

**Workshop on Healthy Aging**

**November 28-30, 2001**

**Part I: Aging and Health Practices**

*Our mission is to help the people of Canada  
maintain and improve their health.*

**Health Canada**

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## Foreword

In November 2001, Health Canada's Division of Aging and Seniors convened experts, non-governmental stakeholders and governmental representatives to a **Workshop on Healthy Aging**. The first part of the workshop – the object of this report – examined aging and health practices, while the second part (featured in a companion report) focussed on seniors and diabetes. Through the *Workshop on Healthy Aging: Aging and Health Practices*, the Division sought advice on strategic directions and priority areas for action on key issues contributing to healthy aging. The *Workshop on Healthy Aging: Aging and Health Practices* was a building block to the creation of new initiatives for seniors, itself built on more than a quarter-century of experience by Health Canada in the area of health promotion for older Canadians.

Many policy documents have helped shape the concept of healthy aging over time: from *A New Perspective on the Health of Canadians* (1974), which recognized that promoting health requires more than treating illness; through the *Ottawa Charter for Health Promotion* (1986) and *Achieving Health For All: A Framework for Health Promotion* (1986), which identified five key strategies for creating health; to *Strategies for Population Health: Investing in the Health of Canadians* (1996), which specified the importance of the broad determinants of health. In the context of these influential papers, Health Canada came to describe “healthy aging” as:

*A lifelong process of optimizing opportunities for improving and preserving health and physical, social and mental wellness, independence, quality of life and enhancing successful life-course transitions.*

“Healthy aging” takes a comprehensive view of health. Using a population health approach, it examines issues in a synergistic fashion, by considering the full range of determinants of health instead of concentrating on individual risk factors. It fosters policies and interventions that reduce the difficulties of daily living, notably for most vulnerable populations. The positive health outcomes it seeks are: low risk of disease and disease-related disability, high mental and physical functioning, and active engagement with life.

The evolving concept of healthy aging has been implicit in the policies and programs undertaken by Health Canada in the area of aging and seniors issues, beginning with the introduction of the New Horizons program in 1972, and continuing into recent programming using the population health approach. All the while, the development of appropriate initiatives for older Canadians

was being informed by the knowledge gained and successes met over the last thirty years. There was now a need for renewed action focussing efforts on the most crucial issues, answering emerging questions such as:

- How can Health Canada enable the achievement of healthy aging?
- What determinants of healthy aging can Health Canada most effectively address?
- What are the most effective approaches?

Starting in 1999, the Division of Aging and Seniors undertook a series of internal studies and investigations addressing these important questions and facilitating future priority setting processes in the area of healthy aging. Throughout the process, the Division solicited the expertise of issue specialists across Health Canada, and shared information with those undertaking other review and priority-setting processes.

In its main investigation, a Branch working group led by the Division of Aging and Seniors compiled lists of determinants of health based on the scientific literature, and identified a set of 34 key determinants that were the most pertinent to healthy aging. An in-house panel of experts was then asked to rate these 34 determinants based on criteria that would assess their importance for healthy aging, and the ability of interventions on each to produce positive health outcomes.\* Following a diagnosis of the rankings, analyses of the higher-rated determinants, and further internal consultations, the panel found that four key issues had the greatest potential for changing or improving the current situation in the area of healthy aging: healthy eating, injury prevention, physical activity, and smoking cessation.

Evidence demonstrated that frailty in old age is largely preventable or reversible, and that as people age, genetic inheritance decreases in importance while environmental factors and lifestyle become more important to health. Evidence pointed to personal health practices, and more specifically to the four issues noted above, as making the most significant contribution to the prevention or delay of chronic diseases and the attainment of healthy aging. All older people, irrespective of age, have the potential to improve their health and well-being through behaviour change. Evidence also showed that focussing on behavioural risk factors could reduce or prevent the burden of chronic diseases such as cardiovascular disease, cancer and diabetes, as these diseases are extensions of lifestyle choices made during the life course. Often, the same lifestyle changes that reduce the risk of one disease will also reduce the risk or delay the onset of other diseases.

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\* The criteria considered by the in-house panel were: the magnitude of the impact on healthy aging; the proportion of Canadians affected; the quality of available evidence in association with healthy aging; the potential for effective modification by intervention; the availability of effective interventions to address the issue; and, the potential political/public support for intervention on the issue.

Physical activity, good nutrition, smoking cessation and injury prevention were found to be the four issues where intervention could make the most significant impact on health in later life. Existing research provided evidence of effective and promising interventions. However, the evidence was not sufficient to underscore the most appropriate interventions to be pursued in those areas, and to point conclusively to a course of action for Health Canada to follow.

The Division of Aging and Seniors thus sought to solicit the advice of experts and stakeholders on the development of an action plan on healthy aging. The Division organized a 1½ day workshop on healthy personal practices with expert presentations and group discussions on physical activity, nutrition, smoking cessation and injury prevention. Prior to the workshop, participants were provided with background papers on the four issues as viewed through a healthy aging lens, summarizing key knowledge and effective interventions related to aging and health practices. Participants were asked to comment on the papers, and revised versions are available as companion papers to this report. Through their discussions, workshop participants developed a series of recommended actions on healthy aging, identifying strategic directions, objectives and potential partners. Summaries of presentations and the results from group discussions constitute the main elements of this report.

Health Canada is committed to continuing its work in the area of healthy aging, building on its experience and successes over the past thirty years. As it moves forward, Health Canada will be able to base its policy and program development on a stronger conceptual foundation, and place the greater emphasis on the four cornerstone issues of: physical activity, healthy eating, smoking cessation, and the prevention of falls and injuries. The guidance provided by the *Workshop on Healthy Aging: Aging and Health Practices* will be significant in framing the development of new Health Canada initiatives and interventions that improve the health and quality of life of older Canadians by promoting key personal health practices and creating environments that support healthy behaviours.

# 1. Introduction

## 1.1 Background and Objectives

From November 28 to 30, 2001, the Division of Aging and Seniors, Population and Public Health Branch, Health Canada hosted a two-part Workshop on Healthy Aging in Ottawa. This is the report of the process and outcomes of *Part I: Workshop on Aging and Health Practices*. This one and one-half day session included presentations by experts and group discussions on injury prevention, nutrition, tobacco use and physical activity. The objectives of this workshop were to:

- discuss how these areas impact on the health of older Canadians and what interventions are known to be effective; and
- seek advice on the development of strategic directions and priority areas for action on healthy aging related to injury prevention, nutrition, smoking cessation and physical activity.

## 1.2 Participants and Process

Some 45 people attended Part I of the workshop. Participants included representatives of national seniors' groups, voluntary and professional health organizations, researchers in healthy aging and Health Canada representatives.

Background papers were circulated prior to the Workshop on Aging and Health Practices, including a general overview of health practices, and papers on injury prevention, nutrition, tobacco use and physical activity, all as viewed through a healthy aging lens. The draft discussion papers were commissioned by Health Canada as a way to summarize key knowledge and effective interventions related to aging and health practices. Participants were asked to review the papers and provide comments in advance of the workshop to a designated expert in each of the four topic areas. The experts synthesized these comments and incorporated them into presentations made at the workshop. The specific issue papers have been revised by the topic experts and are available by request from Health Canada in English and French to participants and others.

The workshop used an interactive process involving presentations, plenary discussions and small group work. Detailed notes from the small group work on suggested strategies are contained in Appendix A. Summary charts of all suggested strategies are found in the Conclusion of this report.

## 2. Overview of the Issues

### 2.1 Introduction to Healthy Aging

**Claude Rocan**, Director General of the Centre for Healthy Human Development, Health Canada, presented opening remarks to put into context the purpose of the workshop on healthy aging. He noted that healthy aging is an issue that concerns everyone. Demographic projections show that Canada is an aging society. Within the next 40 years, 25% of the population is expected to be 65 years of age or older.

Health Canada views healthy aging as an evolving concept and recognizes that governments and communities play a major role in creating the social, economic and environmental conditions that enable healthy aging. This workshop is an important early step for the development of a plan that will help identify strategic and priority areas of action. Mr. Rocan encouraged everyone attending to participate actively. On behalf of the Department, he thanked participants for providing expert advice and counsel in assisting in the strategic positioning of health into the broader aging agenda in Canada.

**Barbara Kennedy**, formerly of the Division of Aging and Seniors and now with the Centre for Chronic Disease Prevention and Control of Health Canada, presented an overview of the developmental work being done within the Department in the area of healthy aging.

She pointed out that Canada has a solid foundation in the area of healthy aging and that the Canadian population health approach to healthy aging reflects an evolution that has been based on work developed over several decades.

Ms. Kennedy presented the following definition of healthy aging:

*A lifelong process of optimizing opportunities for improving and preserving health and physical, social and mental wellness, independence, quality of life and enhancing successful life-course transitions.*

She suggested that healthy aging involves a combination of the following three key factors:

- low risk of disease and disease-related disability
- high mental and physical function
- active engagement with life.

The Interdepartmental Working Group on Healthy Aging identified the four health practices being discussed at the workshop as key determinants of health. While injury prevention, healthy eating, smoking cessation and physical activity were the areas of focus for this workshop, it was noted that these four strategic investments are a starting point only. They are not seen as the only areas requiring strategic investments, but are pressing issues where interventions have been shown to have an impact. Future work should also continue with regard to all the other determinants that have an impact on healthy aging.

Ms. Kennedy ended her presentation by quoting health promotion researcher Renée Lyon:

*The issue of healthy lifestyles and how we approach this topic is critical. As health budgets are squeezed and increased pressure is placed on individuals to live healthier lives, it is incumbent upon policy makers to thoughtfully consider their leadership on this issue.*

## **2.2 Enabling Healthy Aging**

During the morning plenary discussion, workshop participants addressed the following question:

*How can we (governments, education and research sector, voluntary sector) best enable older Canadians to achieve healthy aging through a focus on personal health practices?*

The participants came up with numerous ideas that have been grouped below:

### **Involve Seniors**

Involve seniors at all levels. Older Canadians need to be able to provide input into decision making and policies. We need to ask older Canadians:

- What do you consider to be the issues in healthy aging?
- What does healthy aging mean to you?
- What does the idea of personal health practices mean to you?

### **Re-orient the Health Care System**

Some seniors believe that health is out of their control and that changes depend on professionals and the health care system. The current push to promote healthy aging needs to be seen as more than just a way to help keep costs down. There is a perception currently held by many people that promoting healthy aging means governments are going to invest less in health care. Seniors don't want to be made to feel guilty, or reminded that they need to be healthy to save health care dollars.

Physicians are very influential with seniors. They need to be more active in health promotion and the promotion of self-care. To do so, however, physicians need more time to counsel seniors, as well as effective tools. Nurses and peer counsellors can also help. Pharmacists, though not specifically represented at this workshop, were also seen as key players.

### **Move from Research to Action**

Focus on knowledge development and the transfer of that knowledge into action. There is a need to put into place what is already known.

### **Create Supportive Environments**

Public policies need to support healthy choices. The public policy agenda must relate to the evidence around the different risk factors and take a lifelong approach. Environmental, social and community supports must be in place and accessible to all. Everyone should have access to information that supports positive personal health practice decisions. This information needs to be made available outside the hospital setting, before seniors become ill.

Isolation is a critical issue in rural areas (e.g. Nunavut, Prince Edward Island). One idea to deal with this is to bring back funding programs like “New Horizons.”\*

Psychosocial factors are critical to beginning and maintaining health behaviours. There is a need to foster self-esteem, stress management skills and individual empowerment. Rewards should be offered for living a healthy lifestyle. For example, insurance policies could be re-examined based on whether or not someone is actively trying to be healthy.

\* “*New Horizons*” (1976–1997) was a previous initiative by Health Canada to provide financial assistance for community projects that were designed for and by seniors.

### **Take a Multidimensional Approach That Recognizes Diversity and Builds Sustainability**

There is a need to be aware of cohort, gender and cultural differences when dealing with an aging population. There is no one single way to deal with healthy aging. Any approach taken by an organization needs to be multidimensional.

Governments can play a key role in coordinating activities across the country and sharing information on what is happening. Links are needed with all stakeholders. Non-governmental organizations (NGOs) and governments need to work closely together to provide information to those at risk. Funding for community programs and resources that work need to be sustained over time.

### **Combat Age Discrimination**

Government has a key role in getting messages to the public that debunk myths and stereotypes surrounding aging.

## **2.3 Injury Prevention and Healthy Aging**

### **2.3.1 Presentation on Seniors and Injury Prevention**

**Dr. Vicky Scott**, Director, Falls Prevention Program, British Columbia Ministry of Health and Ministry Responsible for Seniors, gave a presentation on the prevention of unintentional injuries among seniors that incorporated all reviewers’ comments. Unintentional injuries among seniors is a growing and complex problem. Effective prevention requires the collaborative efforts of many stakeholders in the development of varied and integrated approaches.

The amount of data collected in this area is limited. At the same time, not all available data sources are fully used.

Many reviewers noted the focus on only injuries from falls in the paper and the omission of information on other unintentional injuries. It was suggested that one way to examine this was to look at injury mortality trends over time. Dr. Scott pointed out that there are several gender differences in this area and suggested that another way to examine the data was to look at hospital admission rates. However, this is problematic because the recent decline in hospital admissions does not necessarily reflect the number of injuries but recent budget cuts. Future

research should focus on unintentional injuries as a percentage of all hospitalizations by age group and cause.

Some of the classifications used for other unintentional injuries are:

- motor vehicle, pedestrian and other transport
- fire/burns: flame, hot object, scald
- poisoning: medication, alcohol, exhaust
- suffocation: choking
- overexertion
- cut/pierce
- natural environment: bites, stings, excessive cold/heat
- other.

Reviewers indicated having some difficulty understanding direct and indirect costs relating to unintentional injuries. Dr. Scott agreed that the area of cost is currently confusing. She also recognized the importance of clarifying costs to people working in this field because governments that fund programs often require evidence that they are having a monetary impact.

Another area of concern from many reviewers was under-representation of some populations. Dr. Scott agreed that this is a critical issue and that there is a dearth of data in this area.

Dr. Scott informed participants that two new reports were coming out soon examining best practices for fall prevention:

*An Inventory of Canadian Programs for the Prevention of Falls Among Seniors Living in the Community* available at <[http://www.hc-sc.gc.ca/seniors-aines/pubs/inventory/intro\\_e.htm](http://www.hc-sc.gc.ca/seniors-aines/pubs/inventory/intro_e.htm)>  
*The Best Practices Guide for the Prevention of Falls Among Seniors Living in the Community* available at <[http://www.hc-sc.gc.ca/seniors-aines/pubs/best\\_practices/pdf/BestPractice\\_Falls\\_e.pdf](http://www.hc-sc.gc.ca/seniors-aines/pubs/best_practices/pdf/BestPractice_Falls_e.pdf)>

Dr. Scott concluded by saying there is a need for a comprehensive, integrated national action plan for injury prevention among seniors.

### **2.3.2 Plenary Discussion**

Following Dr. Scott's presentation, workshop participants identified the following issues, strategies and priorities:

- There is a huge gap between knowledge, understanding and implementing behavioural changes. We need to figure out how to change this.
- It is important to ensure that public information is available in French and English and that it takes cultural differences into account.
- Older Canadians do not care if healthy aging saves/costs the government money. Seniors want advice to help make them more aware and informed. They do not want more statistics thrust at them. Seniors want clear and relevant information.
- Canada needs to start implementing a national strategy on injury prevention. It's time to start taking action.

- Multisectoral and multifactorial approaches appear to be the most effective, so should be the focus of action plans.
- Teaching people how to fall properly and how to get up from a fall may help minimize severity of injury.
- Building code standards should be revised to reduce the environmental causes of falls.
- The interaction among risk factors should be studied, as opposed to a focus on individual factors.

## 2.4 Nutrition and Healthy Aging

### 2.4.1 Presentation on Nutrition and Healthy Aging

**Dr. Hélène Payette**, Gerontology and Geriatrics Research Centre, Université de Sherbrooke, gave a presentation on nutrition and healthy aging. It sought to build on information found in the nutrition and healthy aging discussion paper distributed for comments prior to the workshop.

For research purposes, “seniors” usually refers to people 65 years of age or older. Malnutrition is more prevalent for people within this age group and research has shown them to have different eating habits and nutritional needs than those of younger adults.

There is a consensus among researchers that seniors’ energy requirements are less than for other age groups due to hormonal differences, reduction in muscle mass and a reduced amount of physical activity. However, the results of recent studies have shown that this may not be the case and researchers in this field now believe that Canada’s energy recommendations for seniors are too low. In addition, current recommendations underestimate the protein needs of seniors. Without the proper amount of protein, muscle mass is lost and seniors are affected in many areas. There is still a need for more data regarding essential nutrients for older Canadians.

Dr. Payette divided the determinants of nutritional status into two sections:

- individual: appetite, chewing/dental status, physiological factors, vision status, food beliefs, stress
- collective (environmental): social support, living arrangements, access to community food services, socio-economic factors, cultural background.

Studies in the community have shown that seniors who are able to move freely about and take care of themselves have the lowest rates of malnutrition. Prevalence of malnutrition is obviously higher for seniors in hospital because they are already sick. Seniors who are functionally dependent (e.g. free-living seniors and those in institutions or nursing homes) are also in the high-risk category.

The Body Mass Index (BMI) is an important factor. Mortality rates are higher among frail seniors. Most weight loss among older Canadians is involuntary and means a loss of bone and muscle as well as fat. This loss of mass is not desirable and has a major impact on hip fractures. There is a need for more education around optimal weight and the problem of weight loss.

Screening and preventive strategies need to focus on:

- population-specific interventions
- evidence-based strategies
- incorporation into health professionals' routines and programs of community
- increased availability of healthy foods
- evaluation of efficacy and effectiveness.

Much research remains to be done in this field, despite the following research barriers:

- lack of substantial financial support
- lack of Canadian researchers (nutrition, epidemiology, physiology)
- no concerted effort involving researchers, key stakeholders, public and private partners.

## 2.4.2 Plenary Discussion

Participants discussed the following:

- Access to healthy food and assistance with feeding if required were identified as key issues. Many long-term care facilities are at a crisis stage and need to be examined in relation to the issue of nutrition and healthy aging.
- There was concern around consistency in messaging. For example, a problem was anticipated regarding healthy weights. Is it healthy to have “extra padding” when it comes to falls but not when it relates to diabetes?
- There was general consensus that more research was needed in the area of healthy weights and healthy eating – particularly in the areas of intervention, what seniors eat, best practices and the impact of physical activity.

## 2.5 Smoking Cessation and Healthy Aging

### 2.5.1 Presentation on Tobacco Use and Healthy Aging

**Dr. Robert Reid** of the University of Ottawa Heart Institute, gave a presentation on tobacco use and smoking cessation among seniors. Statistics show that 12% of seniors smoke. While this number seems small, it reflects the facts that many smokers die before reaching the age of 65 and that seniors, as an age group, are the most successful quitters. While seniors often successfully quit, they are also less likely to try to quit smoking. Seniors are less likely to believe that smoking harms health and more likely to view smoking as a beneficial coping and/or weight control tactic. Unfortunately, the disease consequences of smoking occur disproportionately among seniors.

Dr. Reid indicated that the U.S. *Clinical Practice Guidelines: Treating Tobacco Use and Dependence* and the U.S. Surgeon General's Report are the most authoritative sources on effective interventions for older smokers. *Clinical Practice Guidelines* identifies the following as interventions that have been successful in helping people quit:

- screening for tobacco use
- physician's advice to quit smoking

- supportive counselling
- pharmacotherapy (nicotine patch, Zyban), etc.

Dr. Reid then described key predictors of whether or not cessation efforts will be successful:

- nicotine dependence
- smoking-related disease
- motivation to stop smoking
- readiness to change
- other smokers in the household
- previous quitting history
- educational attainment.

It is possible that people who have failed to quit smoking repeatedly might lose confidence in their ability to quit and become reluctant to make a change in the future.

We continue to require information that is specific to seniors, including:

- why seniors smoke and why they quit
- the effectiveness of interventions tailored for seniors
- techniques that are effective in motivating quitting attempts
- data regarding cost analysis of the problem and the solutions.

Some of the issues identified in the discussion paper that Dr. Reid felt were important to mention include:

- The idea of “hard-core” smokers, who are heavy smokers with weak quitting histories and never expect to quit smoking. They are more likely to be retired and likely to be in older age groups. This group represents a small percentage (approximately 5%) and will be very difficult to convince to quit.
- Psychiatric co-morbidity is a common problem as smokers are more likely to be depressed and use smoking as a coping mechanism.
- Isolation and loneliness can be a cessation deterrent for people living alone. Smoking can be seen as a companion and smokers are reluctant to give it up.
- Interaction between tobacco and medications can make the medications less effective.
- Intolerance among ex-smokers can lead to isolation among seniors who continue to smoke.
- Smoking cessation must be balanced with smoking prevention. The focus on stopping people from starting smoking is laudable; however, the reality is that all of the people who are going to die from smoking over the next 25 years are already smoking.

More emphasis could be placed on:

- what is already happening (best practices)
- specific needs, challenges and issues regarding smoking in seniors
- immediate benefits of cessation and effects of second-hand smoke
- role of seniors’ organizations in creating awareness and promoting cessation programs
- importance of legislation to protect those in rural and remote locations.

Priorities and potential strategies include:

- Increase awareness that quitting smoking is beneficial at any age.
- Develop interventions tailored to seniors and target awareness and cessation programs to older Canadians (involving seniors' organizations).
- Develop more physician-based interventions since physicians are central to a successful interventions process
- Support increased taxation on tobacco products and support legislation for smoke-free spaces.

## 2.5.2 Plenary Discussion

Following Dr. Reid's presentation, workshop participants identified the following issues, strategies and priorities:

- More smoking cessation programs must target older Canadians. Currently, almost all smoking cessation programs are directed at youth.
- Studies are needed about the attitudes of people who provide smoking cessation help. There is a concern that interventions are shown to help only one out of 15 times and that physicians and health care workers are discouraged by these low rates.
- Because nicotine dependence is dose-related, we should look at developing alternative cessation strategies that focus on smoking reduction. This approach might be of some benefit in helping heavy or "hardcore smokers" quit. We need more research and empirical evidence surrounding smoking reduction.
- Physicians and health practitioners play a key role in smoking cessation. There should be education for health practitioners to encourage them to ask seniors about smoking status. Older patients should be asked about smoking habits and given help when they are healthy instead of waiting until they become sick. The entire responsibility, however, should not fall only on physicians. Public awareness campaigns (e.g. commercials, pamphlets) could be developed to help people become active in speaking to physicians. It could point out that even one or two minutes of speaking with a physician can help with smoking cessation.
- Stress management techniques could be taught as an alternative approach since so much of smoking is stress related.
- Punishing smokers could cause low self-esteem that would only add to the problem. Instead, we should focus on what motivates a senior to want to quit smoking.
- There is a need to look at different cultures and smoking.
- There was concern about the issue of seniors' smoking and safety (falling asleep with a lit cigarette).
- A participant pointed out that the fall edition of the reference published by *Y2Quit Newsletter* addressed guidelines and practices for physicians around talking to patients about smoking. There is also a poster available promoting the need for individuals to talk to their doctor.

## 2.6 Physical Activity and Healthy Aging

### 2.6.1 Presentation on Physical Activity

**Dr. Sandra O'Brien-Cousins** of the Faculty of Physical Education and Recreation, University of Alberta, presented information on the link between physical activity and healthy aging.

Thousands of studies have been done regarding physical activity and health; however, we are still lacking research about synergies of the role of physical activity and how it affects the other healthy aging issues discussed at the workshop.

Half of all adults over age 45 are inadequately active. Older people often say that they are thinking about getting active. The problem does not appear to be public awareness, but personal motivation and environmental support.

There is compelling evidence that physical activity has an impact on the broad social determinants of health and is a significant factor in healthy aging. Quality of life benefits derived from physical activity are immeasurable.

Intrinsic and extrinsic barriers to older adults becoming more physically active need to be examined. A percentage of the population hates physical activity and will not become active regardless of information and facts. However, many older Canadians are prepared to become active but have trouble dealing with limitations, such as:

- Time: Evidence exists that many people with good intentions just do not “get around to it” and seniors do not like to have their time regulated.
- Self-consciousness: Older people say they feel foolish exercising because it makes them conspicuous in public. They often fail to see that canes, walkers and wheelchairs are conspicuous, too.
- Winter: Older Canadians who do not “fly south” markedly decrease their outdoor recreation in winter. For women, this is more significant due to a lack of access to indoor and outdoor activities. Seniors need to learn about the basic activities everyone can do indoors.
- The need for positive reinforcement: Behavioural research keeps coming back to the notion that people are more physically active when there are intrinsic and extrinsic rewards.

It is very important that seniors are consulted regarding issues of physical activity. Unfortunately, “soft science” research methods that could really capture what seniors have to say are chronically underfunded.

Overall helpful strategies include:

- making the healthy choices easy choices
- rewarding people for self-care
- providing stable government support to programs that work.

Dr. O'Brien-Cousins ended her presentation with a call to action. Given the ample evidence on the advantages of an active lifestyle in later life, governments and non-governmental groups at all levels need to get started right away in enabling all seniors to adopt an active lifestyle.

### 2.6.2 Plenary Discussion

Participants identified the following important issues, strategies and priorities:

- It's important to recognize and promote the synergies between physical activity and other healthy aging issues. For example, physical activity is key to building appetite and building self-esteem.
- The erosion of resources for health promotion have led to a generation of Canadians who are more at risk (e.g. obesity in children).

## 3. Transtheoretical Model of Change

**Dr. Steve Hotz**, a behaviour expert from the University of Ottawa, provided an overview on promoting healthy behaviour using insights from the Transtheoretical Model of Change. When working to change behaviour, a paradox exists. Some trials suggest successful strategies, but when applied in the field it has proven hard to produce results. There is consensus that this low effectiveness is caused by low motivation. However, few programs or clinicians directly address the issue of motivation.

Clinicians need to take a practical approach to understanding motivation and change. Many clinicians believe that clients who do not change are not motivated. This is a myth and consequently motivation is not explicitly addressed. In reality:

- behaviours are well practised
- behaviours just happen; they are not planned
- motivation has nothing to do with personality
- when people offer excuses, it means that health has fallen lower on their priority list.

What is needed is tailored interventions that take the client's perspectives into account.

There are five stages of change:

- Precontemplation: unaware or unimpressed
- Contemplation: concerned but...
- Preparation: decisions are made
- Action
- Maintenance: fine tuning and maintaining change.

Dr. Hotz said that health professionals tend to counsel action but only 20% of people are at the action stage. There needs to be more focus on people who want to make a change and are in the proper mindset to move from one stage to another. Unfortunately, it is easy to slip back a stage and the things that people need to do to advance a stage are different for everybody. Dr. Hotz noted that people use 10 processes of change to modify behaviours, feelings, beliefs/attitudes and relationships. These processes are stage-specific and the ability to recognize the current stage enables tailored treatment.

The intervention goals for each stage are:

- Precontemplation: engage
- Contemplation: resolve
- Preparation: problem solve, plan, teach
- Action: support
- Maintenance: prevent relapse.

This model can be applied toward enabling seniors to make healthy lifestyle changes by recognizing where they are in the stages of change model, using appropriate interventions for that stage and providing supportive environments that make change easier to do.

## **4. Conclusion**

**Nancy Garrard**, Director of Health Canada's Division of Aging and Seniors, brought Part I of the workshop to a conclusion by thanking all participants for their hard work. She reminded all participants that they will be sent a report of the process and outcomes of the *Workshop on Aging and Health Practices* and that self-identified potential partners will be contacted by telephone.

### **Summary Charts of Strategies for Healthy Aging**

The following five charts summarize the suggested strategies for action developed by the small groups. The charts are grouped under the following key strategic directions:

- Public Awareness and Education
- Public Policy and Legislation
- Community Action
- Professional Information and Education
- Knowledge Development

## 4.1 Public Awareness and Education

<b>Injury Prevention</b>	<b>Nutrition</b>	<b>Smoking Cessation</b>	<b>Physical Activity</b>	<b>Overall</b>
Media Awareness Campaign – use of high-profile spokesperson (a senior) and positive messages	Develop and disseminate clear, non-conflicting messages for seniors re: weight, nutrient needs, healthy food choices and interplay with physical activity	Targeted media campaigns on quitting for seniors (seniors as role models; stress benefits)	Promote synergies between nutrition and physical activity	Develop and disseminate messages that debunk and reverse ageism and help change negative attitudes about seniors and barriers to change
		Include messages about smoking in other campaigns (e.g. safety and injury prevention, heart disease)	Bring back ParticipACTION and launch awareness campaign directed to seniors (use senior role models)	Confront complacency and denial
			Ensure consistent use of terminology (Use Physical Activity Guide as templates)	Tailor strategies for different settings, cohorts and cultures
				Involve seniors at all levels of development and implementation

## 4.2 Public Policy and Legislation

<b>Injury Prevention</b>	<b>Nutrition</b>	<b>Smoking Cessation</b>	<b>Physical Activity</b>	<b>Overall</b>
Submission to Romanow Commission	Develop and implement standards for Meals on Wheels	Enact smoke-free policies in public places that seniors frequent	Change current policies that ban pets in long-term care facilities	Involve seniors
Creation of “senior-friendly” products through market-testing group	Work with food industry re: portions, packaging and balance/nutrient needs for seniors	Include warnings on medications if there is an interaction with tobacco	Offer tax rebates and insurance discounts and seniors discounts for physical activity and physical activity products	Encourage stable funding for health promotion strategies (affecting all ages). Increase funding for community-based population health initiatives in physical activity and other areas
Revise building code standards to make senior friendly	Develop dietary intake recommendations and a focus on seniors in Canada’s Food Guide, including cultural differences		Create safe conditions for physical activity (e.g. ice-free sidewalks)	Assign a percentage of pharmaceutical profits to seniors programs
Develop and implement a national strategy for injury prevention and seniors	Improve collaboration between government and community – bridge information gaps and eliminate duplication			Confront complacency and denial
				Develop national blueprint on healthy aging
				Go big – go culturally appropriate or go home!
				Minister of State for seniors, Cabinet representation
				Tailor strategies for different settings

### 4.3 Community Action

<b>Injury Prevention</b>	<b>Nutrition</b>	<b>Smoking Cessation</b>	<b>Physical Activity</b>	<b>Overall</b>
Create a network of organizations dealing with seniors and injury prevention	Improve access to food for isolated seniors (e.g. provide transportation and social occasions for eating and fellowship)	Involve seniors organizations in efforts to promote cessation, especially in stress reduction programs	Expand ALCOA (Active Living Coalition for Older Adults)	Involve seniors and use as spokespeople
Advocacy for changes in building codes	Work with restaurants and grocery stores re: balance, portions, packaging for seniors	Provide cessation programs for seniors	Encourage long-term care homes to allow pets (walking, companionship )	Tailor strategies for different settings
Support community programs	Improve access to quality foods and assistance with eating in institutions	Target seniors in anti-smoking campaigns and increase the visibility of smoking concerns and seniors	Get seniors and physical activity issues on agenda of health conferences and meetings	Confront complacency and denial
			Build bridges between health care professionals and experts in community physical activity and recreation	Sustain programs and support volunteers
			Make physical activity experts available to counsel on use of Physical Activity Guide for Older Adults and widely distribute the guide	Increase collaboration with universities and schools
			Advocate safe conditions for physical activity (ice-free sidewalks)	Support peer mentoring and self-help groups for seniors
				Encourage/teach seniors to ask questions of health professionals

#### 4.4 Professional Information and Education

<b>Injury Prevention</b>	<b>Nutrition</b>	<b>Smoking Cessation</b>	<b>Physical Activity</b>	<b>Overall</b>
Sessions for health professionals on best practices for injury prevention	Educate health professionals about nutrient needs and handling weight loss	Educate health professionals about the need to help seniors quit or reduce tobacco use	Inform physicians and others about the need to ask seniors about physical activity	Inform health professionals about appropriate messages and counselling at each stage of behaviour change
	Develop tools for professionals to use	Increase health professionals' role and commitment. Provide them with resources to help them counsel seniors.	Build bridges between health care professionals and experts in community physical activity and recreation	Sessions on respect, supporting self-care and reversing ageism
			Help health practitioners learn how to counsel with Canada's Physical Activity Guide for Older Adults	Make health and social aspects of aging part of curricula for health professionals
			Encourage referrals to community resources for physical activity for seniors	Tailor strategies for different settings
				Involve seniors
				Confront complacency and denial
				Mobilize links between health care professionals and family caregivers
				Facilitate self-help and the support of self-care
				Make mental health a priority: links between depression and healthy aging

## 4.5 Knowledge Development

<b>Injury Prevention</b>	<b>Nutrition</b>	<b>Smoking Cessation</b>	<b>Physical Activity</b>	<b>Overall</b>
Improve surveillance and reporting of injuries among seniors, (e.g. expand CHIRRP, note gender differences)	Build a critical mass of researchers in this area	Study specifics related to seniors: why smoke, why quit, successful interventions, cost analysis	Encourage investigation of the synergies between physical activity and other health practices among seniors	Investigate motivations for behaviour change
Widely disseminate information on best practices	Improve surveillance on malnutrition and what seniors eat in all settings	Learn more about tobacco use and seniors in different cultures	Support qualitative research that listens to seniors	Identify appropriate messages in each stage of change
Make sure expertise/research on seniors is included in collaborative work in injury prevention for all ages	National Nutrition Survey with a focus on seniors	Conduct a best practices review specific to older smokers		Involve seniors
				Tailor strategies for different settings
				Confront complacency and denial
				Translate knowledge to seniors and seniors groups in clear language

## Appendix A: Small Group Work - Suggested Strategies

In small groups, workshop participants were asked to identify five priority areas for action and for each priority:

- indicate what you are trying to achieve (overall objective)
- identify key partners/stakeholders who need to be involved.

### A.1 Injury Prevention

**Priority: Disseminating the knowledge we have accumulated to seniors, the general public, families and caregivers through a variety of channels (e.g. seniors community centres, mass media).**

**Strategic direction:** public awareness and education.

**Overall objective:** to increase the general public's knowledge and awareness of unintentional injury among seniors.

**Key partners:** a high-profile spokesperson, general public (e.g. seniors, caregivers, families), media, professional groups, specific interest groups (e.g. farm injuries, Aboriginal, seniors with disabilities), all levels of government, advocacy groups, injury prevention groups, seniors organizations, VON (Victorian Order of Nurses), VAC (Veterans Affairs Canada), insurance industry, emergency services (e.g. fire department, ambulance), funding bodies, Canadian Standards Association, the SmartRisk Foundation, Canadian Health Network, geriatric nurses, building trade (building codes), building inspectors, product manufacturers, surveillance, CHIRPP (Canadian Hospitals Injury Reporting and Prevention Program).

**Other comments:** The group discussed the need for positive images of aging, to replace a lot of the negative images seen by the general public, seniors, caregivers, health professionals and families. The group felt this was an important part of raising awareness. The group also spoke about the need for a high-profile spokesperson to draw attention and research dollars to the issue. This spokesperson would also help to address some of the negative images of aging that are entrenched in our society.

The group discussed the possibility of combining efforts when delivering injury prevention messages to seniors. Some examples included linking the dissemination of information to seniors through the flu shot campaign, existing health fairs, pancake breakfasts in communities, etc.

The issue of priority being given to youth and workplaces (with the exception of farms) was also raised as a concern and a barrier for moving forward.

The group addressed the need to ensure that the diversity among seniors' needs and abilities is always taken into consideration.

**Priority: Develop broader networks of injury prevention programmers and researchers by connecting groups and organizations working on injury prevention.**

**Strategic direction:** public policy and legislation/community action.

**Overall objectives:**

- to increase leadership and coordination in the area of unintentional injury among seniors
- to translate and disseminate accessible information.

**Key partners:** a high-profile spokesperson, general public (e.g. seniors, caregivers, families), media, professional groups, specific interest groups (e.g. farm injuries, Aboriginal, seniors with disabilities), all levels of government, advocacy groups, injury prevention groups, seniors organizations, VON (Victorian Order of Nurses), VAC (Veterans Affairs Canada), insurance industry, emergency services (e.g. fire department, ambulance), funding bodies, Canadian Standards Association, the SmartRisk Foundation, Canadian Health Network, geriatric nurses, building trade (building codes), building inspectors, product manufacturers, surveillance, CHIRPP (Canadian Hospitals Injury Reporting and Prevention Program).

**Other comments:** The group discussed the apparent gap in policy regarding seniors in general. There was a great deal of discussion around the lack of awareness of seniors' issues and the group identified that a link to seniors themselves is missing.

The idea of linking into the Romanow Commission was raised as one way to identify the need to make the prevention of seniors' unintentional injuries a priority issue.

**Priority: Involve industry partners (e.g. product manufacturers, building trades, building inspectors) in developing senior-safe products (e.g. oxygen pack, telephones, stoves, pill bottles, ATM machines, assistive devices). Address stereotyping and ageism among health professionals, institutions and caregivers.**

**Strategic direction:** professional information and education/public policy and legislation.

**Overall objectives:**

- to increase awareness of seniors' unintentional injuries among professionals
- to develop senior-friendly environments.

**Key partners:** a high-profile spokesperson, general public (e.g. seniors, caregivers, families), media, professional groups, specific interest groups (e.g. farm injuries, Aboriginal, seniors with disabilities), all levels of government, advocacy groups, injury prevention groups, seniors organizations, VON (Victorian Order of Nurses), VAC (Veterans Affairs Canada), insurance industry, emergency services (e.g. fire department, ambulance), funding bodies, Canadian Standards Association, the SmartRisk Foundation, Canadian Health Network, geriatric nurses, building trade (building codes), building inspectors, product manufacturers, surveillance, CHIRPP (Canadian Hospitals Injury Reporting and Prevention Program).

**Other comments:** One of the group members raised the idea of introducing a seniors' council of reviewers. This idea has been developed in the United States and is called "1000 elders." The

council is a market-testing group that reviews products which target seniors as an audience. The council can approve the product with “1000 elders seal of approval.” This essentially labels the product as senior friendly.

The group also discussed the conflicting safety needs of children and seniors. Examples, such as pill bottles and stoves, were discussed. The group discussed the complexity of introducing assistive devices or technologies into the home. One member spoke of the difficulty in putting up grab bar rails. She mentioned that the placement of the grab bar rail depends on many factors, including the nature of the disability, the size of the person, the location of the wall studs, etc.

**Priority: Conduct research (e.g. attitudes of seniors regarding unintentional injury prevention, precursors to fall injuries, what works and what does not). Data collection and surveillance resources are also required.**

**Strategic direction:** knowledge development.

**Overall objective:** to increase our knowledge regarding unintentional injuries and seniors.

**Key partners:** a high-profile spokesperson, general public (e.g. seniors, caregivers, families), media, professional groups, specific interest groups (e.g. farm injuries, Aboriginal, seniors with disabilities), all levels of government, advocacy groups, injury prevention groups, seniors organizations, VON (Victorian Order of Nurses), VAC (Veterans Affairs Canada), insurance industry, emergency services (e.g. fire department, ambulance), funding bodies, Canadian Standards Association, the SmartRisk Foundation, Canadian Health Network, geriatric nurses, building trade (building codes), building inspectors, product manufacturers, surveillance, CHIRPP (Canadian Hospitals Injury Reporting and Prevention Program).

**Other comments:** What we have learned about preventing falls in seniors can be applied to the prevention of other unintentional injuries among seniors. There is currently a great deal of “pooling” of researchers across the country. It is crucial that there be appropriate representation of those knowledgeable about injury prevention among seniors included in collaborative initiatives.

Group members discussed the need to capture important unintentional injury information in emergency rooms, doctors’ offices, walk-in clinics, institutions, etc. This information needs to be shared with researchers and then translated and disseminated to programs. CHIRPP collects and analyses data on the circumstances of injuries treated at the emergency department and the group discussed the need to broaden CHIRPP from the current 10 hospitals, of which seven represent children. The group agreed with the background paper that since most of the hospitals are pediatric hospitals, the current capacity for surveillance of seniors is insufficient.

## **Overall**

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In summary, the group would like to implement a multi-strategy approach that includes:

- raising awareness
- community development
- research
- networking
- evaluation and dissemination.

Overall objectives for this strategy are to:

- prevent injuries, not just falls
- influence partners to raise money
- support community programming
- create links between researchers and programmers, policy makers and research funders
- influence policy.

Health Canada's role in this approach would be to:

- provide leadership in policies, programming and knowledge development
- coordinate efforts
- provide resources (money and people).

## **A.2 Nutrition**

### **Priority: Surveillance**

There is a lack of data about nutrition intake for all Canadians, including specific information relating to seniors. The prevalence of malnutrition in institutional settings may be as high as 65%. People in community care situations are also not receiving adequate nutrition services, particularly those who are in their own homes. This can be especially true for those in remote areas and, in particular, in jurisdictions where home care services have been reduced.

***Strategic direction:*** knowledge development.

***What we should be trying to achieve:*** A survey that addresses all segments of the seniors' population, including those in community living situations and both formal and informal home care. It should also take into account cultural differences, as the current Canadian standards are not applicable to all groups (e.g. some groups may have a smaller bone mass and require smaller dietary intakes).

***Key partners and stakeholders:*** Health Canada needs to make the decision to fund and carry out a national survey. Other stakeholders include the National Academy of Science and groups representing different cultures.

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**Priority: Access to good quality food in institutions and in the community.**

Seniors are often alone and on the fringes of the community. If they become aware of something and are enticed to try something new, they can become interested. However, this will not be achieved by young people simply delivering messages, such as take your multivitamins, don't forget your cane when you go out, etc. This is patronizing and does not make the intended actions appealing.

The social aspect of food is often missing in the lives of seniors. Social isolation leads to a lack of interest in nutrition, and poor eating habits. Eating is enhanced in a social environment.

***Strategic directions:***

- public awareness and education
- public policy and legislation
- community action
- professional information and education.

***What we should be trying to achieve:***

- Interest seniors in good quality food and make it available in institutions and in the community, including balanced, appropriate portions in restaurants; balanced, appropriate portions in prepackaged frozen foods in supermarkets (that are easy to prepare and easy to open); fresh, tasty meals delivered to homes.
- Provide transportation to restaurants, supermarkets, etc.
- Make eating a social occasion for seniors.
- The quality, portions and appropriateness (including cultural appropriateness) of food delivered by groups such as Meals on Wheels should meet some standards.

***Key partners:*** restaurants, supermarkets (e.g. Loblaws), long-term care institutions and hospitality organizations.

**Priority: Changing attitudes.**

The attitudes of society at large, professionals and seniors themselves need to change around seniors and physical activity, nutrition and prevention. To do this, we need a better understanding of motivations for change. For example, one of the seniors in the small group discussion uses meditation (which he does in a group setting) to help keep himself motivated.

***Societal attitudes***

Because we live in a capitalistic society that values economic productivity, seniors (who are retired) find themselves at the fringe and feel undervalued. Asian nursing homes in Toronto were cited as an example of successful long-term care facilities where the residents enjoy a high quality of life. This was attributed to the fact that in Asian cultures seniors are seen as valuable members of society, and are valued for their wisdom.

***Seniors***

Older people need to believe it is never too late to change their habits and start eating well, exercising, etc.

*Professionals*

This group also needs to re-evaluate its attitudes toward seniors and respect the expertise of seniors themselves.

***Strategic directions:***

- public awareness and education
- community action
- professional information and education.

***What we are trying to achieve:*** A change in attitude. Seniors need to alter a pervasive belief that health practices cannot be reversed. Many of them feel it is too late to change. Messages should be developed specifically for seniors and be realistic (not focus on recapturing youth). An approach should be developed that does not rely only on messages being passed from the top down. Discussions should be community-based and include seniors as well as professionals.

***Key partners and stakeholders:***

- seniors
- all of society
- health professionals.

***Other:*** This priority is linked with dissemination.

**Priority: Screening.**

This priority is linked to and is a follow-up from surveillance. Screening measures are needed for institutions, individuals and the community.

***Strategic directions:***

- public policy and legislation
- professional information and education
- knowledge development.

***What we should be trying to achieve:***

- Develop appropriate screening tools (including those that are culturally appropriate) to identify those who are at risk.
- Develop proper dietary intake recommendations for seniors.

***Key partners and stakeholders:*** the community, institutions, cultural groups.

### **Priority: Dissemination.**

This is the element which links research with practice. It is essential that knowledge learned from surveillance and screening lead to action.

*Canada's Physical Activity Guide* has been adapted for seniors, but food guides have not been.

#### ***Strategic directions:***

- professional information and education
- knowledge development.

#### ***What we should be trying to achieve:***

- Act on the information gleaned from surveillance and screening.
- Define appropriate intakes and develop culturally appropriate tools in various languages.
- Adapt existing food guides (such as *Canada's Food Guide to Healthy Eating*) for seniors, and make them culturally appropriate.
- Build partnerships to successfully disseminate information.

#### ***Overall***

All of the priorities touch on all of the strategic directions. The proposed priorities should build on what has already been done. A link should be made with the policy report *Nutrition for Health: An Agenda for Action, 1996* which has already been adopted by the federal government.

A group should be formed with knowledgeable individuals at the community level to link with existing initiatives and identify concrete actions. Best practices should be gathered and shared.

A list of government-funded programs and services already exists that can be consulted and used as a starting point. A consultation is currently under way regarding healthy aging and ethnic seniors. About 350 interviews have been held with seniors from different cultural backgrounds across the country. The result will be a compilation of programs and services for seniors from different cultural groups across the country.

If a strategy is being developed to deal with aging and health, it is important that all the determinants of health be incorporated. It must be a holistic piece. The spiritual side of nutrition (and other issues) should not be forgotten.

### **A.3 Smoking Cessation**

**Priority: Provide positive reinforcement for smoking cessation, using seniors as role models and in targeted media campaigns.**

#### ***Strategic directions:***

- public awareness and education
- community action.

***What we should be trying to achieve:*** There was an overall feeling that the “it’s never too late to quit” campaign evokes a negative reaction as it does not address the benefits of quitting smoking. This campaign seems to suggest that smoking must be avoided, but does not provide alternatives for equally pleasurable activities.

The benefit message needs to outweigh the “pleasure” factor associated with smoking. The health implications alone are often not a factor, especially in long-term smokers (a feeling of having already beat the odds), until the individual is presented with an actual compromise in health related to smoking (e.g. emphysema).

A suggested improvement in promoting the benefits message is to include peer groups, for example in group home environments, where other seniors give personal testimonials of how they quit smoking and how it has enhanced their lives. Seniors who do quit smoking also have a higher success rate than the general population; therefore, information dissemination needs to focus on the targeted senior-related data.

Media campaigns are currently focused on “don’t start” campaigns for youth. Focus also needs to be placed on successful quitting campaigns for seniors, as these two groups have very different experiences and attitudes toward smoking. There is a need to make seniors more “visible” in media campaigning.

Campaigns may also use the “love” factor; looking at the effects of seniors’ smoking habits on their loved ones (e.g. spouses, grandchildren). This approach may not be as effective, however, for seniors living alone or who use smoking as a social activity among friends and family.

***Stakeholders:*** CARP (Canadian Association of Retired Persons), Health Canada, long-term care facilities, tobacco control groups, family members, senior peer groups.

**Priority: Incorporate smoking cessation benefits messages into other related health campaigns that focus on seniors.**

***Strategic direction:*** public awareness and education.

***What we should be trying to achieve:*** Include discussions of the positive effects that quitting smoking have on other related health problems, such as diabetes and heart disease.

Smoking can also be related to safety campaigns with respect to personal injury and property damage from fire as a result of careless smoking.

***Key partners and stakeholders:*** Canadian Security Council, Health Canada, community-based health promotion groups.

**Priority: Increase the role of health care practitioners in promoting successful smoking cessation in seniors.**

**Strategic direction:** professional information and education.

**What we should be trying to achieve:** Encourage health care professionals to regularly address smoking cessation programs and strategies with seniors (teachable moments). Provide health care practitioners with resources pertaining specifically to seniors and tobacco use to support this initiative.

A suggestion was also made to include warnings on medication, similar to alcohol warnings, if use of tobacco with the medication can alter the medication's efficacy.

**Stakeholders:** physicians, nurses, public health nurses, pharmacists, health care workers dealing directly with seniors.

**Priority: Conduct a systematic review of best practices and of intervention evidence specifically related to older smokers.**

**Strategic direction:** knowledge development.

**What we should be trying to achieve:** A continual review of best practices is needed to provide new evidence and to reinforce existing evidence of the benefits of smoking cessation for seniors. A systematic review is also needed to provide evidence for the difference in success rates among various intervention programs for seniors.

There is a large amount of clinical data on smoking, but it has not yet been analyzed for age-related trends. This was a suggested next step.

**Key partners and stakeholders:** Health Canada, tobacco control groups, health researchers and professionals.

**Other discussions:** Many of the other priorities this group discussed focused around education and increasing public awareness. The group came up with several ideas dealing with education. They were:

- Target messages toward seniors in promotional materials.
- Education and promotional material should focus on motivating seniors to quit smoking. Older Canadians are more successful in quitting when they decide for themselves.
- Include seniors in anti-smoking campaigns and increase the visibility of smoking concerns relating to seniors.
- Professional information should be provided by physicians, nurses, public health workers and pharmacists.

The group also felt there was a gap in the area of knowledge development, particularly the differences between older and younger smokers. If they do not exist, evidence-based guidelines of best practices for helping seniors quit should be developed.

#### **A.4 Physical Activity**

**Priority: Form a seniors' advocacy group to ensure senior representation and input on matters pertaining to physical activity, or strengthen existing seniors' coalitions. Get seniors on agendas at conferences, meetings and other discussions, and give them the opportunity to provide input on physical activity opportunities and programs that meet their needs.**

*Strategic direction:* community action.

*Overall objective:* to provide a stronger voice for seniors on physical activity in Canada.

*Key partners:* national seniors' organizations, Canadian Association on Gerontology, ALCOA (Active Living Coalition for Older Adults).

**Priority: Get physicians to routinely ask patients about their level of physical activity when they come in for an appointment, and refer them to community resources.**

- Need to provide increased education to physicians and other health care professionals, perhaps through involvement in university curriculum, so they will have the knowledge and tools they need to provide basic guidance and advice to patients on physical activity.
- Build bridges between physicians and the network of experts in physical activity. Interface may have to start with professionals in the community who offer wellness-consulting skills. For example, in Yukon there is a pilot project in which physicians provide patients with prescriptions for physical activity.
- Advocate use of *Canada's Physical Activity Guide for Older Adults* as a tool for all professionals.

*Strategic direction:* professional information and education.

*Overall objective:* to ensure that physicians express interest in patients' physical activity level to raise awareness of the importance of physical activity and to inform seniors of physical activity opportunities.

*Key partners:* College of Family Physicians of Canada, Canadian Nurses Association, Canadian Medical Association.

**Priority: Make *Canada's Physical Activity Guide for Older Adults* more readily available to seniors in their communities and have knowledgeable people available to explain and interpret it.**

***Strategic direction:*** public awareness and education.

***Overall objective:*** to use available tools more effectively to empower seniors to be more physically active.

***Key partners:*** Health Canada, Victorian Order of Nurses, more than 60 Canadian physical activity guide endorsers.

**Priority: Offer tax rebates and seniors' discounts for exercise equipment and fitness club memberships, and give insurance discounts to those who are physically active. Make exercise equipment available for use in public spaces (e.g. shopping malls, waiting areas, airports, libraries, community centres, federal and provincial offices).**

***Strategic direction:*** public policy and legislation.

***Overall objective:*** to reduce financial barriers to physical activity and establish a reward system for those who are physically active.

***Key partners:*** Revenue Canada, Sporting Goods Manufacturers Association, recreation facilities, insurance companies.

**Priority: Use television programs and commercials to provide older adults with messages about physical activity and how it is fun and beneficial, as well as to involve them in physical activity while they are watching television.**

***Strategic direction:*** public awareness and education.

***Overall objective:*** to mobilize people in their homes and communities.

***Key partners:*** television stations, Heart and Stroke Foundation and other health organizations, ALCOA, corporate partners.

***Other priority areas:***

- Increase funding to, revamp and increase social marketing of major physical activity.
- Ensure consistent use of terminology and messaging (i.e. physical activity instead of physical fitness). Refer to Canada's Physical Activity Guide.
- Improve collaboration between the federal government and community groups by sharing information and reducing overlap among initiatives.

- Reduce safety concerns related to physical activity among seniors through all messaging, and by creating safe conditions in which seniors can participate in physical activity (e.g. ensuring streets are cleared of snow and ice).

## **A.5 Overall Strategies**

The fifth group looked at the four main issue areas being discussed at the workshop to identify priority areas and suggest strategies that could have an impact on healthy aging as a whole. These priorities were then grouped by strategic direction.

### **Public Awareness and Education**

Suggestions regarding public awareness and education included:

- Seniors are not feeling supported due to a lack of information and/or a lack of effective dissemination and accessibility.
- Many seniors are fearful of doing exercise after the age of 70.
- Ageism must be exposed. We live in a youth-oriented society and research must examine the impact of ageism on people's perspective on aging.
- Seniors need to be involved in all awareness and education initiatives dealing with healthy aging, especially at the strategic planning level.
- We need to avoid homogenizing seniors; they require tailored strategies for particular needs of various subgroups. For example, the level of seniors' disability/functional capacity determines needs – some seniors are well, others are frail, others are institutionalized.
- Complacency in seniors regarding health matters must be confronted. We need hard-hitting information to break through ignorance, complacency and denial.
- Accessibility is a key issue. Seniors often cannot afford to stay active or are unable to get to seniors centres.
- Many programs are run by volunteers and the volunteer base is shrinking.
- Government needs to put money into healthy aging programs. Sustainability of money for seniors programs has been a problem.

### **Public Policy and Legislation**

The group felt that the issues surrounding public policy and legislation should be examined with the following slogan in mind: "Go big or go home." This slogan referred to the need to make meaningful policy changes or do nothing. There was consensus among the group that hard resources should be allocated to areas of need, from basic survival to self-actualization. The group established that there is a need for a national "Blueprint on Aging." This could include:

- Cabinet-level representation
- reinstating a federal Minister of State for seniors
- an "Older Canadians Act"
- paid staff/incentives for volunteers
- affordable housing for seniors
- 1% of pharmaceutical profits to go to healthy aging
- rebirth of "ParticipACTION" program
- financial incentives (e.g. tax breaks) for healthy living.

### **Community Action**

- There is a need for more involvement and empowerment of seniors.
- There is a lack of care centres or affordable places to go to that are not just drop-in centres, preferably where someone is available to talk with seniors.
- Seniors who are highly visible should advocate for seniors' issues.
- Address the lack of funding for coordination of grassroots effort.
- Make better use of university/college programs, including collaboration between schools and community.

### **Professional Information and Education**

- Health and social aspects of aging needs to be part of the core curriculum in post-secondary education. Currently, healthy aging is conceived as an "add-on." It should be built-in training for doctors, nurses and other health professionals.
- Healthy aging needs to be put on the agenda of professional organizations to lobby and prepare practitioners.
- Mobilize links between professionals and caregivers (e.g. children and spouses).
- Ensure that health care professionals are aware of seniors' issues.
- Facilitate in self-help; offer incentives to professionals to assist.
- Mental health is a priority: seniors cannot eat well or exercise if depressed; bereavement help is hard to find in rural communities and should be made available.

### **Knowledge Development**

- Funding for research projects could be contingent on seniors' involvement, knowledge transfer and "marketing" of knowledge gained.
- Include seniors as part of research team and in planning and dissemination.

### **Other Discussion**

- Healthy aging should not be seen as separate, but should be part of the whole health care system.
- Useful trichotomy is: well seniors; frail seniors; institutionalized seniors.
- Healthy aging is everyone's business.
- Some seniors need to learn how to communicate better; must ask questions and demand answers.