

REGIONAL SENIORS' WORKSHOP ON RESEARCH ONTARIO

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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 Ontario in Toronto, on November 4th and 5th, 2005. This Regional Seniors' Workshop on Research was the fourth in a series to be hosted across Canada. Participants from across Ontario were invited to this important two-day event. The previous workshops aimed to formally initiate knowledge exchange and networking on the topic of research on aging among seniors, seniors' organizations, service providers, and the Institute of Aging. In Ontario, other sectors were also included: practitioners, non-governmental organizations, policy makers, and researchers. More specifically, the Institute of Aging had a number of goals for the Ontario region:

- To increase participants' awareness about the CIHR, the Institute of Aging, and regional activities related to research on aging;
- To gather input on health issues that are priorities for research on aging in different Canadian regions;
- To increase participants' understanding of the perspectives and expertise of different sectors;
- To increase participants' understanding of the research process and its benefits to their lives;
- To increase participants' understanding of established processes to protect individuals involved in research (ethics);
- To increase participants' commitment to research on aging through planned engagements, participation and support of research on aging.

The Regional Seniors' Workshop on Research for Ontario offered participants a range of presentations aiming to enlighten them on the research process and the various research initiatives on aging in the province. Other topics included research informing practice and products and the Canadian Longitudinal Study on Aging.

Among the networking activities, participants of the Regional Seniors' Workshop on Research for Ontario took part in two breakout sessions. The first allowed participants grouped by sector to express their views on which health or social issues should be priorities in research on aging. Issues common to all sectors were as follows:

- Health Promotion
- Knowledge Exchange: ensuring research findings improve the health of older adults
- Access to health services

- 
- Environments that enable quality of life
 - Diversity and inclusiveness
 - Depression

In the second breakout session participants were asked to probe deeper into the issues that were agreed to be common priorities across the different sectors through the first breakout discussions. They were asked to provide specific statements, ideas, and/or research questions on the issues, in order to guide the Institute of Aging in its future selection of priorities.

Through the hard work of all involved, the Regional Seniors' Workshop on Research for Ontario succeeded in realizing its objectives. This two-day exchange shed new light on regional and sectoral health research activities and needs, initiated discussion on processes for sharing research information, and offered participants unique opportunities for networking and dialogue.



Word from the Scientific Director - January 2006 ►►

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 ongoing 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 Regional Seniors' Workshop on Research focused on the Prairies and was held in Regina in June 2004. The second workshop gathered participants from the Atlantic region in November 2004 in Halifax. And the third, covering the British Columbian and northern Canadian communities, was held in Vancouver in March 2005.

This, the Fourth Regional Seniors' Workshop on Research, brought together key representatives from across the province of Ontario in Toronto on November 4th and 5th, 2005. Over 60 seniors, members of seniors' organizations, advocates, practitioners, non-governmental organizations, policy makers, and researchers who work on seniors' issues, participated in this two-day event.

On behalf of the National Organizing Committee, the Ontario Regional Implementation Committee and the Institute of Aging, I am pleased to present the Proceedings of the Regional Seniors' Workshop on Research for Ontario. Committee members, 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



Overview of 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 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 with respect to needs and priorities for research on aging in 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 older adults and those who work with them.

Participants

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

As the regional workshops progressed over the course of 2004 and 2005, it became apparent that including other sectors would offer participants a greater opportunity for knowledge exchange on issues of importance to seniors. For the fourth workshop, in addition to seniors, sectors working with or serving older Ontarians were invited to participate, specifically: practitioners, non-governmental organizations, policy makers, and researchers.

Objectives of the RSWR

The RSWR strive to offer participants several opportunities:

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



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: Perspectives on Priorities in Research on Aging

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

Breakout Session #2a: 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. In reviewing the input received from three diverse Canadian regions through the three earlier workshops (Prairies, Atlantic, and British Columbia), the Institute of Aging felt that this objective had been met

Breakout Session #2b: Specifying the Priorities

The purpose of this session is to probe deeper into the issues agreed to be common priorities across different sectors following the Breakout Session I. The primary outcome being the key research questions and knowledge translation proposals related to the priority in order to guide the Institute of Aging in its future development of strategic programs. This approach was used for the fourth workshop (Ontario).



RSWR for the Ontario Region: Day 1, November 4, 2005 »»

Conference Opening and Welcome

Dr. Anne Martin-Matthews, Scientific Director, Institute of Aging

Dr. Anne Martin-Matthews, Scientific Director of the Institute of Aging (IA) of the Canadian Institutes of Health Research (CIHR), opened the Ontario Regional Seniors' Workshop on Research. She welcomed the participants to the beautiful and elegant King Edward Hotel in downtown Toronto.

Dr. Anne Martin-Matthews explained that this conference was the fourth workshop in a series of five regional workshops being held across the country. The goal of the conference was primarily to gain a better understanding of which health and social issues should be priorities in research on aging. "We are consulting with regional seniors' groups," Dr. Martin-Matthews said, "to get a sense of what's important to you – to hear from you." But she also specified that it was important to the CIHR that conference participants walk away with a better understanding of what the CIHR is and how it serves Canadians.

Because of the linguistic and cultural diversity of delegates from across the province, and because no participants


indicated a need for simultaneous translation, it was agreed that the conference would be conducted in English. However, the PowerPoint presentations were projected in both English and French.

Dr. Martin-Matthews concluded by acknowledging the excellent work of the Ontario Regional Implementation Committee members, National Organizing Committee members and IA staff present (listed in Annex B, C, and F respectively).

Ms. Elizabeth Estevez, Co-Chair, Ontario Regional Implementation Committee Manager, Policy Initiatives, Ontario Seniors' Secretariat, Ministry of Citizenship, Government of Ontario representative on Federal-Provincial-Territorial Committee of Senior's Officials

Ms. Elizabeth Estevez, as Co-Chair of the Ontario Regional Implementation Committee (RIC), outlined the agenda that was designed to showcase some of the research being conducted in Ontario. She explained the importance of gaining the insight of the conference's older adult participants and said their input was crucial to informing CIHR's strategic plan.

"This conference," Ms. Estevez said, "has been organized with the goal to better serve seniors by recognizing the needs of seniors." She also highlighted the importance of organizing a well-



rounded conference. To fulfill this requirement, the CIHR invited seniors, seniors organizations, researchers, non-governmental organizations, governmental policy makers, as well as health care practitioners.

**Dr. Debby Vigoda, Co-Chair, Ontario Regional Implementation Committee
Executive Director, Ontario Gerontology Association**

Dr. Debby Vigoda, Co-Chair of the Ontario RIC, briefly discussed the importance of identifying the research priorities in the field of aging. The conference was designed to help establish those priorities. “When it comes down to it,” Dr. Vigoda said, “the common goal shared by the participants and the organizers is to improve the quality of life for older adults.”

Research on Aging in Ontario

Dr. Anne Martin-Matthews, Scientific Director, Institute of Aging

“I’m going to take a few minutes to explain what the CIHR is all about,” Dr. Anne Martin-Matthews said, “because I’m sure many of you are wondering who invited you here today, what CIHR does and how it relates to you.”


The Canadian Institutes of Health Research (CIHR) is Canada’s major health research agency. Launched in 2000, the CIHR

supports over 5,000 research projects at various universities, teaching hospitals, and research facilities.

The CIHR is a federally funded institution; it is not an advocacy organization. It disburses funds to different research projects and programs around the country, using a multidisciplinary approach. One of many advantages to being a federally funded organization is that it conducts its research according to the highest international standards. “We have a daunting mandate,” said Dr. Martin-Matthews. “How do we ensure that our research improves the life of older adults?”

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 emphasis on the “translation” of research knowledge to those who can use and benefit from it makes CIHR unique. When CIHR’s performance is evaluated and deemed successful, the essential criterion will not be solely on how much research has been funded, but also whether it translated into improved health for Canadians.

The CIHR has four areas of research: biomedical; clinical; health services and health systems; and the health of populations in societal, cultural and environmental dimensions of health.




Cooperation, partnership and excellence, Dr. Martin-Matthews continued, are the principles that guide CIHR. 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 (current Board Members of CIHR-IA are listed in Annex E). Dr. Martin-Matthews used the analogy of a jigsaw puzzle to describe the CIHR. There are 13 equally important pieces in the CIHR puzzle. Each separate Institute has its own scientific director and works independently, yet it simultaneously depends on the other institutes. The Institutes are as follows:

- 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.

People have coveted longevity and youthfulness since the beginning of time. The “fountain of youth” is not a modern-day creation. Most women live for an average of 20 years beyond the age of 65; men live an average of 16 years beyond that age. While most of those years over 65 are spent in relatively good health, a portion of them will be spent with some form of disability. The goal of the CIHR-IA is not simply to extend lifespan, but also to extend quality of life, i.e., to reduce the amount of time that people live with disabilities, be they cognitive, biological, or functional impairments.

The Institute of Aging, 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; and
- foster dissemination and exchange of knowledge and its translation into policies, interventions, services and products.



The IA focuses on five priority areas of research:

- Healthy and successful aging;
- Biological mechanisms of aging;
- Aging and maintenance of functional autonomy;
- Cognitive impairment in aging;
- Health services and policy relating to older people.

The objective is to ultimately improve the health of Canadians, to help make services and products more effective and to bridge the gap between health researchers and its users.

Dr. Martin-Matthews concluded by citing an example of one of the CIHR-IA's success stories. A team based in Hamilton, Ontario conducts research on tinnitus, a condition that causes permanent ear ringing. 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 sounds (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. Their research is having a direct and dramatic effect on their patients. They are developing prevention techniques and treatment procedures. "We want our research to be accessible to the public, not just to scientists," she said. "This is a great example of getting the information out to the public."


New Emerging Team: Canadian Driving Research Initiative for Vehicular Safety in the Elderly (CanDRIVE)

**Dr. Malcolm Man-Son-Hing, University of
Ottawa**

Dr. Malcolm Man-Son-Hing, specialist in geriatric medicine, Ottawa Hospital, and Associate Professor at the University of Ottawa's medical school, introduced conference attendees to a new program called CanDRIVE, which is funded by the CIHR-IA.

Older drivers are the fastest-growing sector of the driving population. Contrary to their reputation in the media and the commonly held misconception, the vast majority of older drivers are exceptionally safe drivers. In fact, public policy should focus more on younger drivers, whose recklessness often causes accidents with much higher casualty rates. However, older drivers do crash more on a per-mile basis. They are more likely to be involved in multiple vehicle accidents, as well as accidents at intersections. Also, older people die at a higher rate in accidents than do other sectors of the population.

CanDRIVE is studying why older people have relatively high crash rates. "What we have found," Dr. Man-Son-Hing told the audience, "is that age itself is not the issue; rather, the health problems that arise as a result of age put older drivers at greater risk." Healthy senior drivers have impeccable records;



because they have experience, they are more cautious, and they drive at slower speeds. However, certain disabilities, such as vision impairment and reduced mobility, diminish some older people's ability to operate a car safely. Other health problems, such as cardiac attacks or cerebrovascular or respiratory difficulties, can cause older drivers to lose control of their vehicles.

Research at CanDRIVE focuses on how to extend the safe driving period. It is not interested in taking the privilege of driving away from older drivers. In fact, past studies inappropriately recommended age-based licence restrictions. CanDRIVE wants to better understand how certain medical and functional impairments affect driving ability. It also wants to study how to lessen the impact of withdrawing someone's driving privileges.

CanDRIVE is a nationwide network of multidisciplinary investigators. "Our goal is to bring together researchers, seniors' groups, clinicians, the various transport ministries, as well as other non-governmental and governmental organizations, to help shape this research," said Dr. Man-Son-Hing.

Research done at CanDRIVE has involved many different stakeholders. Literature reviews have been completed, doctors have been surveyed, and on- and off-road tests have been conducted. The goal is to conduct five-year-long studies that follow older drivers and try to establish why some people crash and others do not. Researchers hope that this will lead

to a screening tool that doctors can use to assess who is at risk.


CanDRIVE estimates that its study will take a minimum of 15 years. Needless to say, more funding is required.

One question from the audience was regarding cultural considerations when studying older drivers. CanDRIVE, so far, has only divided its research into urban and rural parameters, but not cultural limitations. Dr. Man-Son-Hing agreed that it was worth considering.

Knowledge Creation and Translation

Dr. Michael Borrie, St. Joseph's Health Care, London, Ontario

Dr. Michael Borrie, a geriatrician and professor at the University of Western Ontario's medical school, presented on the subject of knowledge creation and its translation (i.e., understanding, uptake, and application in the real world). Knowledge creation arises from people's ability to ask questions and their insight into which questions need to be asked. Events in the real world are what stimulate the need to conduct further research. It is through this research that new knowledge is created. New knowledge is then shared among other researchers, practitioners, service and program providers, policy makers, and product developers. These participants then employ this newfound knowledge and apply it to their different



areas of expertise, be they developing new products or drafting new policy.

Knowledge translation then goes through several steps. First, new knowledge needs to be appraised by those who use it. Once it has been critically examined, it is either adopted or rejected. This evidence is held up against other supporting or contradicting evidence. The second step of knowledge translation is the implementation phase. Once the new evidence has been appraised and accepted, it is then implemented in a clinic, a governmental program or policy, or it is used to develop new products. This new knowledge is then put into practice. It is only through practice that it can be fully tested. But once new knowledge is put into practice, new insight into the matter is gained, which leads to more questions, which takes the process back to the beginning. In a nutshell this is scientific progress.

Dr. Borrie then described the evolution of the study of Alzheimer's disease, to illustrate how knowledge was created and translated. In 1906, Alois Alzheimer first described amyloid plaques and neurofibrillary tangles (NFTs). In the 1960s, Blessed and Roth made the connection between senility and Alzheimer's. Their insight led to further research. In the 1970s, researchers noticed a drop in specific neurotransmitter (Acetyl Choline) levels in the brain as the disease progressed. Their insight led to more research and the further dissemination of their findings.

The 1980s saw the growth of national, provincial, and local Alzheimer's societies. Caregivers and health care professionals were now becoming specialized in the field. As well, advocacy groups and fundraisers emerged, propelling the issue into the mainstream. The year 1988 marked the first international congress on Alzheimer's disease. These advancements, and others that followed, led to the development of treatments, as well as social policies that improved the quality of life of those who had the disease.

In 1997, the term "Mild Cognitive Impairment" (MCI) was first coined. Today there are hundreds of papers a year written on it. In the late 1990s, medical schools began to change their curriculum to reflect this new knowledge of Alzheimer's disease. This would never have come about without effective knowledge creation and translation.

"Our ultimate goal for health research and its translation," Dr. Borrie said, "is the compression of morbidity." If the period of time when someone is suffering can be compressed, then it goes without saying that the quality of life of older adults will be improved.



Breakout Groups: Identifying Research Needs

Delegates broke into groups by different sectors (seniors, non-governmental organizations, practitioners, policy makers, and researchers) to discuss and prioritize 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. Conference delegates were then asked to agree on the five or six themes that were common across the sectors.

Research Priorities—Seniors

There were two groups of seniors. The first group highlighted the fact that all their research priorities fell under the theme “quality of life.” They particularly wanted to point out the disparity between services that were provided to urban older adults versus those offered to rural seniors. They wanted greater access to services, supports and resources, regardless of where they live. Rural seniors often do not even have access to physicians in their own community. Greater access to physicians would undoubtedly raise the rate of early detection and diagnosis of illnesses. They also pointed to social isolation as a priority for research, which they felt stems from the lack of community centres and seniors’ centres. They also wanted more support for informal caregivers.

Financial security was its own priority and was crucial to ensuring a high quality of life. Seniors do not want to have to decide between feeding themselves and

buying personal health supplies. When a senior is healthy, their autonomy is very important to ensuring a high quality of life. This autonomy can only be ensured by financial security.


One participant asked, “Do we need more research on income and financial security, or is it just a question of advocacy?”

Another participant replied, “I think we need some more research to modernize the system. We need research to help figure out how to develop proper legislation.” As a result of effective policies, the number of poor seniors has declined from 20% to 6%.

The second group of seniors structured their priorities differently from the first group. They saw a knowledge gap when it came to musculoskeletal diseases and felt that more money and energy should be spent researching their treatment. Also, they thought that more research should be done to ensure the safety of medications and treatments.

The group also asked for more research on how to transfer knowledge to the seniors themselves. They wanted more studies into the social factors affecting health, such as housing, education, spirituality, and addiction. “We are finding that health is determined by postal codes,” the group presenter said. “How can you level the playing field between the haves and the have-nots?”

This group asked for caregivers to be better supported. They wanted caregivers to be privy to knowledge transfer.



The issue of depression was very important to this group of seniors, who saw an enormous benefit to its early detection.

Finally, the group wanted more research on how to get society to raise awareness of the needs of the seniors. They asked for research to get a better understanding of how society, as a whole, can be made more conscious of the elderly.

Research Priorities—Non-Governmental Organizations

The NGO group identified four priority areas for research. The first was regarding knowledge translation and access to information. They felt that web-based health information should be improved and identified a shortage of information that trickles down to the community level. Improvements in this area would make health care administration more efficient. The group also thought Ontario would benefit from having an ombudsman for palliative care.

The second priority area was access to services. Services are not distributed equally across the province. Also, there is a need for services to take into account the changing cultural makeup of Canada. Language barriers pose a problem in getting necessary information to seniors. Research should be conducted to understand the different barriers to accessing services.

The third research priority was to understand why some seniors live longer

than others. The NGOs were particularly interested in why seniors of one particular cultural background live longer than members of another.


As well, the group wanted researchers to take a closer look at the impact of community health services on the rest of the health system.

Research Priorities—Practitioners

The practitioners identified depression in seniors as the most pressing issue for more research. They would find their work easier if they had a clear idea of how many older adults are affected by depression. This group also wanted more research done on ways of preventing, identifying, treating, and supporting seniors with depression. The practitioners also wanted to know how to best coach the seniors' caregivers, so that they can make it easier for the individual to cope.

Their second priority issue pertained to wellness education and social programs for seniors. The questions researchers should be posing are, "Will these types of programs save health care dollars in the long run? Can we track the benefits of social programs that aim to reduce illness?"

The practitioners wanted research conducted on the benefits of specific gerontological training of health staff. Does this kind of training better equip health care workers, or is it overvalued? Finally, the practitioners wanted studies done on problematic behaviour in older



adults. What are the non-pharmacological solutions for people who live this way?

The doctors and health care workers wanted to highlight the importance of doing this research so that it reflects the entire population, including the older adult population, not just your “average” citizen. Smaller groups should be studied as well including the developmentally handicapped, First Nations, and recent immigrants.

Research Priorities—Policy makers

The policy group was most interested in more research being done on housing and long-term care facilities. Well-designed residences promote healthy lifestyles and improve quality of life. We need to ask, “Are all facilities all things to all people?”

This group wanted to know the most effective and efficient ways of transferring information and knowledge. Once they know this, protocols can be established that standardize the transfer of information. If these standards are put in place, health care workers will be in a better position to deal with their everyday issues.

More research needs to be conducted on all aspects of health and aging as it pertains to the North and rural areas. Service provision, transportation, and housing are completely different issues to those living outside of urban centres, than they are to those living inside. Because most policy makers live in major urban centres, they lack that necessary information.

Finally, the term “knowledge translation” should be taken more literally. The information gathered by the researchers must be “translated” so that it is understood by everyone, not just those who exist in the world of science or academia. Caregivers, policy makers, and the average citizen will benefit from the findings of groups like the CIHR-IA. However, those findings are useless to them if they cannot understand the report.

One other issue that should be studied (and certainly not ignored) is the potential of a two-tiered health care system. How will a two-tiered system affect seniors?

Research Priorities—Researchers

The researchers divided their priorities into four categories: health services, diversity, knowledge translation, and biomedical.

Priorities for health services

- Undertake more research on transportation, housing, chronic care and home care.
- Undertake more research on continuing care, especially the integration of different aspects of caregiving (from the hospitals, to the long-term facilities, to the families).
- Include ethics in any study of health services.
- Study the “experience of illness” and how it affects the delivery of health services.
- Explore the effects, whatever they may be, of placing more emphasis on prevention.



Diversity

- Undertake more research to understand the barriers created through cultural/ethnic differences.
- Examine ways in which these barriers can be torn down.

Knowledge translation

- Evaluate medical and non-medical interventions.
- Assess the current curriculum, as it pertains to senior citizens, for all people involved in delivering care to seniors.
- Gain better understanding of how to make this information accessible to all.

Biomedical research

- Conduct more research on the basic biological mechanisms of aging (stem cell, vaccines, etc.).

Discussion on Common Themes

The conference attendees then identified themes noted by more than one group. They specified the following as an initial list of common themes:

- Knowledge transfer and translation. This was considered very important. Particular emphasis was placed on the continued translation of knowledge through all stages.
- Biomedical research and cellular study. This was particularly important among physicians.
- Prevention and wellness. This theme was mentioned by four of the six groups. As one participant noted, “We look at illness before we look at why people are healthy. But shouldn’t we

find out why some people age well? Is it environment? Is it their lifestyle?”

- Finding information/making information more accessible
- Access to health services
- Multiculturalism. Making the health care system accessible to seniors from different cultural heritages or who speak different languages was deemed significant.
- Including seniors in the decision-making process. Senior participation should not be limited to a handful of regional workshops.
- Depression among seniors

The above input was collated and synthesized to create a list of six common themes. They were as follows:

- Health Promotion
- Knowledge Exchange: ensuring research findings improve the health of older adults
- Access to health services
- Environments that enable quality of life (housing, design, recreation, etc.)
- Diversity and inclusiveness
- Depression



Unlocking the Secrets of Longevity

Dr. Gabrielle Boulianne, Senior Scientist, Hospital for Sick Children and Professor, University of Toronto

Dr. Gabrielle Boulianne presented what she called a “taste” of her lab research to “open up questions for participants to think about in an informal way.” She noted that society has become obsessed with youthfulness, as many books, magazines and anti-aging products demonstrate. While there is a push to live longer and to control or even stop the aging process, Dr. Boulianne wants to consider quality of life as well. “How long will we live?” she asked. If we live longer lives, *how* will we live?

Dr. Boulianne is interested in maintaining levels of mobility during aging so that older people can engage in activities such as cycling and golfing. She defined successful aging as being healthy for a longer period of time.

In her professional research, Dr. Boulianne became interested in the question of what determines how long we live. Is it possible to extend our lifespan? And, given the potential to extend the lifespan through science, “do we really want to”? She asked the audience to consider the implications of such research.


Dr. Boulianne’s work as a scientist has included the study of particular organisms that are “model systems” because of their very fast life cycle – primarily worms

(*c. elegans*) and fruit flies (*Drosophila*). Both species have now been “genome sequenced,” so scientists have detailed knowledge of the number and functions of their genes. While a connection between human health and the lives of worms and flies may not be immediately evident, Dr. Boulianne pointed out that 70% of the genes that cause disease in humans are present in these organisms.

“Is the aging process in flies similar to that in humans?” she asked. The “lifespan curve” is one element that is similar among all organisms, though it occurs over different time spans. The similarity in shape of the lifespan curve suggests that the underlying processes are the same for humans and other organisms.

What causes the initial decline in health (which is always a part of the lifespan curve)? What determines the ultimate length of our lives? Can we actually live to be 120 years old or 200 years old? These are key questions for Dr. Boulianne’s work.

Her research explored the question of what controls lifespans. Looking at the fruit fly (*Drosophila*), there are two key environmental factors that affect lifespan: temperature and caloric intake. For fruit flies, cooler temperatures and lower caloric intake extend lifespan by affecting the metabolic rate and “oxidative damage.” Dr. Boulianne pursued a number of experiments in her research with fruit flies to explore the role of oxidative damage and oxygen defence mechanisms in the lifespan.



Working with the population studies method, which can select for populations of flies that have extended lifespans, she was able to test the levels of defence mechanisms in flies that lived longer. Dr. Boulianne found that these flies were also resistant to a number of stress factors including high temperature and reactive oxygen levels. Her studies suggested a link between oxidative damage and lifespan.

Studies of human neurodegenerative diseases suggest that the nervous system may be particularly sensitive to oxidative damage. Such damage is also associated with other neurodegenerative diseases, such as Alzheimer's disease.

Dr. Boulianne's research with flies suggests that the nervous system may be an important cellular target for aging, with implications for human nervous systems. She experimented with the nervous systems of flies, removing and adding genes to the nervous system, and found that certain genes did increase the lifespan of flies.

Other scientists are also researching mutations in flies and worms that affect lifespan. Now we are starting to identify specific genes that affect aging and health, she said.

These developments in scientific research have brought us to a crossroads. If scientists can identify genes, what are the implications? What should be the role of aging research – long life or improved quality of life? "If we could delay the onset of age-related symptoms, that would be a good thing," said Dr. Boulianne.

She concluded with the statement that research on extending human life has serious social implications, such as the age of retirement and the economic impact of living longer.


Discussion

One participant asked how scientists could actually put genes back into flies, given that they are so small. Dr. Boulianne explained that substances are injected into the embryo of the fly and so become part of the fly's genetic makeup.

Another participant said that, while she admires Dr. Boulianne's work, in her view, scientific advances are developing faster than the sociological changes needed to address them. The speaker said she did not want to extend old age if it was extending a period of "lonely, debilitated, and purposeless life."

Dr. Boulianne agreed that it is important to ask what we want as we age. We want physical health and mental clarity, she suggested. It is our responsibility as scientists, she said, to tell people what is happening in science so that society can be proactive and think about the implications and plan around it.

A participant raised a concern about limits to scientific research that alters genes. "You talk about changing one gene," he said, "but what's after that?" There is research out there that changes the hormonal structure of animals. What else is going on?



Dr. Boulianne responded by noting that flies and worms are her area of specialty as model systems. Other researchers are looking at septuagenarians, such as a group of nuns in France and another in Minnesota. With human studies, scientists are looking for correlations with other organisms, but they can't yet say for sure what those are.

Another participant asked if Dr. Boulianne had seen differences between male and female flies. "Yes, there are differences," she answered. Female flies live longer. But if scientists change the environment, they can change that. People have heard that married men live longer than single men; the same is true for flies.

Another participant asked if Dr. Boulianne was looking at environmental factors, such as smoking and pollution. Environmental factors do play a role, she answered. There is a complex combination of factors for aging and disease in humans. It is hard to control all the factors, even in the environment of flies. Scientists tend to go for the "lowest-hanging apple" – something they can get a handle on to glean insight when they don't understand the whole picture.

Another participant asked, "How does your work reflect on research in mice?"

Dr. Boulianne explained that mice are harder to study, take longer because of their life cycle and are more expensive in the laboratory. She uses information from flies and applies what she has learned to studies of mice. The research findings complement each other. She can also

collaborate with other researchers to share information about mice, flies and worms, she responded.

Another participant said he wanted to return to the quality-of-life issue. He had worked professionally in long-term care and noted that when he started his career, the average life expectancy of those in his care was 72, and when he retired it was 86. "Can you marry the research with assurance that added years have quality?" he asked.

Dr. Boulianne said that, in her research, the long-lived strains of flies and worms are also healthier in that they are active for a longer period. This is also turning out to be the case with mice, she added. So this suggests that they live longer and better at the same time. "I would argue that this will turn out to be the case for humans," she proposed.

Dr. Debbie Vigoda closed the session by thanking Dr. Boulianne and saying that she would never look at a fruit fly in the same way again.



RSWR for the Ontario Region: Day 2, November 5, 2005 ▶▶

New Emerging Team: Individualizing Pharmacotherapy for Seniors

Dr. Lisa Dolovich, Associate Professor,
McMaster University

Dr. Lisa Dolovich gave an overview of the Team for Individualizing Pharmacotherapy in Primary Care for Seniors (TIPPS), which is funded by the CIHR Institute of Aging. TIPPS brings together researchers with diverse backgrounds to focus on medication use by seniors in primary care.

Dr. Dolovich noted that the complexity of medication use is a starting point for a deeper understanding of the medication use process. TIPPS' work to date has identified that there is no single solution. Instead, interventions require combined strategies.

TIPPS is comprised of a number of main investigators from a wide variety of backgrounds including family medicine, clinical pharmacology, sociology, nursing, geriatrics, internal medicine, epidemiology, biostatistics and pharmacy. A multidisciplinary team enriches the solutions, Dr. Dolovich said.

TIPPS has four primary components:

- A number of research projects, ranging in scale from small, local initiatives to large, multi-centre projects;
- A network of patients, physicians, pharmacists and nurses;
- A partnership synergy;
- The training of graduate and postgraduate students.


The conceptual framework focuses on the psychological and informational aspects of drug prescribing, decision-making and use in seniors. The goal is to get to real-world solutions, Dr. Dolovich explained.

TIPPS currently has 55 projects. The broad themes of TIPPS projects are a set of interconnecting aspects of drug use by seniors:

- Policy relevance/needs;
- Evidence-based content;
- Communicating and decision-making;
- Improving patient and provider appraisal skills;
- Integrating providers in the health system;
- Information technology;
- Patient outcomes.

Dr. Dolovich briefly outlined three TIPPS projects:

- Computerization of Medical Practice for the Enhancement of Therapeutic Effectiveness (COMPETE). This project focuses on diabetes and cardiovascular disease. It involves the development,



implementation and evaluation of integrated elements of primary care Electronic Medical Records (EMR).

- Community Hypertension Awareness Program (CHAP). This program aims to improve blood pressure management by improving collaboration and decision-making among professionals. Innovations include volunteer peer health educators, community engagement and an interactive patient website. TIPPS hopes to take this program community-wide in Ontario.
- Integrating Medicine and Pharmacy to Advance Primary Care Therapeutics (IMPACT). This project brings pharmacists and family physicians together to identify drug-related issues. The pharmacists' main service will be individual patient assessments to identify, prevent or resolve drug-related problems. The process of integration, pharmacist service uptake, drug-related patient outcomes and the costs associated with program setup and implementation for sustainability will be evaluated.

Dr. Dolovich noted that the research TIPPS is currently doing is often “messy and complicated” but needs to be done.

Other projects are in the development or pilot project stage. These include research on drug dosing, pain management, improving decision-making in medication adherence, insulin use in the context of insulin under-use, blood thinner drugs and treatment of depression.

The main question that informs TIPPS' research is what do patients think about

when taking medications? Dr. Dolovich said there is a need for better monitoring of drug use after prescription, such as kidney functioning and side effects, so follow-up can take place.

Next steps for TIPPS, in addition to completing current research projects, are to look at “key learnings to date,” to integrate other disciplines into TIPPS, to improve the dissemination of research, to continue to develop the training program and to work across the country. Dr. Dolovich proposed that this work is generalizable across groups of seniors. At age 65, she explained, Ontarians on average take eight medications including over-the-counter drugs.


Discussion

One participant asked about getting community health providers on board as partners. Community agencies are well placed to help.

Dr. Dolovich said this is something TIPPS could expand to. It is trying to take advantage of community pharmacy, she added, and it wants to have doctors send patients to community pharmacies for education.

Another participant suggested that TIPPS could expand beyond primary care.

Dr. Dolovich said primary care is where medication management happens. To identify medical problems in Canada, researchers have not historically looked at primary care in the way that TIPPS is doing. They need to look at medication



use across conditions, she said, because often people are prescribed for one condition without seeing how it will affect another condition.

Another participant raised a concern about the over-medication of seniors. She said her grandmother was very mentally bright when she went into residential care at the age of 99. On her 100th birthday, though, she was not even aware she was having a birthday, because they “had her doped up too much.”

Dr. Dolovich replied that there are many challenges in long-term care facilities. Sometimes drugs are over-used, yet at other times they are under-used. Doctors need medication assessment to be sure to get the right mix, she suggested.

Dr. Debbie Vigoda thanked Dr. Dolovich and noted that her emphasis on partnerships and collaborative understanding tied in with much of what had been said the day before.


Breakout Groups: Specifying the Priorities

The purpose of this second breakout session was to identify the key research questions that will serve to address the six common issues determined in the first Breakout Session on Day One. Each group had a balanced representation of the different sectors and was asked to probe deeper into the six issues, defining research questions or knowledge translation challenges specific to each. The outcome would serve to guide the Institute of Aging in its future development of strategic programs. The six groups then reported back to plenary.

Depression

The group presented a summary statement of its discussion: “Beyond psychiatric research, there is not enough research being done on depression in Canada that is specifically related to the aged population.” The group identified key areas on which research needs to focus:

- The causes, risks, factors and strategies for the prevention of various types of depression. The scope of investigation should include both biological and environmental impacts. For example, is isolation a cause or a result of depression?
- Education and training – including increasing awareness, knowledge translation and outreach for physicians and family members, particularly about the double stigma attached to mental health issues in older people.

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- Identification and screening. These practices need to differentiate depression from other conditions and co-morbidities using appropriate screening tools.
 - Treatment, drugs, programs. Age-sensitive treatments are necessary, and the issue of acceptance of treatment by the older person must be addressed.

Health Promotion

The group summarized its discussion by looking at the question of health promotion from an individual and a systems level.

The Individual Level:

- Health promotion, information and services exist. Why are they not reaching all seniors?
- Researchers need to know what works and what doesn't, and why. Barriers include lack of transportation; language and modes of communication, such as the difference between face-to-face or telephone contact; font size; etc.

The Institutional Level:

- The group noted the new Minister of Health Promotion, Jim Watson.
- There is a need to review current policies and programs to see whether they include a seniors' lens. Too often, there is a heavy focus on healthy youth.
- There is also a need to ensure that studies, initiatives and programs include seniors.
- Look at best practices among seniors.

Discussion

One participant asked whether gender had been raised in the group discussion. He suggested that gender must be addressed in health promotion, because there are some cultures in which women are uncomfortable seeking help from a male doctor.

Access to Health Services


The group proposed two questions that need to be asked by the Institute of Aging about access to health services.

First, from the perspective of seniors living in the community, how can access to information and services be optimized? The group suggested that this issue includes single and multiple accesses to services and the use of local and informal systems. Seniors who are well and those currently in need of services should be included.

Second, from the perspective of seniors living in the community, what are the unmet needs for services?

A qualitative methodology should be employed to gain answers to both questions. Rather than the Institute of Aging gathering information solely from databases, the CIHR-IA should conduct personal interviews.

The issue of knowledge translation was raised. The group proposed that research results will help everyone understand what actions are needed. Groups that



need to be informed about research results include policy makers, planners, and seniors.

Seniors will want to see change and would like to receive a note to inform them of the results of IA research.

Discussion

One participant suggested adding “practitioners” to the list of those who need to be informed about research.

Knowledge Exchange: Ensuring Research Findings Improve the Health of Older Adults

The group summarized its discussion in four key recommendations:

- Put in place specialized translators to disseminate information, with recognition that this requires resources.
- Recognize the effectiveness of the many forms of communication already available including television, pamphlets, the web, radio, seniors’ centres and community channels.
- Foster knowledge exchange by building strong partnerships between researchers, intermediaries and users. This will empower users and improve the health care system.
- Investigate information-seeking behaviours relating to health.

Diversity and Inclusiveness

The group outlined three key areas that need to be addressed:

- Plurality and recognition of systemic barriers. Working across social differences, there is a need for “being committed to the commitments of other people.” Within this issue there is too much token representation. It is not only ethnic minorities who need to be recognized but also people with disabilities, chronic ailments, and others. Research and the impact of research need to be culturally sensitive.
- The research gap. A large-scale review of the inclusion of minority groups is needed. There is little or no research into long-term care in other cultures, for example, the experience of ethnic minorities who have to confront unfamiliar foods and modes of recreation. Be mindful of demographics. Put ideas into action.
- Education. It is important to prepare future research candidates to conduct culturally sensitive research. This is a curriculum issue, and diversity courses need to be maintained.

Environments That Enable Quality of Life (including Housing, Design and Recreation)

The group noted that the subject of “home” had been central to their discussion:

- Knowledge translation. A comprehensive review of existing research on factors that contribute to people staying in their own home should be provided, in an understandable, accessible, useable format.

- Places where people live. Research is needed on the reasons older people have left their homes recently and moved into residential facilities. There is also a need for a contemporary understanding of seniors' relationship to housing. The boomer generation, for example, may have different reasons for moving than previous generations. Seniors' residential housing needs to be designed so that it looks like a home rather than appearing institutional, while still providing necessary supports. How can the isolation of seniors who are aging in their own homes be reduced?
- Public spaces. There is a need to look at the design of spaces including gardens, malls, beaches, streets, stores and churches, to make them senior-friendly (which means universally friendly). Designers of public spaces need to ask new questions, such as how does the design of a beach allow access across sand so that a senior can get into the water? It is also important to create scooter-friendly everyday environments, such as at the grocery store.

It was noted that cultural diversity is also a factor in the design of homes and public spaces. There is no single answer for all cultural groups.

Discussion

One participant raised two specific examples of residential design. Too often seniors cannot clean heavy carpets, he said, so carpets affect respiratory health. The location of garbage chutes close to residential units can disturb sleep.

Another participant noted that there is currently an effort underway to improve stair design for the prevention of falls. He added that a group is working on changing policies on, for example, the building code to include new standards.

One group member asked how to get that kind of information out to seniors.


A member of the depression group added that there had been lots of crossover discussion of all six breakout topics within the group. Depression crosses over all the other common themes discussed today, she said.

So No One Will Die Alone: A Study of Hospice Volunteering in Northwestern Ontario

**Mary Lou Kelley, Associate Professor,
Lakehead University**

Before starting her presentation, Mary Lou Kelley noted that it was good to see hospice care being recognized as part of the health system at the workshop. She was cautious about whether a "best practices" approach would reflect hospice volunteers in the North.

Ms. Kelley explained that the study was conducted in collaboration with Hospice Northwest and the Kenora Rainy River Hospice Palliative Care Association. The research was based on an extensive literature review and phone interviews with 14 hospice volunteer coordinators who coordinate independent but loosely connected groups throughout



Northwestern Ontario. The focus of the study was on how the programs work, who they serve, and what their volunteers do.

The study found that volunteers range in age from young to elderly. Many are former health care professionals, are known to their clients within small communities, and most have a recent experience of caring for an elderly person or someone who has died. Most volunteers did not want their volunteer work to feel like paid work. They wanted to be accountable primarily to the client and the family and were wary of outside pressures to control what they do.

The reasons volunteers do this work included a strong sense of natural, moral obligation to “our elderly,” as well as a deepened sense of meaning in life. It is important to them that their clients know they are volunteering, rather than being paid. They used phrases like “hearing their stories” and “journeying with them to the end” to describe the rewards of visiting “our elderly.”

The clients were described as primarily people who are isolated and at a high risk of dying alone. Most patients have chronic diseases and no one to care for them. Volunteers do long-term visiting with people. The time span of the relationship varies, and volunteers speak of being committed to the long-term process.

What do volunteers do? Many used the phrase “we just . . .” as in, “We just pop in and visit, so they are not alone,” to describe their work. In summary, volunteers provide compassion,


companionship, friendship, and caring. Establishing a close relationship with the client takes time, so volunteers prefer to “begin early” – years before the person dies. Success was defined as being there long enough to become “like family” before the person died.

The role of volunteers was not defined primarily by listing what they do, the study found. Instead, volunteers spoke more broadly of “being there” and “walking the road together.” Volunteer activities with the client included listening, reading, making tea, playing cards, singing together, shopping, and respite for family caregivers. Hospice volunteers are flexible and responsive to whatever the family and client want or need.

The study found that visits are often unplanned, informal, and hard to document. This can make it challenging to quantify work. The guiding principle of the work is that “no one should die alone.”

Discussion

One participant asked about the way the program is organized in terms of recruitment, retention, and qualifications of volunteers. Ms. Kelley asked Danielle Boulianne, a volunteer coordinator from Hospice Northwest, to respond. Ms. Boulianne said that recruitment takes place through local radio, churches, and posting flyers. The volunteers can have any background as long as they can “sit, listen and give.” All volunteers go through a 12-week training program. If the coordinator is concerned about a person’s ability to volunteer after the training, that person



would be counselled not to volunteer. Volunteer coordinators vary in qualifications and background, Ms. Boulianne explained. Some are retired nurses and retired teachers; one is a practicing pharmacist. Most have backgrounds in working with people. What is essential is that they are well respected in the community.

In terms of retention, Ms. Kelley noted that many are motivated to do volunteer work but not to fill in forms or attend meetings. They may “drift off” from this part of the work, but she suggested they are often still out there, doing the work, with an increased skill level.

One participant thanked the presenter for including dying as a part of health.

Another participant said she has been a hospice volunteer for 12 years, and she continues to receive training. Nothing is more rewarding than the work, she said, and just holding their hand and being with them – not providing formal health care per se.

Ms. Kelley closed the session by commenting that she has been doing volunteer work for 10 years, after making a pledge for two years, because of the personal rewards.


The Canadian Longitudinal Study on Aging

Dr. Parminder Raina, Associate Professor, Department of Clinical Epidemiology and Biostatistics, McMaster University

Dr. Parminder Raina introduced his presentation by explaining that he would describe the background of the study, where it has come from and where it is going. There is a need to study aging in Canada, because older people are increasingly making up a larger share of the population. By 2025, one out of every five Canadians (20%) will be 65 or older, compared to one out of eight (12%) in 2000. Baby boomers will begin turning 65 in 2011.

Canada’s aging population has significant implications for the health care system and social programs. The need for evidence-based decision-making and new knowledge is therefore becoming more urgent.

Dr. Raina discussed the complexity of the aging process, which brings about a need for interdisciplinary, long-term studies of aging. The Canadian Longitudinal Study on Aging (CLSA) will examine aging as a dynamic process and will emphasize healthy/successful aging. It will be important to delineate what is “normal” in the aging process (primary aging) and where susceptibility to disease (secondary aging) enters. Genes, nutrition, lifestyle, environment, and chance all play a role in aging but typically, they are studied in isolation. In determining how these



factors interrelate, the innovative study design offered by the CLSA will advance knowledge of aging and health, as well as inform health and social policy.

The study will focus on a group of 50,000 individuals, composed of women and men aged 40 and over. Study participants will be measured every three years over a 20-year period. The research findings will become public data. Data will be released in stages, so the public does not have to wait 20 years.

The issues the CLSA will examine include a number of functions and conditions that make up physical health, psychological health, and social health. Biological issues, such as the genetics of aging, will be examined along with behaviours such as sleep and nutrition, and the use of health services.

The CLSA will collect both active and passive data. Active data collection includes telephone and face-to-face interviews and clinical examinations. Passive data collection will use existing databases, such as medical records. Information about climate, pollution, and neighbourhood characteristics provided by census and municipal data will also be collected. Researchers will also look at quality of life and pain issues.

Dr. Raina noted that the study raises a number of ethical and privacy questions, such as the legal implications of the capacity to consent. These are difficult questions to resolve. If cell lines are taken from biological samples, for example,

who owns them? Facilitating public access of CLSA data also raises ethical issues about privacy, confidentiality, and data ownership. A special committee to address ethical, legal, and societal issues has been set up by the CIHR.


The CLSA will benefit Canadians by providing new knowledge about health and aging, by identifying ways to prevent disease and by adopting new research into practice and policies. The CLSA will provide opportunities for researchers, in Canada and around the world. It will create recognition of Canada's position as a leader in health care research and will stimulate the economy through discovery and innovation.

The principal investigators for the study are Dr. Raina of McMaster University, Dr. Susan Kirkland of Dalhousie University, and Dr. Christina Wolfson of McGill University. The CLSA research team includes 180 co-investigators from 26 universities across Canada. Dr. Raina acknowledged the CIHR's support for the CLSA, mentioning Dr. Anne Martin-Matthews, Dr. Alan Bernstein, President of CIHR, the CIHR Governing Council, and all the other institutes. Dr. Raina cautioned that the CLSA is not yet a "done deal." Seed funding has come from the CIHR, but the CLSA is too large a project for any one funding agency. The proposal will soon be taken to the Federal Cabinet with a request for full support.

The proposed CLSA launch date is 2008, with initial data results envisaged by 2010. Dr. Raina invited participants to visit the



CLSA website at

 <http://www.fhs.mcmaster.ca/clsa>
or to email him at praina@mcmaster.ca for
information.

Remarks by Mario Sergio, Parliamentary Assistant to the Ontario Minister Responsible for Seniors

Ms. Elizabeth Esteves introduced Mr. Mario Sergio, Parliamentary Assistant to the Ontario Minister Responsible for Seniors. She noted that Mr. Sergio is an advocate for seniors' issues and is the Co-Chair of a newly established Committee on Alzheimer's and Dementia.

Mr. Sergio expressed greetings from Premier McGuinty's office. In light of the anticipated increase of seniors in Ontario from 1.6 million in 2005 to 3.6 million in 2031, there is a need for a coordinated approach at all three levels of government. Government bodies must collaborate with each other and listen to seniors.

"As important as listening is, action is also required," Mr. Sergio said. He provided a few examples of action on the part of the provincial government, such as the Ontario Strategy to Combat Elder Abuse and the Ontario Strategy on Alzheimer's and Related Dementia. The partnerships between government and community stakeholders in these two initiatives have become a model of successful collaboration, he suggested. The Alzheimer's Knowledge Exchange (AKE),

a web-based forum, will provide a vehicle to help coordinate people and services. There is also an online resource called the "Seniors Portal."

Earlier this year, the Minister of Health and Long-Term Care for Ontario, George Smitherman, launched the Ontario Health Council to produce reports on how the health care system is functioning. The first report is due in 2006. The council is part of the government's plan to deliver on three key items: keep Ontarians healthy, reduce waiting times for health services, and achieve better access to doctors and services. In conclusion, Mr. Sergio thanked workshop participants for their work.



Closing Remarks

Dr. Vigoda made a few closing remarks. She noted that participants had heard seven outstanding presentations and had identified issues they felt were key research questions. “You provided direction to the Institute of Aging,” she said. “I heard a loud message to share results beyond immediate colleagues.”

Dr. Martin-Matthews addressed two questions that she noted had been raised during the conference. First, she provided more specificity about the idea of “healthy and successful aging.” This term is not meant to imply the absence of illness or of chronic conditions, she said. Rather, its focus is “on optimizing quality of life even when chronic illness is present; adding quality of life to years.” Second, Dr. Martin-Matthews presented a chart to answer participants’ questions about the findings of the consultations conducted in other regions of Canada.

Dr. Martin-Matthews said she heard a message at the workshop about “the desire of participants to be part of research” and to know the results of research supported by CIHR-IA funds. The final report will be formatted in a way that is accessible to participants, she said. Dr. Martin-Matthews also noted that the report will circulate among members of the National Organizing Committee of the workshops.

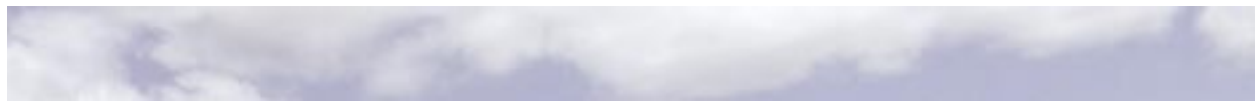
To close, she acknowledged a number of people and thanked them for giving their time. She first thanked the participants for their active presence. She noted

her awareness of the importance of hosting this event in a senior-friendly environment. The number of stairs within the conference floor was not evident on floor plans before arrival, she explained; otherwise a different site would have been selected.

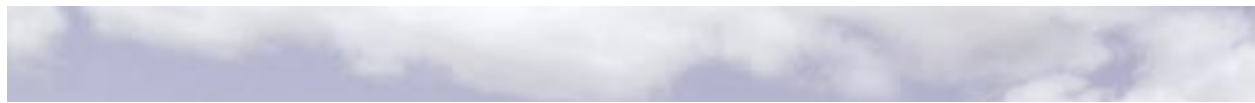
Dr. Martin-Matthews thanked the staff of the IA: Susan Crawford, Linda Mealing and Rowena Tate. She thanked Chantal Laflamme, Kathryn Andrews-Clay and Loretta Wong. She also thanked members of the Ontario Regional Implementation Committee and its two Co-Chairs: Elizabeth Esteves and Debbie Vigoda.

Annex A: Ontario Participants

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Annex B: Ontario Regional Implementation Committee Members

- **Elizabeth Esteves** (Co-Chair), Manager, Policy Initiatives, Ontario Seniors' Secretariat
- **Debby Vigoda** (Co-Chair), Executive Director, Ontario Gerontology Association
- **Joan Barham**, Executive Director, Halton Hills Community Support and Information
- **Max Beck**, National Executive Director, Easter Seals/March of Dimes National Council
- **Amy Go**, Executive Director, Yee Hong Centre for Geriatric Care
- **Melanie Hess**, Senior Policy Analyst, Social Development Canada
- **Mary Lou Kelley**, Graduate Coordinator, Gerontology, Lakehead University
- **Roland Lecomte**, Director, Gerontology Program, University of Ottawa
- **Richard Mayer**, Président Provincial, Fédération des aînés et des retraités francophones de l'Ontario (FAFO)
- **Judy Muzzi**, President, United Senior Citizens of Ontario
- **Douglas Rapelje**, Consultant
- **Linda Stebbins**, Alzheimer Society of Ontario

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 Seniors' Officials
- **Sheila Laidlaw**, Retired, former Head of University of New Brunswick Libraries, and Institute of Aging Advisory Board member
- **Barry McPherson**, Wilfrid Laurier University, President, 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**, Post-Chair, National Advisory Council on Aging
- **Jean-Guy Soulière**, Chair, Coordinating Committee of the National Congress of Seniors' Organizations
- **Sophie Rosa**, Communications Officer, Institute of Aging

Annex D: Facilitators and Speakers

Facilitators

- **Kathryn Andrews-Clay**, Partnership Specialist, Canadian Institutes of Health Research
- **Joan Barham**, Ontario Regional Implementation Committee member
- **Melanie Hess**, Ontario Regional Implementation Committee member
- **Richard Mayer**, Ontario Regional Implementation Committee member
- **Dorothy Pringle**, Institute of Aging – Institute Advisory Board member

Speakers

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- **Howard Bergman** (Chair), McGill University
- **Philip Clark**, University of Rhode Island
- **Max Cynader**, University of British Columbia
- **Carole Anne Esterbrooks**, University of Alberta
- **Janice Keefe**, Mount Saint Vincent University
- **Daniel Lai**, University of Calgary
- **Sonia Lupien**, Douglas Hospital Research Centre, McGill University
- **Verena Menec**, University of Manitoba
- **Mary Ellen Parker**, Alzheimer Society of London and Middlesex
- **Hélène Payette**, Université de Sherbrooke
- **Louise Plouffe**, Division of Aging and Seniors, Health Canada
- **Dorothy Pringle** (Past Chair), University of Toronto
- **Douglas Rapelje**, Consultant
- **Kenneth Rockwood**, Centre for Health Care of the Elderly, Dalhousie University
- **Jane Rylett** (Vice-Chair), Robarts Research Institute
- **Huber Warner**, University of Minnesota



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