RESEARCH PAPER

A Scoping Review of the Implementation of Local Health and Social Services for Older Adults

Examen de la portée de la mise en œuvre des services de santé et sociaux locaux pour les aînés

ALEXANDRA ETHIER, BA, MA
PhD Student
Faculté de médecine et des sciences de la santé
Université de Sherbrooke
Student
Research Centre on Aging
CIUSSS de l'Estrie – CHUS
Sherbrooke, QC

ANNIE CARRIER, BA, LLM, MSc, PhD
Professor
École de réadaptation, Faculté de médecine et des sciences de la santé
Université de Sherbrooke
Researcher
Research Centre on Aging
CIUSSS de l'Estrie – CHUS
Sherbrooke, QC

Abstract

Background: Implementing elder-dedicated local health and social services (LHSS) is primary for older Canadian adults to age in place. However, there is currently no synthesis of the factors (barriers and facilitators) involved in LHSS implementation.
Objective: This study aimed to synthesize current knowledge about the institutional factors involved in elder-dedicated LHSS implementation by describing them and their influence.
Methods: A scoping review was conducted using eight databases and the grey literature. Data were analyzed thematically.
Results: A total of 23 documents led to the identification of 15 inter-influencing factors (12 barriers and 11 facilitators). Indeed, 20 connections were noted among factors, mostly among barriers.

Discussion and implication: Although some barriers and facilitators also affect the implementation of services dedicated to the general population in Canada, the interplay between agism and power issues needs to be taken into consideration for a successful elder-dedicated LHSS implementation.

Résumé

Contexte : La mise en œuvre de services de santé et sociaux locaux (SSSL) dédiés aux aînés est primordiale pour que les personnes âgées canadiennes puissent vieillir chez elles. Cependant, il n'existe actuellement aucune synthèse des facteurs (obstacles et facilitateurs) impliqués dans la mise en œuvre des SSSL.
Objectif : Cette étude visait à synthétiser les connaissances actuelles sur les facteurs institutionnels impliqués dans la mise en œuvre des SSSL dédiés aux aînés, en décrivant ces facteurs et leur influence.
Méthodes : Un examen de la portée a été mené à l'aide de huit bases de données et de la littérature grise. Les données ont été analysées de façon thématique.
Résultats : Vingt-trois documents ont permis d'identifier 15 facteurs s'inter-influençant (12 obstacles et 11 facilitateurs). En effet, 20 connexions ont été observées parmi les facteurs, principalement parmi les obstacles.
Discussion et répercussion : Bien que certains obstacles et facilitateurs affectent également la mise en œuvre des services dédiés à la population générale au Canada, l'interaction entre l'âgisme et les enjeux de pouvoir doit être prise en compte pour une mise en œuvre réussie de SSSL dédiés aux aînés.

Introduction

Although many older adults want to age in place (Kendig et al. 2017), they encounter challenges such as family problems, lack of financial resources and lack of access to local health and social services (LHSS) (Bosch-Farré et al. 2020; Dupuis-Blanchard et al. 2015). LHSS are primarily community-based and home healthcare services (Dupuis-Blanchard et al. 2015; Morley 2012; Tang and Pickard 2008) provided almost exclusively in specific areas or neighbourhoods (Cambridge Dictionary n.d.). Lack of access to LHSS is associated with unmet healthcare needs (Allin et al. 2010; Sibley and Glazier 2009). Unmet needs impact older adults' well-being (Sands et al. 2006) and can result in higher health and social service utilization (Allin et al. 2010). Implementing elder-dedicated LHSS is thus necessary. As such, barriers such as older adults' limited mobility (Dupuis-Blanchard et al. 2015) and the geographical variations in LHSS (Davenport et al. 2005, 2009) could be overcome.

Research has found that factors (barriers and facilitators) within the institutional context are involved in the implementation of elder-dedicated LHSS. The institutional context is one of the healthcare environment's dimensions, ranging from the micro- to the macro-system and comprising three types of factors: legal and regulatory, administrative and organizational

(Carrier 2021). This context is of the utmost importance, as it is a lever for stakeholders (e.g., ministers, high-level officials and managers) to ensure the implementation of quality LHSS. For example, to implement senior housing services, members of parliament vote for specific legislation to protect older adults' safety (legal and regulatory factor), but these can act as a barrier for the implementation team (Guffens 2006). Higher-level managers also decide on the financial resources that will be available to the implementation team (administrative factor), which when sufficient is a facilitator (Pollender et al. 2012) and when insufficient, a barrier (Bigonnesse et al. 2013). Finally, low-level managers organize the services and the work of healthcare staff within senior housing (organizational factor). As such, they can designate formal leaders for the implementation (AUDIAR 2015) or decide to include older adults in the implementation (CQCH 2013), which usually facilitates the process. However, although the institutional context is a lever for stakeholders, their decisions do not always have the expected consequences. For example, in Quebec, the introduction of a new certification regulation to ensure older adults' safety in retirement homes seems to have led to the closure of rural, small-scale facilities in the private market (Bravo et al. 2014). Thus, as the healthcare system is complex and made of interrelated parts (Foster-Fishman et al. 2007; Kannampallil et al. 2011), detailed and precise attention to the institutional factors involved may be required when implementing elder-dedicated LHSS.

As the institutional context is the ultimate lever for stakeholders, knowing the factors involved in the implementation of LHSS is the first step toward identifying its potential for failure or success. There are strong arguments about the importance of successfully implementing LHSS. Indeed, benefits include older adults' positive health outcomes (e.g., improvements in autonomy, mood and satisfaction), improved caregivers' well-being and delayed institutionalization (Gaugler and Zarit 2001), which all might lead to reduced costs for healthcare systems (Marek et al. 2012). Therefore, for stakeholders and practitioners, a synthesis of the factors involved could help identify potential levers and act as a tool to simplify LHSS implementation. Therefore, we aimed to synthesize current knowledge about the institutional factors (facilitators and barriers) involved in the implementation of elder-dedicated LHSS by describing these factors as well as their influence.

Method

A scoping study of scientific articles and grey literature based on the five stages outlined by Arksey and O'Malley (2005) was undertaken to synthesize and map current knowledge on the involvement of institutional factors in elder-dedicated LHSS. Indeed, scoping reviews are useful to identify factors related to a concept (Munn et al. 2018) and to inform policies (Arksey and O'Malley 2005). Thus, this method was better suited than a systematic review, which tends to address the feasibility, appropriateness, meaningfulness or effectiveness of a certain treatment or practice (Munn et al. 2018).

Stage One: Identifying the research question

Our questions were as follows: What are the institutional facilitators and barriers involved in the implementation of elder-dedicated LHSS? How are these institutional factors involved?

Stage Two: Identifying relevant studies

We searched eight databases (CINAHL, Health Management, Health Star, Medline, PubMed, AgeLine, Érudit and the Social Science Database) and grey literature. Sources were also retrieved from the reference lists of relevant documents. The search strategy was developed iteratively with the help of a librarian experienced in gerontology. Keywords such as "LHSS," "implementation," specific elder-dedicated LHSS ("meals on wheels," "congregate housing," etc.) and MeSH terms such as "Health Services for the Aged" and "Home-Based Care Services" were used.

Stage Three: Selecting studies

We included documents in English or French describing the institutional barriers and facilitators encountered when implementing elder-dedicated LHSS. We determined the selection criteria iteratively and did not set limitations regarding time frame and country of implementation. Based on the conceptual model by the Community Health and Social Services Network (2014), we included five types of elder-dedicated LHSS: primary healthcare, health promotion and prevention, home support and living arrangements, social inclusion and caregiver support. LHSS were considered elder-dedicated when services were specifically designed for older adults, according to the authors. We excluded the implementation of techniques (e.g., surgery procedures), interventions (e.g., therapies), care models (e.g., transitional care model for stroke), roles (e.g., geriatric nurse) or programs (e.g., fall prevention programs). The first author (AE) screened the documents by title and abstract and then by reading the full text. When in doubt, both authors read and discussed which documents to include until reaching consensus.

Stage Four: Charting the data

Iteratively, we charted the data in two ways. First, we created a standardized form in Microsoft Word and Excel in which extracted data from the documents were reported as contextual data, such as information about the document and type of LHSS. Second, we extracted relevant data about implementation initiatives and institutional factors from each document and categorized data according to the type of factor involved (legal and regulatory, administrative and organizational). Within each type of factor, synonyms of barriers and facilitators – both in French and English – guided data classification. Impacts of the factors were also extracted to understand how each factor influenced the implementation. To ensure the appropriateness and consistency of the extracting charts, we co-validated the extraction of 10% of the documents.

Stage Five: Collating, summarizing and reporting the results

We analyzed the data within each type of barrier and facilitator (legal and regulatory, administrative and organizational). We used Braun and Clarke's (2006) six-step thematic analysis: 1) familiarizing with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes; and 6) producing the report. Based on the impacts extracted in the fourth stage, we identified connections between our final factors. To do so, we reviewed each final factor with particular attention to its impacts, if any, on the implementation process. Impacts that also represented factors lead to the identification of an association between two factors. For example, within the final factor "partnerships," one impact was "access to financial resources." As this impact represented another factor (i.e., resources), a connection was identified between partnership and resources. Finally, we produced a report wherein we described each factor and the connections between them.

Results

The search strategy yielded 182 potentially eligible documents. The full text of 23 documents were reviewed, from which 50 implementation initiatives were considered for the final analysis. Documents ranged from 2006 to 2021 and were peer-reviewed papers (n = 8) or grey literature (n = 15). Initiatives were implemented in Belgium (n = 1), Canada (n = 13), Finland (n = 1), France (n = 1), the Netherlands (n = 2), the US (n = 2) and multiple countries at the same time (n = 3). Table 1 shows the factors identified.

Factors influencing the implementation of elder-dedicated LHSS

LEGAL AND REGULATORY FACTORS

The following three factors were found: governmental stiffness, standardization and governmental support. The first two are solely barriers, whereas governmental support acts as a barrier when insufficient and as a facilitator when sufficient (Table 1).

Governmental stiffness: Governmental structures lack flexibility, which means that the regulations are restrictive or strictly defined and the ministerial responsibilities are rigid. These structures complexify implementations, especially when more than one ministry is involved (Archambault et al. 2011). For example, in intergenerational housing, older adults and younger residents are subject to different laws and regulations. Thus, housing associations must divide residents by age, contradicting the intergenerational model and its benefits (Guffens 2006).

Standardization: When the government decides that the implementation should be done uniformly everywhere regardless of where the elder-dedicated LHSS is implemented, difficulties in implementation will arise. For example, mandatory financial contributions from communities for elder-dedicated, low-income housing might not be possible in lower socio-economic status communities because they lack the monetary means. Consequently, the standardized requirements are incompatible with the community's ability to pay (Bigonnesse et al. 2013).

Governmental support: Having the local government explicitly endorse the implementation of elder-dedicated LHSS acts as a facilitator (Table 1). However, when the support is unsatisfying or insufficient, it constitutes a barrier. Such unsatisfying or insufficient support includes the lack of specific recognition for the organization (e.g., housing associations for older adults) or lack of rules protecting frail older adults and their ability to age in place. Consequently, innovative LHSS implementation tends to be slowed down as they do not have a formal status (AUDIAR 2015).

ADMINISTRATIVE FACTORS

Four factors were found: fit with an existing offer, fit with the mandate, fit with political and financial incentives and resources. A good fit and sufficient resources are facilitators, whereas a lack of fit and insufficient resources are barriers.

Fit with an existing offer: This factor refers to how well an initiative complements the existing elder-dedicated LHSS offered in an area. As a barrier, the initiative is not congruent with existing services in the area, or the market is already saturated with the same service.

TABLE 1. Factors within their type

Factors	Barriers	Facilitators
Legal and regulatory		
Governmental stiffness	1, 2, 7, 13, 16, 18	–
Standardization	3	–
Governmental support	2, 8, 13, 15	6, 17
Administrative		
Fit with an existing offer	15, 16	13, 15, 16
Fit with political and financial incentives	2, 10, 15, 17, 21	2, 17, 20, 22, 23
Fit with the mandate	1, 8	1, 11, 22
Resources	1–3, 8, 9, 11, 14, 15, 17, 18, 21, 22	1, 4, 6, 11, 15–17, 20, 22
Organizational		
Conciliation of roles	5, 8, 9	–
Unforeseen events	5, 9, 11, 14, 18, 19	–
Informal and formal leadership	–	1, 2, 6, 11, 14–19, 22
Organizational sensitivity	–	1, 6, 11–14, 19, 20
Older adults' participation	–	6, 22
Expertise	3, 8–11, 17	1, 3, 5, 11, 15–17, 19
Partnerships	1, 9, 14, 15, 18, 22	1, 11, 14–20, 22, 23
Planning process	1, 9, 14, 16, 22	9, 11, 15, 18

Factors are presented in the following order: first if they represent a barrier only, second if they are facilitators and third when they are both (a barrier and a facilitator). The number indicates which documents reported the factor: (1) Archambault et al. 2011; (2) AUDIAR 2015; (3) Bigonnesse et al. 2013; (4) Bertrand et al. 2012; (5) CQCH 2013; (6) Gallagher and Mallhi 2010; (7) Guffens 2006; (8) Hassink et al. 2019; (9) Henkin et al. 2017; (10) Jeste et al. 2016; (11) L'APPUI 2016; (12) Leblanc and Deshaies 2014; (13) Lundman 2020; (14) Maltais et al. 2016; (15) Mangiaracina et al. 2017; (16) Meiland et al. 2005; (17) Menec and Brown 2018; (18) Morin et al. 2013; (19) Pollender et al. 2012; (20) Le Réseau canadien de DÉC 2006; (21) Scharlach et al. 2011; (22) Sévigny et al. 2015; (23) Transport Canada 2010.

However, when the initiative is congruent with the market or fills gaps in the service offer (Table 1), the implementation is facilitated.

Fit with the mandate: Resistance can arise when the mandate does not align with the initiative. For example, a meeting centre might newly need to include services for older adults as well as caregivers (Meiland et al. 2005), which may compel the organization to change its missions (Archambault et al. 2011). In contrast, an initiative that fits with the organization's mandate or mechanisms sets winning conditions for a successful implementation (Sévigny et al. 2015).

Fit with political and financial incentives: Initiatives face resistance when they do not fit with the current political climate, government funding or economic situation, but they are facilitated when they are in line with policies and funding incentives that act as a lever, such as age-friendly policies (Sévigny et al. 2015).

Resources: Lacking financial means (i.e., grants and investments) and having difficulty recruiting and retaining staff (i.e., stable and quality staff) will hinder the implementation of elder-dedicated LHSS. For example, initiatives reported lacking the financial resources to adapt facilities to elder-specific regulations (Morin et al. 2013). In contrast, sufficient resources will ease the implementation process and its challenges (Bertrand et al. 2012).

ORGANIZATIONAL FACTORS

Two of the eight organizational factors act as barriers (conciliation of roles and unforeseen events) and three act as facilitators (informal and formal leadership, organizational sensitivity and older adults' participation). Three factors (expertise, partnerships and planning processes) can be either a barrier or a facilitator depending on whether the quantity or quality is insufficient or sufficient.

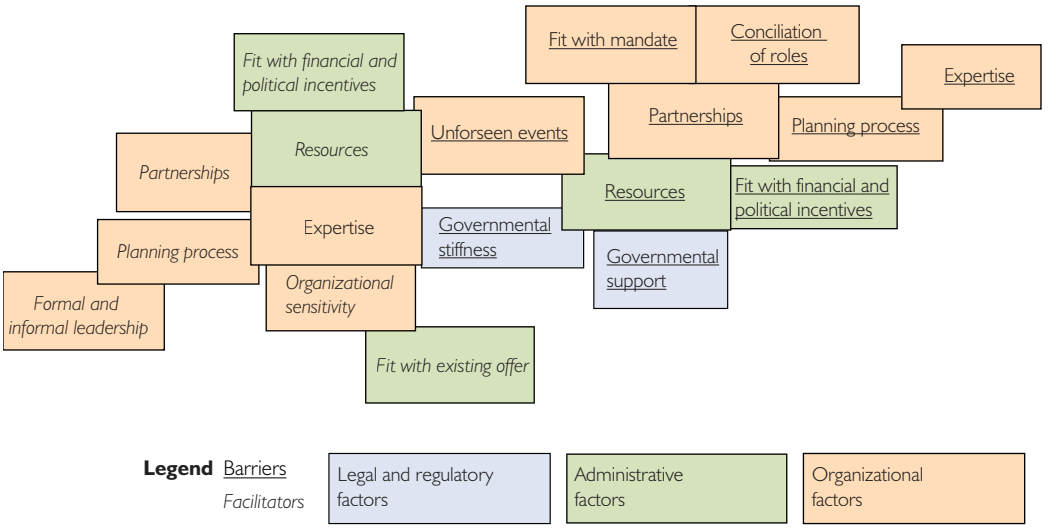
Conciliation of roles: The organization implementing the elder-dedicated LHSS might have difficulty understanding and conciliating the different roles and responsibilities. For example, implementing intergenerational activities in senior housing can be challenging as staff are required to perform supplementary tasks or face a work overload (Table 1). Thus, they feel that they already have enough work and do not see the implementation as a priority (Henkin et al. 2017).

Unforeseen events: These unanticipated events come from the organization's environment and are happening out of its control (e.g., inconsistent student attendance when implementing intergenerational activities; Henkin et al. 2017).

Informal and formal leadership: "Key employees" tend to create a momentum (Gallagher and Mallhi 2010) or lead the implementation (Meiland et al. 2005) by facilitating the process whether officially assigned to the project (formal leadership) or not (informal leadership).

Organizational sensitivity: An organization that listens to the community, adapts and provides support to its staff facilitates elder-dedicated LHSS implementation. Adapting allows the initiative to fit the users' and the community's needs, ensuring that it complements the existing elder-dedicated LHSS offer (L'APPUI 2016).

FIGURE 1. Connections among institutional factors



Factors that overlap in the figure share connections. For example, the facilitator Resources shares connections with the facilitators *Expertise*, *Partnerships*, *Fit with financial and political incentives* and the barrier Unforeseen events.

Older adults' participation: Implementation is facilitated when older adults are included in the processes (e.g., taking an active part in implementation committees). This gives them the opportunity to express their needs and create health and social services accordingly (Sévigny et al. 2015). Although older adults' participation was not identified as a barrier, implementation teams reported that older adults found it difficult to take on roles and responsibilities (CQCH 2013).

Expertise: As a barrier, lack of expertise is insufficient knowledge about the elder-dedicated LHSS being implemented or about ways of implementing it. As a facilitator, expertise is having good knowledge about aging, the implementation context and laws and regulations, as well as having qualified workers. Having expertise allows to adequately respond to the new realities of aging when implementing elder-dedicated LHSS (Bigonnesse et al. 2013).

Partnerships: Partnerships can be formed across government departments and with non-governmental organizations and the private sector (Menec and Brown 2018). Elder-dedicated LHSS implementation is complicated by the challenges inherent to establishing partnerships between involved organizations or by tensions between the partners, which can lead to conflicts (Menec and Brown 2018). However, implementation is facilitated when partners work as a team and their relations are based on mutual collaboration. Such collaboration and team effort allow the sharing of scarce resources (L'APPUI 2016).

Planning process: Implementation of elder-dedicated LHSS will suffer from a lack of dedicated time, but thrive when enough time is afforded to the planning and delivery of the initiative and using a step-by-step method. This type of method means to progressively

implement small components of the elder-dedicated LHSS (L'APPUI 2016). This strengthens the entire process and acts as a lever to implement bigger changes (Gallagher and Mallhi 2010).

Connections between factors

Factors impact each other. In total, 20 (n = 20) connections were identified. Of these, 11 (n = 11) connections were between factors of the same type (e.g., within administrative factors) and nine (n = 9) connections were between different types of factors (e.g., between administrative and organizational factors). Two (n = 2) connections linked a facilitator to a barrier and the rest (n = 18) linked a barrier to another barrier or a facilitator to another facilitator. Most connections happened between organizational factors (n = 9) and between barriers (n = 10). Connections are presented in Figure 1.

Discussion

Our objective was to synthesize current knowledge about the institutional factors affecting elder-dedicated LHSS implementation. Implementations rarely seem to be documented, as we only found 23 documents in this review. In total, we found 15 factors (three legal and regulatory, four administrative and eight organizational), of which we identified 12 as barriers and 11 as facilitators. Factors were facilitators when they fit with the context and when they were sufficient in quantity or quality. Conversely, they were barriers when they did not fit with the context and when they were insufficient in quantity or quality. We also documented connections within and between barriers and facilitators. Connections seem to be supported by the literature on complexity in healthcare systems, which highlights how parts of systems are interrelated (Foster-Fishman et al. 2007; Kannampallil et al. 2011). As such, these relationships must be considered when implementing elder-dedicated LHSS.

Most of the implementation processes reviewed in our study did not directly involve older adults. Initiatives involving older adults reported difficulties in determining how the older adults want to be and should be involved (CQCH 2013) or a potential risk of being used for the benefits of the implementation only (Sévigny et al. 2015). Involving older adults in the implementation could also raise problems such as logistical hurdles (e.g., the need for accommodations for disabilities and transportation), use of jargon and challenges dealing with diseases (Bird et al. 2020). Despite these challenges, involving older adults could ensure appropriate healthcare services (Frankish et al. 2002) and increase their confidence in such services. Considering Canada's underperformance compared to other commonwealth countries regarding patient-centred, safe and timely care (Naylor et al. 2015), increased patient engagement in LHSS implementation should be prioritized. To do so, stakeholders should first consider mobility and accessibility issues such as ensuring that meetings are held at an accessible location or using video conferences. Also, older adults' involvement should not only be clearly defined but also be flexible enough to be tailored to their needs.

Although our study focused on elder-dedicated LHSSs, our findings regarding administrative and organizational factors are similar to those of health service innovations implemented in third-sector organizations. Documented factors include, among others, political and financial incentives, informal and formal leadership, partnerships, planning processes and resources (Barnett et al. 2011). These similarities might reflect the fact that, regardless of the type of LHSS being implemented, some factors are recurrent and might always have to be considered by stakeholders. However, in the context of elder-dedicated LHSS implementation, factors need to be considered differently compared to the general population.

In Canada, despite the increasing aging population (from 15.6% of the Canadian population in 2014 to 23% in 2030; Government of Canada 2014), financing of elder-dedicated healthcare has been insufficient and current financing does not consider inflation or administrative costs (Canadian Health Coalition 2018). Furthermore, there is a lack of workers, formal training and good working conditions within the field of elder-dedicated work. Finally, Canada has yet to develop and implement a national policy for older adults (NIA 2020). Taken together, these elements point toward a potential rampant ageism bias within the Canadian healthcare system (Wyman et al. 2018).

Furthermore, elder-dedicated LHSS tend to be non-specialized health and social services that are geared at prevention. They do not require highly specialized trained experts, whereas the biomedical (Drolet et al. 2020; WHO 2015) hospital-centred model (Drolet et al. 2020) is characterized by a disproportionate emphasis on hospitals and specialized care, and focuses on diagnosing and curing acute health issues (WHO 2008), which is the case in Canada. Indeed, in 2015, hospital expenditure per capita was forecasted to be the biggest of all categories, accounting for 30% of spending in healthcare (CIHI 2015). Furthermore, mechanisms for moving federal funding for healthcare to the provinces are also biased whereby provinces have little incentive to implement health promotional policies (Low and Thériault 2008). Thus, in partnerships between hospital-centred healthcare and local, community or non-profit organizations, ensuring that the realities of the latter are heard might present a challenge because the latter have lesser resources and little recognition (Drolet et al. 2020). This could explain why we documented difficulties with partnerships (Archambault et al. 2011; Menec and Brown 2018) and identified connections between the barrier partnerships: fit with mandate, conciliation of roles and resources. Consequently, partnerships may lead to power struggles, in which one partner is instrumentalized or must change their mandate or roles to bend to the more powerful partner. However, equal relations between partners are of primary importance because older adults now live with diverse and complex long-term health and social needs as opposed to acute care needs (WHO 2015).

As such, a successful LHSS implementation must consider the interplay between ageism and power issues. Thus, greater funding for healthcare outside of hospitals, incentives and better working conditions are needed to recruit workers in healthcare for older adults. Additionally, producing clear guidelines on a local basis detailing the roles of each partner,

what they bring to the implementation (e.g., resources) and the focus of LHSS provision (e.g., social and/or medical) could be the first step toward a smooth process.

Strengths and Limitations

First, despite our wide-inclusion criteria, we located only a few documents about the implementation of LHSS. This could be due to the local aspect of these implementations, excluding French or English documents in many cases. Second, LHSS implementation and its institutional context may not typically be evaluated (or assessed). Third, perhaps, programs and care models now are being implemented in elder-dedicated LHSS as opposed to health and social services. Another limitation is that most of the included documents were grey literature and, as such, not peer reviewed. Considering that no detailed appraisal of the quality of the evidence was done as with other scoping reviews (Arksey and O'Malley 2005), our results must be considered with caution.

Despite these limitations, the use of grey literature uncovered relevant information (Benzies et al. 2006) about elder-dedicated LHSS. As such, to the best of our knowledge, our study is the only one to summarize the institutional factors influencing the implementation of elder-dedicated LHSS, making it a valuable contribution to stakeholders and researchers.

Acknowledgement

At the time of the study, Alexandra Ethier was a Social Sciences and Humanities Research Council and a Fonds de recherche du Québec – Santé #296650 scholarship recipient. Annie Carrier is a Fonds de recherche du Québec – Santé #296437 Junior 1 researcher.

Correspondence may be directed to: Alexandra Ethier, Research Centre on Aging, 1036 Rue Belvédère S, Sherbrooke, QC J1H 4C4. She can be reached by phone at 819 780 2220 x 45662 or by e-mail at alexandra.ethier@usherbrooke.ca.

References

Allin, S., M. Grignon and J. Le Grand. 2010. Subjective Unmet Need and Utilization of Health Care Services in Canada: What Are the Equity Implications? *Social Science & Medicine* 70(3): 46572. doi:10.1016/j.socscimed.2009.10.027.

L'APPUI. 2016. *20 projets inspirants pour soutenir les proches aidants d'aînés du Québec*. L'APPUI pour les proches aidants d'aînés. Retrieved February 4, 2019. <https://www.lappui.org/content/download/10119/file/2016_20%20Projets%20inspirants.pdf>.

Archambault, J., A. Battaglini, N. Bolduc, J. Gervais, J.G. Ntebutse and A.-M. Royer. 2011. *Inspirer, réseauter, innover: recueil d'initiatives déployées dans les réseaux locaux de services du Québec*. Observatoire québécois des réseaux locaux de services. Retrieved January 1, 2019. <http://www.csss-iugs.ca/c3s/data/files/Recueil%20d'initiatives%20d%C3%A9ploy%C3%A9es%20dans%20les%20r%C3%A9seaux%20locaux%20de%20services%20du%20Qu%C3%A9bec%20%28web%29.pdf>.

Arksey, H. and L. O'Malley. 2005. Scoping Studies: Towards a Methodological Framework. *International Journal of Social Research Methodology* 8(1): 19–32. doi:10.1080/1364557032000119616.

AUDIAR. 2015. *Habitat et vieillissement – Les formules de logements intermédiaires pour personnes âgées, entre le domicile personnel et l'hébergement institutionnel*. Agence d'urbanisme et de développement intercommunal de l'agglomération rennaise. Retrieved January 30, 2019. <https://www.audiar.org/sites/default/files/documents/etudes/habitat_vieillissement_octobre2015_web.pdf>

Barnett, J., K. Vasileiou, F. Djemil, L. Brooks and T. Young. 2011. Understanding Innovators' Experiences of Barriers and Facilitators in Implementation and Diffusion of Healthcare Service Innovations: A Qualitative Study. *BMC Health Services Research* 11: 342. doi:10.1186/1472-6963-11-342.

Benzies, K.M., S. Premji, K.A. Hayden and K. Serrett. 2006. State-of-the-Evidence Reviews: Advantages and Challenges of Including Grey Literature. *Worldviews on Evidence-Based Nursing* 3(2): 55–61. doi:10.1111/j.1741-6787.2006.00051.x.

Bertrand, M., S. Bouchard, M. Charpentier, C.-J. Chrysostome, A.F. Noubicier, L. Montminy et al. 2012. *Ligne téléphonique provinciale Aide Abus Aînés: Analyse de l'implantation et de la pertinence clinique*. CSSS Cavendish. Retrieved January 23, 2019. <https://www.aideabusaines.ca/wp-content/uploads/2015/03/FINAL-VERSION_Rapport-LAAA_4-AVRIL-2012_web.pdf>.

Bigonnesse, C., S. Garon and M. Beaulieu. 2013. Une approche de développement des communautés dans le secteur de l'habitation destinée aux aînés: Une étude de cas au Témiscamingue. *Intervention* 4(139): 26–39.

Bird, M., C. Ouellette, C. Whitmore, L. Li, K. Nair, M.H. McGillion et al. 2020. Preparing for Patient Partnership: A Scoping Review of Patient Partner Engagement and Evaluation in Research. *Health Expectations* 23(3): 523–39. doi:10.1111/hex.13040.

Bosch-Farré, C., M.C. Malagón-Aguilera, D. Ballester-Ferrando, C. Bertran-Noguer, A. Bonmatí-Tomàs, S. Gelabert-Vilella et al. 2020. Healthy Ageing in Place: Enablers and Barriers from the Perspective of the Elderly. A Qualitative Study. *International Journal of Environmental Research and Public Health* 17(18): 6451. doi:10.3390/ijerph17186451.

Braun, V. and V. Clarke. 2006. Using Thematic Analysis in Psychology. *Qualitative Research in Psychology* 3(2): 77–101. doi:10.1191/1478088706qp063oa.

Bravo, G., M.-F. Dubois, L. Demers, N. Dubuc, D. Blanchette, K. Painter et al. 2014. Does Regulating Private Long-Term Care Facilities Lead to Better Care? A Study from Quebec, Canada. *International Journal for Quality in Health Care* 26(3): 330–36. doi:10.1093/intqhc/mzu032.

Cambridge Dictionary. (n.d.) Local [B1]. Retrieved September 06, 2019. <https://dictionary.cambridge.org/dictionary/english/local>.

Canadian Health Coalition. 2018. *Policy Brief. Ensuring Quality Care for All Seniors*. Retrieved June 9, 2021. <https://www.healthcoalition.ca/wp-content/uploads/2018/11/Seniors-care-policy-paper-.pdf>.

Canadian Institute for Health Information (CIHI). 2015. *National Health Expenditure Trends, 1975 to 2015*. Retrieved July 7, 2020. <https://www.hhr-rhs.ca/images/stories/CIHI_National_Health_Expenditure_Trends_2015.pdf>.

Carrier, A. 2021. « Performance » et pratique professionnelle dans les services de soutien à domicile offerts aux aînés : effets et actions possibles pour assurer un développement durable [In press]. *Phronésis*.

Community Health and Social Services Network. 2014. *Promoting the Health and Well-Being of English-Speaking Seniors in Quebec*. Health Canada. Retrieved June 4, 2019. <https://chssn.org/pdf/Community-Booklet-Seniors-2016-En.pdf>.

Confédération québécoise des coopératives d'habitation (CQCH). 2013. *Les coopératives de solidarité en habitation pour les aînés au Québec*. Cahiers de l'ARUC-DTC. Retrieved June 25, 2019. <https://www.cooperativehabitation.coop/wp-content/uploads/2015/01/%C3%89tude-sur-les-coop%C3%A9ratives-de-solidarit%C3%A9-en-habitation-pour-a%C3%AEn%C3%A9s.pdf>.

Davenport, J., T.A. Rathwell and M. Rosenberg. 2005. Service Provision for Seniors: Challenges for Communities in Atlantic Canada. *Healthcare Quarterly* 8(4): 9–16. doi:10.12927/hcq.2005.17716.

Davenport, J., T.A. Rathwell and M.W. Rosenberg. 2009. Aging in Atlantic Canada: Service-Rich and Service-Poor Communities. *Healthcare Policy* 5(1): e145–e160. doi:10.12927/hcpol.2009.20937.

Drolet, M.-J., M. Lalancette and M.-È. Caty. 2020. «Brisées par leur travail! OU Au bout du rouleau»: réflexion critique sur les modes managériaux en santé. *Canadian Journal of Bioethics* 3(1): 103–7. doi:10.7202/1070230ar.

Dupuis-Blanchard, S., O.N. Gould, C. Gibbons, M. Simard, S. Éthier and L. Villalon. 2015. Strategies for Aging in Place: The Experience of Language-Minority Seniors with Loss of Independence. *Global Qualitative Nursing Research* 2: 2333393614565187. doi.org/10.1177/2333393614565187.

Foster-Fishman, P.G., B. Nowell and H. Yang. 2007. Putting the System Back into Systems Change: A Framework for Understanding and Changing Organizational and Community Systems. *American Journal of Community Psychology* 39(3–4): 197–215. doi:10.1007/s10464-007-9109-0.

Frankish, C.J., B. Kwan, P.A. Ratner, J.W. Higgins and C. Larsen. 2002. Challenges of Citizen Participation in Regional Health Authorities. *Social Science & Medicine* 54(10): 1471–80. doi:10.1016/S0277-9536(01)00135-6.

Gallagher, E. and A. Mallhi. 2010. *Age-Friendly British Columbia: Lessons Learned from October 1, 2007–September 30, 2010*. Seniors' Healthy Living Secretariat. Retrieved June 25, 2019. <https://www2.gov.bc.ca/assets/gov/people/seniors/about-seniorsbc/afbc/afbc_evaluation_report.pdf>.

Gaugler, J.E. and S.H. Zarit. 2001. The Effectiveness of Adult Day Services for Disabled Older Adults. *Journal of Aging and Social Policy* 12(2): 23–47. doi:10.1300/J031v12n02_03.

Government of Canada. 2014. *Government of Canada – Action for Seniors Report*. Retrieved June 16, 2021. <https://www.canada.ca/en/employment-social-development/programs/seniors-action-report.html>.

Guffens, C. 2006. *Où vivre ensemble?: Etude de l'habitat à caractère intergénérationnel pour personnes âgées*. Les éditions namuroises, Namur.

Hassink, J., L. Vaandrager, Y. Buist and S. de Bruin. 2019. Characteristics and Challenges for the Development of Nature-Based Adult Day Services in Urban Areas for People with Dementia and Their Family Caregivers. *International Journal of Environmental Research and Public Health* 16(8): 1337. doi:10.3390/ijerph16081337.

Henkin, N.Z., T. Patterson, R. Stone and D. Butts. 2017. *Intergenerational Programming in Senior Housing: From Promise to Practice*. Generations United and Leading Age. Retrieved January 23, 2019. <https://www.gu.org/app/uploads/2018/09/17-Intergenerational-REPORT-Programming-in-Senior-Housing.pdf>.

Jeste, D.V., D.G. Blazer II, K.C. Buckwalter, K.-L.K. Cassidy, L. Fishman, L.P. Gwyther et al. 2016. Age-Friendly Communities Initiative: Public Health Approach to Promoting Successful Aging. *The American Journal of Geriatric Psychiatry* 24(12): 1158–70. doi:10.1016/j.jagp.2016.07.021.

Kannampallil, T.G., G.F. Schauer, T. Cohen and V.L. Patel. 2011. Considering Complexity in Healthcare Systems. *Journal of Biomedical Informatics* 44(6): 943–47. doi:10.1016/j.jbi.2011.06.006.

Kendig, H., C.H. Gong, L. Cannon and C. Browning. 2017. Preferences and Predictors of Aging in Place: Longitudinal Evidence from Melbourne, Australia. *Journal of Housing for the Elderly* 31(3): 259–71. doi:10.1080/02763893.2017.1280582.

Leblanc, J. and S. Deshaies. 2014. *Agir au cœur du milieu de vie des personnes aînées isolées*. Observatoire québécois des réseaux locaux de services. Centre de santé et de services sociaux. Institut universitaire de gériatrie de Sherbrooke. Retrieved January 25, 2019. <http://www.csss-iugs.ca/c3s/data/files/Recit35_travmilieu_Rouyn_2014-07-02.pdf>.

Low, J. and L. Thériault. 2008. Health Promotion Policy in Canada: Lessons Forgotten, Lessons Still to Learn. *Health Promotion International* 23(2): 200–6. doi:10.1093/heapro/dan002.

Lundman, R. 2020. A Spatio-Legal Approach to the Intermediate Housing-with-Care Solutions for Older People: Exploring the Adoption of a Retirement Village Concept in Finland. *Ageing & Society* 40(9): 1956–77. doi:10.1017/S0144686X19000412.

Maltais, D., J. Néron, M. Truchon, A. Deschênes, L.-M. Dasilveria and S. Tremblay. 2016. *L'intervention de milieu auprès des aînés en situation de vulnérabilité: l'expérience de trois communautés du Saguenay-Lac-Saint-Jean*. Université Québec à Montréal : Centre de recherche sur les innovations sociales. Retrieved January 25, 2019. <https://constellation.uqac.ca/4700/>.

Mangiaracina, F., R. Chattat, E. Farina, F.L. Saibene, G. Gamberini, D. Brooker et al. 2017. Not Re-Inventing the Wheel: The Adaptive Implementation of the Meeting Centres Support Programme in Four European Countries. *Aging & Mental Health* 21(1): 40–48. doi:10.1080/13607863.2016.1258540.

Marek, K.D., F. Stetzer, S.J. Adams, L.L. Popejoy and M. Rantz. 2012. Aging in Place Versus Nursing Home Care: Comparison of Costs to Medicare and Medicaid. *Research in Gerontological Nursing* 5(2): 123–29. doi:10.3928/19404921-20110802-01.

Meiland, F.J.M., R.-M. Dröes, J. de Lange and M.J.F.J. Vernooij-Dassen. 2005. Facilitators and Barriers in the Implementation of the Meeting Centres Model for People with Dementia and their Carers. *Health Policy* 71(2): 243–53. doi:10.1016/j.healthpol.2004.08.011.

Menec, V. and C. Brown. 2018. Facilitators and Barriers to Becoming Age-Friendly: A Review. *Journal of Aging & Social Policy* 1–23. doi:10.1080/08959420.2018.1528116.

Morin, M., H. Pollender, A. Battaglini and M.-È. Nadeau. 2013. *Vivre chez soi pour une personne en perte d'autonomie, c'est possible!* Observatoire québécois des réseaux locaux de services. Centre de santé et de services sociaux. Institut universitaire de gériatrie de Sherbrooke. Retrieved January 23, 2019. <http://www.csss-iugs.ca/c3s/data/files/Recit_Habitations_St_Christophe_2013_11_28.pdf>.

Morley, J.E. 2012. Aging in Place. *Journal of the American Medical Directors Association* 13(6): 489–92. doi:10.1016/j.jamda.2012.04.011.

Munn, Z., M.D.J. Peters, C. Stern, C. Tufanaru, A. McArthur and E. Aromataris. 2018. Systematic Review or Scoping Review? Guidance for Authors When Choosing between a Systematic or Scoping Review Approach. *BMC Medical Research Methodology* 18(1): 143. doi:10.1186/s12874-018-0611-x.

National Institute on Ageing (NIA). 2020. *An Evidence Informed National Seniors Strategy for Canada – Third Edition*. Retrieved June 10, 2021. <http://nationalseniorsstrategy.ca/wp-content/uploads/2020/09/NSS_2020_Third_Edition.pdf>.

Naylor, D., F. Girard, J. Mintz, N. Fraser, T. Jenkins and C. Power. 2015. *Unleashing Innovation: Excellent Healthcare for Canada: Report of the Advisory Panel on Healthcare Innovation*. Health Canada. Retrieved May 27, 2021. < https://www.canada.ca/content/dam/canada/health-canada/migration/healthy-canadians/publications/health-system-systeme-sante/report-healthcare-innovation-rapport-soins/alt/report-healthcare-innovation-rapport-soins-eng.pdf>.

Pollender, H., S. Deshaies, N. Gosselin, M.-È. Nadeau, J. Archambault and A. Battaglini. 2012. *Vieillir au sein de sa communauté malgré une perte d'autonomie: une région éloignée développe un milieu de vie pour ses aînés adapté à plusieurs niveaux de perte d'autonomie*. Retrieved January 26, 2019. <http://www.csss-iugs.ca/c3s/data/files/Maisondesaines_VF_Revisee_16%20juillet%202012.pdf>.

Le Réseau canadien de développement communautaire [Le Réseau canadien de DÉC]. 2006. *Profil de pratique efficace. Le Santropol Roulant: la popote intergénérationnelle*. Retrieved June 8, 2021. <https://ccednet-rcdec.ca/files/Santrop-20060401-F.pdf>.

Sands, P.L., Y. Wang, G.P. McCabe, K. Jennings, C. Eng and K.E. Covinsky. 2006. Rate of Acute Care Admissions for Frail Older People Living with Met Versus Unmet Activity of Daily Living Needs. *Journal of the American Geriatrics Society* 54(2): 339–44. doi:10.1111/j.1532-5415.2005.00590.x.

Scharlach, A., C. Graham and A. Lehning. 2011. The "Village" Model: A Consumer-Driven Approach for Aging in Place. *The Gerontologist* 52(3): 418–27. doi:10.1093/geront/gnr083.

Sévigny, A., D. Lepage and S. Proulx. 2015. *Les maisons des grands-parents : des connaissances pour soutenir le développement : Le développement des MGP en milieu rural* (vol. 2). Institut sur le vieillissement et la participation sociale des aînés de l'Université Laval.

Sibley, L.M. and R.H. Glazier. 2009. Reasons for Self-Reported Unmet Healthcare Needs in Canada: A Population-Based Provincial Comparison. *Healthcare Policy* 5(1): 87–101. doi:10.12927/hcpol.2009.20934.

Tang, F. and J.G. Pickard. 2008. Aging in Place or Relocation: Perceived Awareness of Community-Based Long-Term Care and Services. *Journal of Housing for the Elderly* 22(4): 404–22. doi:10.1080/02763890802458429.

Transport Canada. 2010. *Bus Routes for the Elderly*. Urban Transportation Showcase Program. Issue Paper 81: 1–8. Retrieved January 23, 2019. <https://publications.gc.ca/collections/collection_2012/tc/T41-1-81-eng.pdf>.

World Health Organization (WHO). 2008. *The World Health Report 2008: Primary Health Care Now More Than Ever*. Retrieved June 10, 2021. <https://www.who.int/whr/2008/whr08_en.pdf>.

World Health Organization (WHO). 2015. *World Report on Ageing and Health*. Retrieved June 9, 2021. <https://apps.who.int/iris/handle/10665/186463>.

Wyman, M.F., S. Shiovitz-Ezra and J. Bengel. 2018. Ageism in the Health Care System: Providers, Patients, and Systems. In L. Ayalon and C. Tesch-Römer, eds., *Contemporary Perspectives on Ageism* (pp. 193–212). Springer.