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Executive Summary

The Institute of Aging of the Canadian Institutes of Health Research (CIHR) was honoured to present the Regional Seniors' Workshop on Research for the Prairies Region in Regina, Saskatchewan, on June 24 and 25, 2004. This Regional Seniors' Workshop on Research was the first in a series to be hosted across Canada. The workshops aim to formally initiate knowledge exchange and networking on the topic of research on aging among seniors, seniors' organizations, service providers (i.e., participants) and the Institute of Aging. More specifically, the Institute of Aging intends to:

- increase participants' awareness about the CIHR, the Institute of Aging, and regional activities related to research on aging;
- gather input on health issues that are priorities for research on aging in different Canadian regions;
- increase participants' understanding of the research process and its benefits to their lives;
- increase participants' understanding of established processes to protect individuals involved in research (ethics);
- gain insight on guiding principles and expectations for an on-going engagement strategy linking the Institute of Aging, seniors' organizations, service providers, and seniors in their communities;
- increase participants' commitment to research on aging through planned engagements, participation and support of research on aging.

The Regional Seniors' Workshop on Research for the Prairies Region offered participants a range of presentations aiming to enlighten them on the research process and the various research initiatives on aging in the Prairies Region. Other topics included ethics, turning research results into products or services, and the Canadian Longitudinal Study on Aging.

Among the networking activities, participants of the Regional Seniors' Workshop on Research for the Prairies Region took part in two breakout sessions. The first breakout session allowed participants to express their views on which health or social issues should be priorities in research on aging. The main issues that arose were isolation, access to health care, support to caregivers, and affordable, appropriate and safe housing for seniors. In the second breakout session, the participants discussed essential elements and best practices for ongoing engagement between the Institute of Aging and communities of seniors, seniors' organizations, and service providers. The strategies brought forward were: communications of research activities and results to seniors in lay terms; inclusion of various communities and not-for-profit organizations in academic research projects; and directories and marketing strategies to make information on research on aging accessible and interesting to seniors.

The Regional Seniors' Workshop on Research for the Prairies Region reached beyond its goal by allowing the Institute of Aging to gather worthwhile information that pushed the boundaries of how it defined health, and by offering participants opportunities for networking and exchange.

Word from the Scientific Director

January, 2005

In May 2003, the Institute of Aging of the Canadian Institutes of Health Research (CIHR) held a National Seniors' Forum for Research in Ottawa. The forum was designed to inform Canada's seniors about the Institute of Aging and its strategic directions, provide information on ways in which older people can be involved in research, and, most importantly, to engage forum participants in discussions of recent trends in research on aging and the identification of gaps in research. As the first step in an on-going consultative process, information on these gaps and concerns is to be brought to the scientific community to inform the future priorities of the Institute of Aging.

One of the principal outcomes of the National Forum was a recommendation that regional workshops be held across Canada to engage a broader community of seniors and governmental and voluntary organizations in these discussions. The first of these regional workshops was held in Regina in June 2004. The two-day event was organized in partnership with the Centre on Aging and Health at the University of Regina, its Director, Dr. Thomas Hadjistavropoulos, and CIHR's Institute of Health Services and Policy Research and Institute of Musculoskeletal Health and Arthritis. Over 50 seniors, representatives of seniors' organizations, advocates and governmental representatives from Manitoba, Saskatchewan and Alberta participated in these discussions.

On behalf of the National Organizing Committee, the Regional Implementation Committee and the Institute of Aging, I am pleased to present the Proceedings of the Regional Seniors' Workshop on Research for the Prairies Region. Committee members and Institute of Aging staff and volunteers are listed in the Annexes to this Report. I sincerely thank them, and the active and engaged workshop participants, for their contributions to this endeavour.

Anne Martin-Matthews
Scientific Director,
Institute of Aging

The Regional Seniors' Workshops on Research

Background

The Institute of Aging of the Canadian Institutes of Health Research (CIHR) held a National Seniors' Forum on Research in May 2003 to discuss national research priorities on aging and health with seniors and representatives of seniors' organizations across Canada. At the conclusion of the meeting, there was general agreement on the need to hold similar regional workshops across the country. Hence, the Institute of Aging (IA) is introducing a series of Regional Seniors' Workshops on Research (RSWR) across Canada. The IA wants to hear seniors' views as to the needs and the priorities in terms of research on aging across Canada. The IA also wants to connect with Canadian seniors, seniors' organizations and service providers, and find ways to stay connected. Regional workshops are to be active, interactive and relevant to seniors and those who work with seniors.

Participants

Participants of the RSWR are mainly seniors, representatives from seniors' organizations and health, social and community services providers. The number of participants at the workshop is typically limited to 50.

Objectives of the RSWR

Give participants an opportunity to:

- express which health or social issues should be priorities in research on aging;
- become familiar with various research projects on aging in their region;
- find out why taking part in research projects is important;
- be informed of their rights as participants in research and researchers' responsibility;
- help plan a strategy to connect the Institute of Aging with seniors, seniors' organizations and service providers.

Key Topics

- Turning research results into services, products or policies;
- Privacy and informed consent in research;
- The roles of seniors in research;
- Research and ethics;
- The Canadian Longitudinal Study on Aging.

Breakout Sessions

Breakout Session #1 - Regional Perspectives on Priorities in Research on Aging

The purpose of this session is to provide a forum for identification and discussion of regional health issues that should be priorities in research on aging.

Breakout Session #2 - Developing an Ongoing Engagement Strategy

The purpose of this session is to get input from participants about essential elements and best practices for ongoing interactive engagement and consultation processes between the Institute of Aging and seniors, seniors' organizations, and service providers.

Seniors' Panel: Sharing Experiences

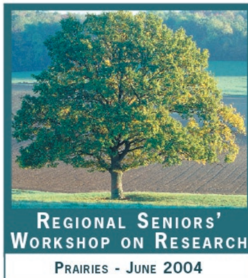
The purpose of the Seniors Panel is to increase awareness of various roles seniors can play in the research process and to promote future engagement of seniors in such a process. Four seniors who have contributed in one role or another to research on aging present their individual experiences. The presentations are followed by a question and answer period. Panel members are selected based on having experience with one or more of the following roles:

- Participants/human subjects;
- Research staff;
- Advisors on user perspectives;
- Members of research ethics boards;
- Participants in selection panels for research grants/contracts;
- Participants in identification of research needs or policy redirection;
- Participants in application or transfer of research results;
- Seniors who returned to school later in life to obtain graduate degrees and are now doing research.

For more information: **www.cihr.gc.ca/e/25710.html**

Prairies Region: Day One

Program



Day One

9:00	**Breakfast**
10:00	**Welcome Address** *Anne Martin-Matthews, Scientific Director of the Institute of Aging (IA)*
10:10	**About the Canadian Institutes of Health Research** *Anne Martin-Matthews, Scientific Director of the IA*
10:25	**Research on Aging:** **Research Programs Supported by the IA** *Anne Martin-Matthews, Scientific Director of the IA* **Making Pain Less Painful; From Conception to Results** *Thomas Hadjistavropoulos, Centre on Aging and Health, University of Regina*
11:00	**Networking Break**
11:30	**Seniors' Panel**
12:15	**Lunch**
1:30	**Breakout Sessions - Regional Issues** *Alberta, Manitoba, and Saskatchewan*
2:30	**Break**
3:00	**Breakout Sessions - Reporting**
4:00	**Impressions of Day One**
4:10 to 5:00	**Cocktail**

Canadian Institutes of Health Research Instituts de recherche en santé du Canada

Opening Remarks

The opening remarks were presented by Dr. Anne Martin-Matthews, Scientific Director, Institute of Aging. Dr. Martin-Matthews is a Professor of Family Studies in the School of Social Work and Family Studies at the University of British Columbia.

Dr. Martin-Matthews welcomed delegates to the RSWR, the first in a series of workshops to be held across Canada. She touched upon the purpose and goals of the RSWR.

About the Canadian Institutes of Health Research

Dr. Martin-Matthews presented a brief overview of the Canadian Institutes of Health Research (CIHR). Dr. Martin-Matthews noted that health research is transforming the lives of Canadians and Canada's health care system. This transformation is driven by our emerging understanding of the molecular basis of life and of human disease, and enriched by our growing appreciation of the interplay among the genetic, social, economic and environmental factors that influence our susceptibility to disease.

Similarly, the creation of CIHR has transformed the way health research is conducted in Canada. As part of the Government of Canada's commitment to research, CIHR was created in 2000 as Canada's health research funding agency. The objective of CIHR is "to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products and a strengthened Canadian health care system."

The First Three Years

In its first three years, shared Dr. Martin-Matthews, CIHR has established several initiatives to improve the health of Canadians, strengthen Canada's health care system, and contribute to a growing knowledge-based economy. They include:

- Long-term research platforms, such as the Canadian Longitudinal Study on Aging, which will provide knowledge to improve the health and quality of life of Canadian seniors;
- Programs to assist researchers in taking their discoveries to the marketplace;
- Programs on important priorities including health disparities among vulnerable populations, rural and northern health research, environmental influences on health, and injury;
- Training initiatives that will support the next generation of health researchers and provide them with the preparation they need in a collaborative, multi-expert research environment.

A Blueprint to Move into the Future

After three years of developing a vibrant health research enterprise, CIHR launched its strategic plan, entitled Blueprint 2007, which identifies five key areas on which CIHR will focus over the period of 2003 to 2008:

- Strengthen Canada's health research communities;
- Draw on research to improve the health status of vulnerable populations;
- Address emerging health challenges and develop national research platforms and initiatives;
- Develop and support a balanced research agenda that includes research on disease mechanisms, disease prevention and cure, and health promotion;

- Support health innovations that contribute to a more productive health system and prosperous economy.

Cooperation, partnership and excellence, Dr. Martin-Matthews continued, are the principles that will guide CIHR in realizing these directions. Individual researchers, research teams, universities, hospitals, the federal, provincial and territorial governments, research agencies, the voluntary health sector, health charities, industry and the public are all partners in their implementation.

A total of 13 Institutes within CIHR address domains of health research of immediate and identifiable importance to Canadians. They are each headed by a Scientific Director and guided by an Institute Advisory Board consisting of volunteers from all parts of the health community. The institutes are:

- Aboriginal Peoples' Health
- Aging
- Cancer Research
- Circulatory and Respiratory Health
- Gender and Health
- Genetics
- Health Services and Policy Research
- Human Development, Child and Youth Health
- Infection and Immunity
- Musculoskeletal Health and Arthritis
- Neurosciences, Mental Health and Addiction
- Nutrition, Metabolism and Diabetes
- Population and Public Health.

The Institute of Aging

The Institute of Aging (IA), said Dr. Martin-Matthews, supports research to promote healthy and successful aging and to address causes, prevention, screening, diagnosis, treatment, support systems and palliation for a wide range of conditions associated with aging. The fundamental goal of the IA is the advancement of knowledge in the field of aging to improve the quality of life and health of older Canadians. To achieve this goal, the IA aims to:

- lead in the development and definition of strategic research directions for Canadian research on aging;
- develop and /or support high quality research programs and initiatives related to aging;
- build research capacity in the field of aging;
- foster dissemination and exchange of knowledge and its translation into policies, interventions, services and products.

An Institute Advisory Board provides advice to the Scientific Director on strategic directions for the Institute. Board members are recruited from universities, government, the private sector, voluntary organizations and seniors groups across Canada. Current Board Members are listed in Annex D.

For more information: www.cihr-irsc.gc.ca

Research Programs Supported by the Institute of Aging

Dr. Martin-Matthews described the IA's five priority areas of research, and the percentage of research funding allocated to each in recent years:

- Healthy and successful aging: 10%
- Biological mechanisms of aging: 23%
- Cognitive impairment in aging: 30%
- Aging and maintenance of functional autonomy: 12%
- Health services and policies relating to older people: 25%.

She explained that the IA facilitates research in a variety of ways and is guided by the Institute's overall strategic orientation toward the development and support of capacity-building initiatives in the field of aging research. The Institute funds teams through Training Programs and the New Emerging Team (NET) program, and provides numerous Training and Investigator awards for those involved in research on aging.

Dr. Martin-Matthews noted that seven NET research programs were funded in 2002. One such was the "CanDrive" program, which aims to identify health-related issues associated with driving safety in seniors who have functional and medical impairments, and investigates psychosocial, cultural, language, and medical/legal issues. The program's overall goal is to develop a screening tool to assess seniors' ability to continue operating a motor vehicle. Some early outcomes of this two-year old project include the following:

- Approval of the CanDrive initiative by the Canadian Council of Motor Vehicle Transportation Administrators (CCMTVA);
- Development of a database of national researchers network;
- Steps towards goals of ensuring that decisive factors for licensing are based on skills, not just on age;
- Enlightened public attitudes about older drivers;
- Increased vehicular safety for all road users.

Dr. Martin-Matthews noted that although the CanDrive research program is based at the University of Ottawa, it does involve researchers from the Prairie Region (at the University of Alberta), and is a good example of a multi-disciplinary approach to research.

A second NET program involves tinnitus (ringing in the ears) research being done at McMaster University in Hamilton, Ontario. Researchers are assessing how brain activity is reorganized in people who suffer from tinnitus. Although this affliction affects the general population, it is more likely to occur with increased age. The goal of the research project is to create training procedures to normalize how the brain processes auditory inputs that are negatively affected by tinnitus, to evaluate the treatment and prevention potential of these procedures, and ultimately to become a clearinghouse for knowledge transfer on tinnitus research.

Knowledge translation is key to the success of any research effort. Dr. Martin-Matthews emphasized that the objective of the CIHR is to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into improved health for Canadians, more effective products and services, and an overall strengthened Canadian health care system.

The IA is complementing CIHR's overall objective by making knowledge translation an integral

part of the Institute's goals. These goals include strengthening relationships among health researchers and users of health knowledge, enhancing mechanisms for knowledge exchange, and accelerating the flow of knowledge into beneficial health applications for seniors. Dr. Martin-Matthews concluded that most research proposals funded by the Institute must have a knowledge translation strategy as an integral part of the proposal, i.e., making research results available to the appropriate user such as the public, clinicians and other health professionals, or government decision-makers.

For more information: **www.cihr.gc.ca/e/8671.html**

From Concept to Result: Making Pain Less Painful

Dr. Thomas Hadjistavropoulos, Director of the Centre on Aging and Health, University of Regina, presented "From Concept to Result: Making Pain Less Painful". The purpose of this presentation was to illustrate the complete research process using a project examining the problems and misconceptions surrounding the diagnosis and treatment of pain in the elderly and cognitively impaired.

Dr. Hadjistavropoulos observed that pain in seniors is both under-assessed and under-managed. The situation is especially serious when it involves seniors with dementia, because their pain often goes undetected. Younger adults tend to receive better diagnosis and treatment for pain, because their medical treatment is geared toward recovery and return to work. In the case of seniors, however, there is a common misconception even among medical professionals that pain is a "natural" part of aging.

Even when pain conditions are known, patients with dementia still receive less medication and attention than seniors without dementia. Psychological treatment programs for pain have proven effective in several clinical trials involving young adults, but have not usually been tailored to seniors, and especially not to seniors with dementia.

Dr. Hadjistavropoulos described the Facial Action Coding System (FACS), developed in 1978 to accurately show a trained observer when an individual is experiencing genuine pain. FACS has been validated by systematic behavioural studies involving vaccinations, blood tests, post-operative physiotherapy, and general physiotherapy. The Centre on Aging and Health also used other systematic observational procedures, examining body movements and pain-avoidance behaviours such as "guarding" and "bracing." Studies have proven that facial activity can be used to differentiate painful from non-painful conditions, and that there are no group differences based on cognitive status. Methods such as FACS are less subject to bias than unsystematic observational ratings of pain, which are sometimes based on such unscientific measures as gender, age, and even "attractiveness."

Dr. Hadjistavropoulos observed that while FACS and other observational procedures are useful for clinical trials, they are too labour intensive to be used in busy clinical settings. As a result, the Centre on Aging and Health developed the Pain Checklist for Seniors with Limited Ability to Communicate (PACSLAC). The checklist takes less than five minutes to complete, can differentiate among calm events, pain events, and non-pain-related distress events, and has been rated as useful by professionals. The checklist indicators were derived from interviews with professional caregivers, and have been validated by statistical procedures. Dr. Hadjistavropoulos noted that there is interest in translating PACSLAC into French for use in Quebec, as well as in implementing PACSLAC throughout the Regina Health District and other jurisdictions.

For more information: **http://uregina.ca/hadjistt/**

Seniors' Panel: Sharing Experiences

Chair: Sheila Laidlaw, former Head of University of New Brunswick Libraries and IA Advisory Board member.
Panelists: Dr. William Klassen, Yhetta Gold, Rosalia Robinson and Maria Reardon.

Ms. Sheila Laidlaw opened the panel discussion by noting that seniors are often seen only as recipients of services. They do not often receive information about or have an opportunity to be involved in the activities and processes surrounding research into seniors' issues. To increase awareness of various roles seniors can play in the research process and to promote future engagement of seniors in such a process, panelists were asked to speak about their personal experience of involvement in the process of research on aging.

Dr. William Klassen

Dr. William Klassen is a retired physician and geriatrics teacher from Regina. Dr. Klassen's interests encompass various topics including third age learning programs, elder abuse, and living wills. He spent decades as a physician and teaching geriatrics to other physicians. He was presented with an Honorary Life Membership on June, 15, 2004, at the Annual Meeting of the Seniors Education Centre of the Seniors' University Group of the University of Regina.

Dr William Klassen discussed the unique characteristics of seniorhood, and how they influence, or should influence, research and its outcomes. The effects of aging are profound: aging is progressive and irreversible, affecting all organs including the brain. Its effects can vary by gender, environment, disease, occupation, socio-economics, and role changes (such as retirement), and it presents numerous psychological issues. Dr. Klassen noted that while 90% of the population handles aging well, research into the impacts of aging will eventually benefit all.

Yhetta Gold

Ms. Yhetta Gold is an expert from Winnipeg on universal design (a method to create environments that adapt to a wide range of the population), a past member of the National Advisory Council on Aging and an advocate for accessibility rights for all ages. She is currently a partner in F.G. Consortium, as a consultant and advisor on disability issues. She focuses not only on the physical aspects of living environments, but lobbies for rights, education and work opportunities for the disabled or should we say, "differently abled."

Ms. Yhetta Gold described the long and intricate process of creating a building specifically for seniors, and the importance of the research undertaken by the seniors themselves in the success of the project. Seniors pulled together to build their own "apartment block" in a major residential subdivision of Winnipeg, using CMHC funding. The group faced numerous challenges, including initial resistance from bureaucrats concerned that the seniors were designing a "Cadillac building for a Ford crowd." The consortium of seniors groups organized, advertised for participants, set up a steering committee, and hired an architect to design the project with as much input as possible from seniors on the design and functionality of the units. Ms. Gold noted that "successful development depends on the quality of the research done before undertaking the project" and that "advocacy without research does not work."

Rosalia Robinson

Ms. Rosalia Robinson currently co-chairs Senior's Voice under the Elderly Friendly program; a group dedicated to the cause of "seniors helping seniors", which has created a number

of neighbourhood based initiatives in Calgary. Ms. Robinson is known for her significant volunteer contributions in diverse areas and her organizational skills derived from a successful career in business and as a graphic designer.

Ms. Rosalia Robinson of Calgary spoke about her involvement in the implementation of "The Elder Friendly Communities" program at the University of Alberta and the role that she and other seniors have played in this program. The program's goal was to assess the services and programs that local seniors wanted; the major concerns expressed by the seniors centred on health care and housing. Ms. Robinson noted that these specific neighbourhoods do not have any special housing projects for seniors, as most seniors prefer to stay in their own homes as long as possible.

Each of the four neighbourhoods organized and named a local seniors' organization, and established programs to support seniors in their homes, such as snow removal (partly staffed by volunteers). In another program, volunteers were trained to assist seniors with the paperwork necessary to apply for special needs funding available under provincial government programs. Seniors' groups also sponsor social activities in their local communities that have a broad range of ethnic diversity. Ms. Robinson concluded by saying that the Elder Friendly Communities Program is succeeding in its goal to give seniors a voice.

Maria Reardon

Ms. Maria Reardon, of Regina, is currently working on a project with "CATALIST" – the Canadian Network for Third Age Learning – that has recently been appointed as the Seniors Affiliate for Health Canada's Canadian Health Network. She builds on a career in health services management education. She is known for developing a volunteer peer teaching program for health care boards.

Ms. Maria Reardon discussed her role in investigating the sustainability of projects created for seniors with respect to the value of intergenerational commitments and seniors' volunteerism. The study investigated 46 seniors' projects, and found that levels of volunteerism were negatively influenced by the interference of other day-to-day priorities. Ms. Reardon cautioned that the number of rural volunteers is decreasing, due in large part to the aging rural population and rural depopulation. She noted that Saskatchewan leads the nation in volunteerism; the average annual contribution of Saskatchewan volunteers being 154 hours each in 2000, an increase of 15% since 1997 and equivalent to 26,000 full-time jobs. Ms. Reardon noted that First Nations Elders make a significant contribution in many areas of volunteerism, but are not widely recognized for their involvement. In conclusion, she stated that volunteering has many tangible benefits for seniors. People who are fully engaged in volunteering receive the added bonus of improved health.

Breakout Sessions: Regional Issues

Delegates broke out into groups by province (Alberta, Manitoba and Saskatchewan) to discuss and prioritize regional health issues related to research on aging. Each panel reported on its top five priority items for research to the full plenary session for discussion.

Alberta Priorities:

- Affordability of being a senior, and related issues such as costs of aging, financial situations that impact directly upon health issues.
- Care of the caregivers. Burnout is a big problem, and guilt is a big issue when care is not—or cannot—be done by a direct relative.

- Support of isolated seniors, especially the rural, the poor, and the culturally disadvantaged. Isolated seniors are very vulnerable. Research is needed to examine if “aging in place” is appropriate for everyone and on transition issues related to isolation.
- Access to the health care system. The system needs to be flattened and better integrated, with more emphasis on continuity of care.
- Seniors’ health care in hospitals, and continuity of support across sectors and services. Seniors are not treated differently than other population groups when care involves hospital stays. There is no special allowance made for seniors in recognition of their different needs.

Manitoba Priorities:

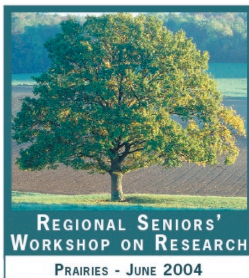
- Housing: poverty, affordability, financial security, ability to make choices, relationship of housing to health outcomes, translating existing research to local situations.
- Access to health services: speed and thoroughness, waiting list analysis by age group, rural equity of access (problem related to cost of transportation, attendants, etc.), impact of regional health authorities.
- Affordable medications: transferability of drug coverage from province to province, non-formulary drugs, generic versus patent drugs in relation to comparative effectiveness, transfer of knowledge to seniors, empowering seniors to ask the right questions concerning medications, drug testing on older people (current age limit is 59).
- Social isolation: its key indicators and components affecting quality of life and health, the role of technology (e.g. the Internet) in helping or hindering contact with the community.
- Transportation, especially in winter for isolated rural seniors, and financial benefits to assist volunteers (e.g., tax credit).
- Matching the needs of older adults to the training of health professionals, in recognition of the growing future need for medical services for seniors.

Saskatchewan Priorities:

- Housing and issues related to affordability, safety, progressive levels, security and appropriateness.
- Aboriginal health, especially in relation to the rate of diabetes in the Aboriginal population.
- Mental health, with a focus on access to psychology services, and specific treatments for the aging.
- Life-long learning and its impact on health.
- Support for caregivers, related to training and financial costs.

Prairies Region: Day Two

Program



Day Two

9:00	**Breakfast**
9:30	**Listening for Directions,** *presented by the Institute of Health Services and Policy Research*
10:00	**Recap of Day One and Agenda for Day Two**
10:15	**Regional Programs and Initiatives** *1. Carol Austin, Elder Friendly Communities Program* *2. Debra Morgan, Rural Dementia Care* *3. Betty Havens, The Aging in Manitoba Longitudinal Study*
11:00	**Networking Break**
11:30	**Breakout Sessions - Ongoing Engagement Strategy** *Group A, B and C*
12:15	**Lunch** *presentation by the Institute of Musculoskeletal Health and Arthritis*
1:15	**Breakout Sessions - Reporting**
2:00	**Ethical Issues Around the Use of Older Participants in Research: From Codes to Conduct** *Paddi O'Hara*
2:35	**From Research to Products** *Geoff Fernie*
3:00	**Networking Break**
3:30	**Canadian Longitudinal Study on Aging** *Anne Martin-Matthews, Scientific Director of the IA*
3:50	**Summary Statements** *Anne Martin-Matthews, Scientific Director of the IA*

Breakfast Presentation: Listening for Direction

Sponsored by the CIHR Institute of Health Services and Policy Research

Laurence Thompson, Health Systems Consultant, Saskatoon, Saskatchewan, led a session on Listening for Direction II, a national consultation process that seeks to identify Canadian health services and policy research priorities. The process was key in determining the implications of research on policy and funding of programs.

Mr. Thompson outlined the main research themes previously identified as priorities in the national consultations called Listening for Direction II, and asked participants to rank them according to their research priority:

- Workforce planning, training and regulation;
- Management of health care workplaces;
- Timely access to quality care for all;
- Managing for quality and safety;
- Understanding and responding to public expectations;
- Sustainable funding and ethical resource allocation;
- Governance and accountability;
- Managing and adapting to change;
- Linking care across place, time and settings (e.g. continuity of care);
- Linking "public health" to health services.

Mr. Thompson thanked participants for their contribution, and said the exercise was an experimental one aimed at further validating the IHSPR's research directions and, once results were tabulated, they would be valuable information.

For more information: www.cihr.gc.ca/e/13733.html

Regional Programs and Initiatives

Dr. Martin-Matthews moderated a series of presentations providing an overview of three significant research projects related to health and aging taking place in three separate provinces in the Prairies Region. Dr. Carol Austin, Professor in the Faculty of Social Work at the University of Calgary, presented the Elder Friendly Communities Program; Dr. Debra Morgan, Associate Professor, Institute of Agricultural Rural & Environmental Health of the College of Medicine, University of Saskatchewan, presented her five-year multi-disciplinary team project on "Strategies to Improve Care of Persons with Dementia in Rural and Remote Areas"; and Dr. Betty Havens, Professor, Department of Community Health Services, University of Manitoba, former President of the Canadian Association on Gerontology and advocate for work on aging in Canada for more than 30 years, described the Aging in Manitoba (AIM) Longitudinal Study.

Elder Friendly Communities Program

Dr. Austin explained that the Elder Friendly Communities Program (EFCP) operates in five Calgary neighbourhoods with large seniors populations. The EFCP was founded in January 2000, when representatives of the City of Calgary, the Calgary Health Region, and the Faculty of Social Work at the University of Calgary met to discuss how to increase the visibility of seniors' issues in Calgary. This ambitious collaborative effort resulted in a new senior-driven program with an agenda of research. The EFCP was based primarily on the

work of Dr. Erik Erikson on “vital involvement.” Dr. Austin quoted Erikson: “Our society confronts the challenge of drawing a large population of healthy elders into the social order in a way that productively uses their capacities. Our task will to be to envision what influences such a large contingent of elders will have on our society as healthy older people seek and even demand more vital involvement.”

EFCP focuses on creating opportunities for the vital involvement of seniors in their neighbourhoods, engaging seniors on issues important to them. It is a demonstration of senior-driven community development, a collaboration among some of the seniors’ service agencies in Calgary, and a research effort. In the neighbourhoods, seniors groups identify issues and develop projects supported by community development workers from the collaborating organizations. A steering committee and three sub-committees—fiscal, research, and communications—oversee the program. Committee membership is comprised of seniors and members from collaborating organizations. The project serves to answer:

- How does community development with seniors affect the quality of life in the neighbourhood population, the development of supportive relationships in the neighbourhood, and the development of neighbourhoods’ ability to address common concerns?
- What is the “process” of community development with seniors?
- How can collaboration among seniors, service providers and academics be strengthened?
- How does cultural diversity among seniors affect the community development process?

To date, research funding has been secured to do the initial needs assessment. The needs assessment includes first, a baseline quality-of-life telephone survey of the neighbourhoods involved and comparison of neighbourhoods, and second, a qualitative research focused on the community development process and the collaboration itself. The needs assessment is based on eight distinct themes: being valued and respected; staying active; building community; making ends meet; a place to call home, or housing and community; feeling safe; getting what individuals need; and transportation.

Research has been the key differentiating factor between EFCP and more traditional program development activities. She added that the program is now ready to move on to a specific demonstration project in another neighbourhood, where the lessons learned in the pilots will be applied, and that a replication of the EFCP is being undertaken in Adelaide, Australia.

For more information: **http://elderfriendlycommunities.org**

Rural Dementia Care

Dr. Debra Morgan reported that her five-year multi-disciplinary team project researching “Strategies to Improve Care of Persons with Dementia in Rural and Remote Areas,” is one of the New Emerging Team projects funded by the IA and partners such as the Alzheimer Society of Saskatchewan and Saskatchewan Health Research Foundation. The research has a distinctly northern focus because very little is known about dementia care in Canada’s north.

The project is a coordinated, interdisciplinary study of dementia care in rural and remote settings. It aims to first, improve the availability of specialized personnel and services that provide assessment and management of dementia; second, improve the accessibility of programs supporting formal and informal caregivers for persons with dementia; and third, improve the acceptability of services for persons with dementia and their caregivers.

Saskatchewan has a very large rural and remote population, and the highest proportion of seniors in Canada. In rural communities of 4000 individuals or less, 35% of the population is over the age of 65, compared to 22% of the population in cities. Rural communities have more seniors per capita, yet have more limited access to specialized services for dementia care.

The “flagship” project for Dr. Morgan’s team is the Rural and Remote Memory Clinic, which began in March 2004 after a lengthy consultation process. The goals of the project are to develop a streamlined, integrated clinic for assessment, diagnosis, and management of dementia, and to evaluate Telehealth as a means of providing care to individuals with dementia and their caregivers. The current six-step pattern for dementia care begins with a referral by a family physician, and ends with monitoring treatment. In contrast, the Rural & Remote Memory Clinic Process conducts pre-screening via Telehealth; a full-day multi-disciplinary assessment and diagnosis session in Saskatoon for two clients at a time. All necessary specialists see the client on that day, develop a consensus diagnosis in cooperation with the family physician via telephone, and meet with the family to discuss their findings. The follow-up process is also modified so that every alternate session is conducted via Telehealth, with the other involving travel to Saskatoon. This avoids scheduling numerous, time-consuming appointments with various specialists—often requiring frequent expensive trips to a larger centre and allows an evaluation of the quality of the Telehealth service. Important data are being collected through the project, including service availability, accessibility and acceptability. The project is also collecting information about knowledge transfer (or uptake), by comparing comfort levels and caregiver confidence before and after, and patient and caregiver measures of burden and psychological distress.

In closing, Dr. Morgan outlined other related projects her team is working on, including the evaluation of utilization of health care services by seniors with dementia in rural, remote and urban communities across the country, using Statistics Canada data. They are also working with the Alzheimer’s Society of Saskatchewan to evaluate a distance education program they have developed for rural caregivers.

For more information: http://iareh.usask.ca/

The Aging in Manitoba Longitudinal Study

Dr. Havens revealed that the Aging in Manitoba (AIM) Longitudinal Study involves a series of projects that began in 1971, and is the longest and most comprehensive study of aging in Canada. She acknowledged the participation of almost 9,000 older Manitobans over the 30 year study period. In 1971, the youngest person involved in the study was 65 years of age; in 2001, the youngest was 77 years of age.

The selected research measures used in the study include demographics, social structure, well-being and functional status, perceptions, assessed needs, and interviewer ratings. It also examines health utilization, physician visits, hospital stays, personal care homes placement (nursing homes, long-term care, etc.), home care and Pharmacare use, immunization, and vital statistics data. Dr. Havens noted that new measures have been incorporated into the study since 1971 as data became available.

Significant policy and senior-relevant opportunities arose during the AIM Studies. Researchers were able to measure the impact of the 1997 Red River floods, contribute data to the Honolulu Heart Health Study and include individuals recently affected by chronic diseases such as diabetes. They were also able to clarify unusual service use patterns, such as

incidence of flu and pneumonia related to immunization, and to maintain a study of “rare sub-populations” such as the oldest of old men.

The studies produced important findings of relevance to seniors’ health. Dr. Havens reported that active seniors tend to have more years of education and higher incomes at older ages, and social isolation is more likely for older women, those who feel their health is poor, or those who have more than four chronic illnesses. Men are less likely to use home care services—usually because they have a spouse or daughter to look after them—and those in urban areas are more likely to use home care than those in rural areas.

Dr. Havens said she was surprised by some of the study information concerning seniors who experienced Manitoba’s 1997 floods. Many older survivors who had sufficient time to prepare coped well, despite increased stress and anxiety. Cognitive functioning and self-assessed health actually improved for flood victims with the greatest exposure to the crisis.

She then listed more than 20 policy measures that had been implemented in Manitoba as a direct result of input from the AIM Study. These ranged from the removal of health care premiums for seniors in 1972, to an increased awareness of older women’s health, to increased sensitivity to older men and the loneliness some of them experience.

In closing, Dr. Havens suggested several opportunities for future research involving the AIM study: continuing research on successful aging, examining depression separately from low morale and continuing to study the prevalence of chronic conditions. She also suggested examining specific diseases that still puzzle medical professionals, such as anaemia and seniors’ housing and residential moves. Finally, it may be worthwhile to compare the AIM study to other studies, such as the National Population Health Survey (NPHS) and the Manitoba Follow-up Study (MFUS).

For more information: www.umanitoba.ca/faculties/medecine/community_health_sciences/AIM

Luncheon Presentation: The Knowledge Exchange Task Force Initiative

Sponsored by the CIHR Institute of Musculoskeletal Health and Arthritis

Flora Dell, member of the National Executive, Osteoporosis Society of Canada, presented an overview of CIHR’s Institute of Musculoskeletal Health and Arthritis (IMHA), which is dedicated to advancing the science of arthritis, musculoskeletal rehabilitation, bone, muscle, skin, and oral health. She also emphasized IMHA’s strong partner engagement philosophy and outlined its Knowledge Exchange Task Force initiative.

Ms. Dell opened by explaining that IMHA focuses on three strategic research themes: first, tissue injury, repair, and replacement; second, physical activity, mobility and health; and third, pain, disability, and chronic diseases.

Canadians are concerned about the economic and human burden of illness. While cardio-vascular illness represents 11.6% of the economic burden of illness, musculoskeletal and oral health, when combined with injuries, account for a more daunting 25%, making it a significant research priority.

Ms. Dell cited the Osteoporosis Consensus Conference as a positive example of

organizations working together. Partners included the Canadian Arthritis Network, the Arthritis Society, and IMHA, along with industry representatives and patients. The organizations jointly established research priorities and developed a research agenda based on collaborative thinking, broad consultation amongst stakeholders, and input from international researchers, patients/consumers, industry, and government. Patients/consumers were equal partners in the process, and it was through their input that "pain and fatigue" were identified as research priorities. IMHA has acted on the priorities identified at the conference, resulting in a $4.4 million investment in osteoarthritis research through New Emerging Team grants. Another outcome of the conference was the development of the Alliance for the Canadian Arthritis Program (ACAP), which focuses on access to care, research, and education.

Ms. Dell outlined and commended the work of the IMHA Knowledge Exchange Task Force (KETF), whose objective is to proactively accelerate the translation and exchange of new research knowledge among and between clinicians and patients/consumers for the benefit and improved health of all. It will develop a universal model for knowledge exchange, which will include methods for members to carry relevant research findings into their respective organizations and communities and facilitate the effective use of scientific knowledge. The process of translating new knowledge into action is very complex. To meet future challenges, IMHA must recruit a broad range of individuals who can help in the exchange and use of scientific knowledge.

Ms. Dell stated that creativity and ingenuity determine the pace and impact of research; however, the challenge now is to mobilize research to bridge the gap between what is known and what is to be done. KETF's goal is to bring together researchers and the users of research to discuss, in lay language, current research related to IMHA's focus issues, which are incorporated into the three strategic research themes.

For more information: www.cihr.gc.ca/e/13217.html

From Research to Products

Dr. Geoff Fernie, Vice President of Research, Toronto Rehabilitation Institute presented "From Research to Products", taking the audience through the steps involved in designing and marketing mobility aid products.

Dr. Fernie opened by telling participants that the total amount of research spending in Canada was about $1 billion, compared to almost $9 billion in the U.S. However, the number of patents generated per million dollars spent was approximately the same in both countries. The Canadian health care system depends on research, without which cures for new illnesses, special joints, and organ transplants would not exist. Many studies have shown that research spending is an excellent investment whether or not results are immediately apparent.

Dr. Fernie then described the steps in the journey from "problem to product" using as an example a bathtub adapted for special needs and the "Toilevator", which raises the height of a toilet at the base of the toilet, making it easier to get on and off, replacing the more common bulky portable toilet seat riser. The process involves eight distinctive steps: understanding the problem; developing concepts; building prototypes of the concepts;

developing a business case; protecting the intellectual property (i.e., new concept/idea/invention); licensing the intellectual property; completing development, testing and certification; and supporting the product, including marketing. Each of these steps has unique challenges.

Dr. Fernie told participants that when research results have promise for commercialization, mystique and secrecy surround the protection of the intellectual property and its eventual appearance in the marketplace. However, Canada's "granting system" does not permit secrecy; researchers who do not immediately disclose the results of their work risk being judged as failures and losing opportunities for future funding.

Patenting is one way to protect the intellectual property developed through research, but it is an expensive undertaking. In the case of the aforementioned bathtub, the initial U.S. patent cost $15,000, and costs have increased since. A special mobility chair developed for use in airports and other facilities cost $800,000 to launch and protect the patents. Issues such as quality control, delivery problems, and skyrocketing liability insurance costs can dramatically increase the cost of getting a product to market successfully.

Problems may also arise when seeking appropriate financial partners to help bring research products to market. Many existing large companies are not interested in assuming the risks associated with launching a new product when it is much less costly to buy-out a successful small start-up company that has the desired product in its portfolio.

Dr. Fernie declared that the time has come to build on Canada's track record of innovation with a bold, coordinated new strategy to create assistive technology that will provide greater functioning to those with physical, cognitive, and sensory deficits. This would be a win-win strategy for the research community, and would support an important emerging industrial sector. Assistive technologies are vital to the whole community, and will become more important as the population ages.

Current assistive technologies may not work well, particularly in the snow and ice of Canadian winters. More research is required to develop assistive technologies that actually work for those who need them. In order to achieve this, Dr. Fernie stated that Canada would need facilities where both research and the technology-based outcomes can be designed, tested, and developed to the point of commercialization.

The Toronto Rehabilitation Institute and the University of Toronto brought forward a concept called "iDAPT" to further this endeavour, and the first phase of the project has already been funded. The theme of iDAPT is "developing technologies for challenging environments." These environments include stairs, winter conditions, roads at night (especially in the rain), and homes. Dr. Fernie described one of the new design labs currently under development, which is being constructed 60 feet underground. It contains a huge simulator that can be used for studying balance, stairways and falls in a controlled environment. The lab is built for the purpose of understanding problems, prototyping and testing solutions, and then validating and commercializing the solutions if partners agree. It is helpful to have individuals with physical, cognitive, and mobility challenges participate in the research and the design lab.

Another potential approach for helping individuals remain in their residential environments longer and more successfully is to use rapidly developing computer monitoring technologies to facilitate and support their success. Dr. Fernie noted that computer processing power and speed double every 18 months; by the year 2017, a laptop computer will have as much computing power as the human brain.

Dr. Fernie concluded his presentation with an invitation to “Join with Us.” He joked that the Toronto Rehabilitation Institute is “disrespectful of institutional boundaries,” meaning that anyone is welcome to come and work with the team in their open environment.

For more information: **www.torontorehab.com/research/index.html**

Breakout Sessions: Ongoing Engagement Strategy

Groups were asked to list their top five recommendations for an ongoing engagement strategy aimed at connecting the IA with Canadian seniors, seniors’ organizations and service providers, and identifying mechanisms for staying connected. Three groups with a random mix of participants provided the following recommendations:

Group 1

- Have CIHR create regional community research institutes.
- Communicate in “lay language” and have the general public make presentations directly to scientific meetings to encourage understanding.
- Make low-cost grants available to include communities and allow them to gather and provide feedback.
- Have CIHR include “knowledge exchange” amongst various levels of interest as a component of granting proposals.
- Emphasize “action results” leading to recommendations and feedback.

Group 2

- Use a “knowledge broker” concept and provide for a CIHR staff person to come out, visit the regions, collect and review, prepare and synthesize knowledge, soliciting input and channel it back to the community.
- Have CIHR insist that workshops be part of the granting proposal process, so that the funding is in place to support information dissemination opportunities. Workshops would be open to policy-makers and the general public, as well as seniors and would support dialogue and provide input into future research developments.
- Develop a directory of organizations: a “who’s who” of who is doing what in terms of research in CIHR. The directory would be a tool for developing better networks on the ground.
- Use multi-media methods (not just text-based messaging), without minimizing the value of in-person meeting and face-to-face communication to provide information and receive input.
- Explore opportunities for smaller conferences, where a knowledge broker could facilitate, and work with seniors’ organizations.

Group 3

- Use a multi-pronged, multi-media approach because different people learn in different ways (print, internet, radio, TV).
- Use interactive communication processes such as community consultations, workshops.
- Look at targeting key organizations that already work with seniors.
- Have direct interaction between government policy-makers and researchers so information can be clearly communicated to those in a position to make a difference.

Dr. Paddi O'Hara, Consultant in Research and Research Ethics and an experimental psychologist and researcher from Ottawa, presented an overview of the various ethics issues relevant to research on aging.

Dr. Paddi O'Hara described research as an "enterprise," because it is a huge undertaking, potentially involving as much as 10% of the population of the country in any given year. There is a relationship of trust between researchers and participants; participants trust they will be involved in an appropriate way and be treated properly, and that the data will be valid and used appropriately. Dr. O'Hara gave an anecdotal history of the need for and development of ethics statements over the past half-century, including references to the Nuremberg Code (1947), the Declaration of Helsinki (1964), and the Belmont Report (1979).

There is no national system of oversight in Canada to ensure that research and the involvement of research participants are done appropriately; responsibility falls to the local Research Ethics Boards (REBs). REBs are found at universities and hospitals across Canada, are made up of people from various disciplines, and have no set rules or code of ethics. Dr. O'Hara said the most important step that Canada has taken in terms of codes of ethics statements was the development of the Tri-Council Policy Statement in 1998. The three federal funding agencies involved were the Medical Research Council (now the Canadian Institutes of Health Research), Social Sciences and Humanities Research Council, and Natural Sciences and Engineering Research Council. Codes of ethics existed before, but this was a major initiative to bring together the various principles and ethical concerns that affect research in biology, biomedicine, the social sciences, and humanities areas. This made it unique in the world among codes of ethics.

The code operates by requiring institutes receiving funding from these agencies to adopt the policy statement as a whole, and to insist that recipients of federal grant funding use the statement as a minimum standard. The statement is based on eight ethical principles: respect for human dignity, respect for free and informed consent, respect for vulnerable persons, respect for privacy and confidentiality, respect for justice and inclusiveness, balancing harms and benefits, minimizing harm, and maximizing benefit.

Dr. O'Hara also provided information on a study in which she is currently involved, to determine if older substitute decision-makers (i.e., an assigned decision maker when an individual has been legally assessed as not mentally capable for a particular decision) understand the content of consent forms used in research. The study involved giving a real-world sample consent form to 72 older persons to find what they understood immediately after reading it. She reported that she was particularly concerned about responses relating to understanding the potential risks of being involved in the study. Individuals did not absorb the importance of all of the potential risks described to them, such as legal problems, lack of confidentiality, and potential costs to the participant. Only 14% correctly identified the purpose of the study, and a little over one-third did not know that the participant could have any say as to whether or not they would be involved in the study.

One conclusion drawn from the study was that some sort of "triage" process might be needed in the consent process, as some people require more information than others. Another conclusion was that repetition of information and time of day consistently play a role in the ability to absorb and understand consent material. Other researchers have pointed out that patients may have perfect comprehension but fail to appreciate consequences, and that a valid way to test this is to ask participants to repeat back information in their own words.

Dr. O'Hara stated that it is important to keep in mind that there may be belief systems that determine the nature of patient interaction with researchers; participants may simply be going along with the individual whom they perceive as an authority figure in a "white coat." Voluntary consent does not necessarily indicate "informed" consent.

The Canadian Longitudinal Study on Aging

Dr. Martin-Matthews provided an overview of the proposed Canadian Longitudinal Study on Aging (CLSA).

Dr. Martin-Matthews opened by attributing the vision of the proposed CLSA entirely to Réjean Hébert, the founding Scientific Director of the IA. The CLSA concept has been in development since 2001. It is a research priority that has been identified by researchers and policy-makers alike; very few national longitudinal studies with such a broad perspective on aging have been conducted, and no such comprehensive studies. There is a continuing need to plan for seniors of today and tomorrow, and the CLSA will be an essential tool.

The CLSA is a large, national, long-term study designed to examine health patterns and trends and to identify ways to reduce disability and suffering among aging Canadians. The development of the CLSA was initiated by the Institute of Aging, and the research team is under the leadership of three principal investigators: Dr. Susan Kirkland (Dalhousie University, Nova Scotia), Dr. Parminder Raina (McMaster University, Ontario) and Dr. Christina Wolfson (McGill University, Quebec). The CLSA research team includes experts from across Canada in biomedical and clinical research, social sciences, psychology, health services and population health. The CLSA will be one of the most complete studies of its kind undertaken to date, both in Canada and around the world.

The CLSA team is also working with CIHR and Canadian experts in fields such as ethics, law and sociology, to ensure that all research is done in an ethical manner, respecting the values of Canadian society and the rights of those involved in the study. Health Canada, Statistics Canada, the Canadian Institute for Health Information, the Canadian Association on Gerontology, the Health Charities Council of Canada, Merck Frosst Canada and the other CIHR Institutes have joined in the planning and overseeing of the study's development. Because of the size and scope of the CLSA and the amount of information that will be produced, more partners will become involved as the study progresses.

The CLSA plans to follow a group of approximately 50,000 Canadian men and women aged 40 and older for a period of at least 20 years. The study will collect information on the changing biological, medical, psychological, social, and economic aspects of their lives. These factors will be studied in order to understand how, individually and in combination, they have an impact on aging. By studying adults over a number of years–before they even enter the older-age population and as they age–researchers will be better able to understand the roles these factors play in both preserving health and in the development of disease and disability.

CLSA researchers will analyze the information collected at different times over the 20 years of the study and report their findings to the public on a regular basis. The CLSA will seek Canadian men and women from age 40 years and older, from across the country, to participate in the study. Unfortunately individuals cannot volunteer to be part of the CLSA, because the study design requires that potential participants be selected at random.

Dr. Martin-Matthews concluded by reviewing the direct benefits of the CLSA which will include new knowledge on the processes and factors that affect health and aging. Health care providers and government policy makers will use this knowledge to identify ways to prevent disease, promote healthy aging and improve health services for older Canadians. The CLSA also stands to benefit Canada by contributing to:

- a healthier nation overall and better quality of life for individuals;
- a strengthened and responsive health system;
- challenging careers for young Canadians;
- rewarding work to keep our best and brightest researchers, and educators in Canada;
- rapid adoption of sound research into health practice, programs and policies;
- stimulation of economic development through discovery and innovation;
- recognition of Canada's position as an international leader in health and health research.

For more information: **www.fhs.mcmaster.ca/clsa/**

Summary Statements

Dr. Martin-Matthews summarized the proceedings of the workshop by reviewing the original objectives outlined on day one, and relating them to what had been learned and discussed:

Objective #1: Provide an opportunity to identify health issues that are priorities for research on aging in the prairies region.
Dr. Martin-Matthews felt that the breakout sessions provided valuable feedback and food for thought on regional priority health issues, and pushed the boundaries on what people typically think health issues should include (e.g., housing).

Objective #2: Increase overall awareness about research on aging, the CIHR Institute on Aging, and why research and involvement in research is important.
Dr. Martin-Matthews noted that delegates have certainly been exposed to much information on significant research programs led by researchers in the Prairies. Informal discussions with delegates reflected many favourable comments on the quality and value of the information provided.

Objective #3: Inform participants about research ethics, the obligations of researchers, and the rights of individual participants in research.
Dr. Paddi O'Hara provided a thorough historical overview and presentation of the ongoing evolution of ethics concerns in relation to research on aging.

Objective #4: Develop an ongoing engagement strategy linking the Institute of Aging, organizations, service providers, seniors and communities.
The breakout sessions identified a number of useful suggestions that the IA Advisory Board will discuss in the coming months.

Dr. Martin-Matthews thanked the individuals involved in the Regional Implementation Committee, the National Organizing Committee, the Centre for Aging and Health at the University of Regina, and the staff at the CIHR IA for their efforts in making the workshop a success. Finally, she thanked delegates for their participation.

ANNEXES

ANNEX A
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- Betty Havens, University of Manitoba;
- Jeannine Dufault, Health Canada;
- Doug Sutherland, Health Canada;
- Joan Bracken, Alzheimer Society of Saskatchewan;
- Lynda Blach, Saskatchewan Seniors Mechanism;
- Kerrie Strathy, Seniors' Education Centre, University of Regina;
- Karen Toole, Soul Seasons Counselling and Consulting;
- Edith Hockley, Calgary Senior Resource Society;
- Helen (Bubs) Coleman, National Advisory Committee on Aging;
- Patricia Raymaker, National Advisory Committee on Aging;
- Mohindar Singh, National Advisory Committee on Aging.

Annex C:
National Organizing Committee Members

- Anne Martin-Matthews, Chair, Scientific Director, Institute of Aging;
- Flora Dell, former Provincial Consultant for Special Populations in the New Brunswick Provincial Government;
- Elizabeth Esteves, Ontario Seniors' Secretariat, Ministry of Citizenship, Government of Ontario representative of Federal-Provincial-Territorial Committee of Senior's Officials;
- Sheila Laidlaw, Retired, former Head of University of New Brunswick Libraries, and Institute of Aging Advisor Board member;
- Barry McPherson, Wilfrid Laurier University, President, Canadian Association of Gerontology;
- Linda Mealing, Assistant Director, Partnerships, Institute of Aging;
- Louise Plouffe, Manager, Knowledge Development, Division of Aging and Seniors, Health Canada;
- Patricia Raymaker, National Advisory Council on Aging (Chair);
- Jean-Guy Soulière, Coordinating Committee of the National Congress of Seniors' Organizations (Chair);
- Sophie Rosa, Communications Officer, Institute of Aging.

Annex D:
Institute of Aging

The Institute Advisory Board Members:

- Dorothy Pringle (Chair), University of Toronto;
- Howard Bergman, McGill University;
- Phillip Clark, University of Rhode Island;
- Max Cynader, University of British Columbia (appointed September 2004);
- Geoffrey R. Fernie, Toronto Rehabilitation Institute;
- Yves Joanette, Institut universitaire de gériatrie de Montréal;
- Janice Keefe, Mount Saint Vincent University;
- Daniel Lai, University of Calgary;
- Sonia Lupien, Douglas Hospital Research Centre, McGill University;
- Mary Ellen Parker, Alzheimer Society of London and Middlesex;
- Louise Plouffe, Division of Aging and Seniors, Health Canada;
- Douglas Rapelje, Welland, Ontario, Consultant (appointed September 2004);
- Karl T. Riabowol, University of Calgary;
- Kenneth Rockwood, Centre for Health Care of the Elderly, Dalhousie University;
- Jane Rylett, Robarts Research Institute, London;
- Huber Warner, U.S. National Institute on Aging (appointed September 2004);
- Betty Havens, University of Manitoba (2001-2004);
- Sheila Laidlaw, former Head of the University of New Brunswick Libraries (2001-2004);
- Graydon Meneilly, University of British Columbia (2001-2004).

IA Staff:

- Anne Martin-Matthews, Scientific Director;
- Susan Crawford, Assistant Director;
- Linda Mealing, Assistant Director, Partnerships;
- Terri Bolton, Administrator;
- Sophie Rosa, Communications Officer;
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