helpful to mitigate these feelings, by expanding his social network and decreasing loneliness. In another example, Participant 4 shared the desire for more social connections:

...it would be nice if apartments...had more of a public meeting place where you can meet down here...I often thought it’d be nice to have somewhere you could just go down and even if you took your own cup of coffee...but I mean, I guess maybe some people can get to be slob and mess things up for you [laughing], you know? But anyway, that was just wishful thinking. I know at Cherryhill they

have quite the entertainment...you know, community things that they get doing but...you can't expect it in the buildings like this, really (Participant 4).

Among participants, friendships were identified as playing a key role in helping older adults feel socially connected and supported and informal (social) community supports in the Westmount community helped facilitate these feelings of connectedness.

4.3.3 Driving Ability

Not unexpectedly, driving was found to be a very important topic and was equated with independence by all participants. The ability to drive afforded participants a convenient way of accessing their community, including access to health services and social supports within the community. Of the 10 participants, seven were still driving, two had stopped driving, and one had never driven. Participants expressed the importance and convenience of being able to drive: "Well I drive my own car... And I dread the time when I can't because I don't know...I've never been on the bus" (Participant 7). If they could drive, they did not have to rely on others or public transportation to take them around, thus making the community, including supports and services, more conveniently accessible:

Of course we've got our health...pretty good health for one thing. And we're able to access these things without having to worry other people, "Can you take me here, can you take me there?" "Oh gee, when can I get a hold of you?" "I feel bad now and you can't pick me up..." I've heard all these things from other people, but we don't have that problem. We can immediately access these things by picking up the car, driving to it and that's what makes it quite easy for us (Participant 5).

However, the 'push-pull' relationship between independence and dependence associated with driving was highlighted by Participants 3 and 9:

...there was one time when my knee did give out that I was going to take myself off the road. The doctor said, "Just give it time"...it was my right knee, so I was kind of worried if I could stop in time on the highway. And both the suggestion of my son and the lady from the vehicle, she said, you know I would just give it a few weeks. So then, I was back to driving and it's nice, cause you can go out anytime you feel like it...Before I had the car, it's about 3 years now. My son used to drive me everywhere. And I hated asking, you know because he was always busy; he was working at that time (Participant 3).

Well as long as I have my driver's license, I can go anywhere...you have to do a test when you're 80. So I've passed that one and so I have to do another one when I'm 82, so hopefully I'll still be sensible enough to drive [laughing]...As I come close to it [driving test] I'll still get very worked up about it. You know, because without me as transport...we're both stuck here (Participant 9's Spouse).

For individuals who were not able to drive and did not have a spouse at home who could do so, transportation was much more of a challenge. Participant 10 explained her struggles with not being able to drive:

...well when my husband retired...we went everywhere together. Well he drove everywhere we went. It clips your wings when you stop driving, it really does, but you get used to it. And of course I'm fortunate to have my son and my daughter take me where I need to go, so far anyway...I should [take public transit], because I could...I would like to go shopping by myself because it sort of bothers you, I mean, they're extremely patient, both my son and daughter...(Participant 10).

Among participants, being able to drive was a critically important topic. Being able to drive provided the reassurance that they could leave the house and go places, at any time, without having to rely on others for help. The ability to drive also allowed participants to use social supports and services, such as community clubs, church, doctor's appointments, and grocery stopping, in a convenient way. However, when the ability to

drive was not there, reliance on formal (traditional) community supports and on family and friends for transportation increased.

4.3.4 *Significant Life Events*

Significant life events, such as previous military service, the death of a loved one, a difficult upbringing, or a serious car accident, were other important factors influencing the use of community support and health services in various ways. Three of the participants were Veterans of the Second World War. These experiences had a significant impact on each of these individuals' lives, but also direct implications on the services available to these individuals. As Veterans, these three participants and their families were able to access an additional array of services provided by Veterans Affairs Canada (VAC). When Participant 5, who was a Veteran, was asked about his use of community support and health services, he expressed confidence in knowing that services were available and accessible if he ever needed them "...well I don't have to worry about that because I make phone calls to VAC, the Veteran's Assistance..." (Participant 5).

Another participant shared her experiences with being involved in her church community. She and her husband were active contributors to their church and were involved in most activities at the church. However, after her husband passed away, her engagement and social network changed:

...Most of our social life was at the church...before my husband became not well...we were in all kinds of...we were in everything that went on at the church.

That was our social life...Um...I don't do much [now] (Participant 10).

For Participant 10, losing her husband had a direct effect on her use of informal (social) community supports. In another example, Participant 4 had to stop driving after a serious accident, which left her unable to bend her knees:

No, no. I haven't drove since the accident...I wasn't able to drive...I didn't feel I'd be safe to drive because I can't move my legs...I mean, people told me you could just swivel your foot, but my foot doesn't swivel very fast...because without the knee connecting properly, it doesn't swivel....So that's kind of out of the question. I...gave up my license because I thought I was a driving risk if I was doing that...that would be 18 years ago (Participant 4).

This inability to drive left Participant 4 reliant on public transportation and family and friends. She indicated that if she needed to attend a doctor's appointment, a community gathering, or to go grocery shopping, she would either call a family member or friend or the Checker's Cab Company, if her family and friends were unavailable.

Significant life events such as the previous three examples show that significant occurrences in one's life do directly affect the use of community support and health services. All in all, the participants in this study were relatively healthy which was reflected in their greater use of informal (social) community supports rather than formal (traditional) community supports and health services. These social community supports such as church membership and community social groups provided social connections and a sense of belonging, very important factors for participants in this study.

4.4 Personal Compensatory Mechanisms

Personal compensatory mechanisms emerged as the second central theme in the use of community support and health services among participants. Within this theme, three subthemes emerged: personality and attitude, insight into personal situation, and problem solving and coping strategies. Personality and attitude can have an impact on the use of supports and services, as a person's unique demeanor can determine if supports and services are deemed necessary, how these services are sought out, and how they are experienced. Furthermore, insight into one's personal situation can be advantageous in

helping understand one's unique needs and, thus, having this insight may translate into implementation of appropriate problem solving and coping strategies, such as self-imposed changes or acquisition of external supports and services.

4.4.1 *Personality and Attitude*

Individual characteristics such as personality and attitude played a significant role in the decision to use community supports and health services and in how these support and services were experienced at an individual level. A person's character can influence if and how care and services are sought. For example, Participant 1 demonstrated a strong will in understanding any prescribed medications and in taking charge of her own health and situation:

...when the doctor prescribes me anything, then I go straight to the computer and see what it is and [if] I don't like it, I don't take it...And you know, the thing with medication...they say always side effect...It fix[es] one problem, you probably gain another one. When you can do without it, you're a lot better to do without it. I take a lot of vitamins (Participant 1).

Participant 1's strong and earnest personality was reflected throughout the interview and was seen to influence the way she approached her healthcare and thus the way she sought out services and how she would do so in the future. When she was asked about using services to remain independent and living in the community, her go-getter personality and attitude came out once again: "But I myself, I think that you should stay in the house so long as you can and get all the help you can get" (Participant 1). Through her interview it was made clear that Participant 1 would not sit back and see what happens, but instead would take charge of her health and independence by using anything that she deemed necessary.

In a similar example, Participant 2 also demonstrated a strong and determined personality. Participant 2 recently lost his wife and, because of this, experienced feelings of great loneliness. Knowing this, a friend of his suggested moving to a retirement community. His dominant personality, driven by his desire to remain independent and to remain living in his own home, came through loud and clear:

...[person] wanted me to come over and live over there. I says “well, it’s like a nursing home to me, you know? Old-age retirement and it’s old. And I like brand-new...and I says “there’s no stores here, what am I going to do?” And she says “well, you look at me” [laughing]. So...well that was the end of...I says “well, I like where I am and I’m going to stay here till I die if I can.” So that’s it on that [laughing] (Participant 2).

Taken together these participants embodied how personality and attitude can influence the use of community support and health services. A person with a strong personality such as the participants described above may seek out and use supports and services in very different ways.

Moreover, personality and attitude can also influence how a person interprets the use of community supports and services. For example, Participant 10 displayed an optimistic and positive attitude throughout the interview. She consistently mentioned being fortunate and was very positive about all of her experiences. In particular, she described her opinion of emergency room wait times: “...I guess the big standby is Emergency at Vic [laughing]. Oh it is...and we’ve had a few waits there, but they’re still...they’re going as fast as they can” (Participant 10). Although she described a negative experience of having to wait for care, she was positive, in that she accepted the wait time and understood that they were doing the best they could to provide adequate

care with the resources available. In another example, when Participant 9 was asked if any services could be improved, she responded:

Um...I don't think so...I think it's on a[n] 'as-needed basis'. If I felt like something needed to be done, you know, I'd be the first one to speak up about it...I'm not backwards coming forwards, as they say in England [laughing] (Participant 9).

Through Participant 9's words it can be seen that her personality would affect her experience of using community supports and services. If she was not satisfied with a particular support or service, she herself indicated that she would definitely speak up and express her concern.

In conclusion, in trying to understand how community supports and health services were experienced by participants, it became clear that their personalities and attitudes played a significant role in how they chose to use supports and services and in how they interpreted their experiences with using these supports and services.

4.4.2 Insight into Personal Situation

Within and across interviews, participants were cognizant of their functional levels: what they could or could not do. Participants also described noticing changes in their level of independence, such as housework becoming more challenging to complete. The majority of participants mentioned being able to perform everyday tasks, getting around town with no issues, and being able to help sustain the household: "But right up to this time I don't need any help. I do my laundry, I buy the groceries" (Participant 2).

Others recognized new changes and challenges that were beginning to arise, that could possibly limit their function. The following participant described the recent changes she had seen in her ability to perform her weekly cleaning routine:

No, I don't have any help. But it is not too easy anymore...I closed one bathroom and two bedrooms upstairs...yesterday I vacuumed the whole house...and it was not too easy because by the time I was finished vacuuming my back kinda bothered me (Participant 1).

As can be seen through Participant 1's experience, cleaning the house is not as easy as it once was and she had no trouble recognizing this. This insight into her own situation can prove advantageous as she can determine what needs to be done to address her changing functional level. In a similar example, Participant 4 was also cognizant of her functional level and clearly understood her limitations:

Oh...I don't do anything too exciting. I like to go out every...at least every other day and...housework...well I can dust and that's about it that I do. Cook a few meals and that's it...As I say there's not much that I can do anymore...(Participant 4).

She went on to explain her struggles with travelling around town:

...somebody said well could I use the ordinary bus, because they have the drop doors... But see, I can't walk out of here because of that...I don't know whether you come in the back way but it's steep...that was supposed to be a slight incline well...when your knees don't hold, it's pretty slow and hard to walk down that slope... So I can't use the general [entrance] unless someone comes to the door to get me...that's my situation. You know, not everybody's...There are some of us, you know, that have trouble walking (Participant 4).

Participant 4's clear insight into her personal situation highlights her awareness of her functional challenges and what is necessary to enable her to remain independent. Participant 4 described liking to leave the house multiple times per week and she also mentioned enjoying taking part in community activities offered by different community groups in Westmount. Recognizing her personal functional level and the challenges she faces are important factors in implementing the proper strategies to ensure her

engagement in these community activities is not affected. Taken together, these examples demonstrate that having insight into one's personal situation can be helpful in recognizing what can be managed alone, what cannot, and when it is time to reach out for help. This understanding of personal needs is critical in determining what must be implemented to fulfill these needs.

4.4.3 Problem Solving and Coping Strategies

Having clear insight into one's personal situation is an essential precursor to the use of personal problem solving and coping strategies. Within and across interviews, it was made clear that participants' use of community support and health services was influenced by personal problem solving and coping strategies. In fact, participants often demonstrated different levels of problem solving. It was seen that participants would often try to take their issues upon themselves through the use of self-imposed coping strategies, such as downsizing their household or adapting their daily activities such as cleaning, accordingly, based on their function. However, if these self-imposed mechanisms were not sufficient to help maintain independence, external help, from community support and health services or family and friends, was acquired.

For example, Participant 4 had been in a serious car accident that severely compromised her mobility and physical functional level. On top of this, her husband was diagnosed with dementia. Having issues of her own in conjunction with having to care for her husband, living in a big house and in a small town was not feasible. She described how these changing circumstances resulted in her and her husband implementing coping strategies and, thus, downsizing to an apartment and moving to Westmount, an area where additional supports and services could be acquired for her husband:

...we've been in this apartment 10 years...[why did you move here?...]for the services and help...I was hiring by myself, somebody to...[do]...What we couldn't do at the time, you know? We couldn't mow the lawn.... That's why we said, we'll get an apartment...[so then] we don't have to worry about all of those things (Participant 4).

In this example, Participant 4 recognized her compromised functional ability and her husband's circumstances and implemented coping strategies to address these issues.

Another coping strategy that was shared by a number of participants was the adaptation of their cleaning schedule. Some participants found that with their increasing age, they were also experiencing decreases in functional ability, causing household cleaning to be more challenging than it used to be. Therefore, they came up with different strategies to combat this decrease in energy or strength. Participant 10 shared her thoughts below:

I used to clean the whole house on Friday, I always did that, that was my religion. And...it was too much...so I thought I'm going to do one room and I can take the time and clear everything and do it really well...The next day, I'll do another room...And the next day another room. Well there's two small bedrooms...I do two of them, there's hardly anything to be done in them, so I do them together...and that works really well. Now if I had to do the whole house, I couldn't do it in one day. Running the vacuum is really wearying. But one room at a time...so that's how I'm working that. But if I got that I had to do it all, then no, I would need a cleaning person (Participant 10).

Participant 10, herself, indicated that if she had to clean the whole house in one day, she would be unable to do so, and would therefore require external help. By adapting her cleaning schedule however, she was able to maintain her independence without having to receive external support.

Similarly, Participant 1 explained that although she is an avid walker, it is not as easy as it once was. She explained that she changed her walking route to travel downhill instead of uphill. Self-imposed coping strategies such as the ones shared by the above participants, were simple ways of altering everyday activities to optimize function and maintain independence. Participants also reported that if these self-imposed strategies were not sufficient to enable them to get through their day, they would then reach out to family and friends and/or would require the use of formal (traditional) community supports.

4.5 Community Design and Structure

Community design refers to the physical layout and infrastructure of a community, in this case the Westmount community, while community structure refers to how services and programs are organized and delivered within the community. This raised issues of availability and accessibility. The interviews revealed that both community design and structure were vital elements in participants' experiences with using community support and health services.

4.5.1 *Community Design*

Before the recruitment process began, the researcher familiarized herself with the Westmount area to determine which community support and health services were available. Appendix D outlines the many supports and services available within the Westmount community, including health clinics, local churches, and grocery stores. Most of these services, not surprisingly, are situated along main intersections within the community. The physical layout of the Westmount community, including boundaries and

services can be seen in Appendices B, C, and D. Accessibility of infrastructure and the Westmount Mall emerged as key subthemes.

4.5.1.1 *Accessibility of Infrastructure*

One of Westmount's greatest assets as expressed by participants was proximity: "you've got everything close near here" (Participant 1). When another participant was asked what he would do if he did not have a car, he responded: "Well as far as shopping, I just walk out to Loblaws [laughing]" (Participant 2). If he were ever unable to drive, his proximity to services would continue to enable him to acquire basic necessities such as groceries.

Although the community offers services that are close by and easy to access, challenges in accessibility occurred for people who had mobility issues. Three participants indicated that this was the case. Participant 4 had significant issues with mobility, she was unable to bend her knees and therefore struggled with accessing different components of the community. In particular, she was not able to use public transportation or most public washrooms because of their design. Her inability to climb stairs consequently caused her to have to call places before she went to them to ensure that she would be able to access the venue. Below she describes her challenges with accessing public transportation services:

...The Voyageur...well, yes I did try taking that in the beginning...it was nice if you could get it booked and as I said, if they didn't run you all over town, if they dropped you first and picked somebody else afterwards...but even so, you know...it's a little awkward cause you got to go on and leave your walker...well at that time I could do it more from the seats, now it's even more [difficult] to be able to walk without any walker...I find that difficult. And then again, the seats

there's no arms, so trying to get up and down, I go forward and I have nothing in front of me to grab a hold of (Participant 4).

Furthermore, she continued describing her issues with using public washrooms:

Well...it's the case that they don't seem to realize the bars...that everybody can't pull themselves up, you need to push. If they have an 'L'-shaped bar on the side, a person can either pull on it or push on it, whichever you want and it's got to be low enough...when I went there [doctor's office] the one girl in the lab had said to me...“Would you go and look at the toilets and see what you think of them?” And I said, “Well they aren't gonna be accessible for me.” And she said, “Well, I told them...I didn't think it was accessible for people.” And so she herself had realized it, but once they've done these things there's no changing...too many places aren't. I mean it's just the one side and nothing else on the other side to hold on to. Not big enough to get your walker in beside it. So you're in trouble there. You don't want to hang on to the paper towel holder because who knows how well secure that is? You could go down good with that one or you know, if they're not put on to the right studding they can be dangerous...well...anyway...I don't know if I'll live long enough to see this happen here (Participant 4).

Participant 4 reported that there were limited washroom stalls within the Westmount community that had the proper infrastructure to allow her to use them. She described this as frustrating. In another example, Participant 10 described the issues she faced when going outside in the winter:

Now people who don't need a walker, the way they plow the sidewalks, it's fine. You just simply walk on top of that little bit of snow. It's people who need walkers or the scooters, it's difficult...most of the people just don't go until they have somebody take them, like son, daughter, whatever (Participant 10).

Participants agreed that accessibility in the Westmount community could be improved.

The Westmount Mall, however, was of greater concern.

4.5.1.2 *The Westmount Mall*

Across interviews, the Westmount Mall was a topic that dominated discussion. Participants used the mall as a place to meet friends, to do some walking, to buy groceries, to go to the bank, to go shopping and to access medical services. It is clear that the Westmount Mall is viewed as an important part of the community. Participants also discussed recent changes to the mall, with the majority of participants expressing concern with the way the mall was changing and evolving:

We got the mall here, now the mall is...in the beginning it was quite good but not that good anymore, but we got everything. When I want to walk, I walk to the mall...everything is here in Westmount...I really really like that. (Participant 1)

And we chose Westmount because...I had stopped driving and I can walk over to the mall, which was great the first couple of years, I'd just walk over anytime I wanted anything, it was lovely. Now it's gone downhill considerably, but that's why we moved here and why it's only been 6 years...it was the convenience...because we looked over condominiums all around the city and this is the only one that you could walk to a shopping...So that's why we chose Westmount...it was really a lot better when we had better shopping because everybody could make it, almost everybody can walk over there... I hate to say it but the grocery store isn't as nice as it used to be...it's just not as nice grocery and losing Zellers, you could do quite well at Zellers. (Participant 10).

Well, my favourite thing was the mall...that's what made me come to this area...but now if I was coming, I wouldn't pick for it for the same reason now [laughing]...I like the area alright. But it's just that shopping is a little sparse...Oh the mall...it was up top and bottom with stores...they were all the way through...I don't know if you knew it before it was torn down? You went in where the mall is and went right through...there was a big...food court upstairs...And the cinema was upstairs too...there was pizza and Subway

and...different ones like that, A&W was there...So you could get a choice of things and it was a big area and the kids used come in and go there...But now there's only Tim Horton's and Zally's – there's only the two places...you can't really have that much of a meal there, like you used to be able to, you know? I mean there is a doctor's office there now...and I mean you've got your pharmacy but they're closed on Saturdays and Sundays...when we first came here there was a big pharmacy down at the bottom... where A&P at that time was...right at the main doorway where now there's an Urban Planet or something like that there. That was Shopper's Drug Mart...a big one. Oh and so many different things...the dentist was there and...different stores. Oh it was entirely different, I mean it was a very busy mall at that time...But now you go and there isn't too much to tempt you to buy...[laughing]...it really went down. They said, "for your shopping pleasure," but when they take a whole floor of the mall away...Used to be packed. But, that's I guess that's the way things are [laughing]...It was A&P and then it turned into Metro and then it sold out to the Chinese Superkings or something...You have to go out the side door up halfway or just past the food court and go out there and walk around and down...it's better at the back anyway...but I mean, they certainly got sidewalks and things there but it doesn't help in the winter or if it's raining or something like that, it was so much nicer when you could just walk in the store. They even had a little liquor store opposite...A&P so you could go get groceries and...your own wine or anything like that you could get it...No, no there's none of that anymore. It's all gone. (Participant 4)

I used to enjoy going to Westmount Mall, but it's deteriorated recently, hasn't it?...it's not used to its full advantage. (Participant 7)

The overwhelming discussion and opinions regarding the Westmount Mall highlighted the importance of the mall to study participants. Some of the participants described moving to the Westmount area because of the proximity to the mall.

Unfortunately, the recent changes to the mall are presenting an increasing number of concerns and challenges. With the loss of many required and desired supports and services, participants must go elsewhere and often further away to receive these supports and services. This may be challenging, especially for those with mobility issues. Participant 7 reported that the mall was not being used to its full potential. She mentioned the possibility of establishing a community center within the mall to provide social, health, and learning opportunities for residents living in the area. It was clear from discussions with participants that the Westmount Mall has immense potential as a central hub in this community.

Another topic that was discussed extensively was the change to the grocery store located in the mall. Changing the grocery store to a less traditional one has caused unease among participants and has resulted in them going elsewhere. Changes to the physical design between the grocery store and Westmount Mall have also created challenges for participants. Before, the grocery store was connected to the mall and one could access the grocery store through the mall. Now, however, the grocery store has its own separate external entrance with no mall access. Having to go outside to enter the grocery store proved challenging for some participants, especially in the winter months.

4.5.2 Community Structure

Community structure refers to how supports and services are organized and delivered. It is important that supports and services are organized in a way that promotes accessibility and user-friendliness. The community must also be structured in a way that ensures residents feel comfortable, respected, and included. Use of community supports,

both traditional and social, use of health services, and awareness and accessibility of both were found to be subthemes of this section.

4.5.2.1 *Community Supports*

Community supports played a key role in the lives of these participants. All participants reported that these supports were very important in enabling them to maintain their independence. Key community supports identified by participants included formal (traditional) community supports, such as help with cleaning, personal emergency response systems (Connect Care), meal support, and transportation, as well as informal (social) community supports which included such things as church membership, apartment building socials and various other community groups. Three main subthemes emerged within this theme: the use of *traditional* supports, the use of *social* supports, and the availability and accessibility of community supports in general.

4.5.2.1.1 *Traditional Supports*

Traditional community supports used included light housecleaning funded by Veterans Affairs Canada (VAC), the use of personal emergency response systems (Connect Care), assistance with window cleaning and assistance with meal preparation. Four of the 10 participants used these supports to help them maintain their independence: “There’s two of them here for an hour. They clean the bathroom and the kitchen and vacuum and dust and...any other little things I want them to do they’ll do it” (Participant 8). The two participants who had Connect Care had a history of previous health conditions and lived alone. Their family members signed them up for the Connect Care service to ensure that if they ever required emergency services, they would be helped.

Both participants expressed that they were thankful for this service as it reassured them and gave them peace of mind:

...it's a wonderful support. Without it, I'm sure I would be nervous...knowing that a stroke can hit you just like that! Um...just think oh if something happens and I fall down and I can't get to the phone and...you know worry...whereas I don't worry you know, that help will come...But you do have to test it once a month, make sure it's working. I'd be very nervous without my Connect Care (Participant 10).

Apart from providing peace of mind in case of emergencies, this service also provided a sense of independence for Participant 10. She realized that if she did not have this service and continued to live alone, she and her family would be worried about her safety. With this service, she was able to continue living independently, while having a backup in case she ever did need help. Acquisition of these formal support services helps to offset the challenge of living alone or the challenges of cleaning a big house or apartment. These services allowed these individuals to continue living at home, to maintain their independence, and offered peace of mind to themselves and their families.

4.5.2.1.2 *Social Supports*

Apart from traditional community supports, it was found that participants also received valuable and necessary community support from social organizations within the Westmount community. In fact, informal social supports were used much more frequently than health services and traditional community supports. This was consistent among the majority of participants (n=9). One of the most important memberships expressed by participants that provided bountiful amounts of support was their church community. Nine of the 10 participants indicated being part of a church community. In addition to this, many of these participants significantly contributed to their church

communities through extended membership in different ministries. Some of these ministries included: the church choir, volunteer outreach programs, bazaar organizing committees, Catholic Women's League, Knights of Columbus, Eucharistic Ministry, and attendance at different events organized by the church. Participants expressed their involvement with their church communities as a vital part of lives. For example, when Participant 7 was asked what her favourite part of Westmount was, she responded: "Well, I'm very involved in the church..." She later went on to explain, "...I'm in the choir and...I'm taking Bridge lessons. And anything that's going on in the church...any activity...I'm usually involved in" (Participant 7). Membership and involvement in their church communities allows participants an avenue for spiritual deepening, personal growth, and socialization, and also provides a sense of belonging.

Other social activities within the Westmount community that were meaningful and provided support to participants included the Westmount Gathering Place, the Berkshire Club, coffee hour, bridge, euchre, and shuffleboard clubs, and various other community gatherings. For the majority of participants (9 out of 10), membership in these social organizations provided an extended social circle, a network of friends with whom to talk, and the formation of ongoing social connections. Participant 3 described her appreciation for one of the community groups:

I was glad when I joined the Seniors, which is...a few years ago we used to be right in Westmount...in the mall, and now we've moved down to the Church...It was nice at both places. One wasn't big enough as we began getting bigger. And everybody I've met I really enjoy...I enjoy people anyway. There's very few that you would ever meet that you wouldn't like. Everybody seems to have...we all have everything in common now that we're getting older...and we discuss different things. Our children mostly, I suppose, as you get older (Participant 3).

These examples show the importance participants placed on community memberships to develop new friendships and maintain active community engagement.

Community membership in these different organizations and clubs provided participants with a 'sense of community'. A sense of community (McMillan & Chavis, 1986) is defined as a sense of belonging; a mutual sense of significance and importance, from community members to the community and the community to its residents. It also encompasses the belief that community members' needs will be addressed and fulfilled, while establishing a shared emotional connection between the members and the community. Experiencing this 'sense of community' can provide a tremendous amount of support for individuals. If individuals feel that they belong, are being appreciated, and are considered important within their community, this can have critical implications on how individuals will become engaged in their communities. This sense of community was evident in participant interviews. For example, Participant 1 described Westmount as the best place to live on several occasions. When she was asked to expand on this all she could say was: "And let me tell ya, when you live in Westmount, that is all...everything." It was clear that she felt a very strong connection to, and a strong sense of belonging with the Westmount community. Participant 1 was an active contributor to her community through volunteering and helping keep Westmount clean by picking up littered pop cans and bottles on her walks. She was also very engaged in different community groups and clubs. Engaging in a variety of different social opportunities within the Westmount community enabled Participant 1 as well as others to foster a sense of community within Westmount. In a similar example, Participant 10 reported feeling comfortable, appreciated, and respected within the Westmount community. This was exemplified

through her description of travelling around town and having individuals offer to help her:

And if it was crowded [the bus], immediately a young person would jump up and give me the seat. And getting off when it was snowy, I've had young people stop and turn around and take my hand and help me out. It's a lovely area. Um...of course we didn't know that before we moved here but we found it...ya, it's a very nice area (Participant 10).

Her sense of community and belonging was further demonstrated in the enjoyment and support she received from participating in the community socials that took place in her apartment building:

...it's just once a week, Tuesday afternoons...we have an hour...anybody in the apartment building is welcome, but naturally it's the same...about 20 us meet Tuesday afternoon. And that's nice to get together and talk, share funny old stories and uh...yes that's nice (Participant 10).

In a similar example, Participant 4, described her appreciation and enjoyment from attending different social clubs and gatherings within Westmount: “most people are very nice around the area...I enjoy going to the clubs...just talking to somebody different about things, you know sharing feelings...well...I can't complain about the people around...I find them pleasant...”(Participant 4).

Participants clearly felt a strong connection to their community in Westmount. The biggest contributor to this ‘sense of community’ was participants’ engagement in various community organizations such as church communities and different community clubs. The importance that participants placed on having opportunities for socialization, community engagement, and developing friendships was widespread across interviews. What was also elucidated from the interviews was that different participants used these social supports for different reasons. Some participants used these supports to increase

social connectedness, develop new relationships, and stay connected in the community, while others used these supports as enjoyable activities and pastimes. Nevertheless what emerged from participant interviews was that these social community supports were very important to these individuals and, furthermore, helped them to remain independent and engaged and made them feel valued and supported.

4.5.2.1.3 *Availability and Access*

Throughout the interviews, critical comments and recommendations were made regarding the availability and accessibility of community supports. Discussion focused on transportation, communication, and the need for more social support and community opportunities. Reliable transportation for individuals who cannot drive was an important issue that was mentioned in four interviews. Participants considered transportation to be a crucial component of accessibility within the community. Furthermore, communication regarding available services was another issue raised. Lack of knowledge or inconsistent information regarding community supports was a concern. Participant 7, when she was asked if there were enough available supports within the community and if these supports were working well, responded:

Well, it's not fair to comment because I'm not aware of what's available....whatever there is, they're not advertising it any way that I've been able to ascertain...“What is available?” I don't know...So whatever they have, they're not doing a very good job of making it known in the community, eh? [Do you find that this lack of knowledge is a common issue among your friends as well?].... Yes! Yes, because I was talking to a lady just recently and she lives in Westmount and she said, “Well, I don't know what's available, so...” (Participant 7).

This lack of knowledge of available services was mentioned numerous times; however it is unclear whether this lack of knowledge is due to insufficient communication on the part of the various services, or if it is because these participants do not require these services: it could simply be lack of knowledge due to lack of need.

Another concern that was discussed was the need to provide more support for frailer older adults. Participant 6 described her feelings on this topic: “Like I really don’t think there is any support system here, at all. You know? Really” (Participant 6). She went on to explain that her family in Ireland has an array of services that are available to them at no cost. These services help individuals with daily tasks, meal preparation, and cleaning. These services may be available here, but come at a cost. Finances and costs were discussed in eight interviews, therefore, indicating that participants consider this an important topic. Participants talked about the costs of living and the techniques that they use to keep costs down. Participant 2, described that more financial support is needed for low-income community-dwelling older adults:

...need more places for and with...reduced rent and help from the government. Because you only get so much old-age pension, you pay your rent, you’ve got nothing to live on. (Participant 2).

Other participants shared recommendations on how to increase supports in the community. For example, when Participant 6 was asked what community support and health services meant to her, she stated:

...it means really a lot....I don’t know how often I... if there was something like a...drop-in center that you could go and ask questions. You know...to me that would be a help... For not only me, but for other people. I don’t know how often it would be used but you know if you don’t want to go to the doctor but there’s

something niggling at you, you know, bothering you?...But then again there's nothing like that (Participant 6).

Similarly, Participant 7 when asked what could be improved within the Westmount community stated: "Well, I'd like to see more social...more social opportunities, you know?" (Participant 7). She further went on to suggest:

I'd like to see a community center put up in Westmount Mall. A place where people could go and have a coffee and chat and have a game of cards...read...have a little library. Maybe a place where you could...have minor health problems looked after. Like if your foot was sore...you know, something like that...Sort of an all-encompassing place, you know? Social and health-wise and educational. They could even have a speaker come in. Maybe some professors from the University or retired professors could make some speeches...that'd be nice (Participant 7).

These discussions suggest there is a tremendous opportunity for the Westmount Mall to not only become a hub for the community and, given its importance to participants in this study, to provide novel and innovative programming to optimize the health, function, and independence of residents living in the Westmount community.

4.5.2.2 Health Services

Few participants used formal health services other than routine visits to their family doctor, dentist and pharmacy. This is not surprising as the majority of residents (9 out of 10) rated their health as good to excellent. Although participants reported using few health services, participants indicated that health services were among the most important features of their community and a top priority in the maintenance of their independence. Simply knowing that health services were available and accessible was comforting to participants.

Overall, participants were satisfied with the health services they were receiving within the Westmount community. Participant 8 expressed satisfaction with both her doctor and her pharmacy:

Oh yes. When I'm out of pills...it's amazing. I call her...prescription was empty yesterday and I knew they had to fax my doctor because there's no refill on it, so I didn't expect that they would be here until maybe the next day or the next day after that. They were here last night (Participant 8).

Similarly, Participant 10 expressed being very satisfied with the healthcare she received: "It's wonderful! So I love the lab, I love Shoppers, the drug store, and their help and they're excellent. Anything you need, they're so good"(Participant 10).

Across interviews, participants shared positive experiences with using health services. Suggestions for improvement focused on better communication between healthcare professionals and their patients.

4.5.2.2.1 *Availability and Access*

Although participants reported using few health services apart from routine monthly or bimonthly check-ups, all participants stated that availability and access to health services was of critical importance. Furthermore, participants indicated having a high degree of awareness of available health services and knowledge of where to turn to find the healthcare they need. This awareness of health services is embodied within the voices of the following two participants:

Everything seems to be working well, if I need anything, I know where to go and who to see and they will direct me to the person who will help me most. As I say, we're very fortunate with our healthcare. That's the most important, I think. (Participant 9)

Well I know there is different ones that you can call on for some of the things. I think VON is one...it has something...I have to look up the whole sheet...I have been given the list of all these different things. I was amazed at how much there was out there that you could get to. (Participant 4)

The issue of finding a family doctor was raised. Three participants expressed having looked for a family doctor within the Westmount community and being unsuccessful in acquiring one. Of these, two participants were forced to find a family doctor outside of the Westmount area and one participant decided to use a walk-in clinic for health needs.

Yup, we trying...6 months now... But I thought I'd wait till the bazaar is finished and then approach them again and just tell them, you know, "We're getting old and we need a doctor close near" (Participant 1).

I tried to get a family doctor. I tried to get my son's doctor...But she wasn't taking on new patients...that was about 5 or 6 years ago, so then when I would get a sore throat. Like I have an inner ear...I have a pierced ear drum...and if it's aching or something, in order to get antibiotics, I had to go to the clinic...But she did suggest that'd it be a good idea to get a family doctor, so she said that they were taking on new patients at Westmount, so I went over, filled in the papers, about a month ago. But so far I haven't heard from anybody. So, I don't know if it's gonna come through or...but in the meantime, I just stay with her. (Participant 3)

Well...they've always been full. They haven't had room for taking on new patients...so that forced us into going to St. Thomas. (Participant 5)

This is not an issue unique to Westmount. Finding a family physician, and especially one willing to take on individuals in advanced age, is a common challenge everywhere (Sinha, 2012). As can be seen, even if most participants use a minimal number of health services, awareness and availability of these services is crucial. The knowledge and

ability to access health services, if needed, serves as a security blanket if the participants were ever to require health services in the future.

Another important issue raised was communication and rapport with health professionals. When participants expressed having a good relationship with health professionals, including doctors, dentists, nurses, and pharmacists, this was conducive with a more positive description of their experiences with using health services. Having good lines of communication between participants and health professionals also helps to create a trusting relationship and an overall good experience. For example, the following participant expressed the relationship she has with her pharmacist of over 30 years:

...She knows everything that I'm allergic to...she has it flagged. Because she'll phone me up and say, "[Participant 9], you can't have this, we'll have to you know, give your doctor a call and tell"...that's good, you know. There's not many people that have that privilege, they could rely on their pharmacist to let you know if you're taking the right thing. (Participant 9)

This participant had developed a strong rapport with her pharmacist and felt fortunate to be able to place her complete trust in this health professional. Similarly, the following participants expressed having good relationships with their healthcare professionals, undoubtedly helping to create more positive experiences for these participants when accessing and assessing health services.

I mean I know this girl [osteopath]...she's been very gentle and very helpful, she knows how things are...because she's kind of explained what's wrong with...the muscles aren't working cause other parts aren't working (Participant 4).

He's very good. Actually...rather than wait and go to my doctor's, I'll call the pharmacist [laughing]. He's more knowledgeable for things like that than my doctor is, I think (Participant 8).

Conversely, when the rapport was not present between participants and health professionals, an evident decrease in positive experiences was seen. For example, the following participant expressed dissatisfaction with walk-in clinics:

The problem with these walk-in clinics...I think it's just a waste of time. They won't give you a prescription and they want to know who your family doctor is, and they say you better go and see your family doctor. So what's the point of going? That's how I feel (Participant 2).

Communication is also a crucial element in establishing rapport and ultimately creating a positive health service experience. Participant 8 expressed situations in which she did not receive the proper communication from health professionals and therefore felt confused as to why certain procedures needed to be done. This diminished her satisfaction in obtaining these health services.

Well I was a little disappointed last time I was there because the assistant came and looked at my mouth and I knew I had a cavity and she said, "We have to X-ray." And I said, "I don't want an X-ray until the dentist had seen it." And maybe she could figure it's not very deep and just drill, you know, like they used to do. "Oh no, she's got to have an X-ray first!" And I was ticked off at that. And when I go back again I will insist no X-ray and if they won't do it, I'm walking out. I think they do too much X-raying. I can see after she has examined it and figured I don't know how deep this is, you might need X-ray. I can go along with that but not until after she's done the examination, not just to have...this person didn't even look in my mouth, she just said, "We have to X-ray." And that ticked me off (Participant 8).

And then to have a colonoscopy you're given a mild sedative, and I don't know what he's gonna do if I have an enema. I have to see my doctor the 29th of this

month, I'll ask her, what's he gonna do. I don't understand it... Ya, they didn't ask me. They just said this is what he's gonna do (Participant 8).

These last two examples show that good rapport and good communication with health professionals is important in establishing a trusting and accessible relationship with patients, thus allowing people to understand their conditions and treatment, and helping to foster a sense of independence among these individuals.

4.6 Theme Summary and Conclusion

All in all, participants in this study were a relatively healthy sample. This was reflected in their limited use of formal health services and greater use of community supports, especially social supports. In trying to understand participants' experiences with community support and health services, it became clear that maintaining independence was at the forefront of all service usage. In summary, three central themes related to the use of community support and health services emerged in this study: life experiences and circumstances, personal compensatory mechanisms, and community design and structure. Implications of these findings are discussed in the following chapter.

5. DISCUSSION

The goal of this hermeneutic phenomenological study was to understand the lived experiences of community-dwelling individuals, 80 years of age and older, using community support and health services. In particular, this study aimed to reach the most frail and isolated community-dwelling individuals in advanced age. Despite targeted efforts to find this specific cohort, this study was not successful in doing so. Our inability to reach these isolated and frail older adults, who have the greatest need for community support and health services, reinforces the critical issue faced by age-friendly city planners and, once again, reinforces the critical need to identify novel strategies that may enable us to do so. This challenge is not unique to the development of age-friendly cities. The very low representation of individuals in advanced old age in clinical practice guidelines and in the studies upon which these guidelines are based has also been raised (Cox, Kloseck, Crilly, McWilliam, & Diachun, 2011).

This study did, however, unexpectedly highlight a unique consideration. Most research with community-dwelling older adults typically falls into two categories: studies involving younger, active retirees, or frailer, older adults. The novel contribution of this study is identification of a third group of older individuals that warrants closer scrutiny in future research initiatives: individuals in advanced age, who are still relatively independent and for whom informal *social supports* are critically important. The role of informal social supports in potentially delaying social isolation and the need for costly health and support services for at-risk individuals hovering around a ‘tipping point’ of transition from independence to dependence, requires further study. These economical

informal social supports may well prove to be a protective buffer, enabling very old individuals to live independently longer.

This section will begin by discussing central themes and their respective subthemes. The main findings will be discussed in relation to the current literature. Implications for practice will be discussed and study limitations will be presented. Lastly, recommendations and suggestions for future studies and directions will be made.

In trying to understand the participants' lived experiences with using community support and health services, it became clear that the maintenance of independence was at the core of this understanding. Services were sought and used to enable a continued maintenance of independence. For example, although most participants indicated minimal use of health services, they did utilize these services for monthly checkups and routine screenings. Furthermore, Participants 8 and 10 used personal emergency response systems (Connect Care) to allow them to continue living independently within their own homes. Similarly, Participant 4, who had significant mobility issues, received help with light housekeeping to allow her to maintain her independence. While few participants used health services and traditional community supports on a regular basis, social supports, such as engagement in community organizations including church communities and social clubs, were used much more frequently and consistently across participants.

Participants' experiences using community support and health services to enable the maintenance of independence can be located within the selection, optimization, and compensation (SOC) model for successful ageing, put forth by Baltes and Baltes (1990). In this model, the notion is to maximize gains and minimize losses (Baltes & Baltes, 1990). Selection refers to the development and elaboration of personal goals. There are

two distinct selective methods: elective selection - changing goals to match the resources available, and loss-based selection - changing goals to deal with losses (Baltes & Baltes, 1990). Optimization focuses on growth-enabling goals through refinement and perseverance. Lastly, compensation refers to the efforts put forth to maintain adequate functioning in the midst of losses (Baltes & Baltes, 1990).

Participant 10 will be used to illustrate the relationship between the use of community support and health services and the SOC model. Participant 10 used to clean the entire house on Fridays. However, in recent years, she found her stamina to be lower and was therefore unable to clean as much or as quickly as before. She had to readjust her goal system to incorporate this loss of stamina, and now cleans one room per day. In changing her goals, Participant 10 used a self-imposed coping strategy to combat her decreasing stamina. The implementation of this self-imposed coping strategy allowed Participant 10 to eliminate the need to reach out to traditional community supports to help with daily cleaning. This is an example of loss-based selection. Participant 10 also displayed an example of optimization in her use of health services to monitor and regulate her blood coagulation levels. This continual monitoring enabled a method to optimize her condition; if her levels were ever off, they could be quickly addressed. Lastly, compensation was seen in Participant 10's use of an emergency response system, Connect Care. Losses of independence resulting from Participant 10's previous heart attack and stroke instigated the need to implement a traditional community support to ensure she could continue living independently within her own home and with peace of mind afforded to both herself and her family. An individual's personal circumstances, past experiences, personal characteristics, problem solving skills, and coping strategies,

as well as the design and structure of the community in which the individual lives, also play an influential role in how community support and health services are used to maintain independence.

5.1 Interpretations of Life Experiences and Circumstances

Life experiences and circumstances are features that are unique to each individual and may have an impact on other parts of the individual's life. Personal characteristics, namely health and functional status, support and social connectedness provided by family and friends, driving ability, and significant life events were found to be complex, interacting, and important elements in understanding participants' experiences with using community support and health services to maintain independence.

Health status was found to be a determining factor in the type and number of services that participants used. This is supported by previous literature that indicates that service usage is increased with multiple comorbidities (Sinha, 2012; Soldo & Manton, 1985; Wolinsky & Johnson, 1991). Similarly, decrease in functional status was also found to be determinant of increased need and acquisition of traditional community supports among participants. For example, Participant 4 had mobility issues and, as such, found household cleaning to be a challenge. This decrease in functional ability was paralleled with the acquisition of formal traditional supports to help with household chores. This trend is consistent with previous literature that has found service utilization to be dependent on functional status (León-Muñoz et al., 2007).

In trying to understand how participants experienced community support and health services, support from family and friends played one of the largest roles. Support provided by family members and friends was found to be the preferred method of

external support among participants, with family as most preferred among the two. This makes sense, because these are the people who know the participant most, and therefore would probably already have an established trusting relationship. Instead of turning to a stranger or hiring a formal support service, turning to a family member or friend seems a feasible option. This is consistent with previous research that has found that older adults rely on family and close friends for assistance, also indicating that reliance is greater on family members than it is on friends (Mancini & Simon, 1984).

Social connectedness is broadly defined as the feeling of belonging through relationships that are formed and maintained with others (Ministry of Social Development, 2005). These relationships include connections with family members, friends, neighbours, and acquaintances. In trying to attribute meaning to participant stories, it became clear that the social connections these participants had with family and friends were a vital element of their daily lives. Substantial evidence has been found to support the important role of social interactions for older adults (de Jong Gierveld, Keating, & Fast, 2015; Register & Scharer, 2010; Rowe & Kahn, 1997). In addition, lack of social relationships (i.e., social isolation) has been shown to be a health risk factor (Rowe & Kahn, 1997), and is linked with physical and cognitive decline (WHO, 2002), whereas having social connections and feelings of connectedness can afford older adults a successful method to obtain meaning and purpose in life (Register & Scharer, 2010). Furthermore, as found in the current study, the meaning and importance that participants attributed to spousal relationships was very significant and provided a tremendous amount of support. Feelings of loss and loneliness were evident among participants who were widowed. This finding is congruent with de Jong Gierveld et al. (2015) who found

marriage in older adults to be an important buffer against loneliness. Moreover, in the current study, it was found that social connections with family and friends might influence the degree of services that were required. Similarly, Rook and Ituarte (1999) found that relationships with family and friends could help provide both emotional and instrumental support and companionship, elements that are essential for successful ageing (Rowe & Kahn, 1997).

Driving was found to be equated with independence among many of the participants' responses. Driving was described as a mechanism of accessing the community and services within the community. Participants who were not able to drive faced greater challenges with community access and experienced a decrease in independence. This finding is in accordance with previous literature that describes driving to be linked with independence, self-worth, and further, a means of performing everyday activities and maintaining connectedness to the community (Al-Hassani & Alotaibi, 2014). Those who did have the ability to drive were able to access the community in a more convenient way and did not have to rely on family and friends or traditional supports for transportation.

Lastly, significant life experiences such as previous military service, serious accidents, a difficult upbringing, and loss of loved ones were also found to be important elements of the participants' life stories. These significant events can greatly contribute to shaping an individual's emotional and social well-being (Kendler et al., 2011) and thus can have impact on how individuals interact with their environment, which services are available to them, how they acquire and use community support and health services, and ultimately how they maintain their independence.

5.2 Interpretations of Personal Compensatory Mechanisms

Personal compensatory mechanisms are intrinsic features that are unique to each individual and influence how community support and health services are acquired and used, and thus, have an impact on how maintaining independence is achieved. The personal compensatory mechanisms that emerged from participant experiences include personality and attitude, insight into personal situation, and problem solving and coping strategies.

Personality and attitudes were found to be important predictors of community support and health service usage. This is in line with previous research that has found personality to be an important element to be considered in health behaviours of older adults (Marks & Lutgendorf, 1999). Furthermore, participants were successful in recognizing their own unique situations. Having a clear insight into their own situation, be that their health status, functional status, or independence level, allowed them to understand what their own unique needs were and, thus, could subsequently facilitate problem solving and coping strategies to ensure their needs were being met.

Across participants it was found that problem solving and coping strategies had an impact on how participants used community support and health services. For example, moving into an apartment building when household maintenance became too difficult, cleaning one room per day to combat decreasing stamina, relying on personal assistive devices such as walkers, and changing walking routes to accommodate changes in mobility, were all compensatory mechanisms used by study participants. These are examples of loss-based selection (Baltes & Baltes, 1990), in which participants had to readjust their goals to adapt to occurring losses. When personal compensatory

mechanisms were not sufficient to regain or maintain independence, external compensatory mechanisms, such as reliance on family friends and community supports and health services, were sought.

5.3 Interpretations of Community Design and Structure

How a community is physically designed, which services are available, and how these services are organized and delivered are important factors that influence how individuals interact with their community and the supports and services within it. This can be explained through the person-environment fit theory of ageing (Nahemow & Lawton, 1973), which describes the importance of the relationship between older adults and their environment. As the needs of the individual increase, the demands placed on the environment also increase (Nahemow & Lawton, 1973). For example, Participant 4 described her limitations with mobility and the issues she had with accessing public transportation, local businesses and organizations, and public washrooms. Although she recognized that attempts have been made to make the environment more accessible, Participant 4 clearly stated that what planners think is accessible, does not always suffice. In her case, although grab bars were present in many public washrooms, she indicated that these did not help her due to their design that was not conducive with her needs. Therefore, understanding how community design and community structure influence the use of community support and health services was central to understanding how these participants were able to maintain their independence.

The design of a community refers to its physical layout and infrastructure. Community design is therefore an important determinant of accessibility (Chippendale & Boltz, 2015; Michael et al., 2006, WHO, 2007a). Most participants found the

environment to be accessible, naming proximity and the ability to drive as the key contributors to this accessibility. This positively perceived accessibility was largely due to the high functional status and independence of participants. However, those who had mobility issues, or those who were unable to drive or take public transit, experienced challenges in accessing their environment. Furthermore, a particular focus of the physical environment in Westmont was the Westmount Mall. Many participants described negative feelings and dissatisfaction regarding recent changes to the mall. Participants used the mall for numerous functions including meeting friends, mall walking, shopping, and acquisition of services. The importance participants placed on the design of the mall indicates that this mall has immense potential. The importance of the mall goes beyond the tangible services that are available, as it can also provide a place where community members gather, develop connections, exercise, and remain engaged in their community. Previous studies have shown that a mall can be the central hub of a community, providing access to services as well as social opportunities (Kloseck, Crilly, & Gutman, 2010).

Community structure refers to how services are organized and delivered. Services must be organized in a way that promotes accessibility and, furthermore, must be delivered in an equally accessible way, with the people for whom the services are being offered in mind. The community must also be structured in a way that ensures residents feel supported, included, and valued. Community supports were found to be a key component of participants' lived experiences, being used much more frequently than health services, demonstrating an increased importance of community support availability for this group of people. Community support was obtained from a number of different avenues, including traditional and social supports. Traditional community supports

included help with household chores, meal preparation, transportation, and Connect Care services, whereas social community supports included meaningful community memberships in church communities and different community activities. Across participants social community supports, in particular, were used more often than traditional supports. Social community supports were critically important to participants as they provided an avenue for participants to create and strengthen social relationships, engage within their community, and help to establish a sense of belonging. Integration of these meaningful memberships fostered a sense of community for participants. For example, being part of a cohesive church community can afford social and emotional support both from fellow congregation members and ultimately through establishment of a closer connectedness with God or a higher being, which has, in turn, been linked with more optimism and better health (Krause, 2002). Other meaningful community memberships, such as various community groups and apartment building gatherings, help to develop social relationships, which are beneficial to emotional and physical health (de Jong Gierveld et al., 2015; Register & Scharer, 2010; Rowe & Kahn, 1997).

Awareness and accessibility issues with supports and services focused on having more financial and social community support opportunities and better communication with health professionals. Improvements that were suggested with regards to community supports involved more information resources and more social opportunities for older adults, both areas that have been established as important criteria for age-friendly communities (WHO, 2007a). Having a good rapport with healthcare professionals was interpreted to be a very important component of health service usage. When participants felt respected and valued by their healthcare professionals, they appeared happier with

the services that they received. Furthermore, when good communication was established between the healthcare professional and the participants, again, participants appeared more satisfied with services received. These findings are congruent with previous literature that has found trust, having a longer relationship with a physician, and having an overall successful relationship with practitioners (Griffin et al., 2004; Kao, Green, Davis, Koplan, & Cleary, 1998; Thom, Kravitz, Bell, Krupat, & Azari, 2002) as indicative of patient satisfaction and effective care.

5.4 Implications for Practice

The current study afforded some interesting and novel insights that are useful to consider in future age-friendly city planning and ageing research. Study findings, for example, highlight the importance of: (1) considering functional levels and not chronological age when targeting specific cohorts, (2) recognizing the importance and potential of informal social community supports to provide a protective buffer for individuals at-risk of losing their independence, and (3) understanding and appreciating the importance of finding creative and innovative strategies to reach frailer older adults who are socially isolated.

This study highlighted the importance of categorizing older individuals by functional ability and not by chronological age. Currently, much of the ageing literature categorizes older adults by chronological age: young-old, oldest-old, third age, and fourth age (Baltes & Smith, 2003). Furthermore, certain characteristics and profiles are often attributed to these differing categories. For example, Baltes and Smith (2003) describe the fourth age, which begins around age 80, as a time of dependency and decline, during which multimorbidity and decreases in cognitive function are frequently present. Much of

the literature also suggests that with increasing age comes increasing multimorbidity and, thus, the need for a greater number of community support and health services (Sinha, 2012; Soldo & Manton, 1985; Wolinsky & Johnson, 1991). However, the importance of classifying individuals according to functional levels and not simply age warrants consideration. It is important to keep in mind that older adults, much like the younger population, exhibit a great deal of heterogeneity and, therefore, age is not always representative of ability, function, health status, or independence. Considering function instead of age when designing and implementing community support and health services, is essential to ensure services are available to meet the unique needs of all residents living in a particular community.

Heterogeneity in advanced age must be considered and incorporated in AFC planning to ensure that no older adults fall between the cracks of service provision. In order to ensure that all older adults' needs are considered, it is important and recommended to be active advocates, reaching out to those that can help ensure varying needs are being considered and incorporated in city planning. For example, getting politically involved. Older adults are often great contributors to political elections. Politicians need to be encouraged to ensure that their platforms are considering the needs of a heterogeneous population of older adults. Furthermore, although it is well known that heterogeneity exists within the older adult population, the use of the generic term, older adult, within the current AFC literature, is not representative of this heterogeneity, and, as such, does not afford insight into the varying needs of older individuals. It is recommended that future documents related to AFC guidelines make clear the heterogeneity that exists within a population of older adults and provide strategies to

enable age-friendly city planners to better reach at-risk and socially isolated individuals within their communities.

This study also highlighted the importance of community supports for individuals in advanced age, in particular social community supports. Social community supports played a vital role in the lives of these participants in that they afforded participants opportunities for social connectedness, community engagement, and meaningful community membership. Although some participants required traditional community supports to help with everyday activities such as cleaning and meal support, all participants described the important role social community supports played in enabling them to remain connected within their community. Availability of these social community supports was of critical importance to allow these individuals to continue leading independent, active, and engaged lives. Many participants expressed the need for even more support services to enable them to meet new people, learn new things, and remain active. Therefore, it is recommended that more social opportunities be implemented within the community, such as having more social gatherings in apartment building complexes. Furthermore, informally-led social opportunities can also be beneficial and are recommended. These informal social opportunities can include activities such as friend groups getting together after church for coffee, mall walking groups, and weekly card games.

Novel and innovative strategies to reach isolated and frail individuals are essential. Suggestions for future recruitment would be to pair researchers with a health service provider, such as a personal support worker, another homecare agency worker or public health nurses who may come in close contact with more isolated individuals.

Church communities and other faith communities may also present a valuable resource to reach socially isolated individuals, in particular, considering parish nurses. Furthermore, using snowball sampling – asking participants for suggestions or referrals to more socially isolated and frail older adults may also be a good option. It is recognized that this may prove challenging, as there are many confidentiality and ethical issues that surround vulnerable populations, but it is truly imperative to reach these individuals as these are often the greatest users of supports and services (Sinha, 2012).

5.5 Limitations of Study

The current study had several limitations. The intent was to reach community-dwelling individuals in advanced old age, including socially isolated older adults; however the researcher was not able to contact isolated individuals. It is important that these individuals be included in future research as they may present very unique needs compared to their counterparts who are current engagers within the community. Further research must be done to capture their voices. Although there were ranges in health status and independence levels, none of the participants were heavy users of traditional community support or health services. It is necessary to conduct further research to understand the lived experiences of heavy users of formal traditional community support and health services, such as frail older individuals. Furthermore, although race was not a component of this research study, all participants were Caucasian. This may compromise transferability of findings because the results may not be representative of other races and cultures. It is important to conduct further research with individuals of other cultures to understand if their experiences with using community support and health services in advanced age are similar or different from the current findings. Lastly, most participants

were Christian (n=9), which again, may compromise transferability of findings. It is important to conduct further research with older adults of different faiths to understand the role of their faith communities in their use of community support and health services.

5.6 Future Directions and Recommendations

Understanding the lived experiences of community-dwelling oldest-old in their use of community support and health services has great potential to inform and create a foundation for future research. People are living longer than ever before (WHO, 2007a) and as such communities need to ensure that they understand and incorporate the varying needs presented across this heterogeneous population of older adults. This study was successful in giving a voice to community-dwelling individuals in advanced age, a population that are understudied in the current literature. However, much more needs to be done to fully understand the varying needs of individuals in advanced age, especially among those of varying functional levels and those who are socially isolated, a group that was not reached with the current study.

Future studies should focus on extending the understanding and knowledge of how community-dwelling individuals in advanced age use and experience their communities, and with this, understand the unique needs they may present. In particular, it is imperative that isolated individuals in advanced age be given a voice. These individuals are the hardest to reach in the community but they are also the ones who present the most complex and increased needs (Baltes & Smith, 2003; Sinha, 2012; WHO, 2007a). To ensure successful age-friendly city development, all cohorts of older adults (e.g., recent retirees, in advanced age, socially isolated, frail, those who do not have children, living in rural communities, economically compromised, etc.) must be

considered and their needs incorporated in the planning process. One size does not fit all. Needs will vary by person and by community, based on the unique characteristics of any given person or community, for example, consider an urban, thriving community with many available supports and services, however, if a person has mobility issues, they may experience challenges accessing these services, even if they are available. Use of bottom-up approaches (Lui et al., 2009), that involve and integrate the individuals for whom services are being created are recommended for future AFC development as this may help ensure practices and policies are reflective of the needs of these individuals.

This study brought forth a novel understanding of the importance that a mall can have on the surrounding community. All participants mentioned the Westmount Mall, indicating that it is an integral and very important component of the Westmount community. Not only did participants use the Westmount Mall for specific services, they also used the mall as a meeting place, a place to walk, and as an enabler to continue engaging within their community. It is clear that participants were not pleased with the recent changes that have occurred at the Westmount Mall. It is recommended that mall owners gather community input in future mall development. It is also recommended that mall owners better communicate with residents in their community to ensure community members are aware of why the changes occurred and that they are given an opportunity to express their concerns. Future research focused on gaining a better understanding of how the presence of a community mall can impact the vitality of a community, in particular its ageing population, would be valuable.

It is clear that the Westmount Mall has immense potential in terms of being a central hub for the Westmount community. Although the Westmount Mall can provide

many advantages to the community, the issue of funding must also be considered. It is irrational to think that mall owners and operators will take on the responsibility of funding an active, thriving, central hub for the community and therefore, external funding resources should be considered. Ontario's Ministry of Health and Long-Term Care (MOHLTC) has enacted the Aging at Home Strategy, with the aim of enabling older adults to live and age at home for as long as possible (MOHLTC, 2013). If the province wants to enable older adults to age at home and remain living independently for as long as possible, community hubs, from which older adults can gain support, maintain community engagement, and continuing fostering independence and a sense of community, are essential. The MOHLTC could partner with local businesses to provide funds to enable community hubs such as the Westmount Mall to flourish and continue providing support for the community, in particular its older adults. Furthermore, the importance of a community hub must also be communicated at the local level. Talking with local city councilors, who sign off on box store development, is essential. It is important to let these individuals know that elimination of community hubs and emergence of box stores which often lack space for people to congregate and socialize, can be detrimental to older adults. Reaching out to city councilors that facilitate planning of these developments can be helpful to establish alternatives and solutions to these issues.

This study also highlighted the importance of church membership for participants. Participants indicated that their church communities allowed for community engagement, social connectedness, fostered a sense of community, and enabled personal growth. However, with an increasing secular society, what will replace the important role of

church communities? Other avenues that allow for community engagement, meeting others, developing connections, and establishing a sense of community, must be considered. For example, the Breakfast Club organized through the Victorian Order of Nurses (VON) enables older adults to socialize with others, develop connections, and engage within their communities.

5.7 Conclusion

Understanding that older adults are not a homogeneous population is imperative to understanding the different needs that they present (Kerr et al., 2005; Caldwell et al., 2008). Effective community support and health services, such as availability and accessibility to a primary care and opportunities to develop connections with others, are essential in maintaining health and independence for older adults, especially those who have multiple morbidities and functional limitations, making them frequent users of health and support resources (Baltes & Smith, 2003; Lloyd-Sherlock et al., 2012; Sinha, 2012; WHO, 2007a; Wolinsky & Johnson, 1991). Examining the day-to-day experiences of the oldest-old in using community support and health services enabled a better understanding of the lived experiences of these individuals. Independence was at the forefront of all discussion. Participants wanted to remain independent, and their experiences with using community support and health services were directed to maintain or regain this independence. Their use of community support and health services was influenced by three central themes: life experiences and circumstances, personal compensatory mechanisms, and community design and structure. Three valuable implications for practice were identified: (1) age does not determine function and, as such, functional ability, rather chronological age, should be considered in AFC planning,

(2) informal social community supports are very important for those in advanced age; AFC planners need to consider that there may be an 'in-between' group, a group of individuals in advanced age with perceived good health who are on the edge of losing their independence, and whose loss of independence may be hastened or delayed based on the informal social supports available, and (3) socially isolated and frail older adults are difficult to reach; therefore, novel and innovative strategies must be implemented to ensure that they are reached, and that their unique needs are discovered and incorporated in community planning. It is hoped that the findings from this study will create awareness that more work needs to be done to meet the needs of *all* older individuals in our communities.

REFERENCES

- Abolfathi Momtaz, Y., Ibrahim, R., & Hamid, T.A. (2013). The impact of giving support to others on older adults' perceived health status. *Psychogeriatrics*, 1-7.
- Age Friendly London Task Force. (2012). *Age Friendly London*. Retrieved from http://www.london.ca/residents/Seniors/Age-Friendly/Documents/AFL_Booklet.pdf
- Aging in place. (n.d). In Centers for Disease Control and Prevention (CDC), Healthy Places Terminology. Retrieved from <http://www.cdc.gov/healthyplaces/terminology.htm>
- Al-Hassani, S.B., & Alotaibi, N.M. (2014). The impact of driving cessation on older Kuwaiti adults: Implications to occupational therapy. *Occupational Therapy in Health Care*, 28(3), 264-276.
- Allan, D.E., Funk, L.M., Reid, C., & Cloutier-Fisher, D. (2011). Exploring the influence of income and geography on access to services for older adults in British Columbia: A multivariate analysis using the Canadian community health survey (Cycle 3.1). *Canadian Journal on Aging*, 30(1), 69-82.
- Alley, D., Liebig, P., Pynoos, J., Banerjee, T., & Choi, I.H. (2007). Creating elder friendly communities: Preparations for an aging society. *Journal of Gerontological Social Work*, 49(1/2), 1-18.
- Anderson, J.M. (1991). The phenomenological perspective. In J.M. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (revised ed., pp. 15-26). Salt Lake City, UT: Sage.

- Austin, C.D., Des Camp, E., Flux, D., McClelland, R.W., & Sieppert, J. (2005). Community development with older adults in their neighbourhoods: The elder friendly communities program. *Families in Society: The Journal of Contemporary Social Services*, 86(3), 401-409.
- Ball, M.S., & Lawler, K. (2014). Changing practice and policy to move to scale: A framework for age-friendly communities across the United States. *Journal of Aging & Social Policy*, 26, 19-32.
- Baltes, P.B., & 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 behavioural sciences* (pp. 1-34). New York, NY: Press Syndicate of The University of Cambridge.
- Baltes, P.B., & Smith, J. (2003). New frontiers in the future of aging: From successful aging of the young old to the dilemmas of the fourth age. *Gerontology*, 49, 123-135.
- Barusch, A.S. (2013). Age-friendly cities: A social work perspective. *Journal of Gerontological Social Work*, 56, 465-472.
- Beard, J.R., & Petitot, C. (2010). Ageing and urbanization: Can cities be designed to foster active ageing? *Public Health Reviews*, 32(2), 427-450.
- Beard, J.R., & Warth, L. (2013). Building an age-friendly world, one city at a time. *Aging Today*, 34(2), 7.
- Béland, D., & Viriot Durandal, J.P. (2012). Aging in France: Population trends, policy issues, and research institutions. *The Gerontologist*, 53(2), 191-197.

- Black, K. (2008). Health and aging-in-place: Implications for community practice. *Journal of Community Practice, 16*(1), 79-95.
- Boecking, W., Klamar, A., Kitzmann, F., & Kirch, W. (2012). Pharmaco-economic impact of demographic change on pharmaceutical expenses in Germany and France. *BMC Public Health, 12*, 894-901.
- Branca, S., Bennati, E., Ferlito, L., Spallina, G., Cardillo, E., Malaguarnera, M., & Motta, M. (2009). The health-care in the extreme longevity. *Archives of Gerontology and Geriatrics, 49*, 32-34.
- Buffel, T., McGarry, P., Phillipson, C., De Donder, L., Dury, S., De Witte, N.,...Verte, D. (2014). Developing age-friendly cities: Case Studies from Brussels and Manchester and implications for policy and practice. *Journal of Aging & Social Policy, 26*, 52-72.
- Buffel, T., Phillipson, C., & Scharf, T. (2012). Ageing in urban environments: Developing 'age friendly' cities. *Critical Social Policy, 32*(4), 597-617.
- Caldwell, K., Saib, M., & Coleman, K. (2008). The ageing population: challenges for policy and practice. *Diversity in Health and Social Care, 5*, 11-18.
- Callen, B.L., & Wells, T.J. (2003). Views of community-dwelling, old-old people on barriers and aids to nutritional health. *Journal of Nursing Scholarship, 35*(3), 257-262.
- Canadian Institute for Health Information (CIHI). (2013). *National health expenditure trends, 1975 to 2013*. Retrieved from https://secure.cihi.ca/free_products/NHEXTrendsReport_EN.pdf

- Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. (2010). *Tri-Council policy statement: Ethical conduct for research involving humans*. Retrieved from http://www.pre.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf
- Cantor, M.H. (1989). Social care: Family and community support systems. *Annals of the American Academy of Political and Social Science*, 503, 99-112.
- Cherry, K.E., Walker, E.J., Brown, J.S., Volaufova, J., LaMotte, L.R., Welsh, D.A.,...Frisard, M.I. (2013). Social engagement and health in younger, older, and oldest-old adults in the Louisiana health aging study (LHAS). *Journal of Applied Gerontology*, 32(1), 51-75.
- Chi, I., & Lubben, J. (1994). The California preventive health care for the aging program: differences between the younger old and the oldest old. *Health Promotion International*, 9(2), 169-176.
- Chippendale, T., & Boltz, M. (2015). The neighbourhood environment: Perceived fall risk, resources, and strategies for fall prevention. *The Gerontologist*, 55(4), 575-583.
- City of London. (2013). *Neighbourhood profiles* [Data files]. Retrieved from <http://www.london.ca/About-London/community-statistics/neighbourhood-profiles/Pages/default.aspx>
- Clark, K., & Glicksman, A. (2012). Age-friendly Philadelphia: Bringing diverse networks together around aging issues. *Journal of Housing for the Elderly*, 26, 121-136.

- Cox, L., Kloseck, M., Crilly, R., McWilliam, C., Diachun, L. (2011). Underrepresentation of individuals 80 years of age and older in chronic disease clinical practice guidelines. *Canadian Family Physician, 57*, e263-e269.
- Creswell, J.W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, California: Sage Publications.
- Crist, J.D., & Tanner, C.A. (2003). Interpretation/analysis methods in hermeneutic interpretive phenomenology. *Nursing Research, 52*(3), 202-205.
- Dall, T.M., Gallo, P.D., Chakrabarti, R., West, T., Semilla, A.P., & Storm, M.V. (2013). An aging population and growing disease burden will require a large and specialized health care workforce by 2025. *Health Affairs, 32*(11), 2013-2020.
- de Jong Gierveld, J., Keating, N., & Fast, J. E. (2015). Determinants of loneliness among older adults in Canada. *Canadian Journal on Aging, 34*(2), 125-136.
- De Raad, B. (1998). Five big, big five issues: Rationale, content, structure, status, and crosscultural assessment. *European Psychologist, 3*(2), 113-124.
- Dickinson, A., Horton, K., Machen, I., Bunn, F., Cove, J., Jain, D., & Maddex, T. (2011). The role of health professionals in promoting the uptake of fall preventions: A qualitative study of older people's views. *Age and Ageing, 40*, 724-730.
- Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies, 44*, 131-142.
- Drummond, D. (2012). *Commission on the reform of Ontario's public services (Chapter 5: Health)*. Retrieved from <http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf>

- Everingham, J., Petriwskyj, A., Warburton, J., Cuthill, M., & Barlett, H. (2009). Information provision for an age-friendly community. *Ageing International*, 34, 79-98.
- Federal/Provincial/Territorial Ministers Responsible for Seniors. (2007). *Age-friendly rural and remote communities: A guide*. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2007/AFRRC_en.pdf
- Feldman, P.H., & Oberlink, M.R. (2003). The AdvantAge Initiative developing community indicators to promote the health and well-being of older people. *Family Community Health*, 26(4), 268-274.
- Feng, Z., Liu, C., Guan, X., & Mor, V. (2012). China's rapidly aging population creates policy challenges in shaping a viable long-term care system. *Health Affairs*, 31(12), 2764-2773.
- Finlay, L. (2002). "Outing" the researcher: The provenance, process and practice of reflexivity. *Qualitative Health Research*, 12(4), 531-545.
- Flood, A. (2010). Understanding phenomenology. *Nurse Researcher*, 7(2), 7-15.
- Gadamer, H.G. (2004). *Truth and method*. (2nd revised ed.). New York, NY: Continuum Publishing Group.
- Garon, S., Paris, M., Beaulieu, M., Veil, A., & Laliberte, A. (2014). Collaborative partnership in age-friendly cities: two case studies from Quebec, Canada. *Journal of Aging & Social Policy*, 26, 73-87.
- Glass, A.P., & Vander Plaats, R.S. (2013). A conceptual model for aging better together intentionally. *Journal of Aging Studies*, 27, 428-442.

- Glicksman, A., Clark, K., Kleban, M.H., Ring, L., & Hoffman, C. (2014). Building an integrated research/policy planning age-friendly agenda. *Journal of Aging & Social Policy, 26*, 131-146.
- Goins, R.T., Williams, K.A., Carter, M.W., Spencer, S. M., & Solovieva, T. (2005). Perceived barriers to health care access among rural older adults: A qualitative study. *The Journal of Rural Health, 21*(3), 206-213.
- Golant, S.M. (2014). Age-friendly communities: Are we expecting too much? *IRPP Insight, (5)*, 1-20.
- Gondo, Y. (2012). Longevity and successful ageing: implications from the oldest old and centenarians. *Asian Journal of Gerontology & Geriatrics, 7*(1), 39-43.
- Green, G. (2012). Age-friendly cities of Europe. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 90*(S1), S116-S128.
- Griffin, S.J., Kinmonth, A.L., Veltman, M.W.M., Gillard, S., Grant, J., & Stewart, M. (2004). Effect on health-related outcomes of interventions to alter the interaction between patients and practitioners: A systematic review of trials. *Annals of Family Medicine, 2*(6), 595-608.
- Gu, D., Zhang, Z., & Zeng, Y. (2009). Access to healthcare services makes a difference in healthy longevity among older Chinese adults. *Social Science & Medicine, 68*, 210-219.
- Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In Denzin, N.K. & Lincoln, Y.S. (Eds.), *Handbook of qualitative research* (pp.105-117). Thousand Oaks: Sage.

- Guillemin, M., & Gilliam, L. (2004). Ethics, reflexivity and “ethically important moments” in research. *Qualitative Inquiry*, 10(2), 261-280.
- Hallman, B., Menec, V., Keefe, J., & Gallagher, E. (2008). Making small towns age friendly: What seniors say needs attention in the built environment. *Plan Canada*, 48(3), 18-21.
- Hans, J.S. (1978). Hans-Georg Gadamer and hermeneutic phenomenology. *Philosophy Today*, 22(1), 3-19.
- Harris, M. (2012, June 11). What’s better for old people: city or suburb? *MinnPost*. Retrieved from <http://www.minnpost.com/cityscape/2012/06/what%E2%80%99s-better-old-people-city-or-suburb>
- Harvey, P.W., & Thurnwald, I. (2009). Ageing well, ageing productively: The essential contribution of Australia’s ageing population to the social and economic prosperity of the nation. *Health Sociology Review*, 18(4), 379-386.
- Heidegger, M. (1996). *Being and time* (J. Stambaugh, Trans.). Albany: State University of New York Press. (Original work published 1953).
- Hinck, S. (2004). The lived experience of oldest-old rural adults. *Qualitative Health Research*, 14(6), 779-791.
- Hoogendijk, E.O., Muntinga, M.E., van Leeuwen, K.M., van der Horst, H.E., Deeg, D.J.H., Frijters, D.H.M.,... van Hout, H.P.J. (2013). Self-perceived met and unmet care needs of frail older adults in primary care. *Archives of Gerontology and Geriatrics*, 58, 37-42.
- Hunt, M. (2001). Settings conducive to the provision of long-term care. *Journal of Architectural and Planning Research*, 18(3), 223-233.

- Husserl, E. (1931). *Ideas: General introduction to pure phenomenology*. London: Allen and Unwin.
- Isaacs, B., Miller, G., Harris, G., & Ferguson, I. (2007). Bracing for the demographic tsunami: How will seniors far in an aging society. Design for the young and you exclude the old; design for the old and you include the young. *Plan Canada*, 47(4), 20-21.
- Jacobs, J.M., Rottenberg, Y., Cohen, A., & Stessman, J. (2013). Physical activity and health service utilization among older people. *Journal of the American Medical Directors Association*, 14, 125-129.
- Jagger, C., Collerton, J.C., Davies, K., Kingston, A., Robinson, L.A., Eccles, M.P., ...Bond, J. (2011). Capability and dependency in the Newcastle 85+ cohort study. Projections of future care needs. *BioMed Central Geriatrics*, 11(21), 1-11.
- Kadoya, Y. (2013). Toward an age-friendly city: the constraints preventing the elderly's participation in community programs in Akita city. *Working with Older People*, 17(3), 101-108.
- Kao, A.C., Green, D.C., Davis, N.A., Koplan, J.P., & Cleary, P.D. (1998). Patients' trust in their physicians. *Journal of General Internal Medicine*, 13, 681-686.
- Keenan, T.A. (2010). *Home and community preferences of the 45+ population*. Retrieved from <http://assets.aarp.org/rgcenter/general/home-community-services-10.pdf>
- Keller, K.L., Flatten, E.K., & Wilhite, B.C. (1988). Friendly visiting as a means of informing homebound senior citizens of health-related community services. *Journal of Community Health*, 13(4), 231-240.

- Kendler, K., Eaves, L., Loken, E., Pedersen, N., Middeldorp, C., Reynolds, C.,... Gardner, C. (2011). The impact of environmental experiences on symptoms of anxiety and depression across the life span. *Psychological Science, 22*(10), 1343-1352.
- Kennedy, C. (2010). The city of 2050 – an age-friendly, vibrant, intergenerational community. *Journal of the American Society on Aging, 34*(3), 70-75.
- Kerr, B., Gordon, J., MacDonald, C., & Stalker, K. (2005). *Effective social work with older people*. Retrieved from <http://www.scotland.gov.uk/Resource/Doc/47121/0020809.pdf>
- Kihl, M., Brennan, D., Gabhawala, N., List, J., & Mittal, P. (2005). Liveable communities: An evaluation guide (based on publication by Pollak, 2000). *American Association of Retired Persons*. Retrieved from <http://www.clark.wa.gov/planning/aging/documents/livablecommunitiesaarp.pdf>
- Kim, J. (2013). Innovations in Aged Care ‘HAPI’ life model for the new older generation in Korea. *Australasian Journal on Ageing, 32*(2), 135-141.
- Kiyak, H.A., & Reichmuth, M. (2005). Barriers to and enablers of older adults’ use of dental services. *Journal of Dental Education, 69*(9), 975-986.
- Kloseck, M., Crilly, R., & Gutman, G.M. (2010). Naturally occurring retirement communities: Untapped resources to enable optimal aging at home. *Journal of Housing for the Elderly, 24*, 392-412.
- Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: philosophy, rigour and representation. *Journal of Advanced Nursing, 24*, 174-184.

- Koch, T. (1999). An interpretive research process: Revisiting phenomenological and hermeneutical approaches. *Nurse Researcher*, 6(3), 20-34.
- Krause, N. (2002). Church-based social support and health in old age: Exploring variations by race. *Journal of Gerontology*, 57B(6), S332-S347.
- Krause, N. (2010). Close companions at church, health, and health care use in late life. *Journal of Aging and Health*, 22(4), 434-453.
- Kwok, J.Y.C., & Tsang, K.K.M. (2012). Getting old with a good life: Research on the everyday life patterns of active older people. *Ageing International*, 37, 300-317.
- Lai, D.W.L., & Chau, S.B.Y. (2007). Predictors of health service barriers for older Chinese immigrants in Canada. *Health & Social Work*, 32(1), 57-65.
- Laslett, P. (1991). *A fresh map of life: The emergence of the third age*. Cambridge, MA: Harvard University Press.
- Lehning, A.J. (2014). Local and regional governments and age-friendly communities: A case study of the San Francisco Bay Area. *Journal of Aging & Social Policy*, 26, 102-116.
- León-Muñoz, L.M., López-García, E., Graciani, A., Guallar-Castillón, P., Banegas, J.R., & Rodríguez-Artalejo. (2007). Functional status and use of health care services: Longitudinal study on the older adult population in Spain. *Maturitas*, 58, 377-386.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Lloyd-Sherlock, P., McKee, M., Ebrahim, S., Gorman, M., Pruchno, R., Gutman, G., ... Vellas, B. (2012). Population ageing and health. *The Lancet*, 379, 1295-1296.

- Lui, C., Everingham, J., Warburton, J., Cuthill, M., & Bartlett, H. (2009). What makes a community age-friendly: A review of international literature. *Australasian Journal on Ageing, 28*(3), 116-121.
- Mancini, J.A., & Simon, J. (1984). Older adults' expectations of support from family and friends. *Journal of Applied Gerontology, 3*(2), 150-160.
- Marks, G.R., & Lutgendorf, S.K. (1999). Perceived health competence and personality factors differentially predict health behaviours in older adults. *Journal of Aging and Health, 11*(2), 221-239.
- McGarry, P. (2012). Good places to grow old: age-friendly cities in Europe. *Journal of Intergenerational Relationships, 10*, 201-204.
- McGarry, P., & Morris, J. (2011). A great place to grow older: A case study of how Manchester is developing an age-friendly city. *Working with Older People, 15*(1), 38-46.
- McIlwain, J. (2011, August 17). Suburbs, cities, and aging in place. *Urban Land Magazine*. Retrieved from <http://urbanland.uli.org/economy-markets-trends/suburbs-cities-andaging-in-place/>
- McMillan, D.W., & Chavis, D.M. (1986). Sense of community: A definition and theory. *Journal of Community Psychology, 14*, 6-23.
- Menec, V.H., Means, R., Keating, N., Parkhurst, G., & Eales, J. (2011). Conceptualizing age friendly communities. *Canadian Journal on Aging, 30*(3), 479-493.
- Menec, V.H., Novek, S., Veselyuk, D., & McArthur, J. (2014). Lessons learned from a Canadian provide-wide age-friendly initiative: The age-friendly Manitoba initiative. *Journal of Aging & Social Policy, 26*, 33-51.

- Meslin, E.M. (2010). The value of using top-down and bottom-up approaches for building trust and transparency in biobanking. *Public Health Genomics, 13*(4), 207-214.
- Michael, Y.L., Green, M.K., & Farquhar, S.A. (2006). Neighborhood design and active aging. *Health & Place, 12*, 734-740.
- Miles, M.B., Huberman, A.M., & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook*. (3rd Edition). Thousand Oaks, California: SAGE Publications.
- Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods, 5*(1), 25-35.
- Ministry of Health and Long-Term Care (MOHLTC). (2013). *Ontario's aging at home strategy*. Retrieved from http://www.health.gov.on.ca/en/public/programs/ltc/33_ontario_strategy.aspx
- Ministry of Social Development. (2005). *The Social Report*. Retrieved from <http://socialreport.msd.govt.nz/documents/2005/social-report-2005.pdf>
- Morrow, S.L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52* (2), 250-260.
- Morse, J. (1991). Strategies for sampling. In J. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (2nd ed., pp. 127-145). Newbury Park, CA: Sage.
- Morse, J.M. (2000). Determining sample size. *Qualitative Health Research, 10*(1), 3-5.
- Muramatsu, N., Yin, H., & Hedeker, D. (2010). Functional declines, social support, and mental health in the elderly: Does living in a state supportive of home and

community-based services make a difference? *Social Science & Medicine*, 70, 1050-1058.

Nahemow, L., & Lawton, M.P. (1973). Toward an ecological theory of adaptation and aging. In *Environmental design research: fourth international EDRA conference* (pp. 24-32). Retrieved from http://www.edra.org/sites/default/files/publications/EDRA04-Nahemow24-32_0.pdf

National Institute on Aging. (2007). *Why population aging matters: A global perspective*. Retrieved from <http://www.nia.nih.gov/sites/default/files/WPAM.pdf>

Neal, M.B., & DeLaTorre, A. (2009). The WHO age-friendly cities project. *Journal of the American Society on Aging*, 33(2), 74-75.

Neal, M.B., DeLaTorre, A.K., & Carder, P.C. (2014). Age-friendly Portland: a university-city community partnership. *Journal of Aging & Social Policy*, 26, 88-101.

NVivo qualitative data analysis software©, QSR International Pty Ltd. Version 10, 2014.

Ozanne, E., Biggs, S., & Kurowski, W. (2014). Competing frameworks in planning for the aged in the growth corridors of Melbourne. *Journal of Aging & Social Policy*, 26, 147-165.

Palys, T. (2008). Purposive sampling. In Given, L.M. (Ed.), *The Sage encyclopedia of qualitative research methods* (697-698). Thousand Okas, CA: Sage Publications.

Parry, J. (2010). Network of cities tackles age-old problems. *Bulletin of the World Health Organization*, 88, 406-407.

- Patton, M. (1990). Purposeful sampling. In *Qualitative evaluation and research methods* (pp.169-186). Beverly Hills, CA: Sage.
- Patton, M.Q. (2001). *Qualitative evaluation and research methods* (3rd ed.). Newbury Park, CA: Sage Publications.
- Plouffe, L.A., & Kalache, A. (2010). Towards global age-friendly cities: Determining urban features that promote active aging. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 87(5), 733-739.
- Plouffe, L.A., & Kalache, A. (2011). Making communities age friendly: state and municipal initiatives in Canada and other countries. *Gaceta Sanitaria*, 25(S), 131-137.
- Pollak, P.B. (2000). Liveable communities: An evaluation guide. *American Association of Retired Persons*. Retrieved from http://assets.aarp.org/rgcenter/consume/d16905_communities.pdf
- Potts, M.K. (1997). Social support and depression among older adults living alone: The importance of friends within and outside of a retirement community. *Social Work*, 42(3), 348-362.
- Prior, M.K., Bahret, B.A., Allen, R.I., & Pasupuleti, S. (2012). The efficacy of a senior outreach program in the reduction of hospital readmissions and emergency department visits among chronically ill seniors. *Social Work in Health Care*, 51(4), 345-360.
- Provencher, C., Keating, N., Warburton, J., & Roos, V. (2014). Ageing and community: Introduction to the special issue. *Journal of Community & Applied Social Psychology*, 24, 1-11.

- Register, M.E., & Scharer, K.M. (2010). Connectedness in community-dwelling older adults. *Western Journal of Nursing Research*, 34(4), 462-479.
- Richard, L., Gauvin, L., Gosselin, C., & Laforest, S. (2008). Staying connected: neighbourhood correlates of social participation among older adults living in an urban environment in Montreal, Quebec. *Health Promotion International*, 24(1), 46-57.
- Rook, K.S., & Ituarte, P.H.G. (1999). Social control, social support, and companionship in older adults' family relationships and friendships. *Personal Relationships*, 6, 199-211.
- Rowe, J.W., & Kahn, R.L. (1997). Successful aging. *The Gerontologist*, 37(4), 433-440.
- Ruza, J., Kim, J.I., Leung, I., Coyan, C., Li, A., Kam, C., & Ng, S. (2012). Sustainable, age friendly cities: an evaluative case study. *American Society of Civil Engineers*, 196-203.
- Saldaña, J. (2009). *The coding manual for qualitative researchers*. Thousand Oaks, California: SAGE Publications.
- Scharlach, A.E., Davitt, J.K., Lehning, A.J., Greenfield, E.A., & Graham, C.L. (2014). Does the village model help to foster age-friendly communities? *Journal of Aging & Social Policy*, 26, 181-196.
- Schoenberg, N.E., & Coward, R.T. (1998). Residential differences in attitudes about barriers to using community-based services among older adults. *Journal of Rural Health*, 14(4), 295-304.

- Service Ontario. (2013). *A guide to programs and services for seniors in Ontario*. Retrieved from <http://www.seniors.gov.on.ca/en/resources/seniorsguide/English.pdf>
- Sinha, S. (2012). *Living longer, living well*. Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors_strategy/ocs/seniors_strategy_report.pdf
- Smee, D.J., Anson, J.M., Waddington, G.S., & Berry, H.L. (2012). Association between physical functionality and falls risk in community-living older adults. *Current Gerontology and Geriatrics Research*, 2012.
- Smith, J., Borchelt, M., Maier, H., & Jopp, D. (2002). Health and well-being in the young old and oldest old. *Journal of Social Issues*, 58(4), 715-732.
- Smythe, E.A., Ironside, P.M., Sims, S.L., Swenson, M.M., & Spence, D.G. (2008). Doing Heideggerian hermeneutic research: a discussion paper. *International Journal of Nursing Studies*, 45, 1389-1397.
- Soldo, B.J., & Manton, K.G. (1985). Changes in the health status and service needs of the oldest old: Current patterns and future trends. *Health and Society*, 63(2), 286-319.
- Statistics Canada. (2013). *Canada's population estimates: Age and sex, 2013*. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/131125/dq131125a-eng.htm>
- Statistics Canada. (2014). *Census subdivision of London, CY- Ontario* [Data file]. Retrieved from <https://www12.statcan.gc.ca/census-recensement/2011/as-sa/fogs-spg/Facts-csdeng.cfm?LANG=Eng&GK=CSD&GC=3539036>

- Steed, J. (2007). Boomer tsunami: Ready or not. *The 2007 Atkinson Fellowship in Public Policy*. Retrieved from <http://atkinsonfoundation.ca/wp-content/uploads/2013/07/boomertsunami-ontario-braces-for-a-grey-wave.pdf>
- Streubert, H., & Carpenter, D.R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative* (5th ed.). China: Lippincott Williams & Wilkins.
- Thom, D.H., Kravitz, R.L., Bell, R.A., Krupat, E., & Azari, R. (2002). Patient trust in the physician: Relationship to patient requests. *Family Practice*, *19*(5), 476-483.
- Thorpe, J.M., Thorpe, C.T., Kennelty, K.A., & Pandhi, N. (2011). Patterns of perceived barriers to medical care in older adults: A latent class analysis. *BioMed Central Health Services Research*, *11*, 181-192.
- Tompkins, L. (2008). Planning for the seniors surge – one municipality’s response. *Plan Canada*, 30-33.
- Tracy, S.J. (2010). Qualitative Quality: Eight “big-ten” criteria for excellent qualitative research. *Qualitative Inquiry*, *16*(10), 837-851.
- Uhlenberg, P. (2013). Demography is not destiny: The challenges and opportunities of global population aging. *Journal of the American Society on Aging*, *37*(1), 12-18.
- United Nations (UN). (2001). *World population ageing: 1950-2050*. Retrieved from <http://www.un.org/esa/population/publications/worldageing19502050/>
- United Nations (UN). (2009). *World population ageing 2009*. Retrieved from http://www.un.org/esa/population/publications/WPA2009/WPA2009_WorkingPaper.pdf

- United Nations Population Fund (UNFPA). (2007). *UNFPA state of world population 2007: Unleashing the potential of urban growth*. Retrieved from http://unfpa.org/webdav/site/global/shared/documents/publications/2007/695_filename_owp2007_eng.pdf
- Van Houtven, C.H., & Norton, E.C. (2004). Informal care and health care use of older adults. *Journal of Health Economics*, 23, 1159-1180.
- van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. (1st Edition). London, Ontario: The Althouse Press.
- van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy*. (2nd Edition). London, Ontario: The Althouse Press.
- Vilpert, S., Ruedin, H.J., Trueb, L., Monod-Zorzi, S., Yersin, B., & Bula, C. (2013). Emergency department use by oldest-old patients from 2005 to 2010 in a Swiss university hospital. *BioMed Central Health Services Research*, 13, 344-351.
- Waldbrook, N., Rosenburg, M.W., Brual, J. (2013). Challenging the myth of apocalyptic aging at the local level of governance in Ontario. *The Canadian Geographer*, 57(4), 413-430.
- Wallace, D.C., & Hirst, P.K. (1996). Community-based service use among the young, middle, and old old. *Public Health Nursing*, 13(4), 286-293.
- Wallace, K.A., & Bergeman, C.S. (1997). Control and the elderly: "goodness-of-fit". *International Journal of Aging and Human Development*, 45(4), 323-339.
- Ward-Griffin, C., Hobson, S., Melles, P., Klooseck, M., Vandervoort, A., & Crilly, R. (2004). Falls and fear of falling among community-dwelling seniors: The

dynamic tension between exercising precaution and striving for independence.
Canadian Journal on Aging, 23(4), 307-318.

Wolinsky, F.D., Bentler, S.E., Liu, L., Geweke, J.F., Cook, E.A., Obrizan, M.,
...Wallace, R.B. (2010). Continuity of care with a primary care physician and
mortality in older adults. *Journal of Gerontology*, 65A(4), 421-428.

Wolinsky, F.D., & Johnson, R.J. (1991). The use of health services by older adults.
Journal of Gerontology: Social Sciences, 46(6), S345-S357.

World Health Organization. (2002). *Active ageing: a policy framework*. Retrieved from
http://whqlibdoc.who.int/hq/2002/WHO_NMH_NPH_02.8.pdf

World Health Organization. (2004). *A glossary of terms for community health care and
services for older persons*. Retrieved from
http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf

World Health Organization. (2007a). *Global age-friendly cities: a guide*. Retrieved from
http://whqlibdoc.who.int/publications/2007/9789241547307_eng.pdf

World Health Organization. (2007b). *WHO Age-friendly cities project methodology:
Vancouver protocol*. Retrieved from
http://www.who.int/ageing/publications/Microsoft%20Word%20-%20AFC_Vancouver_protocol.pdf

World Health Organization. (2009). *WHO global network of age-friendly cities
(brochure)*. Retrieved from <http://www.who.int/ageing/Brochure-EnglishAFC9.pdf?ua=1>

World Health Organization. (2011). *Global health and ageing*. Retrieved from
http://www.who.int/ageing/publications/global_health.pdf

World Health Organization. (2012). *Knowledge translation framework for ageing and health*. Retrieved from

http://www.who.int/ageing/publications/knowledge_translation.pdf

World Health Organization. (2013). *WHO global network of age-friendly cities and communities*. Retrieved from

http://ciudadesamigables.imserso.es/InterPresent1/groups/imserso/documents/binario/rc_201303.pdf

Yoder, S. (2013, June 6). Millions of seniors are moving back to big cities. *Business Insider*. Retrieved from <http://www.businessinsider.com/millions-of-seniors-are-moving-to-cities2013-6>

Zagaria, M.A.E. (2013). Access to health care: Influential factors and cultural competence. *US Pharmacist*, 38(9), 20-22.

APPENDICES

Appendix A. Ethics Approval Form



Research Ethics

Western University Health Science Research Ethics Board HSREB Delegated Initial Approval Notice

Principal Investigator: Dr. Marita Kloseck
Department & Institution: Schulich School of Medicine and Dentistry\Medicine-Dept of,Western University

HSREB File Number: 105645
Study Title: What are the needs of the oldest-old? The missing piece in age-friendly city development.
Sponsor:

HSREB Initial Approval Date: September 23, 2014
HSREB Expiry Date: August 31, 2015

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Letter of Information & Consent		2014/08/29
Western University Protocol		2014/08/29
Recruitment Items		2014/08/29
Instruments	Interview guide	2014/07/30
Instruments	Demographic questionnaire	2014/07/30
Other	Environmental scan/ scoping map and map legend of the community support and health services found in the Westmount community in London, Ontario (as of July, 2014).	2014/07/14
Other	Map of the Westmount community boundaries with census details.	2014/04/06
Other	Neighbourhood map of London, Ontario, showing the different community boundaries within the city.	2014/04/06

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above named study, as of the HSREB Initial Approval Date noted above.

HSREB approval for this study remains valid until the HSREB Expiry Date noted above, conditional to timely submission and acceptance of HSREB Continuing Ethics Review. If an Updated Approval Notice is required prior to the HSREB Expiry Date, the Principal Investigator is responsible for completing and submitting an HSREB Updated Approval Form in a timely fashion.

The Western University HSREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use Guideline for Good Clinical Practice Practices (ICH E6 R1), the Ontario Personal Health Information Protection Act (PHIPA, 2004), Part 4 of the Natural Health Product Regulations, Health Canada Medical Device Regulations and Part C, Division 5, of the Food and Drug Regulations of Health Canada.

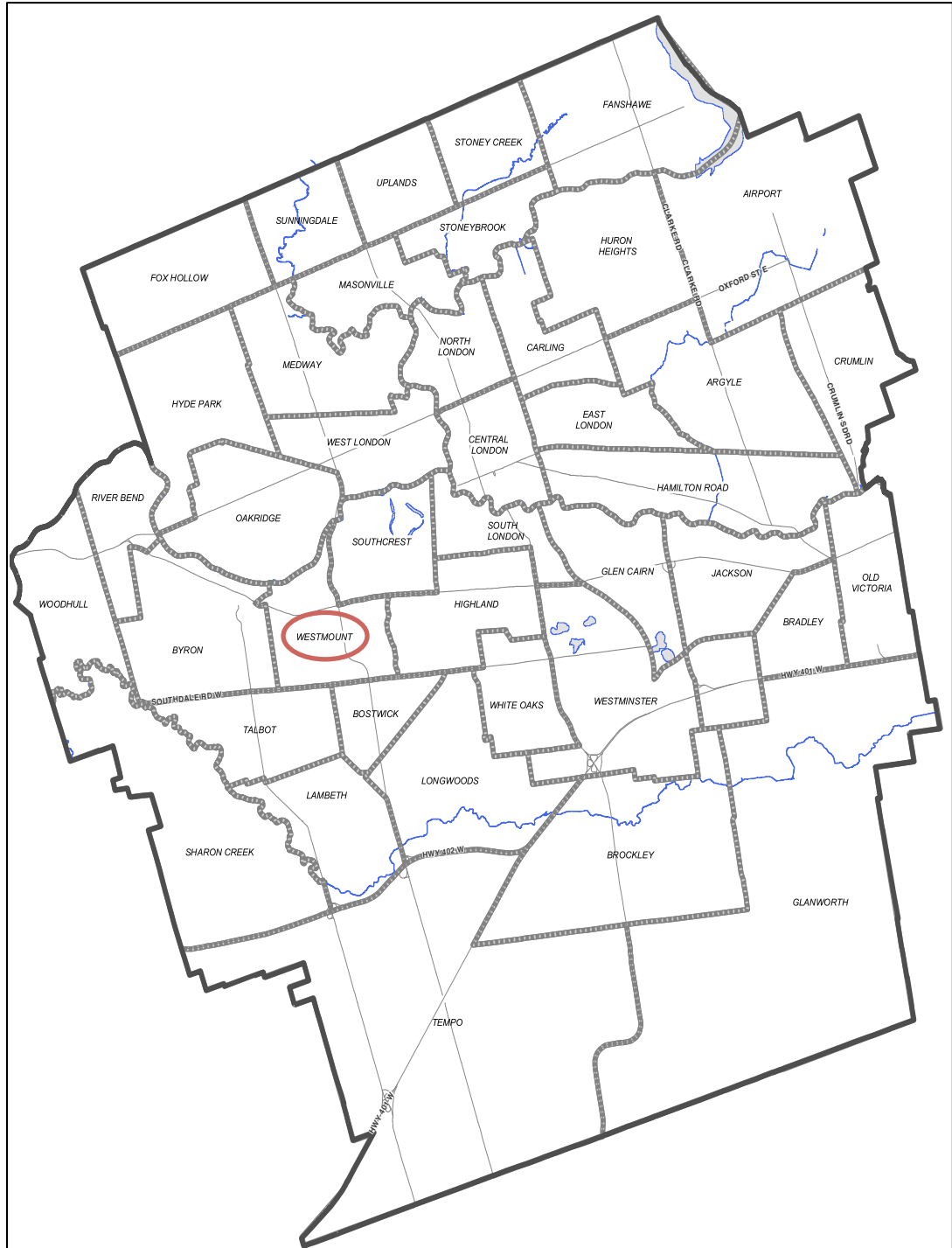
Members of the HSREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

This is an official document. Please retain the original in your files.

Appendix B. Map of London, Ontario

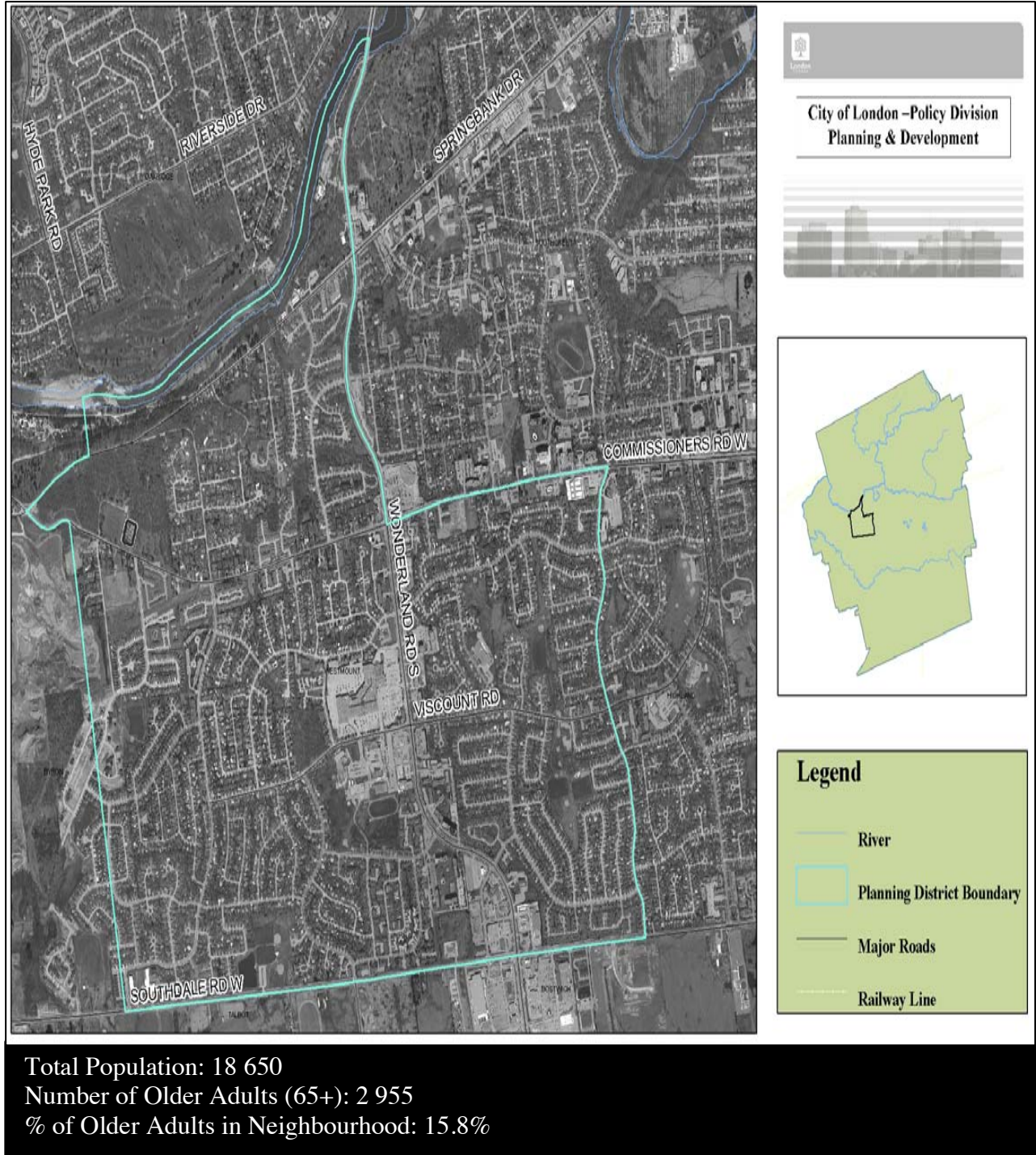
Map of London Ontario showing the different neighbourhood boundaries throughout the city. (Source: City of London, 2013. Information last updated: 2006).



Total Population: 347 450
Number of Older Adults (65+): 45 200
% of Older Adults in Neighbourhood: 13%

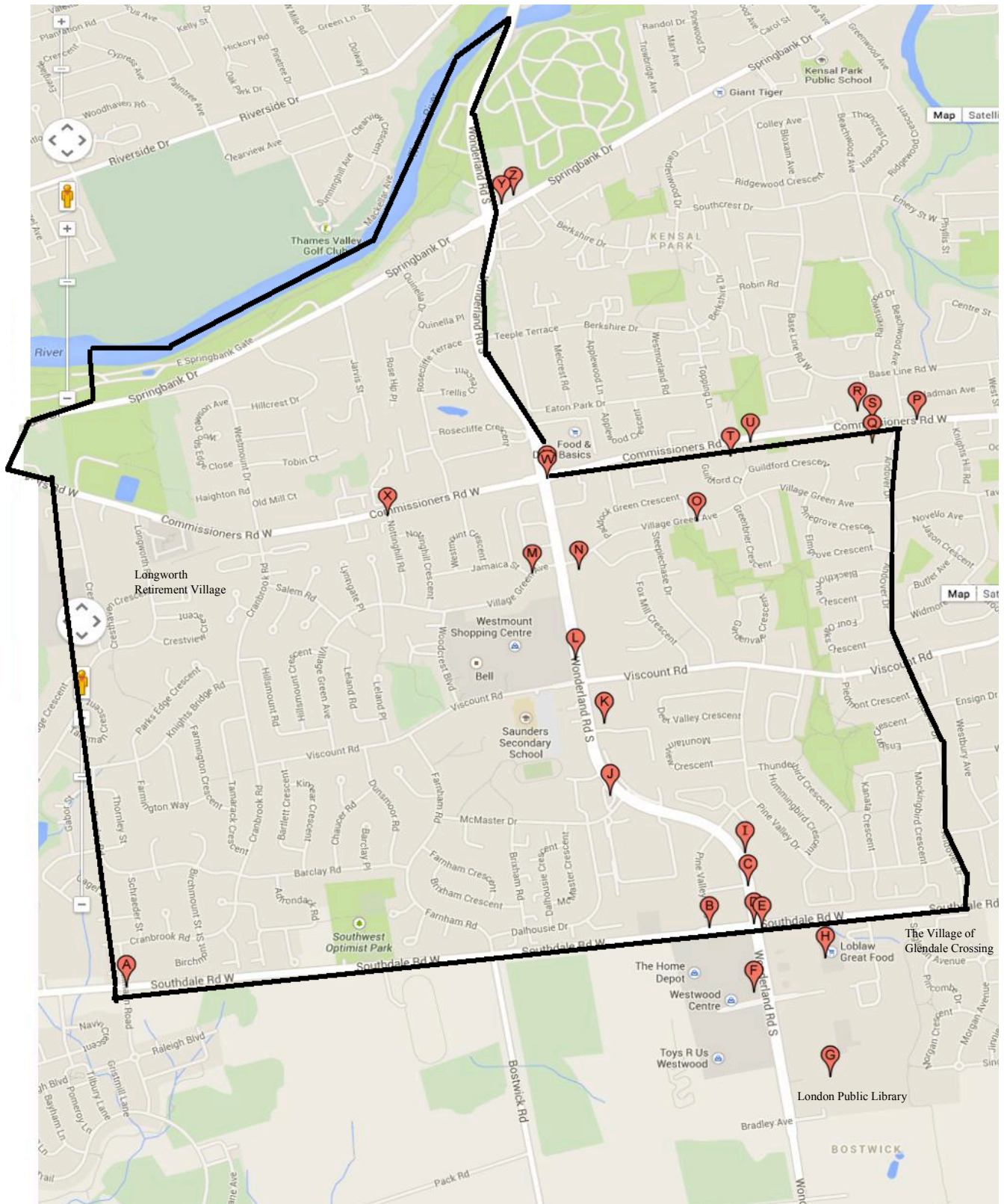
Appendix C. Map of Westmount Neighbourhood

Map of the Westmount neighbourhood and census details (Source: City of London, 2013.
Information last updated: 2006).



Appendix D. Environmental Scan of Westmount

Scoping Map of the community support and health services found in the Westmount community in London, Ontario (July, 2014).



Map Legend

A: Massage Addict

B: Pine Valley Dental

C: 1051 Wonderland Road South

- AIM Health Group (Medical Centre, After-hours clinic, Physiotherapy, Chiropractor, Massage Therapy, Rehabilitation)
- Shoppers Drug Mart
- London Dental Studio

D: 1061 Wonderland Road South

- Wonderland Dental Office
- Wonderland Guardian Pharmacy

E: Listen Up – Hearing Healthcare Centre

F: Iris Opticians and Optometrists

G: Athletic Club

H: 3040 Wonderland Road South

- Loblaw Great Food and Drugstore
- GoodLife Fitness

I: Westview Baptist Church

J: 925 Wonderland Road South

- Westmount Medical Walk-in Clinic
- Westmount Dental Office

K: 844 Wonderland Road South

- My Care Pharmacy
- Clincare Walk-in Clinic

L: Westmount Shopping Centre:

- Body Mechanics
- Cummins Optical
- ivision
- Kidney Care Centre LHSC
- Sears Optical
- Shoppers Simply Pharmacy
- SuperKing SuperMarket
- Target Pharmacy
- The Kidney Foundation of Canada
- West London Family Health Clinic
- Westmount Family Physicians

M: Westmount Presbyterian Church

N: Village Green Community Church

O: Forest Edge Community Pool

P: London Gospel Temple Family Church

Q: 312 Commissioners Road West

- Palombo Chiropractic & Wellness Centre
- The Medicine Shoppe Pharmacy

R: London West Health Centre

S: 305 Commissioners Road West

- Spanda Yoga Centre & Retreats
- Merle Norman: Comestiques and Day Spa

T: The London Free Methodist Church

U: 390 Commissioners Road West

- Bentley Hearing Services
- Chiropractor and Naturopath
- Dentistry 390
- General Dentistry

V: 509 Commissioners Road West

- Food Basics and Pharmacy
- Dove Dental Centre
- Anytime Fitness

W: Shoppers Drug Mart

X: Westmount Foot Clinic

Y: Westmount Optometrists

Z: Citadel Community Church

Appendix E. Letter of Information and Consent



Health and Rehabilitation Sciences

Letter of Information

What are the needs of the oldest-old? The missing piece in age-friendly city development.

Principal Investigator

Dr. Marita Kloseck, PhD
School of Health Studies, Western University

Co-Investigator

Flora Vieira Zamora, BSc, MSc Candidate
School of Health Studies, Western University

Conflict(s) of Interest

The PI and the co-investigators have no conflicts of interest to declare for this study.

Introduction

You are being invited to participate in this research study as we hope that you can help us to better understand the needs that older adults living in the community have with accessing and using community support and health services. Furthermore, we want to learn about your everyday experiences using these support and health services within your community.

The purpose of this letter is to provide you with the information required for you to make an informed decision regarding participation in this research study. This letter will also allow you to explain and discuss this research study with your family and friends and thus acquire their input on your potential participation in this study.

Background and Purpose of the Study

The design and structure of the community within which one lives, and one's home environment, play an important role in maintaining independence and helping individuals stay in their own homes as long as possible. This has been recognized by our policy makers through projects such as the creation of Age-Friendly Cities. As part of the planning process to make cities more age-friendly, there are eight areas that most policy makers focus on: outdoor spaces and buildings, transportation, housing, social participation, respect and inclusion, civic participation and employment, communication and information, and community support and health

services. We are interested in community support and health services for older people. We would like to hear about your experiences and the needs you have related to community support and health services. We would especially like to hear from individuals who are 80 years of age and older regarding their experiences. We know that in later life one's needs to remain independent and active are very different from those of younger individuals. We also know that, for a variety of reasons, it is often difficult for individuals in advanced age to participate in the many community planning sessions that are offered to gather feedback. Our goal is to ensure that the voices of everyone, and especially older individuals who have different health needs, are heard and included in the planning of age-friendly communities and cities.

The purpose of this study is to better understand how individuals, 80 years of age and older, acquire and use community support and health services.

Inclusion Criteria

We are looking for individuals who are 80 years of age or older, who live in the Westmount community and who speak fluent English to participate in this study.

Exclusion Criteria

Individuals who are younger than 80 years of age and those who do not live in the Westmount community or who are unable to speak fluent English are not eligible to participate.

Study Procedures – What is involved if you choose to participate?

If you agree to participate in this study, you will be asked to take part in one individual interview, lasting approximately one hour, to discuss your experiences acquiring and using community support and health services in the Westmount community. The interview will be conducted by Flora Vieira Zamora who will ask you questions about your day-to-day experiences using community support and health services, how you feel about these services, and what you feel you need in your community to help you remain living independently in your home as long as possible. Before the interview begins, you will be asked to complete a demographic survey to provide us with general overall information and the use of community support and health services generally. The interview will be held in a place of your choosing. If you choose to have the interview in a public place such as Westmount Mall or a local coffee shop, assistance will be provided to anyone who has difficulty with walking to the mall or coffee shop. This study will be conducting individual interviews with 10 people, 80 years of age and older, living in the Westmount Community. All interviews will be audio-recorded using a digital recorder to ensure that the information transcribed is accurate. If at any time you wish to stop the audio-

recording, please advise the researcher. If you do not want to be audio-recorded you are still welcome to participate.

Confidentiality

Data collected in this study will be kept confidential. The information that we collect from you will only be for the use of the study investigators. The results of this study may be presented or published, however, your name will not be used so as to maintain your anonymity. All information will be kept strictly confidential and will be stored in a locked filing cabinet, in a locked research office at the University of Western Ontario. Representatives from the University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

Voluntary Participation

Your participation in this study is voluntary. You may decide not to be in this study, or to be in this study now and then change your mind later. You may leave the study at any time without affecting your future access to community support and health services.

Risks – What are the possible risks if you participate?

There are no known risks associated with participating in this study. Some people, however, may experience emotional stress that may occur from recalling specific memories. You are free to choose what you will and will not discuss. Some people may also experience fatigue during the interview. Breaks will be offered at any sign of fatigue.

Benefits

You may not directly benefit from participating in this study but we hope that the information gathered in this study will be used to deliver better community supports and health services to older individuals living in communities such as Westmount.

Questions About the Study

If you have any questions about this study or if you require any further information regarding your participation in this study please contact Flora Vieira Zamora.

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics.

Other Information

Please note the consent form attached to this document. If you are interested in taking part in this study, please sign the consent form and return it to Flora Vieira Zamora, graduate student at the University of Western Ontario.

This letter is yours to keep. If you are interested in the results of this study, we are happy to provide you with our general findings once the study has been completed.

Consent Form**Project Title:**

What are the needs of the oldest-old? The missing piece in age-friendly city development.

Study Investigator's Names:

Dr. Marita Kloseck
Flora Vieira Zamora

I have read the Letter of Information and I have had the nature of this study explained to me. I have been given the opportunity to ask questions. All questions have been answered to my satisfaction and I agree to participate in this study.

Do you give permission for your interview to be audio recorded? Yes No

Participant's Name (please print): _____

Participant's Signature: _____

Date: _____

Person Obtaining Consent (please print): _____

Signature: _____

Date: _____

Attention Westmount Residents:

If you are 80 years of age or older

We Want to Hear from You!

We want to hear about YOUR experiences with health and community services in the Westmount area.



Principal Investigator: Dr. Marita Kloseck, PhD

Details: I am Master's student at the University of Western Ontario wanting to learn more about older adults' experiences in accessing and using health and community services. If you are 80 years or older and would like to hear more about the study, please contact me (Flora Vieira Zamora). Thank you!

Western 

Version Date: 29/Aug/2014

Appendix G. Socio-Demographic Questionnaire



Health and Rehabilitation Sciences

Demographic Questionnaire

Section A: General Information

1. How many years have you lived in the Westmount community? _____ years
2. Are you: _____ male _____ female
3. In which year were you born? _____
4. What is your marital status (check one):
_____ single _____ married
_____ widowed _____ divorced
_____ separated _____ common-law
5. What are your current living arrangements? Do you live (check one):
_____ alone
_____ with your spouse or partner
_____ with another member of your family (e.g., child; grandchild)
_____ with a friend or roommate
_____ or with someone other than mentioned above
(please specify: _____)
6. Do you currently have a caregiver or helper? _____ yes _____ no

If yes, who is your caregiver or helper (check one):
_____ relative _____ health professional
_____ friend _____ other (please specify: _____)
7. What is the highest level of education you have completed?
_____ public school (1-8 years)
_____ high school (9-12 years)
_____ college (diploma)
_____ university with a Bachelor's degree
_____ university with a Master's degree
_____ university with a PhD or MD
_____ other education (please specify: _____)

8. How often do you leave your home (check one)?
- | | | | |
|--------------------------|----------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | nearly every day | <input type="checkbox"/> | once every two weeks |
| <input type="checkbox"/> | 3 to 5 days per week | <input type="checkbox"/> | once per month |
| <input type="checkbox"/> | 1 to 2 days per week | <input type="checkbox"/> | less than once per month |
| <input type="checkbox"/> | mostly on weekends | <input type="checkbox"/> | almost never |
9. In general, would you say your health is (circle the number that best describes how you feel):
- 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
 excellent very good good fair poor extremely bad
10. In general, how independent do you feel (circle the number that best describes how you feel):
- 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
 completely very somewhat very little not at all completely
 independent independent independent independence independent dependent

Section B: Community Support and Health Service Information

11. Who do you turn to when you need help? _____
12. Do you currently use **community support services** in Westmount? ___ yes ___ no
- If yes, please list the community supports you use:
- _____
- _____
- _____
- _____
13. How often do you use these community support services:
- | | | | |
|--------------------------|----------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | every day | <input type="checkbox"/> | a few times per month |
| <input type="checkbox"/> | a few times per week | <input type="checkbox"/> | once per month |
| <input type="checkbox"/> | once per week | <input type="checkbox"/> | rarely |

14. How satisfied are you with these community support services (circle the number that best describes how you feel):

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6
 extremely usually somewhat somewhat usually extremely
 satisfied satisfied satisfied dissatisfied dissatisfied dissatisfied

15. Do you currently use **health services** in Westmount? ____ yes ____ no

If so yes, please list the health services you use:

16. How often do you use these health services:

_____ every day _____ a few times per month
 _____ a few times per week _____ once per month
 _____ once per week _____ rarely

17. How satisfied are you with these health services (circle the number that best describes how you feel):

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6
 extremely usually somewhat somewhat usually extremely
 satisfied satisfied satisfied dissatisfied dissatisfied dissatisfied

18. Are the community support and health services that you are aware of and/or use easy to access (circle the number that best describes how you feel)?

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6
 very easy usually somewhat easy somewhat difficult often difficult not
 to access easy to access to access to access to access accessible



19. Do you have all the required community support and health services you need in your neighbourhood? _____ yes _____ no

If no, please explain:

20. What are the MOST IMPORTANT community support and health services that you need to help you remain independent in your home (please list in order of importance):

1. _____
2. _____
3. _____
4. _____
5. _____

Name: _____
Address: _____
Telephone: _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS

Appendix H. Interview Guide



Health and Rehabilitation Sciences

Interview Guide

“Again, thank you so very much for helping us with our research study.”

“Before we get started, I would like to remind you that obtaining your feedback regarding your experiences accessing and using community support and health services is part of the research process. I would also like to assure you that your participation in this study is a completely voluntary and that you may refuse to participate at any time without any consequences. If at any point during the interview you feel tired or anxious, please let me know and we will stop the interview and reschedule if necessary.”

“This interview will be tape recorded to ensure that I capture your feedback accurately. The recorder can be turned off at any time if you would like to share something that you do not want to be recorded.”

TURN ON THE TAPE RECORDER.

Introductory question icebreaker: Please tell me how long you have lived in Westmount and your favourite part of living in this neighbourhood.

I. INTRODUCTION TO COMMUNITY SUPPORT AND HEALTH SERVICES

1. What do community support and health services mean to you?
 - a) Are there many community support and health services available in your community?
 - b) Do you hear about the support and health services available in the Westmount community?
 - c) Who do you turn to when you need help?
 - d) Do you receive any help or support to help you stay independent and living in your own home?
 - e) What support do you currently receive?
 - f) Who provides this support?
 - g) What health or medical services do you need?
 - h) What health or medical services do you currently use?
 - i) Who provides these services?

II. EXPERIENCES WITH COMMUNITY SUPPORT AND HEALTH SERVICES

2. How do you experience community support and health services in your everyday life?
 - a) Please describe your experiences in accessing and using these services.
 - b) Please tell me how community support and health services fit into your daily routine.
 - c) What specific support and health services do you need?
 - d) How frequently do you use these services?
 - e) Are these services easy to access?
 - f) How do you feel about the support and health services you receive?
 - g) Is everything you need available in the Westmount neighbourhood?
 - h) If not, what is missing?
 - i) What is working well?
 - j) What are your greatest challenges?
 - k) What are your greatest fears?

III. FEELINGS REGARDING COMMUNITY SUPPORT AND HEALTH SERVICES

3. How do you feel about the community support and health services in Westmount?
 - a) Do the community support and health services in Westmount work the way you want them to?
 - b) Is there anything that would make these services better?
 - c) If you could, is there anything you would change about these services?
 - d) What do you like most?
 - e) What do you like least?
 - f) Overall, how satisfied are you with the community support and health services that are available in Westmount?

IV. INDEPENDENCE AND COMMUNITY SUPPORT AND HEALTH SERVICES

4. How important are community support and health services to help you stay independent and living in your own home?

- a) Do you feel your level of independence would change if you didn't have these community support and health services?
- b) What would happen if you didn't have these supports or health services?
- c) Do you feel that if you had more community support and health services made available to you, your independence would increase?

V. CONCLUSION

5. Do you have any other thoughts about community support and health services or experiences that you would like to share? Have we missed anything?

Appendix I. Wholistic Thematic Analysis: Participant Snapshots

Participant	Snapshot
1	Female. Interview took place in participant's home. Lives in a house with spouse. Quite healthy, uses minimal health services. Independent, does not use any formal support services. Still drives. Extensively engaged in the community. Long history of volunteering. Strong social circle – family and friends. Very strong connections with family. Resilient, good coping skills.
2	Male. Interview took place in participant's home. Lives alone in an apartment building. Widowed. Healthy and independent. Uses minimal health services and does not use any formal community supports. Still drives. Engaged within the community. Lack of social connections. Wants more social opportunities. Sense of loneliness. Some support from family mentioned.
3	Female. Interview took place in participant's home. Lives in a house with son and daughter-in-law. Widowed. Quite healthy, uses minimal health services. Independent, does not use any formal support services. Still drives. Son and daughter-in-law provide any needed help. Very engaged in the community. Very strong connections with family.
4	Female. Interview took place in participant's home. Lives in an apartment building alone. Widowed. Quite healthy, uses minimal health services. Limited independence, need rides to pick up right at door. Has cleaner come in twice per month to help with light housekeeping. Accessibility to community is an issue. Strong support system with family and friends. Engaged within the community, wants more social opportunities. Strong connections with family. Veteran.
5	Male. Interview took place in participant's home. Lives with spouse in basement apartment of house shared with daughter and son-in-law. Very healthy, uses minimal health services. Very independent, does not use any formal support services. Still drives. Very involved and integrated in community and with friends. Very active lifestyle. Strong familial connections, lots of familial support, if needed. Veteran.
6	Female. Interview took place in participant's home. Lives in an apartment building alone. Spouse is in a long-term care facility. Quite healthy and independent, uses minimal health services, does not use any formal support services. Still drives. Social connectedness is desired, feelings of loneliness. Wants more support and more social opportunities. Does engage within the community, but limited due to nursing home visits. Some familial support. Perceived independence was rated lower than what seemed apparent.
7	Female. Interview took place at a local church. Widowed. Did not share too much, was brief with answers. Very healthy, active, and independent. Still drives. Uses minimal health services. Does not use formal community services. Would like a community center and more social opportunities. Family is very important.
8	Female. Interview took place in participant's home. Lives alone in an apartment building. Widowed. Was seated for the duration of the interview, did not seem very mobile. Quite a few health conditions, therefore uses regular health services. Limited independence, must use walker outside, has cleaning service come in biweekly, orders frozen dinners. Still drives. Very engaged within the community. Strong connections with family. Veteran. Was involved in sport for many years. Self rated health and self-perceived independence levels were high. Receives multiple traditional supports to help with activities of daily living.
9	Female. Interview took place in participant's home. Lives in an apartment building with spouse. Was seated for the duration of the interview, did not seem very mobile. Quite healthy, uses minimal health services. Very limited independence, does not use any formal support services. Spouse and children provide help. Must use walker outside of house and does not drive. Does not engage within the community. Very strong connections with family.
10	Female. Interview took place in participant's home. Lives alone in an apartment building. Widowed. Quite healthy, uses minimal health services. Limited independence, must use walker outside of house and does not drive. Has Connect Care service for emergencies. Engages in weekly church service and apartment gatherings. Has many hobbies. Has strong connections with family. Children provide transportation. Very positive person.

Appendix J. Second Cycle Coding Example: Health Services

Health Services	"We're getting old and we need a doctor close near"
	bad healthcare experience - early removal of stitches
	been waiting for 6 months for family doctor in Westmount
	challenges finding a family doctor in area
	desired family doctor - will be ver accessible, can walk
	doesn't take any medications
	during recovery used other services - chiro, physio - didn't comment too much on how much she liked it
	fear of nursing home/loss of independence
	good and fast experiences with St. Joe's Urgent Care Centre
	good experiences with St. Elizabeth's Clinic
	good experiences with VON nurses
	good healthcare
	has hear good reviews about Westmount clinic in mall from friends
	health service use
	long wait times at Victoria Hospital, disorganized, needs change
	minimal use of health services: family doctor, dentist, routine check-ups
	pharmacy is easy to work with
	positive experiences with doctor
	really likes St. Elizabeth's Clinic
	Shoppers Drug Mart
	Shoppers is great - very accessible
	skeptical about medications
	St. Elizabeth clinic helped her a lot
	St. Joe's very quick
	switched doctor - good experience
	VON nurse
	VON nurse came 2-3 times per week during recovery
	worried about medication side effects

		<p>the community.</p> <p>2.1.3 Satisfaction</p> <p>Definition: any expressed content, satisfaction, or good experiences with community supports.</p> <p>2.1.4 Gaps</p> <p>Definition: any expressed dissatisfaction or suggested improvements with regards to community supports.</p> <p>2.2 Informal Community Support (social supports)</p> <p>2.2.1 Community Membership</p> <p>Definition: membership in community groups that may provide support to the individual.</p> <p>2.2.2 Sense of Community</p> <p>Definition: a sense of belonging; a mutual sense of significance and importance (community members to the community and the community to the members); belief that community members' needs will be addressed and fulfilled; the importance of a shared emotional connection between the members and the community (McMillan & Chavis, 1986).</p>	<p>tasks around the home, help with outdoor maintenance, Meals on Wheels, Connect Care, frozen meals delivery, don't use many community supports, help with light housework, not much outside help is needed, library.</p> <p>Examples: things are working well, banks are easy to work with, likes private cleaning service, enjoys frozen meals that are delivered, Connect Care provides peace of mind, good experiences with cleaning services, happy with services available.</p> <p>Examples: not many supports available within the community, change of grocery store quality in the Westmount Mall, would like a weekly bus service to run errands, need for accessible transportation for people with mobility issues.</p> <p>Examples: community groups, community clubs, being part of a church community, apartment building gatherings, social groups.</p> <p>Examples: Berkshire Club, Westmount Gathering, Boys and Girls Club, apartment building groups, being part of different church communities.</p> <p>Examples: Westmount is the best place to live, it's a nice area, the people are polite and friendly, if the bus was overcrowded a young person would give me their seat, Westmount has everything, I like the area alright, Westmount Mall acting as a central hub for the community, Westmount Gathering, Berkshire Club, Apartment Building Gatherings, services that bring people together, feeling like community has not made an effort to address the needs of physical limitations, "I really don't think there is any support system here, at all [within the community]."</p>
3	Informal Supports	<p>Definition: any health or community support offered by family, friends, neighbours, or acquaintances, excluding community-based supports.</p>	<p>Examples: turns to family member when needs help (son, daughter, spouse, grandchild, etc.), support from friend groups, church community, residents of building, support from children and spouse, inability of family to provide help with home maintenance, children take them grocery shopping, children call everyday to check in, friend/family accompanying to medical appointments, friends that will bring needed items.</p>
4	Community	<p>Definition: any physical or</p>	<p>Examples: location of services is</p>

	Structure & Design		structural feature within the community that enables or impairs access to the community and its services.	convenient, all stores are close by, Westmount Mall is/was the central hub of the community, services are accessible, proximity, walkability, banks were moved further away, grocery stores are located far from the Westmount Mall, deterioration of the Westmount Mall, post office moved to inconvenient location, in winter the sidewalks are not accessible to people that need to use walkers or scooters, public washrooms are not accessible to all, curbs are too high, accessibility of some buildings is low (having to call before going), steps, bulletin boards, advertisements that enable knowledge of services.
5	Independence	5.1 Function 5.2 Self-Adaptations	Definition: level of functional independence. Definition: strategies or changes implemented (upon self, excluding hiring help or help from family and friends, as these are included under community services and informal services, respectively) to address changes in independence level.	Examples: very independent, cooks own meals, drives, goes grocery shopping, not so independent, reliant on others, not able to clean house, challenges doing the house/yard work, need walker. Examples: compensation, cleaning one room per day, taking breaks, pacing oneself, setting limits.
6.	Self-Engagement	6.1 Individual Activities and Hobbies 6.2 Group Activities and Hobbies 6.3 Planning for the Future	Definition: participation (or lack of participation) in any solo everyday activities or hobbies. Definition: participation (or lack of participation) in any everyday group activities or group hobbies. Definition: any plans or lack of plans for future (potential) needs.	Examples: swimming, walking, sewing, shopping, reading, laundry, watching TV, daily exercises, puzzles, emails, Facebook. Examples: swimming, walking, bridge, Euchre, shuffleboard, shopping, craftwork, Bingo, going to the movies, playing cards, volunteering, daily exercises. Examples: “When the time comes, I’ll just figure it out”, “if I can’t drive, I don’t know what I’ll do”, looking forward to going to retirement/nursing home, wanting to age in place, no plan, uncertainty about what future will bring.
7	Social Connectedness		Definition: the quantity and the quality or richness of social relationships with family, friends, neighbours, and acquaintances.	Examples: loneliness, minimal social connections outside family unit, more social opportunities wanted, wants more friends, turn on TV for company, regular contact with family and friends, socializing, importance of family, more social opportunities wanted, tries to stay connected with others, likes to know what’s going on in world (news), family and friend connections.
8	Personal Attributes	8.1 Health Status	Definition: current or previous health situation including any features that may or may not affect	Examples: chronic conditions, mobility issues, taking multiple medications, thyroid problem, arthritis, cancer

		8.2 Personality & Attitudes	(or that have or have not affected) daily life and independence. Definition: any expression of participant’s individual character, including individual attitudes (i.e. way of thinking or feeling about something), and any factors that are very important to participant (intrinsic motivators).	diagnosis, mention of medications, previous heart attack, previous stroke. Example: caring, compassionate, schedule-driven, stubborn, timid, Big Five personality traits (extraversion, agreeableness, conscientiousness, neuroticism, and openness to experience (De Raad, 1998)), thinking health services are important, content with amount daily activities, having a positive outlook on life, “my life isn’t too exciting”, thankful, it’s important to keep active, wanting to help others, volunteering, wanting to remain independent, wanting to stay healthy, family is important.
		8.3 External Factors	Definition: any extrinsic motivators and any life events that have had significant impact in the individual’s life on a physical, emotional, or social level.	Examples: death of spouse, death of other family member, estrangement from family members, hard childhood/upbringing, car accident, spouse having dementia, car accident, serving in the war, previous engagement in sport.
9	Finances		Definition: any mention of finances or costs.	Examples: set income, cost of services, too expensive, transportation is too expensive, choosing more price-friendly grocery store, cost for Connect Care, VAC covers cleaning service.
10	Security		Definition: any mention of security in the community (to self, family, or property).	Examples: feeling safe, expressing concern about safety, safety is important, break-in, being weary of potential scams.

CURRICULUM VITAE
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EDUCATION

McMaster University
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2015-2017 BScN

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LHSC Auxiliary Educational Scholarship
London Health Sciences Centre, May 2015

Best Oral Presentation. "What are the needs of the oldest-old? The missing piece in Age-Friendly City Development." Health and Rehabilitation Sciences Graduate Research Conference. The University of Western Ontario, February 2015.

Best Oral Presentation. "What are the needs of the oldest-old? The missing piece in Age-Friendly City Development." Health and Rehabilitation Sciences Graduate Research Forum. The University of Western Ontario, February 2014.

Best Student Presentation, Cell Biology Category. "The post-translational regulation of telomerase reverse transcriptase (TERT) in human embryonic stem cells." Biology Thesis Day. The University of Western Ontario, April 2012.

Western Scholarship of Excellence
September 2008

RELATED WORK EXPERIENCE

Teaching Assistant – HS 2700 – Dr. Laura Brunton
The University of Western Ontario
September 2014 – December 2014

Teaching Assistant – HS 2700 – Dr. Treena Orchard
The University of Western Ontario
September 2013 – December 2013

Summer Assistant
Rural Ontario Medical Program
April 2012 – August 2012

Exam Proctor – Department of Biology
The University of Western Ontario
September 2011 – April 2012

ACADEMIC ACTIVITY

Research Experience

Sam Katz Community Health and Aging Research Unit: *MSc Student*
Supervisor: Dr. Marita Klooseck
September 2013 – August 2015

Betts' Stem Cell Laboratory: *Fourth Year Undergraduate Thesis Student*
Supervisor: Dr. Dean Betts
September 2011 – April 2012

Language and Speech Disorders Laboratory: *Scholar's Electives Program*
Supervisor: Dr. Janis Cardy
September 2008 – April 2009

Publications

Radan, L., Hughes, C.S., Teichroeb, J.H., Vieira Zamora, F.M., Jewer, M., Postovit, L.M., & Betts, D.H. (2014). Microenvironmental regulation of telomerase isoforms in human embryonic stem cells. *Stem Cells and Development*, 23(17), 2046-2066.

Conference Presentations

Vieira Zamora, F.M., Klooseck, M., Fitzsimmons, D., Zecevic, A., & Fleming, P. (2015). What are the needs of the oldest-old? The missing piece in age-friendly city development. Aging 2015: Innovation in Care, Networks and Communities, Ontario Gerontology Association, April 21-22, 2015, Toronto, ON. (Abstract accepted, poster presentation).

Vieira Zamora, F.M., Klooseck, M., Fitzsimmons, D., Zecevic, A., & Fleming, P. (2015). What are the needs of the oldest-old? The missing piece in age-friendly city development. 3MT (Three Minute Thesis Competition), Faculty of Health Sciences Heat, March 25, 2015, London, ON.

Vieira Zamora, F.M., Klooseck, M., Fitzsimmons, D., Zecevic, A., & Fleming, P. (2015). What are the needs of the oldest-old? The missing piece in age-friendly city development. Faculty of

Health Sciences Research Day, March 25, 2015, London, ON. (Abstract accepted, poster presentation).

Vieira Zamora, F.M., Kloseck, M., Fitzsimmons, D., Zecevic, A., & Fleming, P. (2015). What are the needs of the oldest-old? The missing piece in age-friendly city development. Health and Rehabilitation Sciences Graduate Research Conference, February 4, 2015, London, ON. (Abstract accepted, oral presentation).

Vieira Zamora, F.M., Kloseck, M., Fitzsimmons, D., Zecevic, A., & Fleming, P. (2014). What are the needs of the oldest-old? The missing piece in Age-Friendly City Development. Canadian Association on Gerontology 2014: Landscapes of Aging, October 16-18, 2014, Niagara Falls, ON. (Abstract accepted, poster presentation).

Vieira Zamora, F.M., & Kloseck, M. (2014). What are the needs of the oldest-old? The missing piece in Age-Friendly City Development. Health and Rehabilitation Sciences Graduate Research Forum, February 5, 2014, London, ON. (Abstract accepted, oral presentation).

Teichroeb, J.H., Zamora, F.M.V., & Betts, D.H. (2012). Alternative splicing of telomerase reverse transcriptase (TERT) in human embryonic stem cells. 1st Canadian Symposium on Telomeres & Genome Integrity, May 10-13, 2012, London, ON. (Abstract accepted, oral presentation by Teichroeb).

Invited Lectures

Vieira Zamora, F.M., Kloseck, M., Fitzsimmons, D., Zecevic, A., & Fleming, P. (2015). What are the needs of the oldest-old? The missing piece in age-friendly city development. Invited guest lecture, Health and Aging Graduate Seminar, The University of Western Ontario.

Brennan, D., Garcia, L., & Vieira Zamora, F.M. (2013). HA HA HAgeism. Invited guest lecture, Health and Aging Graduate Seminar, The University of Western Ontario.

VOLUNTEER EXPERIENCE

- London Health Sciences Centre, University Hospital: *ICU Volunteer*
October 2013 – September 2015
- Health and Rehabilitation Sciences Graduate Student Council: *VP Internal Communications*
September 2014 – June 2015
- Health and Rehabilitation Sciences Graduate Research Conference: *Marketing Leader*
October 2014 - February 2015
- Heart & Stroke Foundation of London
May 2014 – September 2014
- Extreme Response Canada, *Quito, Ecuador Mission*
June 2014

- The University of Western Ontario, Society of Graduate Students: *Councillor*
October 2013 – May 2014
- Alternative Spring Break Western, *Costa Rica Medical Initiative*
February 2014
- Collingwood General and Marine Hospital, *Volunteer*
May 2011 – August 2013
- Chelsea Park Retirement Residence, *Volunteer*
October 2012 – April 2013
- UWO Seniors in I.T.: *Instructor*
September 2009 – April 2012
- UWO Portuguese Connexion: *Vice President (2009-2010), President (2010-2012)*
April 2009 – April 2012
- Rural Ontario Medical Program: *Administrative Volunteer*
July 2011 – September 2011
- UWO Leadership and Mentorship (LAMP) Volunteer Committee, *Member*
September 2008 – April 2009

PROFESSIONAL DEVELOPMENT AND AFFILIATIONS

- Basic First Aid & CPR HCP, Canadian Red Cross
- Teaching Assistant Training Program, Western University, September 2013
- Certificate in University Teaching & Learning, In Progress
- The Canadian Geriatrics Society, Member
- Ontario Gerontology Association, Member
- Canadian Association on Gerontology, Member