It's Time to Unleash the Power of Naturally Occurring Retirement Communities in Canada

NATIONAL INSTITUTE ON AGEING

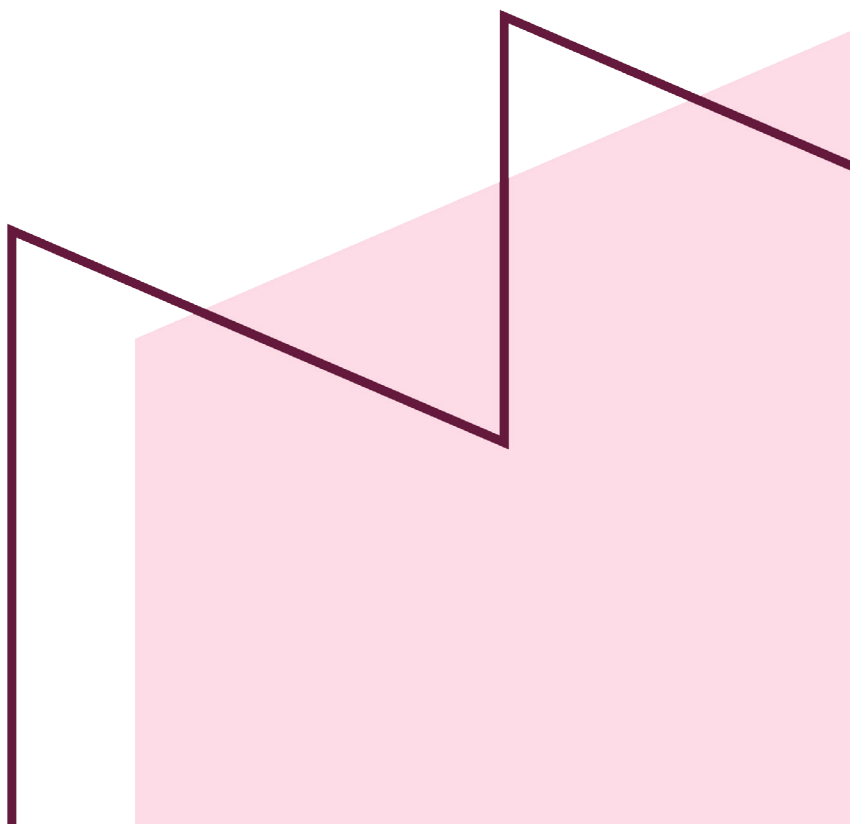NORC Innovation Centre at UHN

AGEING IN THE RIGHT PLACE

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National Institute on Ageing

Ted Rogers School of Management
350 Victoria St.
Toronto, Ontario
M5B 2K3
Canada

NORC Innovation Centre

Toronto General Hospital,
University Health Network
200 Elizabeth Street
Toronto, Ontario
M5G 2C4
Canada

About the National Institute on Ageing

The National Institute on Ageing (NIA) is a public policy and research centre based at Toronto Metropolitan University (formerly Ryerson University). The NIA is dedicated to enhancing successful ageing across the life course. It is unique in its mandate to consider ageing issues from a broad range of perspectives, including those of financial, psychological, and social well-being.

The NIA is focused on leading cross-disciplinary, evidence-based, and actionable research to provide a blueprint for better public policy and practices needed to address the multiple challenges and opportunities presented by Canada's ageing population.

The NIA is committed to providing national leadership and public education to productively and collaboratively work with all levels of government, private and public sector partners, academic institutions, ageing related organizations, and Canadians.

About NORC Innovation Centre at University Health Network

The NORC Innovation Centre at University Health Network is a first-of-its-kind centre dedicated to advancing a 21st century model of integrated care in naturally occurring retirement communities (NORCs). By leveraging multiple capabilities across the UHN enterprise, the NORC Innovation Centre seeks to provide Canadians with new options for aging in place with dignity and choice. It was born out of the efforts of UHN OpenLab, an interdisciplinary design and innovation studio dedicated to finding creative solutions at the intersection of health and society.

University Health Network (UHN) is Canada's leading research hospital. UHN encompasses Toronto General Hospital, Toronto Western Hospital, Princess Margaret Cancer Centre, Toronto Rehabilitation Institute and the Michener Institute of Education at UHN. The breadth of research, the complexity of the cases treated, and the magnitude of its educational enterprise has made UHN a national and international resource for patient care, research and education.

Authors

Madison Brydges, Ph.D.
Health Policy Researcher
National Institute on Ageing, Toronto Metropolitan University
Toronto, Ontario

Nilanee Koneswaran, MPP
Policy Analyst
NORC Innovation Centre, University Health Network
Toronto, Ontario

Tai Huynh, MBA, MDes
Policy Lead
NORC Innovation Centre, University Health Network
Toronto, Ontario

Julie Dunning, MPH
Senior Policy Advisor
National Institute on Ageing, Toronto Metropolitan University
Toronto, Ontario

Jen Recknagel
Director of Innovation and Design
NORC Innovation Centre, University Health Network
Toronto, Ontario

Samir Sinha, MD, DPhil, FRCPC, AGSF
Director of Health Policy Research, National Institute on
Ageing, Toronto Metropolitan University; Director of Geriatrics,
Sinai Health System and University Health Network; Professor
of Medicine, Family and Community Medicine, Health Policy,
Management and Evaluation, University of Toronto

Expert Reviewers

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Executive Summary

Canada's rapidly ageing population has drawn attention to the housing and care needs of older adults. It has long been recognized that many Canadians want to age in the home and community of their choosing (NIA, 2021; Mahmood et al., 2022). The COVID-19 pandemic strengthened this perspective, with a recent National Institute on Ageing (NIA) and Canadian Medical Association (CMA) survey finding that 96 per cent of respondents 65 years and older "would do everything they can" to avoid moving into an institutional setting (NIA, 2021).

The demand from Canadians wanting to age in their homes and communities for as long as possible has outpaced the health, social and housing infrastructure needed to do so. Underpinning this challenge is a lack of policies that can enable not just ageing in place, but what the NIA calls Ageing in the *Right* Place (AIRP): "the process of enabling healthy ageing in the most appropriate setting based on an older person's personal preferences, circumstances and care needs" (NIA, 2022a, p. 18).

Effective AIRP policies would address many of the issues confronting older Canadians today. For example, with the health care sector experiencing labour shortages, many older adults have unmet health and care needs; greater investments and efficiencies in home and community-care services could help fill some of those gaps (CMA, 2021; Agrba, 2021; Merali, 2022). Many older adults also struggle with a shrinking social network, which means they have less support for their care needs and fewer opportunities for meaningful social interactions that can help prevent social isolation and loneliness (NIA, 2022b). Most homes and communities

were not designed to be accessible, which can make it more difficult for older adults living with worsening functional abilities to maintain their independence (Bigonnesse & Chaudhury, 2022; Mahmood et al., 2022). Further, individuals with intersecting social identities that have historically been marginalized by society — such as members of Black, Indigenous and racialized communities, people living with disabilities, those who identify as 2SLGBTQIA+ and those with lower incomes — are typically under-represented in discussions about ageing in place (Mahabir et al., 2021; Phillips-Beck et al., 2020; Feher et al, 2017; Nelson & Rosenberg, 2022; Bigonnesse & Chaudhury, 2022).

Supporting older Canadians to age in the *right* place will require innovative housing models and infrastructure that can support their independence, safety, health and social well-being. This report examines one such model: Naturally Occurring Retirement Communities (NORCs). To begin with, there is a difference between a NORC and a NORC program. The original concept of NORCs was coined by Hunt & Gunter-Hunt in 1986, and refers to communities that over time may naturally come to house a high density of older adults (Hunt & Gunter-Hunt, 1986). In the absence of an agreed-upon definition of NORC parameters (Parkniak et al, 2022), the NIA and NIC further propose that NORCs may also include communities that were designed to house a large concentration of older adults (e.g. aged 55-plus apartment buildings, rent-geared-to-income housing or other communities for older people) but were not purpose-built to provide care for older adults in the way that retirement homes, assisted living facilities or LTC homes were. NORCs can be

identified across different housing types (e.g. single-family homes in one geographical area, a multi-residential building or complex, condos or co-ops).

A recent analysis conducted by UHN OpenLab identified buildings as NORCs if at least 30 per cent of their residents were aged 65 years and older, and there were at least 50 older people per building. They span market, co-op and social housing buildings, and include buildings exclusively for older people other than LTC and retirement homes. Using these criteria, OpenLab's Ontario-wide search identified 1,941 residential buildings as NORCs, housing a total of 217,000 older adults. This is approximately 10 per cent of Ontario's population of 2.68 million older adults, and is higher than the number of people in Ontario living in LTC homes (approximately 75,500) (Advantage Ontario, 2022) and retirement homes (56,491) combined (Costa et al, 2021).

Identifying NORCs provides an opportunity to leverage the density of older adults living in one place to provide a range of health and social supports and services (DePaul et al., 2022). In this report, we refer to these supports and services as "NORC programs." NORC programs often integrate health, social and physical supports directly within the community to make it easier to enable AIRP (Mahmood et al., 2022; Parniak et al., 2022). Many are designed by and for older adults living in the community and require collaborative partnerships across different levels of government, community agencies, health services, residents and property owners.

Over several decades, a growing body of evidence has come to support the notion of integrating services directly within an ageing community. NORC programs were implemented in New York State in the mid-1980s, and have grown to become recognized in state legislation and receive stable government funding (Altman, 2006; Vladeck, 2004; Personal Communication, 2022a). There are currently 41 NORC programs across the state that provide services including health and wellness activities, community engagement opportunities and educational programs (NYC Department for the Aging, n.d.; Personal Communication, 2022c).

In Canada, there have been several NORC pilot programs. In 1996, the Cherryhill Healthy Ageing Program (CHAP) was launched in a community with a large proportion of older adults in London, Ont. (Kloseck et al, 2002, 2010). The Oasis Senior Supportive Living model, which was developed in 2009 by the Frontenac Kingston Council of Aging, has recently expanded to sites across Ontario and British Columbia (Oasis Senior Supportive Living, 2022; DePaul et al, 2022). During the COVID-19 pandemic, the Ontario COVID-19 Science Advisory Table used NORC criteria to propose and inform a mobile vaccination program to administer vaccines on-site in buildings located within communities at a heightened risk of hospitalization, morbidity or mortality from a COVID-19 infection (Huynh et al., 2021). However, in most communities across Canada, there has been little effort to identify existing NORCs, let alone provide the public funding to foster programs that support residents with opportunities for meaningful engagement, integrated health and social services and assistance with everyday tasks.

With their high density of older adults, NORCs provide an ideal opportunity to realign the delivery of existing health and social services in a more efficient and forward-looking way. NORC programs also create meaningful opportunities

for social participation and community engagement and enable improvements to the physical environment. Further to this, the density parameters used to designate NORCs can be determined based on the needs of local communities, enabling NORC programs in urban, suburban and rural areas.

In the absence of an enabling policy environment, attempts to harness the potential for NORC programs have largely been limited to grassroots, localized initiatives. Thus, the NIA and NORC Innovation Centre have developed the following policy recommendations for all levels of government:

1. Develop a national strategy to better advance NORC programs across the country

2. Support and engage with local communities to enable the development of NORC programs

3. Establish sustainable funding mechanisms and other opportunities to encourage the development of local NORC programs

4. Build greater system capacity for innovation, research and knowledge exchange around NORCs and NORC programs across Canada

New service models are urgently needed for older adults to age where they want to be: in their homes and communities for as long as possible. Canadians deserve access to a range of housing options that provide the support they need to age with dignity, autonomy and a high quality of life. With support from all levels of government, community organizations and older adults themselves, NORC programs can be one of these options.

Introduction

In 2021, one out of every five Canadians was 65 years and older, and the number of Canadians aged 85 years and older is expected to more than triple over the next 25 years (Statistics Canada, 2022a, 2022b). Accompanying this rapidly ageing population is an increasing desire among older Canadians to age in their homes and communities of choice (Employment and Social Development Canada, 2016b; Mahmood et al., 2022). This view has persisted in the wake of the COVID-19 pandemic, with 96 per cent of respondents of a 2021 National Institute on Ageing (NIA) and Canadian Medical Association (CMA) survey reporting they "would do everything they can" to avoid moving into an institutional setting (NIA, 2021).

Canada's ageing population presents particular challenges that require new ways of conceptualizing community-based services and support for older adults. Canadians are living longer with more complex health, social and functional challenges (Bigonnesse & Chaudhury, 2022; Forsyth et al., 2019). Many older adults have unmet caregiving needs, face barriers to accessing and navigating health and social services, and struggle to afford out-of-pocket expenses (CIHI, 2020) and affordable housing (Government of Canada, 2017). The risk of social isolation and loneliness increases with age due to a variety of factors, such as declining health, loss of a partner or family member and accessibility barriers (Mahmood et al., 2022; NIA, 2022b; Townsend et al., 2021). Maintaining social engagement and connectedness throughout life has been linked to higher rates of physical activity, mental well-being and improved cognitive functioning (Townsend et al., 2021).

Many older adults require health and social services to age in place. However, there are currently insufficient services to keep up with demand, with funding for these services lagging behind funding for institutional care (MacDonald et al., 2019). The Canadian Institute for Health Information (CIHI) recently found that one in nine older adults could have avoided moving to a long-term care (LTC) home if they had received the right amount of support at home (CIHI, 2020). This problem is anticipated to intensify, with the demand for home and community-based care services expected to grow more than 50 per cent over the next 10 years (CMA 2021).

Going beyond ageing in place, the National Institute on Ageing's conceptualization of Ageing in the *Right* Place (AIRP) (see Box 1) acknowledges that older adults need differing levels and types of support to age in a way that supports their physical and mental health and well-being. The concept draws attention to opportunities to integrate health and social services and remove barriers to their access; create more accessible homes and communities; and provide meaningful opportunities for social connectedness and engagement (Bigonnesse & Chaudhury, 2022; Greenfield et al., 2012). Solutions to enable AIRP must address structural and contextual factors that impact individual-level choices about where they want to live (Bigonnesse & Chaudhury, 2022; NIA, 2022a).

The NIA's Four Pillars of Ageing in the _Right_ Place

The National Institute on Ageing defines Ageing in the _Right_ Place (AIRP) as "the process of enabling healthy ageing in the most appropriate setting based on an older person's personal preferences, circumstances and care needs." Based on this definition, the NIA has identified four "pillars" of factors that are fundamental to enabling AIRP:

1. Promoting Preventive Health and Better Chronic Disease Management

2. Strengthening Home and Community-Based Care and Supports for Unpaid Caregivers

3. Developing More Accessible and Safer Living Environments

4. Improving Social Connections to Reduce Loneliness and Social Isolation

(NIA, 2022a, p. 8)

This report examines one example of a potential model to enable AIRP: Naturally Occurring Retirement Community (NORC) programs. To begin with, there is a difference between a NORC and a NORC program. The original concept of NORCs was coined by Hunt & Gunter-Hunt in 1986, and refers to communities that over time may naturally come to house a high density of older adults (Hunt & Gunter-Hunt, 1986). In the absence of an agreed-upon definition of NORC

parameters (Parkniak et al, 2022), the NIA and NIC further propose that NORCs may also include communities that were designed to house a large concentration of older adults (e.g. aged 55-plus apartment buildings, rent-geared-to-income housing or other communities for older people) but were not purpose-built to provide care for older adults in the way that retirement homes, assisted living facilities or LTC homes were. NORCs can be identified across different housing types (e.g. single-family homes in one geographical area, a multi-residential building or complex, condos or co-ops).

There is a high potential for the development of NORC programs across Canada. Canada's "baby boomer" generation is currently the largest population cohort in Canada, comprising 24.9 per cent of its population in 2021 (Statistics Canada, 2022a). Therefore, Canada's rapidly ageing population, combined with a large number of older adults living in close proximity to one another, creates a clear opportunity to realign the delivery of health- and social-care services in a way that takes advantage of naturally occurring population density.

> Identifying NORCs makes it possible to leverage the concentration of older adults living in a given area to provide a range of health and social supports and services, such as health promotion and chronic-disease management, social and recreational programming, and meal support and care delivery.
>
> (Kyriacou & Vladeck, 2011; Parniak et al, 2022; DePaul et al., 2022)

In this report, we refer to these supports and services as NORC programs. NORC programs often integrate health, social and physical supports directly within the community to make it easier to enable AIRP (Mahmood et al., 2022; Parniak et al., 2022).

Throughout this report, we describe the leading NORC programs to date across Canada and the United States. These programs are diverse in nature and many date back to the 1980s and 1990s, starting as grassroots, localized efforts. Some have expanded to communities at the provincial and state level (Oasis Senior Supportive Living, 2020; Vladeck, 2004; DePaul et al, 2022).

The public health potential of NORCs was recently showcased during the COVID-19 pandemic. Before the second COVID-19 vaccine boosters were available for most adults in Ontario, Middlesex London Health Unit used NORC parameters to expand the eligibility criteria for adults 50 years of age and older (Middlesex-London Health Unit, 2022). NORC criteria were also used to provide pop-up vaccination programs in four Oasis NORC buildings in Kingston, Ontario (Queen's University, 2022). In Toronto, NORC criteria were used to propose and inform a mobile vaccination program to administer vaccines on-site in buildings located within communities at a heightened risk of hospitalization, morbidity or mortality from a COVID-19 infection (Huynh et al., 2021).

There is evidence in support of programs that integrate a range of services — including health services, home and community-based care services, physical supports and social and recreational activities — directly where older individuals live (Agarwal et al, 2019;

Hey Neighbour, 2021, 2022). For example, in Vancouver, B.C., the West End Seniors' Network provides the Close to Home initiative, which offers on-site social events and activities to a building composed of 30 per cent older adults (Hey Neighbour Collective, 2021). Activities include birdwatching and socializing in the common area of the building (Hey Neighbour Collective, 2021; West End Seniors' Network, 2021). In Toronto, the St. James Town community, the largest high-rise community in Canada, has its own extensive health and social hub called The Corner, which provides health and social services for older adults — such as physical- and mental-health services, health-navigation support, meal programs, recreational programs including lawn bowling, support groups and community events (Kowalchuk, 2021). While St. James Town houses individuals from all age groups, 50 per cent of older adults residing there live alone, 53.3 per cent of whom live in poverty. In 2019, an apartment building housing older adults in Burlington, Ont., launched the Program of All-Inclusive Care Community Hub (Alzheimer Society of Brant, Haldimand Norfolk, Hamilton Halton, 2022; CBC News, 2022). The program is inspired by the well-established American Program of All-Inclusive Care for the Elderly (PACE) model, which — like NORCs — aims to integrate health, social, wellness and housing services to prevent avoidable institutionalization. Thus, our understanding of NORC programs can build on the experiences of other place-based programs and models that bring services directly to communities of older adults.

Throughout this report we showcase the potential for NORC programs across Canada. However, there are significant gaps that currently prevent NORC programs from expanding across the country. Thus, the purpose of this report is two-fold. First, our goal is to introduce the concept of

NORCs and NORC programs and propose key features of the model. In doing so, we situate NORC programs within the landscape of community-based care models in Canada. NORC programs are not aiming to replace LTC or retirement homes. Rather, they can delay and even prevent some older adults from being admitted to LTC homes by providing a flexible and responsive continuum of services where they live in the community (Xia et al, 2022). Secondly, we propose a policy framework that will be needed to support the greater expansion of NORC programs to scale hyper-local efforts and create an organized, pan-Canadian initiative. Our design principles and policy recommendations were informed by a review of the scientific literature on NORC programs and analogous housing support models, expert interviews and the specialist knowledge of the NORC Innovation Centre, UHN OpenLab and the NIA.

Leveraging Toronto NORCs to Enable the COVID-19 Vaccination Program

In 2021, the Ontario COVID-19 Science Advisory Table proposed targeting NORCs with a mobile COVID-19 vaccination program (Huynh et al, 2021). By providing an on-site vaccination service, the initiative could target communities at a heightened risk of hospitalization, morbidity or mortality from a COVID-19 infection. NORCs for this initiative were defined as "apartment, condo, co-op and social housing buildings with at least 30 percent of their residents aged 65 years or above, and with at least 50 older people per building" (p. 2). Providing on-site vaccinations within NORCs took advantage of the high density of older adults residing in high-risk neighbourhoods, and allowed older adults with mobility challenges and those experiencing difficulty accessing or understanding online booking systems to get their vaccines at their place of residence.

To demonstrate the impact of NORC vaccination programs, the Science Advisory Table identified the age distribution of residents living in NORCs in Toronto, and the number of older adults living in NORCs located in neighbourhoods with high rates of COVID-19 (Huynh et al, 2021). This was done by analyzing the age distribution for all residents in Toronto's postal codes from the Registered Persons Database for the fiscal year 2019-20 (excluding long-term care and retirement homes).

The analysis identified 489 residential buildings (illustrated in Figure 1 below) that can be characterized as NORCs in Toronto, housing 70,013 adults aged 65 years and older, and 30,346 adults aged 80 years and older (Huynh et al., 2021). Of these NORCs, 256 (52.4 per cent) were located in neighbourhoods with a high rate of COVID-19. These 256 buildings were home to 40,955 adults aged 65 years and older, and 18,144 adults aged 80 years and older.

UHN OpenLab also used this data to support vaccination efforts in NORCs in Toronto by working with volunteers to go door-to-door to enroll older adults for on-site vaccinations and address any concerns (UHN OpenLab, 2021a; 2021b).

Figure 1: Location and Population Size of 489 Naturally Occurring Retirement Communities (NORCs) in the City of Toronto, by Building Type and Neighbourhood Incidence of SARS-CoV-2 from January 23, 2020 to January 16, 2022
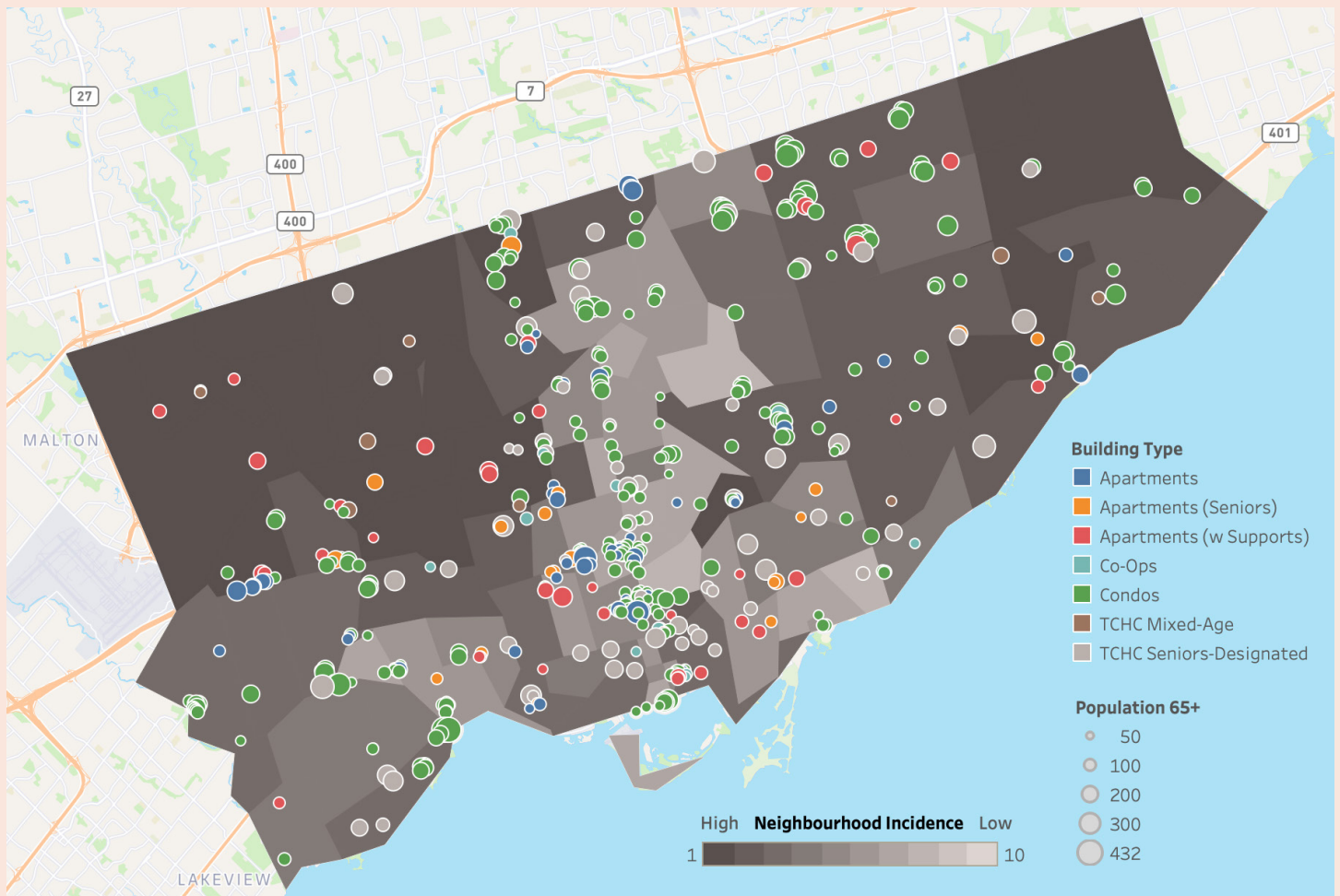
Shaded map showing Toronto neighbourhoods ranked in 10% increments of COVID-19 risk by the cumulative incidence of SARS-CoV-2 infections among Ontario neighourhoods from Jan 23, 2020 and Jan 16, 2021. Neighbourhoods are defined by the first three characters of a resident's postal code, known as "forward sortation area". Group 1 includes neighbourhoods with the highest cumulative incidence of SARS-CoV-2 infection, whereas group 10 includes neighbourhoods with the lowest cumulative incidence of SARS-CoV-2 infection. The City of Toronto does not have any neighbourhoods in risk groups 9 or 10. The map is overlaid with 489 NORCs, defined as apartment, condo, co-op and social housing (Toronto Community Housing Corporation) buildings with at least 30 percent of their residents being 65 years of age and above, and with at least 50 older persons per building. Data for cumulative incidence of SARS-CoV-2 infections sourced from the Public Health Case and Contact Management Solution and other case management systems (CCM plus), extracted on January 16, 2021; data for demographics of NORCs sourced from the Registered Persons Database for fiscal year 2019/2020

Understanding the Differences Between NORCs and NORC Programs

There are no consistently agreed-upon parameters for a residential community to be defined as a NORC (Parniak et al., 2022). In the peer-reviewed literature, thresholds for a geographically contained area to be considered a NORC range from 25 per cent to 50 per cent of residents being older adults (DePaul et al., 2022; Parniak et al., 2022). The minimum age parameters for older adults have also ranged from 50 to 65 years of age. NORCs can be horizontal (i.e. housing that is spread out over a specific geographical area) or vertical (i.e. a contained building or series of buildings are usually that owned and operated by a housing provider) (Bronstein & Kenaley, 2010; Enguidanos et al., 2010; DePaul et al, 2022). A building or neighbourhood can also evolve over time into and out of its status as a NORC, in line with its changing population dynamics. However, the identification and examination of horizontal NORCs remains limited and are less discussed in the literature, particularly in the Canadian context (with the exception of DePaul et al, 2022).

NORCs are an inherently flexible geographical concept and are thought to emerge for different reasons. There is research that suggests some NORCs emerge due to the departure of younger residents in combination with existing residents choosing to remain in the community, or the in-migration of older adults to the area (Hunt, 2001; Rivera-Hernandez, 2015; Xia, Buys & Yigitcanlar, 2021). A combination of factors can lead older adults to remain in their homes, such as a connection to the area, the fear of not being able to live elsewhere and a lack of alternative housing options (Hunt, 2001). In Ohio, a spatial analysis of NORCs from 2000 to 2010 found that NORCs were dynamic, and had various patterns of "emerging, disappearing, and enduring," a finding consistent with the overall high migration rate within the state (Rivera-Hernandez et al, 2015, p. 624).

Local amenities may also influence the emergence of NORCs. Hunt & Gunter-Hunt (1986) remarked on the value of neighbourhood services and amenities in improving the experience of older adults wanting to age in their own homes for longer. In Australia, a recent analysis identifying NORCs found that many were located in the same coastal communities where many older adults outside of NORCs also prefer to live, due to the close proximity to scenery and social and recreational activities (Xia, Buys & Yigitcanlar, 2021)

A particular appeal and value of NORC programs is their ability to leverage the naturally occurring density of older adults living in one place and integrate a diverse array of programs to support their well-being (Parniak et al, 2022; Xia et al, 2022). NORC programs achieve this goal through a community capacity-building approach which includes co-designing and developing the program with NORC residents, community organizations and services, and the public sector (Xia et al, 2022; DePaul et al, 2022). This approach is inherently flexible — as the needs of the NORC residents shift, the program will as well.

Key Features of NORC Programs

Participatory Decision-making

NORC Programs

Integrated Health Care and Supportive Services

Social Well-being

Common Spaces

For the purposes of this report, the NIA and NORC Innovation Centre suggest principles that can help inform the identification of NORCs that may benefit from additional programs and services. In the context of NORC programs, older adults are the target population for these services.

1. Geography

NORCs can exist within a residential building (i.e. vertical NORC) or a neighbourhood, which can cover a larger geographical area (i.e. horizontal NORC).

2. Age

Resident age is often a key demographic factor used to identify potential NORCs. To identify NORCs, stakeholders must be aware of the demographic makeup of their community at the level of buildings (to identify vertical NORCs) or smaller defined geographical areas (to identify horizontal NORCs).

3. Percentage of Older Residents Living in the Community

NORCs are typically communities with a minimum proportion of older residents. This helps to identify NORCs that would benefit from older resident-specific programming, as well as to also allow for greater efficiency in delivering place-based services, as there is likely a sustained demand for services in these locations.

4. Minimum Number of Older Adults

A key opportunity of NORCs is their ability to target a number of older adults living in one place to provide specific services. Defining a minimum number of older adults requires a balanced approach that ensures programs are organized and delivered efficiently, while also being inclusive to meeting the needs of geographical areas or building communities that are less populated. Smaller communities will, therefore, likely set lower minimum thresholds for the number and percentage of older adults needed to provide various services.

What Do We Know About NORC Programs?

Different types of NORC programs have been piloted across North America (Kloseck et al., 2002; Vladeck, 2004; Altman, 2006; Maclaren et al., 2007; Kyriacou & Vladeck, 2011; Oasis Senior Supportive Living, 2020; DePaul et al., 2022; Xia et al, 2022). While the NIA and NORC Innovation Centre's research revealed diverse characteristics of NORC programs, many shared a similar underlying philosophy of mobilizing cross-sectoral resources to build a safe and vibrant environment for older adults to enable AIRP and improve or maintain well-being.

Many current and past NORC programs share at least some of the following aims:

- They address social isolation by providing opportunities for social relationships and connection between residents and their local community;

- They aim to reduce a wide range of unmet health needs by increasing access to services, information and resources;

- They provide opportunities for community and civic engagement;

- They re-imagine the community's physical environment by providing a common shared space that is accessible, provides meaningful activities and programs and fosters social interactions.

- They are resident-driven initiatives that formally recognize the voices of older adults in informing program design and delivery.

The NORC concept was first described by researchers in the United States in 1986 (Hunt & Guneter-Hunt, 1986). Since then, NORC programs have received considerably more attention in the United States than in Canada or other countries (Parniak et al, 2022; Huo & Cao, 2022; Xia et al, 2022), although published research on NORCs has recently been emerging from Australia and South Korea (Xia et al, 2022). In both the United States and Canada, securing sustainable funding for programs has been a challenge, research outcomes are primarily descriptive and there is a lack of robust evaluation frameworks, consistent NORC parameters and program formats. These factors make it difficult to compare NORC programs or evaluate their intermediate and long-term outcomes (Vladeck & Altman, 2015; Parniak et al, 2022; Chum et al, 2022).

Many of the notable impacts of individual NORC programs are discussed in the case studies below. In summary, there are diverse models of NORC programs and the literature examining individual programs has found benefits at the individual and system level.

Increased access to health services and preventive care:

- NORC programs often offer services, information and health screenings that aim to improve access to services that help residents proactively manage chronic conditions (Kloseck et al., 2002, 2017; Kyriacou & Vladeck, 2011).

- In an evaluation of four NORC programs in New York from 2004 to 2006, staff increasingly identified residents in need of support through integrated health assessments and shared planning between the NORC program and primary-care centres (Kyriacou & Vladeck, 2011). For example, at a Queens NORC site, program staff conducted 100 fall-risk assessments. This study also found that residents were more likely to report and seek help to manage falls and emotional health issues (Kyriacou & Vladeck, 2011).

- In the Cherryhill CHAP NORC program, a highly trained geriatric nurse practitioner built trust with residents and worked in the community with government-funded home care co-ordinators and nurses to provide education around geriatric assessment, help manage complex cases and proactively identify at-risk residents (Kloseck et al., 2002).

- Analysis of two NORC programs found a decreased likelihood of emergency department visits (Kyriacou & Vladeck, 2011; Oasis Senior Supportive Living, 2022), hospital admissions and injurious falls amongst residents (Oasis Senior Supportive Living, 2022).

Improved health outcomes:

- A study of residents in four New York NORC–Supportive Service Programs found residents had improved health indicators (Kyriacou & Vladeck, 2011). For example, residents of one site showed improved levels of metabolic and cardiovascular biomarkers and reduced blood pressure (Kyriacou & Vladeck, 2011). At another site, residents' emotional health improved from 41 per cent to 88 per cent (Kyriacou & Vladeck, 2011).

Delayed admission to LTC homes:

- A 2009 analysis of the Kingston, Ont., Oasis program found that 12 residents who were deemed eligible for placement in a LTC home subsequently decided not to go as they were receiving sufficient support from the NORC program (UHN OpenLab, 2018, p. 81).

- A study of a NORC program in St. Louis, Mo., found that over the course of six years, the number of people who moved to LTC homes dropped by two per cent, which resulted in an estimated 50 fewer people entering LTC homes (Elbert & Neufeld, 2010). Furthermore, the average age of residents who did move into a LTC home was 87, or five years above the state average.

Improved social well-being:

- Many NORC programs have been described as positively impacting older adults' sense of community engagement and social relationships, addressing social isolation and loneliness (Cohen-Mansfield et al., 2010; Elbert & Neufeld, 2010; Greenfield et al., 2013; Kloseck et al., 2002; Parniak et al., 2022; UHN OpenLab, 2018; Chum et al, 2022).

- NORC programs provide older residents opportunities for leadership and engagement through volunteer roles in their own communities or informing the kinds of programs offered within the NORC (Kloseck et al, 2002; Greenfield & Fedor, 2015; DePaul et al, 2022) .

Realizing the Potential of NORC Programs

NORC programs have the potential to create efficiencies in the delivery of home care and community-support services

Many older Canadians who want to age in their homes for as long as possible will require some level of support to do so, often in the form of home and community-based care (MacDonald et al., 2019) and caregiver support. By 2050, there will be about 30 per cent fewer close family members who are able to provide care to a loved one (National Institute on Ageing, 2020). Personal support workers (PSWs) or care aides and related occupations were already in short supply well before the COVID-19 pandemic (Agrba, 2021; Merali, 2022). For instance, in January 2020, home care employers across Canada reported 46 per cent of their job vacancies had gone unfilled for more than 120 days (Canadian Medical Association, 2021).

The growing shortage of paid care providers and unpaid caregivers is contributing to widening gaps in the provision of home and community-based care that can lead to increasing unmet daily health and personal care needs, such as homemaking and personal care, and extended hospital stays (CIHI, 2022). A 2021 preliminary estimate of health expenditure trends conducted by the Canadian Institute for Health Information (CIHI) found that home and community-based care accounted for only four per cent of all health care spending across Canada, compared to 50 per cent allocated to hospitals, drugs and physician services (CIHI, 2021b). The Canadian Medical Association (CMA) has further predicted

that the demand for home care will increase from 1.2 million people in 2019 to 1.8 million people by 2031 (CMA, 2021). CMA projects that this will increase costs of home care from "$29.7 billion in 2019 to $58.5 billion in 2031", resulting in an overall cost of $490.6 billion between 2021 to 2031 (p. 2). In Ontario, pressures on the home and community-care sector have been exacerbated by the COVID-19 pandemic, with new client requests for publicly funded home care services being met only 55 per cent of the time, compared to 95 per cent before the pandemic (Ogilvie, 2022).

Currently, there are some NORCs and other settings where some residents receive publicly funded home and community-based care and community-support services. However, it is well known that many of the services being delivered in the same building are often not coordinated by location, with multiple organizations sometimes providing the same types of services within the same building and using different providers (Expert Group on Home & Community Care, 2015). The need to better integrate the delivery of home care and community-support services in a place-based model has already been identified as a key method to address rising demands for services (Toronto Central CCAC, n.d.; NE-LHIN, n.d.; Expert Group on Home & Community Care, 2015).

In several Ontario retirement homes, the Personal Support Cluster Care program was developed to allow a single dedicated team of PSWs to deliver care to an entire building (NE-LHIN, n.d.). This model gave the team greater flexibility in how services were co-ordinated among their clients and reduced the time needed for PSWs to travel to clients. In 2011, a Neighbourhood Care Teams (NCTs) model was also trialed in Toronto, Ont., which consisted of a multidisciplinary health care team that provided on-site services in defined neighbourhoods (Toronto Central CCAC, n.d.) NCTs were implemented to enhance both the client and care provider experience, improve staff satisfaction and build a better value for money by supporting clients at home, thereby avoiding costly hospital and emergency department visits (Toronto Central CCAC, n.d.). A preliminary evaluation of the first phase of the pilot showed enhanced efficiency, with 18 per cent more clients served, and only a three per cent increase in service utilization. These two examples of innovative location-based care delivery models point to ways in which care can be better streamlined and co-ordinated in NORCs.

In the context of rising demands for health, home and community-based care services, NORC programs provide an opportunity to more efficiently provide place-based, integrated services and offer better value through economies of scale. NORC programs can help reorganize the often-fragmented delivery of home care service via multiple providers into neighbourhood care teams and clustered care models that can more flexibly deliver a number of integrated services. Having a small, dedicated, interprofessional team of providers that understand the needs of their clients and the broader community allows them to provide person-centred care that addresses their needs more efficiently.

NORC programs have the potential to address the barriers older adults face in accessing services and navigating health and social–services systems

One reason that older adults do not seek out health care or other services is that they experience accessibility barriers. Many residential buildings and communities lack inclusive social and physical spaces (Mahmood et al., 2022; Masotti et al., 2010). For example, for individuals living with a disability, spaces or communities with inaccessible design pose barriers to physical activity, social interactions and health care services. Further, older adults in many Canadian communities do not have equal access to transportation if they do not have their own vehicle or can no longer drive (Mirza & Hilko, 2022). This is a considerable gap, as transportation is a key enabler of accessing health care services and social interactions. Physical environments that inadequately support older adults' autonomy are important "push factors" that can prevent older adults from ageing in their preferred location (Huo & Cao, 2022, p. 11).

Access to health and social services is also dependent on an individual's knowledge of the system. Canada's "health care system has been described as fragmented and uncoordinated" and can be especially difficult for older adults and their caregivers to navigate (Heckman et al., 2013, p.200). Older adults, their families and their caregivers are often required to navigate these systems on their own and learn as they go (Funk, 2019). The time caregivers spend understanding how to access public services has economic and social costs, as it takes away from the time they could have spent on other care activities (Funk, 2019). For example, consultations for the Manitoba government showed that 36 per cent

of caregivers of older adults reported that they needed help navigating the system (Funk, 2019). Marginalized groups face further challenges understanding which services are available to them due to language barriers and differences in income and education (Funk, 2019).

Accessing information and care digitally adds another layer of challenges. While digital technology can contribute to healthy ageing by improving access to health care and other related information, too many older adults lack the devices, internet connectivity or digital literacy they need to access to these services, and technological advancement rarely considers the needs of older adults (Abdelaal & Andrew, 2021; Akinola, 2021). These barriers are exacerbated when older adults from marginalized groups try to access this information digitally. For example, a study on digital inclusion and older adults in London, Ont., found that immigrant or low–income older adults tend to experience more barriers like cost, language and connectivity that affect their ability to access information digitally (Crosby et al., 2018).

NORC programs bring services directly to residents, addressing accessibility barriers that hinder physical and social wellness. Common spaces can be designed to ensure accessibility for all residents. NORC programs can also create a program co-ordinator position responsible for organizing the delivery of services within a NORC, alleviating the pressure on older adults and unpaid caregivers to navigate the complex health and social services system.

NORC programs have the potential to enhance the social well–being of older adults

Social well–being is considered a key aspect of health and well–being (NIA, 2022b). While individuals of all ages can be lonely or socially isolated, these issues have specific implications for the health, well–being and quality of life of older adults (Nicholson, 2012; Townsend et al., 2021). Research has repeatedly shown that social isolation increases the risk of stroke, cancer, dementia, coronary heart disease and functional decline for older adults (Nicholson, 2012; NIA, 2022b).

Research shows about 30 per cent of Canadian older adults "are at risk of being socially isolated," meaning their social network is substantially diminished (Employment and Social Development Canada, 2017; NIA, 2022b). Social isolation can lead to the experience of loneliness, a subjective assessment that one's "social relationships are lacking" (NIA, 2022b, p. 15). The COVID–19 pandemic exacerbated Canadians' experiences of social isolation, with a recent NIA/ Telus Health survey finding that "40 per cent of Canadians aged 55 years and older experienced a lack of social connections and companionship throughout the pandemic" (MacDonald et al., 2019, p. 13).

Older adults who are immigrants, low–income or identify as 2SLGBTQIA+ report higher levels of loneliness and are at heightened risk of social isolation due to systemic discrimination (Employment and Social Development Canada, 2016a). Older adults can experience social isolation even in living settings such as high–rise apartment buildings where they are surrounded by other people. For instance, a report examining the social connectedness of Vancouver residents living in high–rise buildings found high levels of loneliness, and many residents reported they did not know their neighbours (Hogg & Hoar, 2020).

Programming that encourages and enables social cohesion will be key to addressing isolation and loneliness and enabling older adults to age in the right place. For instance, a quarter of adults aged 65 years and older want to participate in more social activities (Hughes et al., 2006, p. 1; NIA, 2022b). Barriers to social participation can include inaccessible physical spaces in the community, declining health or physical mobility, or a lack of opportunities for social engagement (Bigonnesse & Chaudhury, 2022; Greenfield et al., 2012; Townsend et al., 2021). Previous research on NORCs has found that many NORC residents were single and lived alone (Kloseck et al, 2002; Huo & Cao, 2022), further suggesting the need for social interventions among this population.

Evidence from NORC programs that prioritize social programming show that building social connectedness has a multitude of benefits for residents. NORC programs directly address social isolation by providing spaces for both organized and informal social interactions. NORC programs also aim to foster community-building and collective empowerment by prioritizing residents' voices in the program's design, and providing opportunities for leadership and volunteering.

NORCs have the potential to address the systemic marginalization and inequities experienced by older adults from equity-deserving communities

There is long-standing evidence that historically marginalized groups experience health inequities stemming from systematic barriers relating to language, culture, racism, gender identity and/or gender expression, sexual orientation and income (Mahabir et al., 2021; Mahmood et al., 2022; National Advisory Council on Aging, 2005; Phillips-Beck et al., 2020). Certain conceptions of ageing in place have under-represented the lived experiences of older adults from equity-deserving communities, such as members of Black, Indigenous and racialized communities, immigrants and newcomers, people living with disabilities and those from 2SLGBTQIA+ communities (Mahabir et al., 2021; Phillips-Beck et al., 2020; Ferrer et al, 2017; Nelson & Rosenberg, 2022; Bigonnesse & Chaudhury, 2022).

Older adults who experience low income are more likely to experience poorer health and face structural barriers to improving their health. Consequently, older adults with lower household-income levels experience higher rates of functional decline and loneliness (American Psychological Association, 2010; Perissinotto et al., 2012) and are less likely to be physically active or access preventive health care (ONPHA, 2016). Low income also impacts older adults' experiences finding appropriate housing and affording out-of-pocket expenses (Canadian Public Health Association, n.d.; Williamson et al., 2006; Government of Canada, 2017).

Approximately 40 per cent of the 1,941 NORCs in Ontario are located in postal codes where at least 25 per cent of residents identify as racialized. A recent scoping review found that

the NORC Supportive Services Program model in New York State has often been successfully applied in multicultural communities where older adults have lower to middle incomes (Hou & Cao, 2022).

The participatory approaches used in NORC programs acknowledge that equity deserving communities can also be powerful sources for driving change within their own communities. This aligns with other recent calls to identify the strengths and agency of local communities in building resilient communities that can manage sudden crises, such as an extreme weather event (Poland et al, 2021) and in establishing meaningful opportunities for community engagement, care and support (e.g. the ResilientTO experiment) (Centre for Connected Communities, 2022; Fitzgibbons & Mitchell, 2020).

Local areas can prioritize NORC programs in equity-deserving communities where there is a high need for services and existing services fall short. The NORC program model also recognizes the expertise and knowledge of residents, including those from equity-deserving communities, by creating equitable opportunities for engagement in the design of NORC programs. However, providing a space for members of equity-deserving communities to voice their concerns doesn't always mean they'll feel safe or comfortable doing so. Further, community engagement efforts need to ensure that the voices of residents are upheld in decision-making processes. NORC programs should ensure there are meaningful forms of engagement to help ensure programs are culturally specific and safe.

Lessons Learned from NORC Program Case Studies

New York State Neighborhood and Classic NORC Program
New York State

Overview

- The first and best-known NORC program in North America was developed in New York City in 1986 (Vladeck & Altman, 2015). The program started as a grassroots initiative spearheaded by the United Jewish Appeal (UJA), and attracted attention from other organizations that replicated the model in their own communities (UJA-Federation of New York, n.d., Vladeck, 2004).

- In the 1990s, housing companies and co-ops became key funding sources for some of the replicated models, increasing community-level support for NORC programs. Community support and significant advocacy work led by the UJA motivated the State to formally organize and fund NORC programs in 1995. (Altman, 2006; Forsyth et al., 2019; Personal Communication, 2022a; Vladeck, 2004).

- New York State is the only jurisdiction in North America that recognizes NORCs in government legislation. There are 41 NORC programs in operation across the state (NYC Department for the Aging, n.d.; Personal Communication, 2022c).

- In 2006, New York State adopted the World Health Organization's Age-Friendly Cities model, and in 2017, it launched a statewide plan that supported collaborations between the public sector, private organizations and the general public (Forsyth et al., 2019). New York ultimately supports NORC programs as a mechanism to improve older adults' quality of life, enhance access to community services and prevent unnecessary hospitalizations and LTC admissions for community-dwelling older adults (Bronstein & Kenaley, 2010).

- New York NORC programs are primarily staff-driven (Forsyth et al., 2019), although they do include opportunities for residents to volunteer, sit on advisory boards and provide input into program design (Greenfield & Fedor, 2015). While resident-led programs are not the primary feature of the New York model, the services offered within NORC programs are shaped by resident needs (Greenfield, 2016; Vladeck, 2004). Residents also support each other through information sharing and the development of informal relationships (Greenfield, 2016).

Parameters

In order to be eligible for state funding:

- The Applicant must be a not-for-profit agency specializing in housing, health or other human services which serves or would serve the community within which NORC is located (NY Elder L § 209, 2012).

- The proposed service area must meet the parameters of a Classic or Neighborhood NORC as defined under Elder Law. Classic or Neighborhood NORCs aren't predominantly built for older adults nor do they restrict admission to older adults. They also have their own population thresholds.

    - Classic NORC: "At least 40% of units have to have an occupant who is an older adult 60 years or older in which at least 250 of the residents of an apartment building are older adults or 500 residents of a housing complex are older adults. A majority of these older adults have to be of low or moderate income" (NY Elder L § 209, 2012).

    - Neighborhood NORC: The Elder Law defines thresholds for rural and non-rural areas. In a non-rural area, at least 30% of residents must be adults 60 years of age or older, or have a unit occupied by an adult 60 years of age or older. In a rural area, at least 20% of residents must be adults 60 years of age or older, or have a unit occupied by an adult 60 years of age or older (NY Elder L § 209, 2012). Neighborhood NORCs can be vertical or horizontal and include "low-rise buildings six stories or less and/or single and multi-family homes, provided that apartment buildings and housing complexes may be included in rural areas" (NY Elder L § 209, 2012).

- Applicants must match 25% of the State funding that is awarded, with at least 50% of the match contributed by housing owners, managers, or residents. Match requirements are waived for applicants that are low income or from a hardship community (NY Elder L § 209, 2012).

    - A community is considered low-income if the annual income for the majority of residents is 50% less than the median family income (to align with "Very Low" income limits provided by the U.S. Department of Housing and Urban Development) (Personal Communication, 2022a).

    - A hardship community is "a community that does not qualify as low income, but due to other factors, such as the frailty or isolation of the residents, or a lack of funding available for supportive services, the residents are disadvantaged" (Personal Communication, 2022a)

Impact

- NORC program participants have reported improvements in self and collective efficacy, a greater sense of community, increased social support, reduced social isolation and reduced unmet needs (Kyriacou & Vladeck, 2011; Greenfield, 2016).

- A review of the first NORC program at Penn South in New York City conducted by the UJA Federation in 1997 estimated that the program prevented 460 hospital admissions and 316 LTC home admissions (Maclaren et al., 2007).

Lessons Learned

- **State funding has been critical for long-term sustainability.** Public funding from the city and state has been an important driver of the long-term sustainability of New York NORC programs and has created buy-in for building owners to become additional funding sources (Vladeck, 2004).

- **Recognition in legislation allowed NORC programs to expand.** New York formally recognizes and defines NORCs, and in doing so, provides a framework for NORC programs that identifies population thresholds and eligibility criteria for public funding. Both the state and city require communities to self-identify as NORCs and identify the key partners that will support the NORC when they apply for funding (Personal Communication, 2022a). This allows communities to self-identify as NORCs when they meet program-specific criteria and provides them with ownership and shared responsibility for the success of the program.

- **There is a need for long-term evaluation reports.** There is a lack of quantitative data on short-, intermediate- and long-term outcomes of NORC programs in New York. Programs should be required to have a built-in evaluation strategy to identify and monitor key outcomes from t
heir inception.

Cherryhill Healthy Ageing Program
London, Ont.

Overview

- The Cherryhill Healthy Ageing Program (CHAP) was a NORC program that started in 1996 and was led by Western University's Division of Geriatric Medicine with the goal of piloting a new model of service delivery that could help co-ordinate community-based care for older adults, particularly frail older adults. The Cherryhill community was selected as the pilot site due to the large proportion of older adults residing in 13 buildings, who had varying health levels and needs.

- The defining feature of the Cherryhill model was that it was based on a community-systems approach that included residents, key stakeholders, researchers, property owners and local businesses (Kloseck et al., 2002, 2010). Researchers were interested in determining if the program could generate and sustain this community capacity-building approach.

- The Cherryhill community consisted of 13 buildings and a mall with full amenities (grocery store, bank, post office, professional services and health services) that was frequented by residents (Kloseck et al, 2002). It was located near downtown London, Ont., and near Western University. The complex was self-contained and residents were typically able to access everything they needed without leaving their community.

- There were three components of the program: delivery and management of health information at the Cherryhill Health Information Centre located in the nearby mall, staffed by resident volunteers; health promotion, prevention and clinical health programs; and program innovation, research and learning partnerships.

- The program was initially funded by a small grant from two local hospitals (Kloseck et al., 2002). From 1997-2000, the Health Information Centre received more than $600,000 of funding and in-kind contributions to sustain its operation. In 2002, the research funding ended and the Ontario Ministry of Health (through the Victorian Order of Nurses Canada) began funding the program (Kloseck et al., 2010). After 2002, a variety of factors led to changes to the program structure and delivery and the subsequent loss of the Health Information Centre.

Parameters

- The Cherryhill apartment complex was chosen because researchers were aware of the large percentage of older adults living in the buildings and high rates of home care usage.

- In 1997, 85 per cent of residents (2,500 out of 2,925) were aged 65 years and older (Kloseck et al., 2002); 77 per cent of residents were women, many of whom were living alone.

Impact

- Researchers at Western University used a participatory research process, a multi-level (individual-community-system) participatory evaluation framework with process and outcome indicators, and Goal Attainment Scaling (GAS) methodology to measure the impact of the program (Kloseck et al, 2010). GAS methodology aims to set goals and measure the degree of goal attainment on a five-point scale: under-attainment (–2, –1), full attainment (0) and over-attainment (1, 2). At Year 1, the program had achieved its goals at or above their expected level.

- Researchers identified the potential for volunteers to co-deliver services. Residents were seen as an untapped resource of people who wanted to drive change in their community. Many residents came forward with skills that could help other residents (Kloseck et al., 2002, 2010). The program started with 28 volunteers in 1996 and had 220 volunteers by 2008, providing more than 13,200 service hours per year.

- After the program was taken over by the Ministry of Health, the Western Division of Geriatric Medicine launched a new phase of research that identified an additional benefit of residents delivering programs within NORCs. A randomized control trial of participants in a community education and mentorship program found that peer mentorship led to more older adults seeking out osteoporosis assessments, diagnosis and treatment from their family doctor (Kloseck et al., 2017). Research in the Cherryhill NORC, in partnership with a British Columbia NORC, also identified gaps in the emergency preparedness of NORC residents in disaster situations (Kloseck et al., 2014).

Lessons Learned

- **Strong community buy-in from the building owner, public services and private businesses was essential.** The original Cherryhill building owners strongly supported the program and had already identified the need for residents to have additional services. The building owners provided free space and renovations in the mall (which they also owned) for the Health Information Centre. The Health Information Centre was also supported by 10 private businesses in the mall and 15 community health organizations. Balancing public health-focused mandates with private mandates was identified as a key challenge.

- **Residents had high levels of unmet needs.** Many residents were already ageing in place, as they had been living in the buildings for more than 10 years, but had chronic conditions and gaps in their caregiving needs (Kloseck et al, 2002). Only 21 per cent of residents had a primary unpaid caregiver and 11 per cent of residents were an unpaid caregiver for someone else in their household. About 400 individuals were estimated to have various degrees of dementia. An estimated 15 per cent of residents were unable to leave their apartment to access health care or shop.

Lessons Learned (Continued)

- **Residents were treated as equal collaborators.** Collaboration between older adult residents, community agencies and government bodies took time, flexibility and a framework for collaboration that ensured accountability. Residents had key insights into the needs of the community and were recognized as valuable contributors to the NORC program (Kloseck et al, 2002; 2010). An analysis of this approach found that NORC residents' role in the program grew over time: "NORC residents have become increasingly knowledgeable and self-directed, shifting from helpers to program leaders to peer educators and now independently working with other communities to implement similar programs" (Kloseck et al, 2010, p. 403).

- **Integrated professional health services and leadership played a central role.** The integrated model at the CHAP program was a cross-sectoral partnership between home and community-based care services, hospital services, community stakeholders (businesses, building owners) and residents. A geriatric nurse practitioner (GNP) became an essential point of contact for residents, helping them navigate the health care system and providing assessments, referrals and case management support. The GNP was also able to build relationships with isolated residents who had "fallen through the cracks" and had a history of rejecting care due to fears of forced institutionalization (Kloseck et al, 2002, p. 105). Further, the GNP supported the education of home and community-care case managers in conducting geriatric assessments, which was a critical focus of the integrated CHAP model. Cherryhill residents did not play a key role in the delivery of health care, as many residents were not comfortable sharing their personal health information with peer volunteers.

- **Champions and advocates were critical to the program's success.** The Cherryhill CHAP program was supported and advocated for by a team of researchers, health care professionals, residents and a building owner who shared a similar vision and goal of co-ordinating community care to support the Cherryhill community to age in the right place for as long as possible.

Oasis Senior Supportive Living

Kingston, Ont.
Expansion sites: Hamilton, Quinte-West, Kingston, London (Ontario), and Vancouver, B.C.

Overview

- The Oasis program was launched in 2009 as a three-year federally funded pilot (New Horizons) led by the Frontenac Kingston Council on Aging in an apartment building where 27 of 60 residents were aged 65 years and older (UHN OpenLab, 2018).

- The Oasis program follows a participatory decision-making approach that reflects residents' needs and perspectives in program design and aims to address social isolation, nutrition and physical fitness by offering a variety of community programs to its residents (Oasis Senior Supportive Living, n.d.).

- The program relies on sustainable public funding from the Ontario Ministry of Health that pays for the program co-ordinator and program and administrative costs (Adekoya, n.d.; Ayerst, 2018).

- Through a research project led by two professors in the Queen's School of Rehabilitation Therapy, the Oasis program has expanded across Ontario (dePaul et al, 2022) and into two sites in British Columbia. The primary purpose of the research is to evaluate the program's effect on healthy ageing, mobility and social isolation from 2021–25 (Oasis Senior Supportive Living, 2020).

    - The model inspired similar programming in a Toronto apartment building in 2018 (Simmons, 2018; UHN OpenLab, n.d.).

    - In 2018, Oasis received funding from the Baycrest Centre for Aging + Brain Health Innovation, and Ontario's Ministry of Health and Long-Term Care and Ministry for Seniors and Accessibility, to support the expansion of the model across six additional NORC sites in four cities in Ontario: Hamilton (1), Quinte-West (1), Kingston (3) and London (1) (Oasis Senior Supportive Living, 2020).

    - In 2021, Oasis and its research partners secured further funding from the Canadian Institutes of Health Research (CIHR) to expand the model across 12 communities in Canada, develop a sustainability plan, and build a pan-Canadian network to support healthy ageing across the country (Oasis Senior Supportive Living, 2022). The first site outside of Ontario was in Vancouver, B.C.

Case Study #3 Continued

Parameters

- While there were no parameters set for the original Oasis NORC program, 45 per cent of the building residents were aged 65 years and older (UHN OpenLab, 2018).

- In the 2018 expansion, all sites had a minimum of 25 per cent older adults who were aged 55 years and older (DePaul et al., 2022). The expansion sites are in different types of communities, such as high-rise buildings, low-rise buildings and a mobile home community. The selection process for the expansion sites involved a systematic process whereby the researchers considered a number of variables such as census data, mapping software and outreach to the building landlords and residents regarding their needs. The engagement and commitment of the older adult residents of the NORC was paramount among these considerations.

Impact

- In 2015, UHN OpenLab evaluated the Oasis program in comparison to two buildings with residents sharing a similar demographic profile. They found that 83 per cent of Oasis program members rarely felt isolated, compared to 45 and 40 per cent in the comparison groups. A quarter of Oasis members participated in daily activities with their families or friends, compared to none in either of the comparison buildings (UHN OpenLab, 2018). Notably, none of the 12 Oasis residents who were eligible to move to a LTC home in 2009 decided to go, as they were able to receive enough support to age in the right place with Oasis services (UHN OpenLab, 2018).

- Another analysis of residents in the original Oasis NORC building compared to older adults residing in the community found that Oasis residents were "26% less likely to go to the emergency department, 40% less likely to be admitted to a hospital, 37% less likely to have an injurious fall and 45% less likely receive publicly-funded home care" (Oasis Senior Supportive Living, 2022, p.19). It also found that residents of the original Oasis building who were required to enter LTC homes were able to delay their admissions by one year.

- A preliminary evaluation of residents participating in the Oasis program across Ontario from 2018 to 2020 found that the proportion of older adults identifying themselves as "lonely" on a standard loneliness scale decreased from 32.6 to 23.3 per cent within nine months of implementation (Oasis Senior Supportive Living, 2022, p.19). In addition, fewer participants reported experiencing "one or more falls over a six month period, with the greatest drop in people with multiple falls" (Oasis Senior Supportive Living, 2022, p.19).

Impact (Continued)

- A recent publication by DePaul et al (2022) showcases the detailed and systematic methodology used to identify the Oasis expansion sites. At publication time, emerging data about participation in programs showed that an average of 20.5 activities per month were hosted at each site with participation increasing over the first three months, averaging 7.7 residents per activity. Programs included social activities, meal sharing and educational events such as guest speakers.

Lessons Learned (original site)

- **Landlord support was critical to enable programming within the site.** The owner and landlord of the Oasis Kingston building supported programming in their property. The landlord provided and renovated space for communal activities.

- **The Volunteer Board of Directors created a clear process for decision-making and community collaboration.** The board is responsible for governance and oversight of the annual budget and maintaining frequent conversations with Oasis residents to understand their needs. It also plays a key role in connecting and maintaining relationships with other organizations. Current directors are not residents and are active volunteers in a variety of community initiatives.

- **It was important to develop a partnership with a service provider who shared the same values.** The Oasis program currently has a partnership with Providence Care, a provider of geriatric care services, which supports programming and reporting requirements through a program co-ordinator. Finding a suitable partner has been an ongoing process over the course of the program, as some previous providers were challenged in fulfilling the broad mandate of the Oasis program.

- **A full-time program co-ordinator is essential.** The onsite program co-ordinator is a central component of the Oasis program. The co-ordinator engages the residents in identifying their needs and interests, and facilitates and organizes programming and events based on those needs and interests. At the original Oasis site, the original program co-ordinator held the position for 14 years, which allowed them to build trust and connections with residents. Similarly, at the expansion sites, onsite co-ordinators have earned the trust of members and are valued by the membership.

Lessons Learned
from the 3 Case Studies

Successes

- High demand for services from residents in the NORC

- Collective support for the philosophy of NORC programs from governments, community organizations, building owners and residents

- A framework or structure to enable collaboration and shared decision-making between stakeholders

- A knowledgeable and consistent program co-ordinator

- Common space within the NORC to host programs and formal and informal social events

- Support from professional health and social services

Challenges

- Gaps in NORC program evaluation, cost analyses and research examining long-term outcomes

- Lack of policy mechanisms to enable collaboration between different levels of government (federal, provincial, municipal) and different sectors of government (housing, health, public health)

- Lack of dedicated and sustainable funding sources

- Unclear or inconsistent terminology, parameters and methodologies to enable the identification of NORCs

- Challenges in aligning the philosophy of NORC programs with other partners and stakeholders

Key Features of Successful NORC programs

The NIA and NORC Innovation Centre describe four key features of successful NORC programs: participatory decision-making; social well-being; common spaces for community-building; and integration of health care and supportive social services. NORC programs tend to include some, if not all, of these aspects, and it is the intentional integration of these features that distinguishes NORC program models from other place-based programs.

Participatory decision-making

A central aspect of NORC programs is that they are provided with a community, not in a community (Kloseck et al, 2002; 2010; Greenfield & Frantz, 2016; DePaul et al, 2022). This distinction enables the involvement of older adults in the program in various capacities, rather than treating residents as passive recipients of services. Participatory decision-making gives older adults a sense of agency and choice over their lives and the services they receive – providing them with the sense of vitality needed to continue living independently as their health needs change. This approach legitimizes the expertise and knowledge of residents through a shared decision-making framework, ensuring that the NORC program meets their needs, avoids duplications of service and is culturally safe and appropriate (Greenfield & Frantz, 2016). Further to this, residents should have autonomy over their participation in NORC programs.

Despite NORCs having a high concentration of older adults, many of them do not develop a sense of community organically. Thus, NORC programs must deliberately aim to build community capacity through enhanced resident-engagement efforts. Many NORC programs we reviewed have found various ways of doing this effectively. For example, in New York State, communities must mobilize resources and relationships at the local level to be eligible for state and municipal NORC funding. In the Cherryhill NORC program, residents were equal members of the program's governance and advisory body, alongside community, education and business partners (Kloseck et al, 2002; 2010). Oasis' volunteer board of directors, which is responsible for the governance of the organization, must consult regularly with their members about Oasis programming. Members are also invited to regular board meetings. Resident engagement has been continued as an important aspect of the Oasis expansion sites (DePaul et al, 2022). The NORC Ambassadors Program, described below, is an additional example of how residents can play a key role in how they age.

NORC Ambassadors Program

Many residents want to continue living in their home for as long as possible, and would benefit greatly from the support of caring neighbours. Through OpenLab's **NORC Ambassadors Program**, older adults are encouraged to lead the development of inclusive ageing communities. OpenLab team members partner with older adults living in NORCs and work together to understand what support residents need to enable and strengthen AIRP in their buildings (UHN OpenLab, 2021c). The program aims to develop older adults' capacity for leadership as champions of re-shaping how and where they age. Residents co-design activities that support healthy living for older adults and encourage a sense of community belonging (UHN OpenLab, 2021c). These activities, whether solely resident-led or in collaboration with a community service agency, directly address the community's specific needs and can include social activities, health information and wellness activities, recreational activities and safety and emergency-preparedness planning (UHN OpenLab, 2021c).

Five buildings are selected to join the program on an annual basis. Residents are responsible for finding a small team of neighbours; gaining support from the property manager, condo board or landlord; and committing to meet the OpenLab team once a month for nine months (UHN OpenLab, 2021c). The program helps bring residents' ideas to life through team-building, skill-building, connecting groups to other agencies for long-term support, and funding in the form of a one-time micro-grant (UHN OpenLab, 2021c).

Following their nine months in the program, residents have the option of joining the NORC Ambassadors Alumni Network. These experiential, quarterly workshops allow current and past program participants to access ongoing skill-development from invited guest speakers and share stories with residents from other buildings (UHN OpenLab, 2021c).

Social Well-being

A key principle of NORC programs is that they create intentional opportunities for social interaction that aim to mitigate social isolation and loneliness (Greenfield et al., 2012; Chum et al, 2022). Having social relationships and feeling socially connected is an important component of individual and community well-being (Hogg & Hoar, 2020; Townsend et al., 2021). NORC programs can achieve this principle by providing formal and informal opportunities for social interactions. For example, the original Oasis building has a shared physical space that provides the opportunity for casual social encounters, such as having a coffee, and the program offers several catered and communal meals every week to encourage social participation (Simmons, 2018 DePaul et al, 2022).

The Cherryhill CHAP program also created a central role for older adults as peer supporters and volunteers, which fostered social interactions between residents (Kloseck et al, 2002). Research on the Cherryhill and New York programs found that many residents had the skill and capacity to help others through volunteering, but the work needed to be flexible to allow for residents' changing needs and abilities (Greenfield & Frantz, 2016; Kloseck et al., 2002; Mahmood et al., 2022).

Common Spaces for Community-Building

NORC programs enable community-building by providing common gathering spaces for residents (DePaul et al, 2022; Chum et al, 2022). These spaces are designed with the accessibility needs of older adults in mind — such as

modifications for mobility, dexterity, vision, hearing and cognitive limitations. The common space can be on the main floor or in other areas of the building — such as a communal kitchen or garden — and can be used to host health and well-being programming, social programs, information sessions, or meaningful activities such as hobbies or other events (Age-Friendly Housing Committee, The Council on Aging of Ottawa, 2021). Some NORC buildings may already have an available physical environment to enable programs, such as the Cherryhill and Oasis programs (Kloseck et al, 2010; DePaul et al, 2022). For example, the Cherryhill buildings had green space, garden plots and were strategically located in downtown London, Ont., close to a mall that housed the program's Health Information Centre.

While this section primarily focuses on improvements to buildings themselves, NORCs exist within a broader community that impacts their residents' ability to age in the right place. Some communities, including Cherryhill, drew on existing community assets such as businesses, parks and other local services, as well as the nearby mall and amenities. Residents were able to collectively advocate for community improvements, getting the municipality to install stop signs at a nearby intersection to calm traffic and move a mailbox closer to their community (Kloseck et al., 2010). However, other NORCs exist in isolated geographic areas. In these cases, the surrounding community may need to build infrastructure to improve walkability, provide spaces for social interactions and green spaces, and address safety issues such as traffic (Masotti et al, 2010).

Integration of Health Care and Supportive Social Services

Some NORC programs place a strong emphasis on the health and well-being of residents (Kloseck et al, 2002). As described by Greenfield et al, NORC programs "aim to address community-level challenges, including the limitations of existing home and community-based care service delivery systems, by facilitating participants' access to a range of resources to prevent poor health and functional decline" (2012, p. 280). NORC programs can provide a continuum of integrated health care and supportive services and enhance system navigation for a broad range of health services (Greenfield et al., 2012; Kloseck et al., 2010; Huo & Cao, 2022). Further, NORCs can be ideal sites for the delivery of more effective and efficient services through innovative care-delivery methods, such as neighbourhood care teams or cluster care models (NE-LHIN, n.d., Toronto CCAC, n.d., Bringing Care Home, 2015), as they can take advantage of a large number of older clients living in the same location.

Services and programs can be tailored to the needs of individual residents or the community as a whole. For instance, not all residents will need daily home care or health support; however, all residents may benefit from vaccination programs. In Toronto, NORCs identified by the Ontario COVID-19 Science Advisory Table were used to target COVID-19 mobile mass-vaccination programs, demonstrating the potential for NORCs to improve the efficiency of public health programs (Huynh et al., 2021; UHN OpenLab, 2021a, 2021b). A public health lens unlocks the potential for future vaccination programs, health screening events and addressing gaps in emergency preparedness plans (e.g. heat waves, building evacuations).

The COVID-19 pandemic also saw an increased demand for virtual care (Bestsennyy et al., 2021). As virtual care technologies and telemedicine programs become more reliable, there is an opportunity to incorporate new, innovative technologies in the delivery of NORC programs to improve the quality of life of older adults, slow functional decline and delay potential institutionalization (Recknagel et al., 2020). For example, technologies such as remote monitoring and Bluetooth-connected medical devices can monitor biometrics and track health behaviour (Recknagel et al., 2020). Integrating technology can also mean offering virtual services or classes on how to use technologies such as Zoom to further enable social connectedness among older NORC residents.
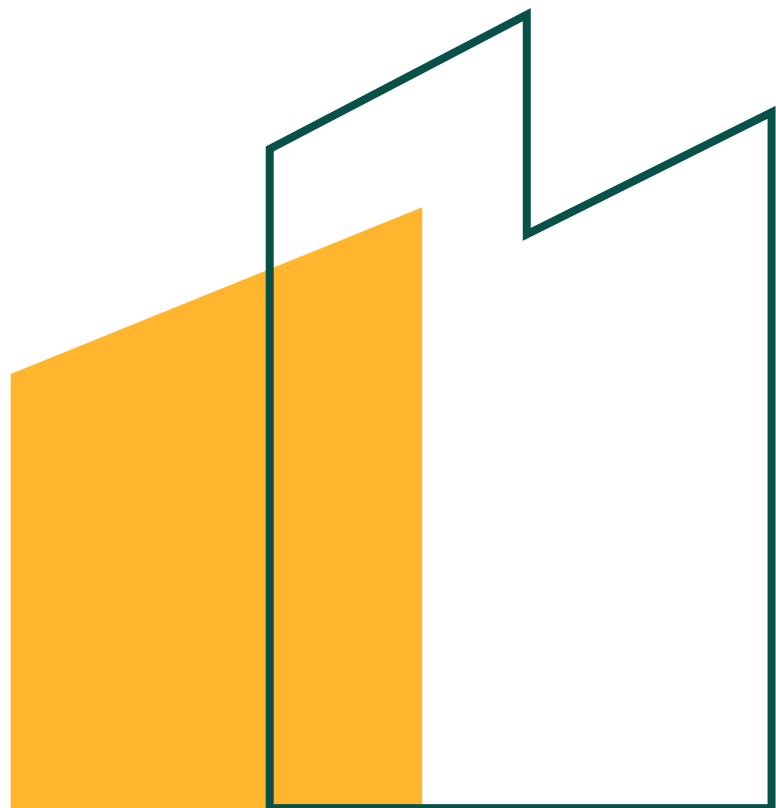
Who are the Key Stakeholders in NORC programs?

NORC programs at their core are based on a collaborative model of program creation and delivery. In this section, we describe the roles of six key stakeholders. We have based these roles on a review of the literature and expert interviews; however, stakeholder interaction is complex and in part will be determined by a NORC program's local needs and resources. The roles of various stakeholders may also be fluid. For example, residents may take on roles as volunteers or decision-makers, or shift to participants if their health needs change.

1. Residents

NORC programs are resident-centred initiatives. All of the NORC programs we reviewed incorporated older adults from their inception. Programs such as Cherryhill and the Oasis model had built-in accountability measures to ensure residents were equal collaborators in the program.

Many programs also use volunteers in varying capacities to provide services or peer support (Greenfield & Fedor, 2015; Kloseck et al., 2002).

2. Property Owners and Managers

Property owners and managers play a key role in NORC programs, such as by supporting the provision of common spaces. In the Oasis and Cherryhill models, landlords donated space in the buildings for communal activities (Oasis Senior Supportive Living, n.d.; Kloseck et al, 2010).

The needs of property owners and managers are under-explored (DePaul et al, 2022). NORC program designers should thus collaborate with property owners and managers to identify their needs and perspectives.

3. Regional Health–system Planners, Professionals and Social Care Providers

NORC programs can modernize and cluster health care, home care and community care service-delivery models. Collaboration between health-system planners and providers will be critical to enabling the health function of NORC programs.

In a recent scoping review of 60 studies examining NORC programs, 21 programs had professional staff available to co-ordinate day-to-day functions (Parniak et al., 2022). Even in NORC models where residents had an active role (e.g. Cherryhill), there was a key role for a program coordinator that primarily managed the program (Greenfield, 2016; Kloseck et al., 2002). The Oasis program also found that having a consistent co-ordinator was key to building trust with its Kington NORC residents, which enhanced participation in programs.

5. Government

The different levels (federal, provincial, municipal) and sectors (housing, health) of government play a critical role in guiding and supporting NORC programs. We describe the policy role of each level in government in the Policy Recommendations section below.

4. Community Organizations and Businesses

NORC programs collaborate with community organizations and services and the not-for-profit sector. Community organizations can provide services and products as part of the NORC program, such as meal programs, caregiver support resources, education sessions, health programs, fitness programs or day trips.

Local businesses can also support services and programs within NORCs. For example, at the Cherryhill CHAP program, private businesses within the complex donated resources to support the ongoing operation of the health information centre.

6. Researchers and Experts

Many NORC programs have had expertise and support from the academic and research and innovation sectors (e.g. Queen's, McMaster and Western Universities, Oasis Expansion Research Team). These researchers and organizations provide and advocate for local and system-level support. They also have expertise in research and evaluation, addressing a gap in understanding the best practices, system impacts and outcomes of NORC programs.

Policy Recommendations

The primary goals of NORC programs are to enable older adults to maintain their quality of life and have access to health care, supportive services and a social network to allow them to age in the right place — something that is more important than ever as Canada is confronted with an ageing population and an overtaxed LTC sector. To do so will require reimagining how the current system of health and social supports, housing and social infrastructure is designed and provided. To that end, the NIA and NORC Innovation Centre have developed the following policy recommendations for all levels of government.

Recommendation 1: Develop a national strategy to better advance NORC programs across the country

NORC programs are a model for AIRP that requires a pan–Canadian, evidence–informed strategy to enable their identification, implementation and overall sustainability. A national strategy can better enable federal, provincial, territorial and municipal governments to respond in a systematic way while also recognizing local needs. It should recognize the potential of NORC programs to re–conceptualize AIRP through a proactive, flexible, integrated approach.

A national strategy for NORC programs should encourage the following:

- *Cross-sector Collaboration*: A national strategy should enable partnerships between different levels and sectors of government, public and private building owners and citizens. Collaboration can be enabled through the creation of a National Advisory Committee which would provide an oversight platform for all levels of government, community representatives, researchers and NORC experts.

- *Social equity*: Equitable approaches should recognize that equity deserving communities — such as members of Black, Indigenous and racialized communities, immigrants and newcomers, people with disabilities and those who identify as 2SLGBTQIA+ — face cumulative sources of disadvantage that impact their ability to age in the right place. A strategy should consider the steps needed to build relationships with residents from equity deserving communities to ensure they have an active voice and role in the creation of NORC programs that are accessible and culturally safe, appropriate and specific.

- *Best practices in program design and impact:* The NIA and NORC Innovation Centre's understanding of NORC programs will evolve as communities explore the potential of this inherently flexible model. A national strategy can identify starting points for shared principles to inform program design and key outcomes related to the program's impact on residents and their communities.

Recommendation 2: Support and engage local communities to enable the development of NORC programs

NORC programs are community-level initiatives. Governments can play a role in supporting community engagement and ensuring the needs of local communities are identified and met. A framework for community capacity-building that allows local communities to collaborate around shared needs and concerns could further enable this. A framework to guide NORC program implementation should consider:

- *That the concept of NORCs is flexible and adaptable*: The demographic profile of a community and the needs of its residents may change, meaning they would no longer be a NORC or benefit from NORC programs. NORC programs should have plans in place for the long-term sustainability of NORCs. For instance, governments may consider conducting periodic reviews of community demographics to identify NORCs, in addition to reviewing existing NORC programs to ensure they are meeting their intended goals as identified by the community being served.

- *Meaningful approaches in engaging with key stakeholders*: Residents and their unpaid caregivers should be active collaborators in the program design. The principles of social equity should be incorporated throughout their engagement. Building and property managers can also play an important role in enabling NORC programs by providing the common space(s) they need that can support social and health programming.

- *Provincial/territorial governments can support the re-organization of home and community-based services:* There is a need to modernize and cluster various health care, public health, home and community-based care organizations as part of the development and operation of NORC programs. Collaboration between health system planners and providers will be critical to enabling the health function of NORC programs. For example, programs can leverage existing care roles to create enhanced navigator roles that better serve the holistic needs of NORC residents.

- *Municipal governments can play an important role in addressing the physical environment of NORCs and the surrounding communities:* Municipalities have the power to enable improvements to green spaces, housing and public transportation, and to address walkability and traffic issues. For example, the City of Toronto recently implemented Residential Apartment Commercial (RAC) zoning, which allows small-scale non-residential uses like classes, shops and community initiatives in more than 400 apartment buildings in the City that were previously zoned to be exclusively residential (City of Toronto, 2017). A similar policy in other municipalities can enable building owners and property managers to provide NORC programs in their buildings.

Recommendation 3: Establish sustainable funding mechanisms and other opportunities to encourage the development of local NORC programs

Nearly all the NORC programs identified in this report have struggled with maintaining year–over–year funding, which has threatened their operations. The success of the New York model can be attributed in part to funding programs for five-year periods, which provides community organizations enough time to ensure the program is operational. It would be difficult to have the same level of impact if funding was only provided via annual or one–time short–term grants.

To identify NORCs and enable NORC programs, long–term sustainable funding is needed to support capital infrastructure and programming costs. Governments can help by providing financing, grants and incentives, potentially through the National Housing Strategy and other housing initiatives. There are also evidence-based practices that would support an emphasis on flexibility in funding models in order to adapt funds to individual and community needs.

There are several federal, provincial and territorial funding streams that could serve as examples to guide the creation of funding streams for NORC programs.

Federal funding examples:

- The New Horizons for Seniors Program provides funding for projects aiming to improve community engagement and social participation for older adults (Government of Canada, 2022).

- The Age Well at Home initiative provides $90 million of funding over three years for community based–organizations and regional and national projects to support initiatives that would allow older adults to age in their homes (Government of Canada, 2021). The federal government is also considering the creation of an Aging at Home benefit and recently appointed Canada's National Seniors Council to serve as an expert advisory panel on its development. This benefit could become a future mechanism that can empower older Canadians to directly support the creation of NORC programs in their own community.

Provincial and territorial funding examples:

- In Nova Scotia, the Age–Friendly Communities grant program provides planning and project funding to support the creation of "age-friendly environments and promote healthy ageing" (Province of Nova Scotia, 2022. p.1).

- In the Northwest Territories, the Healthy Choices Fund provides dedicated funding for community projects that help create age-friendly communities for older adults (Government of Northwest Territories, 2022).

- In Saskatchewan, the Facilitating Independence of Older Adults in the Community grant program aims to provide funding for 10 community projects that support older adults to live independently in their own homes for as long as possible (Government of Saskatchewan, 2022).

- In Ontario, the Seniors Community Grants program provides funding to organizations that target the well–being and social inclusion of older adults (Ontario Ministry for Seniors and Accessibility, 2022).

There is also a need for funding that would enable the infrastructure required for the NORC programs and for the development and support of program operations.

- *Capital infrastructure funding for developing accessible common spaces within residential buildings*: Funding for building retrofits is currently only available at the individual homeowner or unit level, and not for community spaces. To fill this gap, the governments could provide funding incentives for building and property owners to create or retrofit spaces for community programming, or update the building's infrastructure. Further to this, key stakeholders, such as older adults, landlords, architects and accessibility experts, could collaborate to define the design parameters and features (e.g. safety, accessibility, sociability and adaptability) needed to support AIRP.

- *NORC Program development funding*: Government funding can be made available at different stages of a NORC program — for instance, through planning grants to help communities identify NORCs and build connections between stakeholders. Much of this work requires a foundation of strong relationships and trust.

- *Program operation funding for health and social services*: Provincial and territorial governments can provide policy direction and funding for integrating health care and social services. They can either directly fund or incentivize the modernization of health and social services to meet the needs of local NORCs. The scope of health services can include: public health initiatives (e.g. vaccination clinics), health screenings, primary care, home care and community support services, nutrition services, community paramedicine, dementia supports, specialized geriatric and palliative care.

Recommendation 4: Build greater system capacity for innovation, research and knowledge exchange around NORCs and NORC programs across Canada

Best practices for NORC programs should be shared across Canada and beyond. Having an organized approach to knowledge sharing can also prevent the duplication of efforts across the academic, community and government sectors. This can be achieved through the creation of centres of excellence that can specifically support knowledge translation and exchange efforts.

- Centres of excellence can provide a platform to connect academics, policymakers, citizens and community organizations around topics related to NORCs. This can be achieved by sharing best practices, making information about NORC programs publicly available, and hosting events such as conferences, webinars and public talks to further thinking around NORCs.

- Centres of excellence can further support the development of robust evaluation frameworks, data analysis and knowledge-sharing methods that can advance the development of more NORCs and NORC programs across Canada. In alignment with the participatory, community-based approach of NORC programs, evaluation methodologies should engage all stakeholders, identify the processes and outcomes best suited for evaluation, and assess a variety of short-, intermediate- and long-term outcomes.

- While there has been recent research to identify NORCs in Ontario (DePaul et al, 2022 and OpenLab, 2021), there are still gaps in best practices for identifying NORCs best suited to programs across Canada. There is also limited definitive evidence regarding the short- and long-term outcomes of NORC programs, or even how to evaluate their economic value. NORC programs have the potential to address rising healthcare costs through the creation of more clustered and integrated care models. To capture this potential, further research is needed to determine methodologies for identifying NORCs and understanding the value of NORC programs. Local administrative health data could be used to identify how services offered through NORCs can find efficiencies in the health care system and improve health and social outcomes.

Conclusion

The time has come for the expansion of more community-based models to allow older adults to age in their own homes and communities for as long as possible. This report has pointed to evidence from Canadian and U.S. NORC programs that show the positive individual- and community-level impacts of NORC programs. For example, by leveraging the high density of older adults living in one place, NORC programs can provide an opportunity to better streamline health and social-care delivery and community support services in order to improve capacity and the overall sustainability of publicly funded services. Furthermore, at the individual level, NORC programs can enable AIRP by providing opportunities for more inclusive self-empowerment through resident-led programming and activities that help build meaningful social networks and relationships.

To advance this agenda, the NIA and NORC Innovation Centre have proposed four recommendations to better enable the creation and sustainability of NORC programs across Canada that build on the existing capacity of governments and strengthen cross-sectoral and community relationships. There is a need for a national strategy and vision, efforts to support community engagement, sustainable funding mechanisms, and expanded system capacity for knowledge-sharing. With these in place, NORC programs can truly become a sustainable model that will provide Canadians with more options to enable ageing in the *right* place.

Glossary

Ageing in the *Right* Place (AIRP)

The process of enabling healthy ageing in the most appropriate setting based on an older person's personal preferences, circumstances and care needs (NIA, 2022a).

Home and Community-based Care

Care that is provided in home-based settings rather than in a hospital or long-term care or nursing home, and which allows individuals to remain independent in the community (Government of Canada, 2016a). This type of care can be provided by regulated health care providers (i.e. nurses, therapists), but also by non-regulated care providers such as personal support workers (PSWs) — also known as health-care, continuing-care or simply care aides (H-/C-/CAs) — or nursing aides, volunteers and unpaid caregivers (i.e. friends, family and neighbours) (Government of Canada, 2016a).

Naturally Occurring Retirement Community (NORC)

The original concept of NORCs was coined by Hunt & Gunter-Hunt in 1986, and refers to communities that over time may naturally come to house a high density of older adults (Hunt & Gunter-Hunt, 1986). In the absence of an agreed-upon definition of NORC parameters (Parkniak et al, 2022), the NIA and NIC further propose that NORCs may also include communities that were designed to house a large concentration of older adults (e.g. aged 55-plus apartment buildings, rent-geared-to-income housing or other communities for older people) but were not purpose-built to provide care for older adults in the way that retirement homes, assisted living facilities or LTC homes were. NORCs can be identified across different housing types (e.g. single-family homes in one geographical area, a multi-residential building or complex, condos or co-ops).

NORC Programs

NORC programs often integrate health, social and physical supports directly within the community to make it easier to enable ageing in the *right* place (Mahmood et al., 2022; Parniak et al., 2022).

Long-Term Care (LTC)

The NIA defines long-term care as a range of preventive and responsive care and supports, primarily for older adults, that may include assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), provided by either not-for-profit or for-profit providers or unpaid caregivers, in settings that are not location-specific and thus include both designated buildings and in-home and community-based settings.

Long-Term Care (LTC) Homes

Designated building-based places for individuals to live and receive 24/7 supervised care and a range of professional health- and personal-care services, as well as supports with activities such as meals, laundry and housekeeping. As this type of care is not insured under the Canada Health Act, each province and territory develops its own legislation, policies and regulations to govern LTC home-based care in its jurisdiction (Government of Canada, 2004).

Supportive Housing/Assisted Living/Retirement Homes

Describe a different type of living arrangement in a specific location. The defining feature of this type of housing is that the support services are included in a resident's monthly rent. These services vary but can include meals, assistance with bathing, or an on-call nurse or non-regulated care provider (Government of Canada, 2010). Some of homes are owned and operated by private businesses, others by not-for-profit organizations such as faith-based groups, and some are owned by the provincial/territorial government and operated by local municipalities.

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