COVID-19 EXPERIENCES & ADVANCE CARE PLANNING AMONG OLDER CANADIANS:

Influence of Age Group, Gender, & Sexual Orientation

AN iCAN-ACP DIVERSITY ACCESS TEAM REPORT

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PREPARED BY

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FOREWORD AND ACKNOWLEDGEMENTS

This study is part of a series conducted under the Canadian Frailty Network (Formerly TVN) Transformative Grant Program, focused on increasing access, uptake, and impact of Advance Care Planning (ACP) among frail elderly Canadians across the continuum of care – i.e., from primary care through to long term care and hospital care. Like the previous studies, three minority groups are of particular interest: LGBT, Chinese and South Asian – the latter two chosen because they represent the largest visible minority groups in Canada, the former because they represent a historically marginalized group. This study differs, however, from the prior studies in the series by including a comparison group of general population (i.e., heterosexual) white older adults, and in employing an online survey rather than face-to-face focus groups/personal interview methodologies. The examination of COVID-19 (or any disaster) as a potential stimulus for ACP is novel. The project builds (in terms of background research and theoretical underpinnings as well as research team expertise) on three disparate lines of research literature: disasters and aging (Gutman); palliative care/end-of-life/advanced care planning (de Vries, Gutman, Daudt); and LGBT aging (de Vries, Beringer).

This report is focused on answering the following questions:

1. What are trends for the sample as a whole in terms of their experiences with the COVID-19 pandemic, previous pandemics, health and functional status, social support, and planning for the future?
2. Underscoring the importance of diversity, are there differences in any of these domains:
    a. between age groupings within the older adult population (i.e. between persons aged 55-64, 65-74, and 75+)?
    b. as a function of gender (male compared to female)?
    c. as a function of sexual orientation (LGB compared to heterosexual persons)?

For purposes of analysis, specifically to address issues of sample size, the comparisons are simplified. For example, while the age range for the sample as a whole is 55-99, there were too few in the 85-94 and 95 and over groups to justify 10-year age groupings. Similarly, while some individuals identified as non-binary and some as transgender, both were included in the total sample although their numbers are small. Their voices will be heard separately in other planned publications, as will the voices of Chinese and South Asian older Canadians who similarly are present in numbers too small for inclusion in these sample-wide analyses. Other publications will also report on “diversity within diversity” – specifically differences between the COVID-19 experiences of gay males, who tend to be the focus of much of the LGBT aging literature, and the lesser explored lesbian, bisexual and transgender subpopulations.

Organization of this Report

This report begins with a brief introduction that describes some of our reasons for examining the impact of the COVID-19 pandemic in conjunction with our three variables of interest: age group, gender and sexual orientation. It also introduces the theoretical underpinnings of our work. This is followed by details about our methods of recruiting survey participants and about the construction and organization of the survey itself. The next section provides details concerning the sample. We compare the sociodemographic and health characteristics of our respondents (n=4380) to data from the 2016 census of Canada concerning the age 55+ population. Where feasible, we also compare it to North American data on persons who responded to online health-related surveys and/or who were recruited via social media. More data are presented in our “Meet the Sample” section than one usually finds in reports of projects of this nature, but we wanted to establish that, with a few exceptions (e.g. a higher level of education), our sample is remarkably similar to the English-speaking population age 55+ that currently resides in Canada.

The results of the research come next. We describe our sample’s response to pandemic-related stressors, issues they faced regarding healthcare, support source if help is needed, and any actions that they had taken before and during the pandemic towards future healthcare. Each section begins with some background to the questions we asked. In reporting answers to our questions, we first present findings for the sample as a whole, followed in each section with highlights of any age group differences we observed, gender differences, and differences between heterosexual individuals in the Canadian age 55+ population and those who self-identified as lesbian, gay or bisexual (LGB). All the differences reported are statistically significant. Key findings are highlighted in a series of infographics that accompany the text in each section. Readers are encouraged to distribute the infographics, and the full report, to their networks. Feedback is also welcomed. You can contact us via the “Conversations Project” website (https://www.sfu.ca/lgbteol).
We gratefully acknowledge funding provided by the Canadian Frailty Network, supported by the Government of Canada through the Networks of Centres of Excellence (NCE) program. Finally, we would like to acknowledge Victoria Hospice for supporting the participation of Dr. Daudt in this project.

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1. INTRODUCTION

COVID-19 is a global pandemic that poses the greatest health risk to older adults, in particular those with pre-existing medical conditions.[1] Little, however, is known about the personal and social experiences among Canadians age 55+ during this pandemic. In this study, we are interested both in how women and men, younger, middle and older age older adults, and both heterosexual and LGBT older Canadians perceive the impact of COVID-19 on their current as compared to their pre-pandemic physical and mental health and lifestyle, and on its impact on their preparations for future healthcare.

Exploring the experiences and preparations of these populations and understanding how they are coping with the disease, fills an information gap that could be useful to the groups themselves as well as in preparing healthcare planners and practitioners for future pandemics. Determining if COVID-19 is having an effect upon ACP is important because such preparations can improve the patient experience at one of life's most stressful times and align treatment with patient preferences, avoiding unwanted and costly invasive treatments.

In terms of current impact, LGBT older adults are thought to be vulnerable given their overall poorer health and higher rates of disability, relative to heterosexual older adults.[2] Negative health effects may be exacerbated by what research has found to be general distrust of and reluctance to access healthcare by LGBT older adults which is often based upon stigma and the cumulative effect of discrimination experienced over the life course.[3] In addition, LGBT older adults report high rates of loneliness, isolation and depression, and it is unknown to what extent these conditions may be exacerbated by social distancing during the pandemic. Alternatively, LGBT older adults may be better able than their heterosexual age peers to cope with COVID-19 as a result of their prior experience with (and having survived) the HIV/AIDS epidemic.[4] Regarding ACP, there is some research indicating that members of the LGBT community engage in it at a greater rate than their heterosexual counterparts, again perhaps related to their prior experience with the HIV/AIDS epidemic.[5]

The Health Equity Promotion Model,[6] the theoretical framework underpinning this research, has its origin in the LGBT aging literature. The model is useful, however, for directing examination of the impact of COVID-19 more generally, highlighting as it does: (a) the fact that there is heterogeneity and intersectionality within communities; (b) the importance of considering the influence of structural and environmental context, and the social determinants of health; and (c) that despite adversity, some individuals within marginalized (and by extension racialized) communities exhibit resilience and enjoy good health. The model is also important in integrating a life course developmental perspective within the health-promotion model and reminding us to include this perspective when examining between and within group health disparities in late life.

Our research focused on the COVID-19 experiences of community-dwelling Canadians aged 55+. The experiences of older adults living in seniors housing or assisted living is the subject of a separate survey currently in progress.

2. METHODS

Information presented in this report derives from an online survey that explored older Canadians' current experiences and future care plans during the COVID-19 pandemic. The survey, which ran from August 10 to October 10, 2020, opened to an invitation page that screened respondents to ensure they were aged 55 or over and living in Canada. The invitation described the purpose of the survey as follows: "to explore any pandemic-related stressors you may be experiencing, issues you are facing regarding healthcare, and any actions taken toward planning for future care." We further indicated that we were seeking both those who had and those who had not contracted COVID-19 and that we were seeking respondents from the general population as well as from minority groups, in particular, LGBT, Chinese and South Asian.

From this invitation, potential respondents could click on a consent page which described the research team, outlined their rights as research participants, and provided email and phone contacts if individuals had questions about their participation and/or the study. Upon consent, respondents were able to enter the online survey, created using an online survey tool (www.surveymonkey.com). Simon Fraser University's Research Ethics Board approved the study.

The survey questions were developed by the authors of this report and informed by our work as members of The Diversity Access Team (DAT), which is part of a larger pan-Canadian ACP study (https://icanacp.ca/). Within the larger study, the DAT is focused on assessing, tailoring, implementing, and evaluating ACP tools aimed at minority populations, in particular LGBT, South Asian and Chinese older adults. The 61-item survey included a set of questions gathering basic demographic information and a series of questions that were concerned with health and functional status, pandemic-related stressors, healthcare access, and planning for the future. The cross-sectional, mixed-methods survey (a copy is available online at https://www.sfu.ca/lgbteol.html) included a blend of Likert-scale items (e.g. improved/stayed the same/gotten worse), questions where respondents choose from a set list of items (e.g. chronic condition/ please check all that apply), and open-ended questions (e.g. ways that COVID-19 has impacted your life positively or negatively that we haven't asked about). The time spent to complete the survey was, on average, 13 minutes and 21 seconds.

Respondents were recruited using social media, direct email, and Facebook advertising. As well, we enlisted assistance with recruitment from organizations serving older adults in general and LGBT, South Asian and Chinese older adults, in particular. Over 85 local community, regional and national organizations assisted in promoting the study. We chose Facebook advertising knowing that 68% of U.S adults use Facebook (and we assumed these numbers would likely be similar in Canada) and it is a platform accessed by all ages including older adults.[7] Facebook's delivery system uses algorithms so that advertising may be used to target an audience of interest. The bulk of our advertising was directed to the general population of adults age 55 and over residing in Canada, and we reached 111,100 who saw the ad at least once; this resulted in 7,933 post engagements (reacting, commenting

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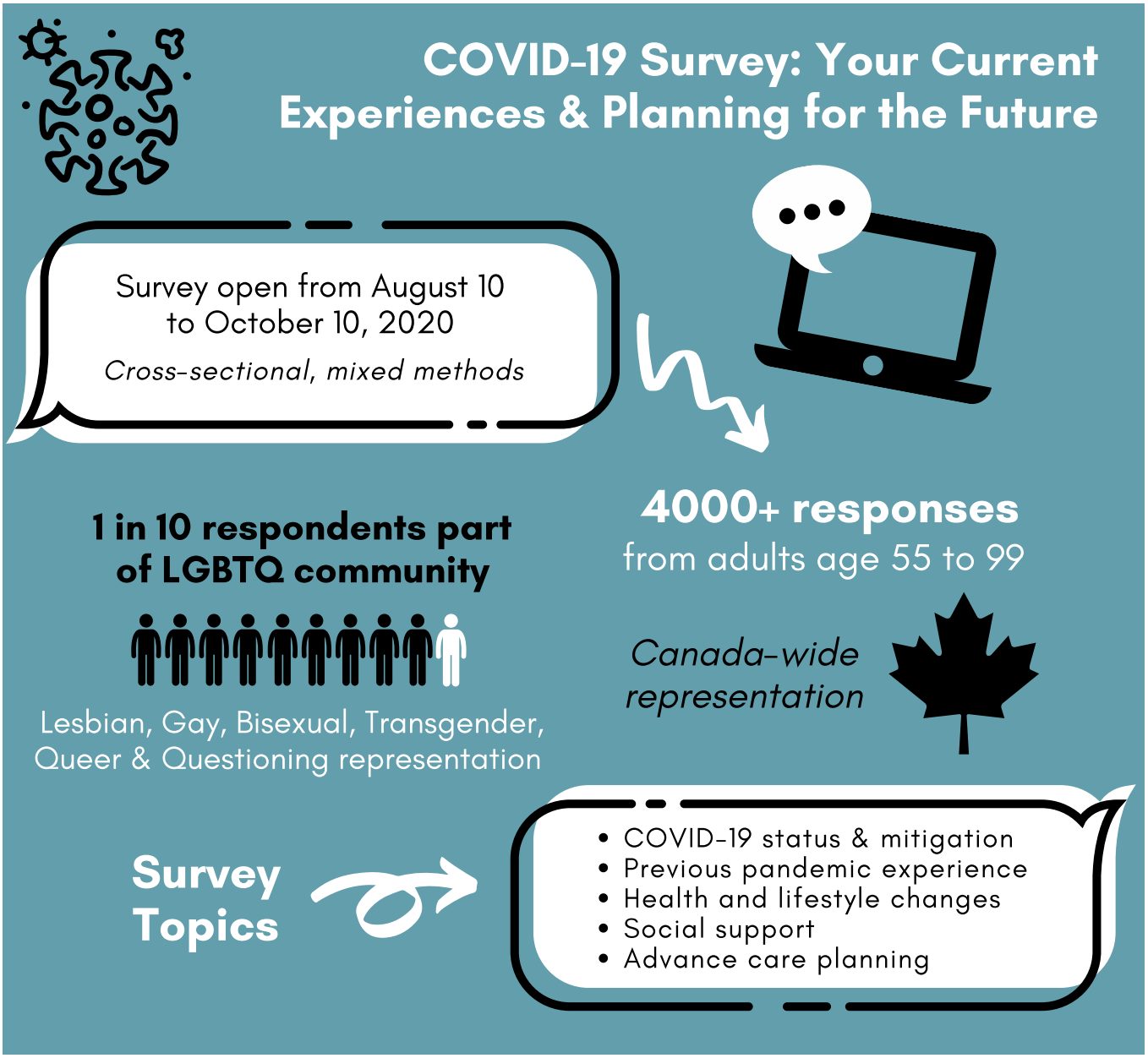
sharing) and 7,024 link clicks. We also used Facebook advertising to target LGBT (e.g. using the Facebook algorithms, ads would appear to those who indicated an interest in “LGBT community” and/or “LGBT culture”) and here we reached 18,393 Canadians and this resulted in 935 post engagements and 534 link clicks. We also attempted to reach out to South Asian and Chinese older adults using Facebook algorithms but were less successful in recruiting sizeable numbers. The Facebook ads were monitored, and any comments made by Facebook users viewing the ad were regularly removed to avoid the potential that these outside comments might influence decisions to participate or not in the survey.



3. MEET OUR SAMPLE

Distribution by Province and Territory

As per our eligibility criteria, 100% of our 4380 respondents were residing in Canada, and they came from all provinces and territories.

Province/Territory	N	%
British Columbia	1486	34
Alberta	437	10
Saskatchewan	151	3
Manitoba	214	5
Ontario	1504	34
Quebec	149	3
New Brunswick	99	2
Nova Scotia	259	6
Newfoundland and Labrador	54	1
Prince Edward Island	18	<1
Yukon	4	<1
Northwest Territories	3	<1
Nunavut	2	<1

Table 3.1 Distribution by Province/Territory, our sample

In comparison to data from the 2016 Canadian census, there were two geographic areas where our sample differs noticeably. First, representation of British Columbians (34% of all respondents) is much higher than the proportion of Canadians age 55+ who reside in BC (14%).[8] This is likely a result of the location of our team's headquarters (Simon Fraser University Gerontology Research Centre) which is based in Vancouver, BC. One of our recruitment methods was to ask community organizations to share a link to our survey with their members, and just over one-quarter of the organizations that did so (25/89 or 28%) were BC-based. Second, only 3% of respondents resided in Quebec whereas, this province accounts for 25% of the Canadian 55+ population.[8] This is likely due to our survey, which was only available in English where in Quebec, 50% of residents read and write only French.[9]

Distribution by Type of Community

We asked what type of community our respondents lived in, and again the sample is found to be broadly distributed:

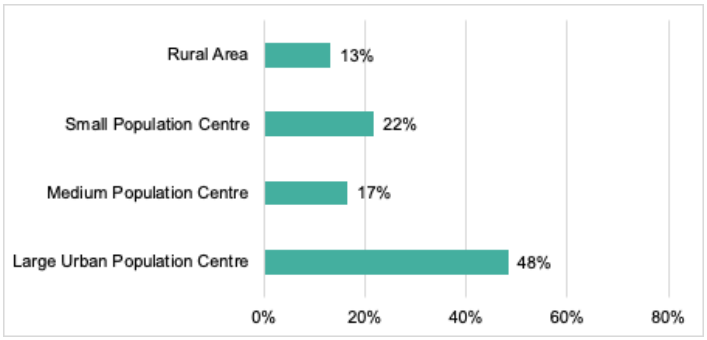


Figure 3.1 Community type, our sample

Our survey used the same definitions of community size as are used by Census Canada,[10,11] in order to enable us to assess the representativeness of our sample:

- Rural Area (Less than 1000 people)
- Small Population Centre (1,000 to 29,999 people)
- Medium Population Centre (30,000 to 99,999 people)
- Large Urban Population Centre (100,000 or more people)

We were under-represented in rural areas (sample 13% versus 19% in the 2016 census), and in large urban centres (sample 48% versus 60% in 2016 census). The rural sample under-representation may be due to a rural/urban divide in terms both of internet penetration (2 million Canadians, mostly rural and remote region dwelling do not have reliable internet access) as well as quality of Internet (rural upload/download speeds are 1.19 Mbps/6.05 Mbps respectively, in comparison to urban settings where speeds measure 10.25 Mbps/34.13Mbps).[12]

MEET OUR SAMPLE

Distribution by Age

We asked respondents: What is your age (years)? For the total sample, the age range was 55 to 99; the mean age was 66.87 (SD=7.47). The age distribution for our 4380 respondents was as follows; 55-64 group N=1775 (41%), 65-74 group N=1926 (44%), and the 75+ group N=679 (16%).

	Men N= 970	Women N= 3376	Heterosexual N=3961	LGB N=331
Mean (SD)	68.12 (7.83)	66.56 (7.32)	67.03 (7.49)	65.28 (7.07)
Range	55-98	55-99	55-99	55-86

Table 3.2 Age by gender and sexual orientation, our sample

As shown above, women were younger on average than men and the LGB group was younger than the heterosexual group.

Distribution by Highest Level of Education

Our sample had a relatively high level of education (43% with Bachelors' degree or above). This is consistent with findings from a U.S. study of adults age 60 and over (N=17,704), which reported that people using the internet to access health information (a group we felt may be comparable to ours) tended to be those with higher levels of socioeconomic attainment (i.e. in education, household income, employment status and home ownership).[13]

How does our sample compare to Canadian census data? Those who have not completed high school were most noticeably under-represented. However, while a limitation of our study, it needs to be remembered, as noted above that our sample is not atypical as far as online health surveys go.

Highest Level of Education	Our Sample	Canada 2016[14]
Did not complete high school	3%	23%
High school graduation but no post-secondary degree	17%	27%
Trade certificate	12%	11%
Other certificate or diploma below bachelor's degree	24%	21%
Bachelor's degree or above	43%	18%

Table 3.3 Highest level of education, our sample vs 55+ census group

Distribution by Race/Ethnicity

Our question on race/ethnicity was introduced with the statement: "People living in Canada come from many different ethnic and cultural backgrounds. Please check the one that best describes your background." While our sample was predominately white, visible minority representation approximates that of the age 55+ group in the 2016 census.

Answer choices	Our Sample	Canada 2016[15,16]
White	88%	87%*
Chinese	4%	4%
South Asian	1%	4%
Black	<1%	2%
Filipino	<1%	1%
Latin American	<1%	1%
Southeast Asian	<1%	1%
Arab	<1%	1%
Japanese	<1%	<1%
Korean	<1%	<1%
First Nations	1%	<1%
Inuit	<1%	<1%
Metis	1%	<1%
Background not listed/mixed	3%	1%

Table 3.4 Race/Ethnicity, our sample vs 55+ census group

*Statistics Canada refers to this group as "not a visible minority"

The ethnic distribution is also consistent with U.S. data showing higher proportions among whites than among minorities who use the internet at least once per day.[17] While we had hoped to equal or oversample older adults who identify as Chinese and South Asian, we were successful in the case of Chinese (4% of our respondents identified as

MEET OUR SAMPLE

Chinese compared to about 4% of all Canadians age 55+) but not in terms of South Asians (just 1% of our respondents identified as South Asian compared to 4% of all Canadians age 55+).

Distribution by Religion

Fewer Roman Catholics completed our survey than the proportion of Canadians 55+ in the 2011 National Household Survey (16% vs 44% of Canadians), the source of our data on religion in this segment of the population. The proportion reporting no religion or another religion also differed, but other religions were represented in comparable proportions (e.g. 1% of our sample were Buddhist and 1% of Canadians report Buddhism as their religion).

Answer choices	Our Sample	Canada 2011[18]
Anglican (Church of England, Episcopalian)	11%	8%
Baptist	4%	3%
Buddhist	1%	1%
Eastern Orthodox	<1%	2%
Islam (Muslim)	<1%	1%
Jewish	3%	1%
Lutheran	2%	2%
Other Christian	9%	6%
Pentecostal	2%	1%
Presbyterian	2%	2%
Roman Catholic	16%	44%
Sikh	1%	1%
United Church	12%	10%
No religion (Agnostic or Atheist)	28%	15%
Another religion not listed (please specify)	9%	1%

Table 3.5 Religion, our sample vs 55+ 2011 National Household Survey data

Distribution by Sexual Orientation

We asked our sample, “Do you consider yourself to be: heterosexual, homosexual, bisexual or don't know/no answer."

Answer choices	N	%
Heterosexual	3961	90
Homosexual	257	6
Bisexual	74	2
Don’t know/No answer	88	2

Table 3.6 Number and percentage by sexual orientation, our sample

There are limited national data on the number of Canadians age 55 and older who identify as members of the LGBTQ+ community (data are mostly collected for those ages 18-59).[19] Of all Canadians age 55+ in 2016 (10,846,385), a low estimate of those who are gay or lesbian make up 2% (184,388) of the population[20] and those who are bisexual make up 1% (141,003).[21] Higher numbers (542,319) and proportions (5%) are estimated in non-government publications.[22] Our recruitment of LGBT totalled 426 (10%). Due to small and unreliable cell sizes, the analytic sample (331) excludes those who indicated, “don’t know” or “no answer” to the sexual orientation question.

Distribution by Gender

We asked, “what is your current gender identity? Choose one”:

Answer choices	N	%
Male	970	22
Female	3376	77
Nonbinary	18	<1
Additional gender category	16	<1

Table 3.7 Number and percentage by gender, our sample

Just over three-quarters of our sample (77%) identified as female compared to 53% female age 55+ in Canada’s 2016 census. This difference was not unexpected given that much of our recruitment was conducted via Facebook

advertising where, as of November 2020, it was found that more Canadian women (54%) than men (46%) hold accounts.[23] Further, in terms of social media use, as of 2019 it was reported that 75% of Canadian women use social media on a daily basis, whereas only 62% of Canadian men are daily users.[24]

Transgender Respondents

We asked our participants: "Do you identify as transgender?"

Answer choices	N	%
Yes	21	<1
No	4359	>99

Table 3.8 Number and percentage transgender, our sample

While only a small percentage of our respondents identified as transgender (<1%), it was close to what is expected in terms of population (also <1%).[25]

Distribution by Marital Status

Our sample is highly representative of the Canadian population age 55+ with respect to marital status, with a majority married or living common-law.

Marital Status	Our Sample	Canada 2016[26]
Single, never married	8%	7%
Married or living as married (common-law)	61%	65%
Widowed	12%	14%
Divorced	15%	10%
Separated	3%	3%

Table 3.9 Marital status, our sample vs 55+ census group

Our sample is also representative of the Canadian LGB population in terms of marital status. In our sample 46% of those who identified as lesbian, gay, or bisexual reported that they were married or living common law, compared with 44% of LGBT Canadians reported elsewhere to be married and living with a partner.[27] These figures contrast with the heterosexual population age 55+ in our sample, 61% of whom reported being married or living common law.

Distribution by Employment Status

22% of our sample is employed compared with 35% of the Canadian population age 55+ (i.e. workers are under-represented).[28]

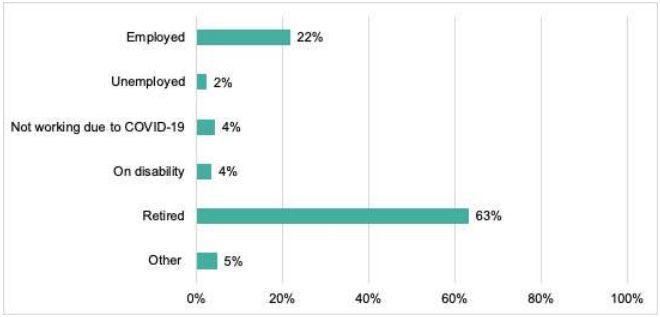


Figure 3.2 Current employment status, our sample

As is to be expected, the majority still working are in the 55-64 age group (42% of this group for the sample as a whole; similar proportions for men and women).

	Percent of Age Group Employed	Men	Women
55-64	42%	42%	43%
65-74	10%	13%	9%
75+	2%	5%	1%

Table 3.10 Employment status by age group and gender, our sample

Living Arrangement

Just under one-third (30%) of our sample live alone, compared with 21% of all Canadians age 55+.[29]

	Percent of Age Group Living Alone	Men	Women
55-64	21%	21%	21%
65-74	31%	23%	34%
75+	50%	30%	59%

Table 3.11 Living alone by age group and gender, our sample

MEET OUR SAMPLE

The larger proportion of those living alone in our sample may be due in part to the large number of our respondents being LGB (8%); older gay men are far less likely to be partnered than their heterosexual counterparts and also more likely to be living alone.[30,31]

Chronic Conditions and Functional Status

On average, our respondents have been diagnosed and are living with about three (mean=2.8) chronic conditions. The table below shows the specific conditions we asked about, and their prevalence in our sample.

Chronic Condition	N	%	Chronic Condition	N	%
Any Anxiety disorder (e.g. Panic disorder, Generalized Anxiety, Post-Traumatic Stress disorder, Obsessive-Compulsive disorder)	783	18	HIV/AIDS	23	1
Any heart disease or history of heart attack or stroke	580	13	Hypertension	1122	26
Alzheimer or other dementia	14	<1	Macular degeneration	137	3
Any auto-immune disease (e.g. Lupus, MS, Rheumatoid Arthritis, Psoriasis, Crohn's disease, Inflammatory bowel disease)	645	15	Osteoarthritis	1027	23
Any chronic lung disease (e.g. Asthma, Emphysema, COPD)	725	17	Osteoporosis	351	8
Back problems	1054	24	Parkinson's	8	<1
Bipolar disorder	50	1	Problems hearing even with hearing aid	204	5
Cancer	556	13	Problems seeing/reading even with glasses	316	7
Cataracts (untreated)	273	6	Renal failure/kidney disease	98	2
Depression	886	20	Severe obesity	209	5
Diabetes	607	14	Substance abuse disorder	46	1
Eating disorder	64	1	Thyroid disease	563	13
Epilepsy	31	1	Tuberculosis	19	<1
Gastritis	148	3	Urinary incontinence	228	5
Glaucoma	155	4	Recurrent urinary tract infections	132	3
Hepatitis	77	2	None of the above	579	13
High Cholesterol	973	22	Other condition(s)	349	8

Table 3.12 Chronic conditions, our sample

Almost one in four persons in the sample lived with hypertension, back problems, osteoarthritis and/or high cholesterol; over one in five lived with depression. About one in six persons lived with anxiety and/or lung disease. Over one in ten lived with an autoimmune disease, heart disease, diabetes, thyroid disease and/or cancer. There were no overall age differences in the number of chronic conditions across the three age groups. However, among the conditions reported by more than 10% of the sample, a greater percentage of the older respondents reported having heart disease and cancer and a smaller percentage reported having anxiety or depression, relatively to those in the 55-64 group.

Overall, women reported a slightly greater number of chronic conditions than men (mean=2.9 vs 2.6 respectively); and women were more likely than were men to report anxiety, autoimmune disease, lung disease, depression, osteoarthritis, and thyroid disease. Men were more likely to report high cholesterol, diabetes and heart disease. LGB respondents reported a greater number of chronic conditions (mean=3.6) than heterosexual respondents (mean=2.8), and were more likely than heterosexual respondents to report anxiety, depression, back problems and high cholesterol.

Despite the above conditions, the vast majority (88%) were mobile without the use of assistive devices. Only 8% reported using a cane, 4% used a walker, <1% a sit-down scooter, and <1% a wheelchair.

4. FINDINGS

COVID-19 PREVALENCE AND MITIGATION
In our sample

BACKGROUND
Even before the COVID-19 outbreak was labelled a pandemic by the World Health Organization, age was identified as the major risk factor for morbidity and mortality and, men were identified as at higher risk of death from COVID-19 than women, in all OECD countries except Canada.[32] Canada was the exception because the vast majority of our deaths were among residents of long-term care (LTC) facilities, which are predominantly occupied by women.[32] While outbreaks in LTC facilities have and continue to be monitored (https://ltc-covid19-tracker.ca/) and death rates regularly reported on TV and in the newspapers, the same is not the case for community-dwelling older adults. Similarly, while there have been reports of people having symptoms of COVID-19 but not seeking help because of the stigma associated with the disease, and of not seeking care for other medical conditions because they were fearful of contracting it in hospital or clinic waiting rooms, prevalence data are lacking. Therefore, in addition to asking our respondents if they had been diagnosed with COVID-19, we enquired about COVID-19 symptoms and other medical conditions they had experienced but had not sought help for.

Age Differences
Contrary to expectation, the proportion in each age group diagnosed with COVID-19 decreased (non-significantly) with increasing age: from 2% in the 55-64 age group, to 1% in the 65-74 age group to <1% among those age 75+. The same pattern, though significant, was found among those reporting COVID-19 symptoms or other medical conditions for which they had not sought help.

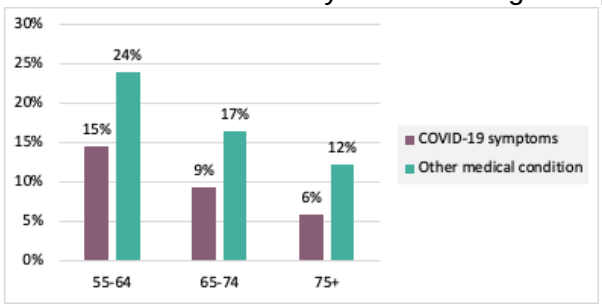


Figure 4.1 Medical symptoms experienced no help sought, by age group

Gender Differences
There were no gender differences among those who experienced COVID-19 symptoms but did not seek help. However, women (20%) were more likely than men (16%) to experience other medical conditions for which they did not seek help.

Sexual Orientation Differences
There were no statistically significant differences between heterosexual and LGB respondents.

PREVALENCE
- Only 61 (1%) respondents indicated that they had been diagnosed with COVID-19. Of these, 37 reported that the severity of their infection was “mild [with] symptoms effectively managed at home”; 14 reported that the severity was “moderate” with serious symptoms requiring brief hospitalization; and 5 reported that their symptoms were “severe” and required lengthy hospitalization and ventilation.
- 471 (11%) respondents reported that they had experienced COVID-19 symptoms for which they did not seek help.
- 787 (19%) reported that since the beginning of the pandemic, they had experienced a medical condition other than COVID-19 for which they did not seek help.

Pandemic Mitigation Behaviours

Respondents were asked three questions about their behaviours related to virus mitigation efforts: Did they practice social distancing (maintaining a distance of 2 meters from others); wear a mask when they "are near other people not in [their] household/bubble"; and about socializing with "family and/or friends at home." The first two questions have response options including "seldom or never; some of the time; most of the time." The question on socializing included the following responses: "no, once, several times, daily."

FINDINGS

- The overwhelming majority of our respondents practice social distancing (87%) and wear masks (75%) most of the time.
- About a third of respondents (34%) reported they do not socialize with others at home, 28% reported socializing once, 33% have socialized several times and 6% have done so daily. Findings need to be interpreted with caution however, because it was not clear in the way the question was worded that socializing "with family and friends at home" was referring to people outside their social bubble.

Age Differences

There were age group differences on two of the three mitigation questions. Both the two older groups were more likely to wear masks most of the time (78%) than those aged 55 to 64 (72%). A similar difference was found on the social distancing measure; those 65 and older were more likely to social distance most of the time (90%) than were those aged 55 to 64 (84%).

Gender Differences

There were gender differences on all three mitigation questions. Women were much more likely to wear masks most of the time (79%) than men (62%). Women were also much more likely to social distance most of the time (91%) than men (76%). Fewer women (37%) than men (45%) reported socializing with friends and family many times over the past two weeks.

> **"I don't like it when people do not follow government recommendations on COVID-19 prevention…such as wearing masks, how to take care of ourselves, hand washing, etc."**
> 72-year-old heterosexual woman

Sexual Orientation Differences

LGB persons were more likely to wear masks most of the time (82%) than heterosexual persons (75%); 94% of LGB persons reported social distancing most of the time compared with 87% of heterosexuals. And, fewer LGB persons (29%), than heterosexual persons (40%), reported socializing with friends and family at home many times over the past two weeks.

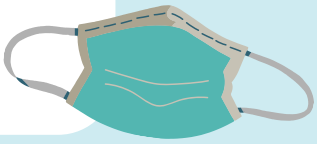
> **"I go out, some young people joke that they don't need to wear masks or use distance caution since it is mainly seniors who are expendable…"** 70-year-old lesbian

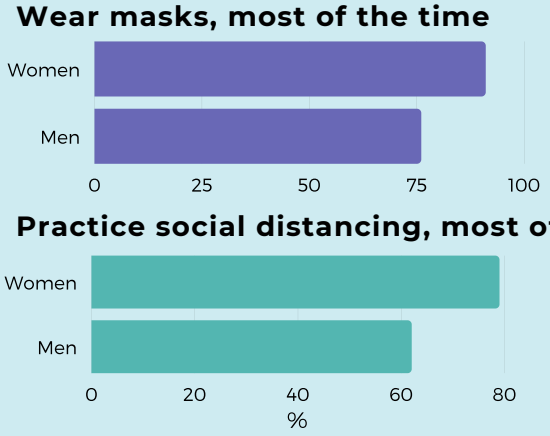
COMPLYING OR COMPLAINING?

CANADIANS 55+ & COVID-19 POLICIES

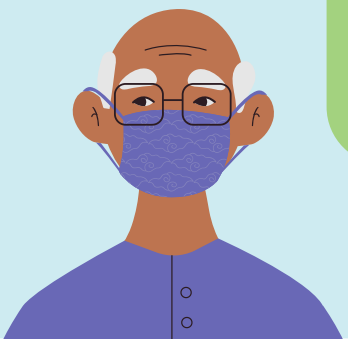
WOMEN MORE LIKELY TO FOLLOW COVID-19 GUIDELINES

than men the same age





Those **65+** more likely to **wear masks** and **social distance** than those 55-64



LGB PERSONS MORE LIKELY TO FOLLOW COVID-19 GUIDELINES

than heterosexual persons

Fewer LGB persons (29%), than heterosexual persons, (40%) report **socializing with friends and family at home** "many times"

LGB: Lesbian, gay, and bisexual

Findings from Fall 2020 survey of 4380 Canadians age 55+

SFU GERONTOLOGY RESEARCH CENTRE

iCAN ACP Advance Care Planning

COVID-19 AND LIFE CHANGES
In our sample

BACKGROUND

To avoid overburdening healthcare systems and given the high transmissibility of COVID-19, Canada and other countries have enforced lockdowns or similar restrictions. Some of these measures include the closure of recreation facilities, school extracurricular activities, prohibiting indoor gatherings and shifting in-office routines to work-from-home protocols.[33] To explore the resulting lifestyle changes and their economic and psychosocial sequela, respondents were asked a series of questions, adapted from Stoddard and Kaufman's[34] Coronavirus Impact Scale, concerning changes in their life since the COVID-19 pandemic began. They were also asked about changes in exercise level.

FINDINGS

The largest area of change was in routines, where 90% of all respondents reported significant change (in multiple areas of life). Access to extended family and non-family support as well as medical healthcare access were the next most frequent areas of change (83% and 79%, respectively). From 35% to 41% reported a negative change in their income, food access and an increase in family discord.

"COVID-19 has impacted every aspect of my life" 59-year-old lesbian

Age Differences

A strong majority (90% of both the 55-64 and 65-74 groups) and 85% of the 75+ group reported at least some change in routines of life (e.g., work, education, social life, hobbies, etc.). The age groups did not differ in access to family and non-family support or on access to medical healthcare, the next two items on which there was the greatest change reported. On the item addressing family income/employment, there was a more direct decrease by age. Even as the majority (59%) reported no change, 51% of those ages 55-64 reported at least some change as did 39% of those between the ages 65-74 compared with only 20% of those age 75+. A similar pattern was noted on the item of stress and discord in the family; again, the majority reported no change (59%) but half of those between the ages of 55-64 reported at least some change, along with 39% of those ages 65-74 and 25% of those ages 75+. Access to food was the

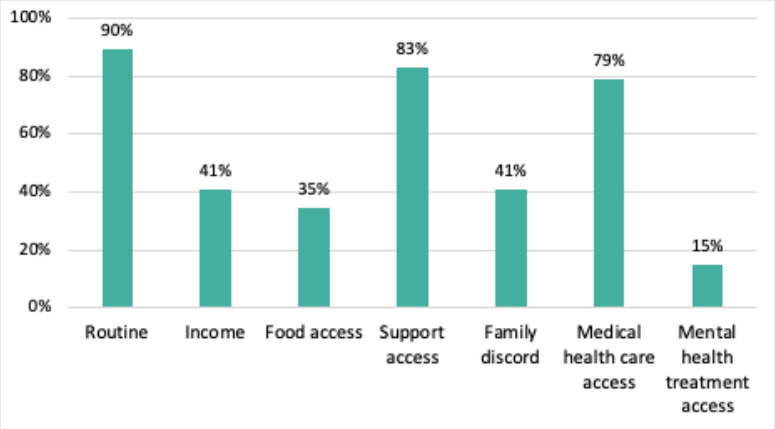


Figure 4.2 Change on domains of Coronavirus Impact Scale

next item, in terms of the amount of change experienced/reported; the percentages were 38%, 35% and 26%, for those 55-64, 65-74, and 75+, respectively. Finally, access to mental healthcare was the item where the change in access was the least noted (by just over 15% of the total sample), and by 20% of the 55-64 year-old respondents, 13% of the 65-74 year-old respondents and by 8% of those ages 75+.

Gender Differences

Gender differences were found on all of the Coronavirus Impact Scale items except family income/employment, with women reporting greater changes due to the COVID-19 pandemic than men. Specifically, the percent reporting at least some change, in order of descending proportions, was as follows: routine (92% of women compared with 81% of men); access to family and non-family support (87% of women, 71% of men); access to medical healthcare (80% of women, 75% of men); stress and discord in the family (43% of women, 36% of men); access to food (37% of women, 27% of men); and, access to mental healthcare (16% of women, 11% of men).

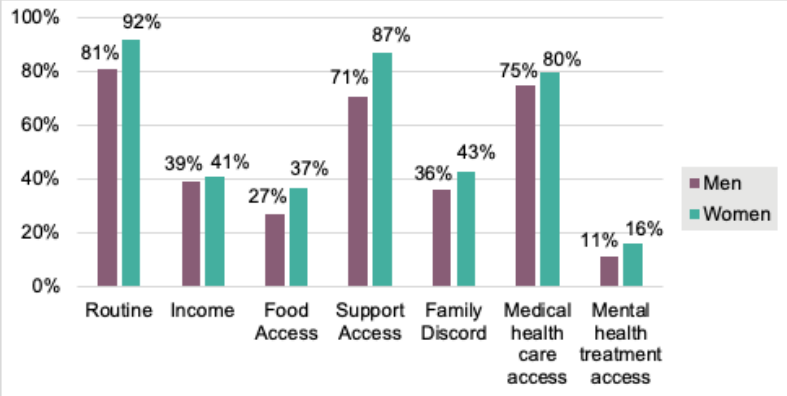


Figure 4.3 Change on domains of Coronavirus Impact Scale by gender

Sexual Orientation Differences

On the items of the Coronavirus Impact Scale, the only significant differences were for the health items. On access to medical health, 85% of LGB persons reported at least some change compared with 79% of heterosexual persons. On access to mental healthcare, 25% of LGB persons reported at least some change compared with 14% of heterosexual persons.

"Not to see people or go to church, it's very depressing, talking on the phone isn't the same"

70-year-old heterosexual woman

"...In short, just about everything that made it worthwhile to get up in the morning has ended."

71-year-old bisexual woman

Exercise Since COVID-19 Outbreak

BACKGROUND

Prolonged time spent indoors compounded by the surge in technology use for socialization, career, or educational purposes has resulted in an increase in sedentary behaviour[35]; high sedentariness is linked to an elevated risk for various chronic conditions.[36] Exercise challenges for older adults related to COVID-19 restrictions include closure of 55+ programs at recreation centres and access to swimming pools as well as closure of rehabilitation programs for those living with chronic diseases.[35] Gender preferences regarding physical activity engagement, type of activity, and motivation to exercise may have implications for how older adults are affected by the restrictions brought about by COVID-19. van Uffelen et al.[37] note that there may be differences in the choice of exercise between genders, with older women more likely to prefer activities based in social-settings and less likely to prefer vigorous or competitive-based activities than male age peers. In addition, older women tend to be more motivated to exercise by social factors, such as being able to spend time with others and meeting new friends.[37]

OUR SURVEY

Respondents were asked if, since the outbreak of COVID-19, they were exercising more, exercising less or exercising at their usual level.

FINDINGS

Almost half (49%) of our respondents reported exercising at their usual levels since the pandemic outbreak. Over one third (37%) of all respondents, however, have reported a decline in exercise.

Age Differences

Since the pandemic outbreak, younger respondents (55-64) were more likely to report that they are exercising more. Older respondents (75+) were more likely to have been exercising at their usual amount, as compared to those between 55-74.

Gender Differences

In our sample, men were more likely to report exercising at their usual amount, while women were more likely to report exercising less, since the pandemic outbreak.

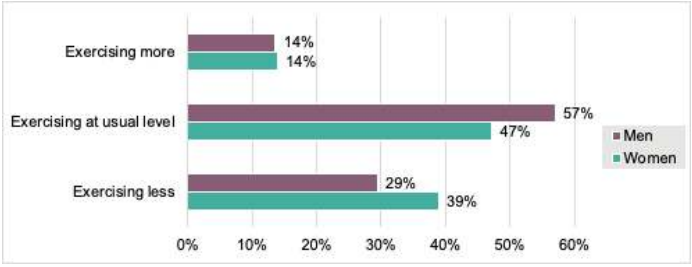


Figure 4.4 Exercise since outbreak by gender

Sexual Orientation Differences

Heterosexual respondents were more likely to report exercising at their usual amounts, as compared to LGB respondents. LGB respondents, however, were more likely to report exercising more since the pandemic outbreak.

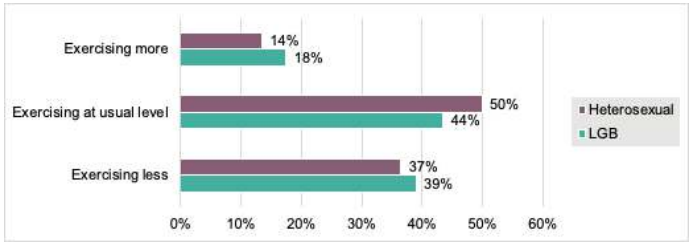


Figure 4.5 Exercise since outbreak by sexual orientation

"Miss group classes at gym miss socializing"
69-year-old heterosexual woman

"Investigated new exercise opportunities... encouraged the regular practice of some exercise regimes" 67-year-old heterosexual man

COVID-19 & LIFE CHANGES

IN CANADIANS 55+

DAILY ROUTINES

90% saw a change in routines including: work, education, social life, hobbies or activities

SOCIAL SUPPORT

83% have had their access to family & non-family social supports affected

ACCESS TO MEDICAL CARE

79% saw a change in healthcare appointments, prescriptions, & general delays

Women reported more negative changes compared to men in areas such as:

- discord at home
- access to food
- social support

EXERCISE

37% have been exercising less than their pre-pandemic levels

LGB persons reported more changes than heterosexual persons in access to:

- medical healthcare
- mental healthcare

LGB: Lesbian, gay, and bisexual

Findings from Fall 2020 survey of 4380 Canadians age 55+

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PREVIOUS PANDEMIC EXPERIENCE
In our sample

BACKGROUND

Notwithstanding reports of COVID-19 being the first pandemic of our lifetimes, the world has experienced others, including the "Spanish Flu" early in the 20th century and Tuberculosis first seen in the late 19th century. There has been some discussion of how the oldest amongst us lived through or, more likely, lived with parents who lived through what was known as the "Spanish Flu" which killed an estimated 50 million worldwide.[38] More recently, the world experienced the SARS pandemic of 2002 and the H1N1 Influenza pandemic of 2009-2010. Polio was an epidemic of the 1950's and HIV/AIDS was first identified in the early 1980's. LGBT persons, and gay and bisexual men in particular, have been, and continue to be, disproportionately affected by the HIV/AIDS epidemic. Many within the US older LGBT community cared for and grieved the deaths of the more than 330,000 gay men who have died from HIV/AIDS since the 1980's.[39] Wight et al.[40] found, in their sample of over 200 gay men aged 44 to 75, that almost one quarter had lost 15 or more friends to AIDS.

OUR SURVEY

We asked respondents if they or someone close to them had been affected by one or more of the following previous pandemics: Spanish flu, TB, Polio, HIV/AIDS, SARS or H1N1 flu. If they had experience with at least one pandemic, respondents were asked if since the COVID-19 pandemic began they had:

1. Thought about that previous pandemic experience (on a 5-point scale ranging from "a lot more than usual" to "a lot less than usual")

And, on a 5-point scale ranging from "very strongly agree" to "very strongly disagree" respondents were asked if they had:

1. Felt like they had been here before because of the previous pandemic experience
2. Felt prepared for what is happening because of the previous pandemic experience
3. Felt like they needed to act/do something because of the previous pandemic experience
4. Felt like they couldn't handle it again because of the previous pandemic experience

FINDINGS

28% of our respondents reported having experienced at least one previous pandemic, most commonly H1N1.

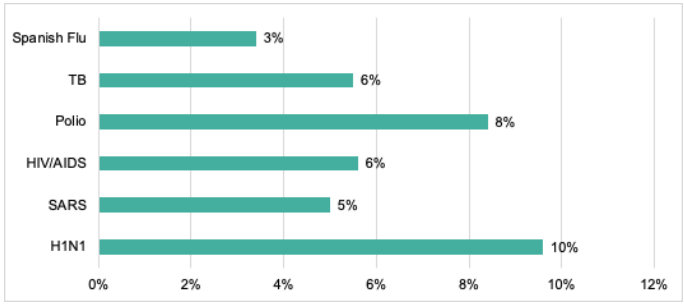


Figure 4.6 Previous pandemic experience

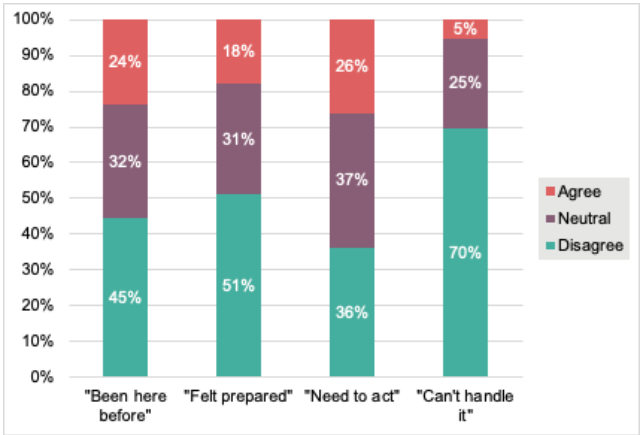


Figure 4.7 Reflecting on previous pandemic experience

Age Differences
The oldest respondents (75+) were more likely to have had experiences with Polio than the youngest respondents (55-64). Respondents age 65+ were more likely to report experiences with both the Spanish Flu and TB than were those between 55-64; those in this younger age group, however, were more likely to report experiences with H1N1 than were those in either of the two older groups. There were no age differences in experiences with either HIV/AIDS or SARS.

Over one third (39%) of respondents reported that they thought about their previous pandemic experience "about the same amount as usual". Other than the statement reflecting "the need to act" (for which the most common response was "neutral"), most respondents disagreed with the statements ("been here before", "felt prepared", and "can't handle it again"). Two age group differences were found: a higher proportion of the oldest respondents agreed with the statement about feeling prepared (23% of those 75+ compared with 17% of those younger) and disagreed with the statement about not being able to handle it again (77% of those 75+ compared with 69% of those younger).

Gender Differences
HIV/AIDS and H1N1 were the only two pandemics on which there were gender differences; men were more than twice as likely to indicate having experienced HIV/AIDS (10%) as compared with women (4%) and women were more likely to have experienced H1N1 (11%) than men (8%). Men and women did not differ in terms of their thoughts "about the previous pandemic" or feeling "like [they] can't handle it again".

On the other three measures, a greater percentage of men agreed with statements about having "been here before" (37% as compared with 20% of women), "felt prepared" (25% of men as compared with 16% of women), and "felt the need to act" (32% of men and 24% of women).

> **"My wife was an ICU nurse on the SARS team in a major hospital. She talks about the fear on a few occasions since C-19."**
> 72-year-old heterosexual man

Sexual Orientation Differences
Sexual orientation differences were found on two previous pandemics: TB (which 9% of LGB respondents reported having experienced, compared with 6% of heterosexual respondents) and HIV/AIDS (which LGB respondents were 10 times more likely to identify than heterosexual respondents, 35% and 3% respectively). LGB respondents did not differ from heterosexual respondents in terms of their thoughts "about the previous pandemic" or feeling "like [they] can't handle it again". On the other three measures, a greater percentage of LGB persons agreed with statements about having "been here before" (38% as compared with 21% of heterosexual persons), "felt prepared" (27% of LGB persons as compared with 17% of heterosexual persons), and "felt the need to act" (34% of LGB persons and 25% of heterosexual persons).

> **"The world feels strange in that we always need to keep socially distant. This differs from previous similar illnesses I have been exposed to."** 64-year-old gay man

COVID-19: BEEN HERE BEFORE?

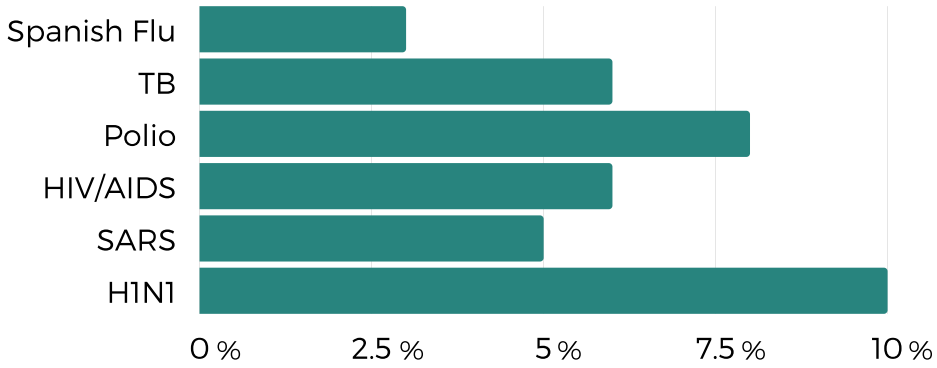
PREVIOUS PANDEMIC EXPERIENCE IN CANADIANS 55+

28% report they, or someone close to them, have been affected by a previous pandemic

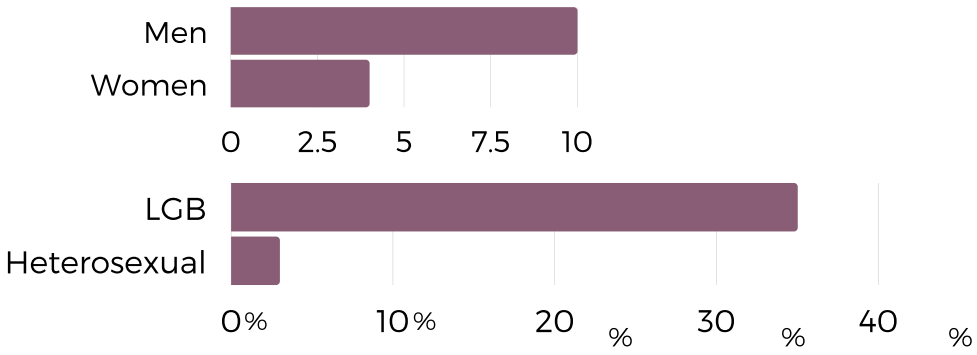
Since COVID-19 began, MEN & LGB persons with previous pandemic experience more likely to:

- "feel prepared"
- "feel the need to act"
- "feel they have been here before"

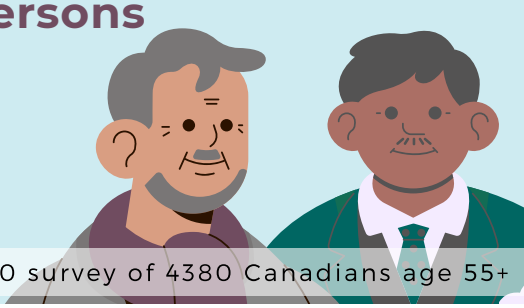
Previous pandemic experience



Experience with HIV/AIDS pandemic



LGB persons 10x more likely to have past experience with HIV/AIDS pandemic than heterosexual persons



LGB: Lesbian, gay, and bisexual

Findings from Fall 2020 survey of 4380 Canadians age 55+

SFU GERONTOLOGY RESEARCH CENTRE

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Health Status

BACKGROUND

The general expectation is that physical health will be worse, because people are reluctant to go to doctor's offices or healthcare centres lest they be exposed to COVID-19 and/or because of postponement of needed treatments and especially surgeries, so as to leave hospital beds open for COVID-19 patients. The shift in medical healthcare appointments to telehealth may further impact the health of older adults who are not well-versed in technology, while for others, virtual appointments may serve as a benefit. Worries about the mental health sequela of social distancing have been broadly expressed in both the scientific literature and the popular media, where Santini et al.[41] report that social disconnectedness increases the risk for depression and anxiety in older adults.

OUR SURVEY

Respondents were asked if, since the outbreak of COVID-19, their health improved, stayed the same, or has gotten worse.

FINDINGS

A majority of respondents (80%) reported no change since the pandemic outbreak.

"My physician is 5 hours away and they are in a hot zone... my physical health may be at risk"
60-year-old heterosexual woman

"The pandemic has triggered the worst depression and anxiety I've ever experienced in my life."
57-year-old heterosexual woman

Age Differences

Respondents in the 55-64 age group were more likely to report that their health had either improved or gotten worse, than older respondents.

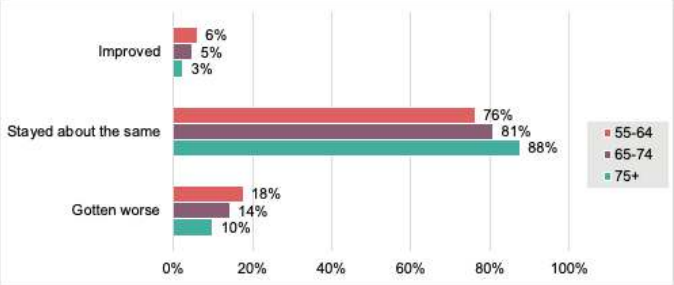


Figure 4.8 Health since outbreak by age group

Gender Differences

In our sample, women were more likely than men to report that their health has gotten worse, while men were more likely to report improved health.

Sexual Orientation Differences

LGB respondents were more likely to report that their health had either improved or gotten worse, than heterosexual respondents.

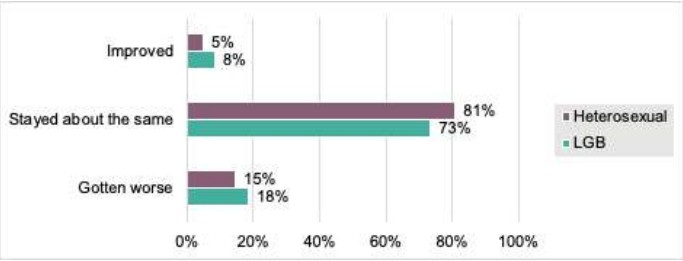


Figure 4.9 Health since outbreak by sexual orientation

Emotions and Feelings of Judgement/Shame Since Outbreak

OUR SURVEY

The questions on emotions were part of the "Pandemic-related stressor/social impacts" section of the survey. There were nine questions, each of which were phrased "since the outbreak of COVID-19" and offered respondents three options describing how they feel: "most of the time;" "some of the time;" and "seldom or never." (Analyses below group some of the time and most of the time into the category, "at least some of the time.") The specific emotional responses enquired about were: depressed; lonely; isolated; anxious; judged/shamed by others; sad (labelled "negative" emotions); and relaxed, happy, and accepted in their community (labelled "positive emotions").

FINDINGS

With the exception of feeling judged, half or more of our sample reported experiencing the negative emotions at least some of the time. A small proportion seldom experienced the counterbalancing impact of positive emotions.

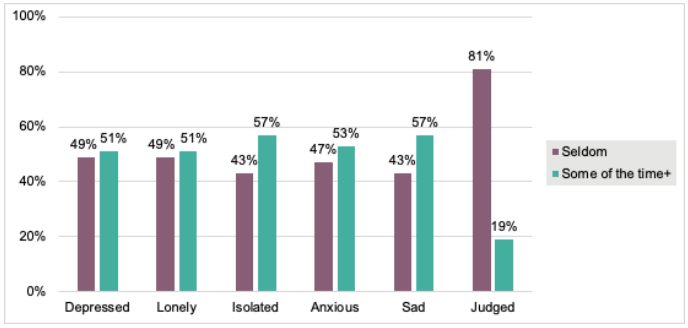


Figure 4.10 "Negative" emotions experienced

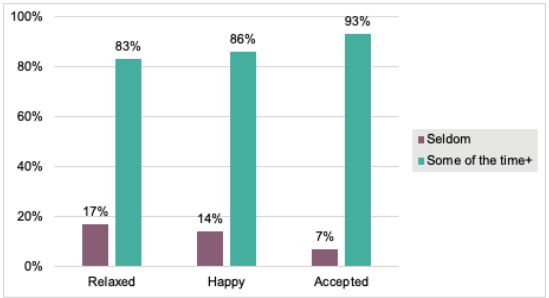


Figure 4.11 "Positive" emotions experienced

Age Differences

There was a consistent pattern across age groups, with respondents in the youngest group (55-64) most likely to report "negative" emotional reactions at least some of the time.

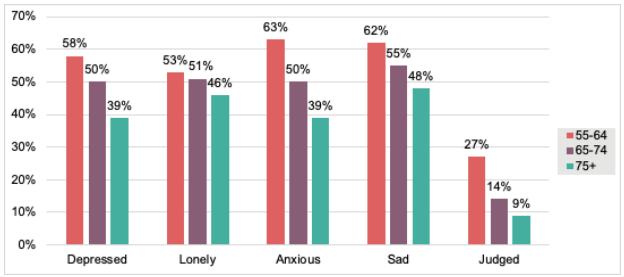


Figure 4.12 "Negative" emotions at least some of the time by age group

Similarly, younger respondents (i.e., those younger than 75) were less likely to experience "positive" emotions.

Gender Differences

Women were more likely than were men to report feeling all negative emotions inquired about (except judged) at least some of the time. That is, women were more likely than were men to experience feeling depressed, lonely, isolated, anxious, and sad at least some of the time. Interestingly, women and men did not significantly differ on any of the positive emotions (i.e., relaxed, happy, and accepted).

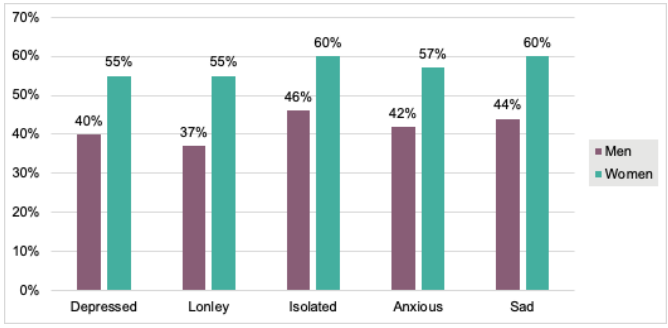


Figure 4.13 "Negative" emotions at least some of the time by gender

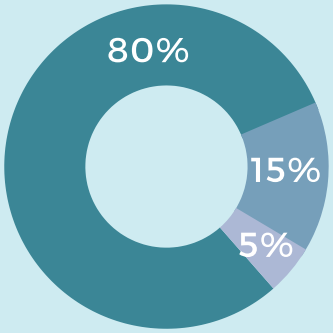
Sexual Orientation Differences

LGB older adults were more likely than heterosexuals, respectively, to report feeling depressed (59% as compared with 51%), anxious (59% as compared with 53%), and sad (63% as compared with 56%).

HEALTH IMPACTS OF COVID-19

IN CANADIANS 55+

Physical health SINCE the pandemic outbreak



- Stayed the same
- Gotten worse
- Gotten better

Women more likely to report that their health has worsened

Younger adults (55-64) more likely to report changes in health

Mental health SINCE the pandemic outbreak

51-57% of older Canadians report negative emotions, at least some of the time

- depressed
- lonely
- isolated
- anxious
- sad

BUT 83-93% of older Canadians also report positive emotions, at least some of the time

- relaxed
- happy
- accepted

Who has felt the biggest mental health impact?

LGB > Heterosexual

Women > Men

Younger (55-64) > Older (65+)

LGB: Lesbian, gay, and bisexual

Findings from Fall 2020 survey of 4380 Canadians age 55+

SFU GERONTOLOGY RESEARCH CENTRE

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SOCIAL SUPPORT
In our sample

BACKGROUND

Physical distancing, staying at home and self-isolation are currently part of the widespread practices aiming to contain the spread of coronavirus.[41,42] These practices have, however, brought disruption to social connectedness which in turn may contribute to negative psychological outcomes. Saltzman et al.[43] note that during times of crisis, social support plays a protective role with respect to mental health.

Santini et al.[41] reported that social disconnectedness predicted higher perceived isolation which in turn predicted higher depression and anxiety symptoms in older adults (ages 57-85). Under ordinary conditions, LGBT older adults report high rates of loneliness, isolation and depression, and it is unknown to what extent these conditions may be exacerbated by social distancing.

Social distancing requirements may also impact the assistance older adults rely on to manage their health and care needs. Evandrou et al.[42] surveyed individuals aged 70 and older during the first period of lockdown in England. They report that among older people who required assistance with at least one activity of daily living before the pandemic, about 25% reported receiving no support from outside their household during the lockdown.

OUR SURVEY

We asked respondents three sets of questions related to their social connections.

> **"Service provider help is less available, and quality [is] down"**
> 68-year-old heterosexual woman

1. The first set focused on general assistance. We asked respondents if they required assistance with any of the following:

- Bath or shower
- Personal hygiene and grooming (tooth brushing, brushing/combing hair, etc.)
- Dressing
- Toilet hygiene (getting to the toilet, cleaning oneself, and getting back up)
- Functional mobility (transferring, moving from one place to another while performing activities)
- Self-feeding (not including cooking or chewing and swallowing)

Those requiring assistance were asked if since the outbreak of COVID-19 they have required more, about the same amount, or less assistance. They were also asked if since the outbreak of COVID-19, those who assist them have increased, decreased or not changed their availability to assist.

2. The second set focused on community connections and acceptance. We asked if since the outbreak of COVID-19, they felt accepted in their community most of the time, some of the time or seldom or never.
3. The third set of questions focused on whom they did or would call on for help if needed a) to run an errand, get a ride, pick up groceries/prescriptions (short term help) and b) if they had an accident or serious illness (long term help) and, if there had been changes since the outbreak of COVID-19 and if so, in what way.

FINDINGS

- Assistance required – 3% of our sample reported needing assistance with at least one activity of daily living. Most needed help with functional mobility (2%) and/or bathing or showering (2%). Of these, 62% required about the same amount of assistance since the outbreak of COVID-19, 35% required more assistance and 3% required less assistance. Caregiver availability did not change for 56% of the people needing assistance and 24% of caregivers have increased the amount of time available to assist. However, one fifth of the caregivers (21%) have decreased the amount of time available to assist.
- Community connections – The majority of respondents (76%) felt accepted in their community most of the time.
- Who they would call on for help – Respondents with a spouse/partner (62% of our sample) would call upon them most of the time for both short term and long term help. The majority of respondents without a spouse/partner would call upon other relatives, close friends or neighbours for both types of help; 17% would call upon someone different for short term help and 12% would change who they would call for long term help. About 5% of those without a spouse/partner reported having no one to turn for help.

Age Differences

Among those with a spouse or partner, older respondents (75+) were less likely to call upon them for short term help (72% as compared with 83% of younger respondents). There were no age group differences for long term help (92%).

Among the sample in general, younger respondents (55-64) were less likely to call upon other relatives, neighbours, and faith, spiritual or religious communities for help (short term or long term) compared to older respondents. Younger respondents were more likely to have no one to call upon for long term help than older respondents (75+). The older respondents were more likely to report that they would call upon a formal caregiver for long term support than those ages 55-64.

	Short Term Help			Long Term Help		
	55-64	65-74	75+	55-64	65-74	75+
Other relatives	43%	51%	57%	50%	58%	69%
Close friends	39%	41%	42%	29%	31%	30%
Neighbours	19%	26%	31%	9%	11%	14%
Faith / Spiritual	5%	6%	8%	5%	6%	8%
Formal caregiver	1%	2%	2%	5%	8%	9%
Social service provider	4%	4%	5%	7%	9%	10%
No one	6%	5%	3%	6%	6%	3%
Other	4%	4%	6%	3%	3%	5%

Table 4.1 Short term and long term social support by age group

Gender Differences

Among those with a spouse/partner, there were no gender differences in the proportion who

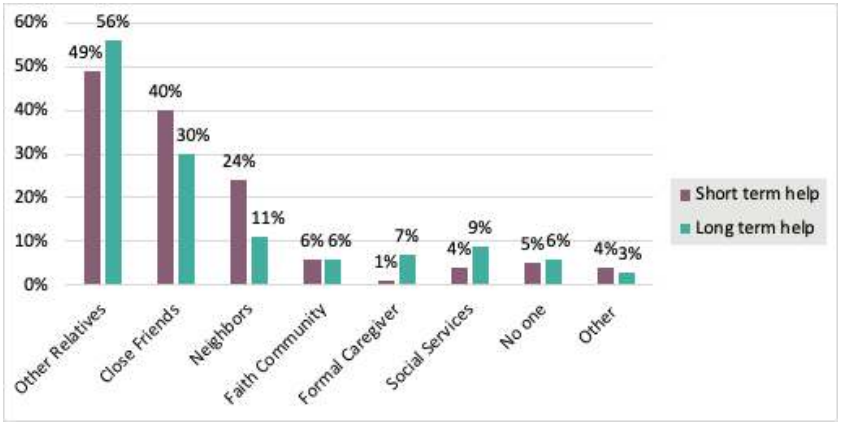

Figure 4.14 Short term and long term social support

would call upon their partner for either short term (82%) or long term (92%) help.

Among all respondents, women were more likely than men to call upon other relatives and close friends for both short and long term help. Women were also more likely than men to turn to formal caregivers for long term help. However, even as the percentages and differences were small, men were more likely to call upon social service providers or agencies than women and were also more likely to have no one to whom to turn for short term help.

	Short Term Help		Long Term Help	
	Men	Women	Men	Women
Other relatives	39%	52%	48%	59%
Close friends	35%	42%	26%	31%
Neighbours	23%	25%	10%	11%
Faith / Spiritual	5%	6%	6%	6%
Formal caregiver	2%	1%	5%	7%
Social service provider	5%	4%	8%	9%
No one	6%	5%	6%	5%
Other	4%	4%	4%	3%

Table 4.2 Short term and long term social support by gender

Sexual Orientation Differences

Among respondents who reported having a spouse or partner, LGB persons were more likely to call upon them for short term help then heterosexual persons (92% versus 82%). There were no differences amongst those who call upon their partner for long term help (92%).

	Short Term Help		Long Term Help	
	Heterosexual	LGB	Heterosexual	LGB
Other relatives	51%	28%	58%	41%
Close friends	39%	59%	29%	46%
Neighbours	24%	26%	10%	12%
Faith / Spiritual	6%	7%	6%	6%
Formal caregiver	1%	3%	7%	7%
Social service provider	4%	8%	8%	12%
No one	5%	6%	5%	9%
Other	4%	5%	3%	3%

Table 4.3 Short term and long term social support by sexual orientation

Among all respondents, heterosexual persons were more likely to call upon other relatives for both short and long term help than LGB persons. However, LGB persons were more likely to call upon close friends for both short term and long term help (almost twice as likely) and to turn to formal caregivers for short term help and social service providers for both short term and long term help than heterosexual persons. LGB persons were also more likely than heterosexual persons to have no one to turn to for long term help.

"Two friends that I would have called upon would no longer help out… realize who ones true friends are." 76-year-old gay man

"…I stopped [home support] for 3 months due to their policies…I am receiving less due to them always cancelling…No one to help clean I can't afford help" 55-year-old heterosexual woman

SOCIAL SUPPORT DURING COVID-19

IN CANADIANS 55+

5% of all older Canadians have no one to reach out to for help

Men more likely to have no one to call on for short term help than women

LGB persons more likely to have no one to call on for short term & long term help

Who are Canadians more likely to call for help? by sexual orientation

Heterosexual persons

Relatives

LGB persons

Friends

LGB: Lesbian, gay, and bisexual

Findings from Fall 2020 survey of 4380 Canadians age 55+

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PLANNING FOR THE FUTURE
In our sample

BACKGROUND

Advance Care Planning (ACP) is an integrative process wherein individuals, of all ages and conditions of health, are encouraged to reflect on, document, and communicate their values, wishes and preferences for future care, including care at end of life.[44] ACP has a more immediate relevance for those with life-limiting conditions and offers structure for the consideration and communication of care preferences to loved ones and caregivers.[45] ACP also has particular salience for older persons—especially in the present context as age is the major risk factor for COVID-19.[46] The relevance of the pandemic is also heightened for those whose lived experiences are outside of conventional heteronormative (family) domains, traditionally around which ACP is formed.[47]

Teixeira et al.[48] reported on the general experience of Canadians (ages 18 to over 65 years) with ACP. They found that few (16%) knew the term “Advance Care Planning”; less than half (47%) had designated a person to be their healthcare decision-maker in the event of incapacity and only 20% had a written advance care plan. Further, just over half (52%) of their respondents had engaged in any discussions with family or friends about healthcare treatment preferences in the event that they became too ill or injured to speak for themselves; only 10% had held ACP discussions with healthcare professionals. Older age, higher education and income and gender (women) were associated with having discussed ACP with family or friends and with ACP behaviours.

OUR SURVEY

The “Planning for the Future” section began with a definition of Advance Care Planning (ACP) drawing from Sudore et al.[44]: “a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of ACP is to help ensure that people receive care that is consistent with their values, goals, and preferences during serious and chronic illness.” It was also noted that ACP may include the preparation of documents and respondents were asked which, if any, of the following documents they had prepared prior to the COVID-19 outbreak (in one question) and since the outbreak (in another question). The response options included:

- Will (legal document indicating disposition of property and money after death)
- Power of Attorney for Property (a legal document that gives one or more persons authority to manage your financial and legal affairs)
- Continuing/Enduring Power of Attorney (it continues - or endures - if you become mentally incapable)
- Advance Directive (a legal document, which in the US is called a living will, that gives instruction for future heath care treatment)
- Power of Attorney for Medical Care (gives authority to the person of your choice to make personal and healthcare decisions for you if you become incapable).

Finally, two questions were posed related to conversations in which respondents may

have engaged about ACP. Specific examples were offered; these included: “I’d like to receive intensive care for an illness or injury, as long as my brain is not damaged” and “I would not like to be on a feeding tube or ventilator, because it does not align with my spiritual beliefs.” Respondents were provided a range of options from which they could select all that apply; these options were: no (no discussion); yes, with a spouse/partner; yes, with a family member; yes, with a friend; yes, with a doctor; or other. As above, these questions were framed, in the first instance, as prior to the COVID-19 outbreak and, in the second instance, since the COVID-19 outbreak.

FINDINGS

The documents most commonly completed before the COVID-19 pandemic included a will completed by 65% of respondents, Power of Attorney for Property completed by 42% and Power of Attorney for Medical completed by 35% of our respondents. 62% had held care discussions prior to the pandemic, and 43% reported engaging in care discussions since the pandemic outbreak.

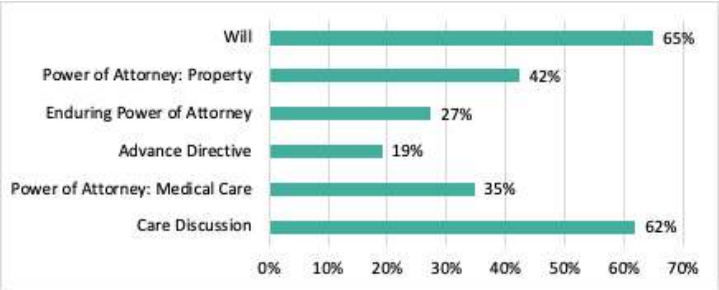


Figure 4.15 ACP document completion and care discussions prior to pandemic

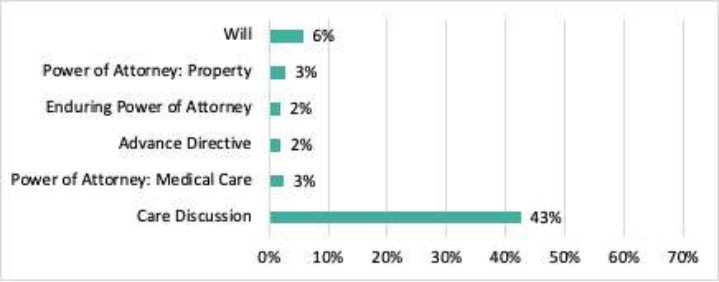


Figure 4.16 ACP document completion and care discussions since pandemic outbreak

While 43% had engaged in care discussions since the pandemic began, few had prepared or revised any of the documents we enquired about.

Among those who were partnered, both prior to and since the pandemic outbreak, ACP discussions were most commonly held with their spouse/partner. Family and friends were next most common discussants. Overall, surprisingly few had held care discussions with a doctor (5% pre-pandemic; 2% since pandemic outbreak).

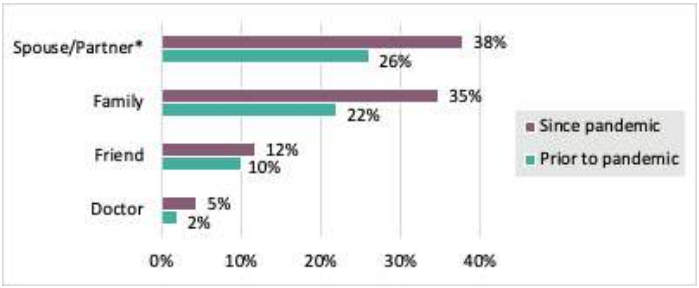


Figure 4.17 ACP discussions prior to and since pandemic

*Discussions with partner/spouse include only those who previously reported they are partnered

Age Differences

The extent of ACP engagement, prior to the pandemic outbreak, was consistently (and significantly) higher among the older respondents than among the younger respondents.

ACP Activity	55-64	65-74	75+
Will	50%	64%	74%
Power of Attorney: Property	27%	43%	58%
Enduring Power of Attorney	18%	27%	40%
Advance Directive	12%	19%	27%
Power of Attorney: Medical	22%	36%	45%
Care Discussion	62%	66%	71%

Table 4.4 ACP document completion and care discussions prior to pandemic by age group

There were no significant differences across the age groups in document completion since the pandemic outbreak or in care discussions. Pre-pandemic, older,

partnered respondents were less likely than those 74 and younger to have held ACP discussions with their spouse/partner; older respondents were generally more likely, however, to have discussed ACP with family friends and their doctor. Since the pandemic outbreak, a similar pattern was found, though discussions were fewer across all groups with no differences in discussion with friends.

Gender Differences

Prior to the pandemic outbreak, women were more likely to have completed all of the ACP documents than were men. Women were also more likely than men to have had a care discussion prior to the pandemic outbreak (65% as compared with 51%). Since the outbreak, women and men did not differ in their completion or revision of any of the ACP documents. However, women were more likely to have engaged in a care discussion (45% as compared with 35%).

Both prior to and since the pandemic outbreak, women were almost twice as likely as men to have held an ACP discussion with a family member other than their spouse, or with a friend. Discussions with a doctor were few among both men and women and proportions were similar (5% pre-pandemic and 2% after it began).

Sexual Orientation Differences

Prior to the pandemic outbreak, LGB respondents were more likely to have completed an advance directive than were heterosexual respondents (25% as compared with 19%, respectively) and were more likely to have had a care discussion (69% as compared with 61%). As noted above, only a small percentage of respondents completed or revised documents since the pandemic outbreak; however, sexual minority respondents were significantly more likely than were heterosexual respondents to have done so.

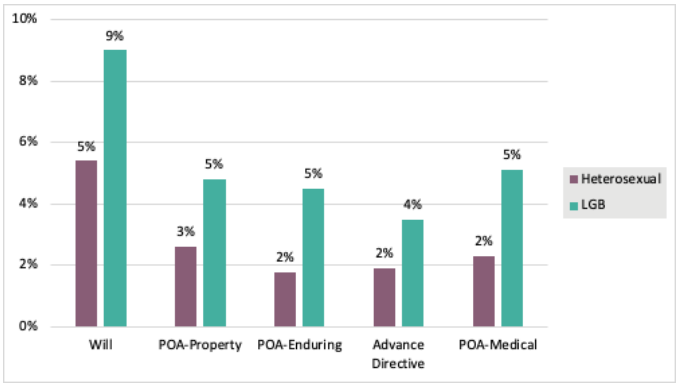


Figure 4.18 ACP document completion and care discussions since outbreak by sexual orientation

Both prior to and since the pandemic outbreak, LGB respondents were more likely to have engaged in conversations related to ACP, and particularly with their friends with whom they were twice as likely to have had such conversations (22% as compared with 11%).

> **[Since COVID-19] I have had conversations with my spouse regarding will, power of attorney, personal directive"**
> 62-year-old heterosexual woman

COVID-19 & Advance Care Planning (ACP)

AMONG CANADIANS 55+

Most common pre-pandemic activities...

- Made a will → 65%
- Informal Discussions → 62%
- Power of attorney-property → 42%
- Power of attorney-medical → 35%

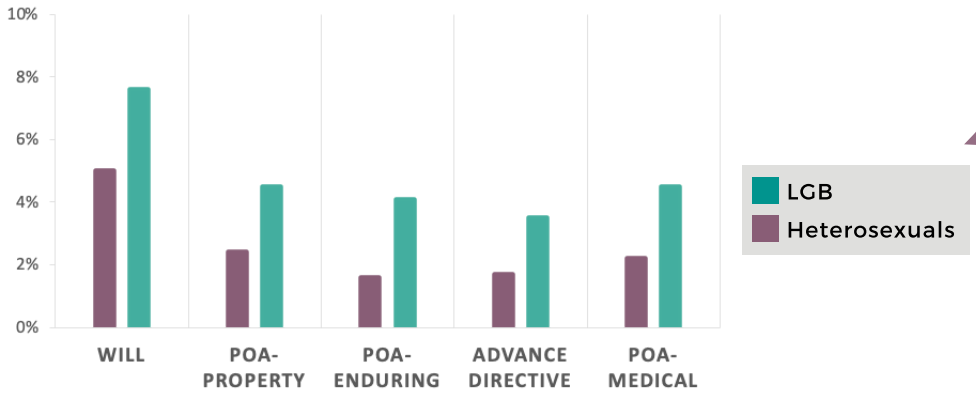
Only 5% of Older Canadians have had discussions with their doctor

Since the pandemic outbreak...

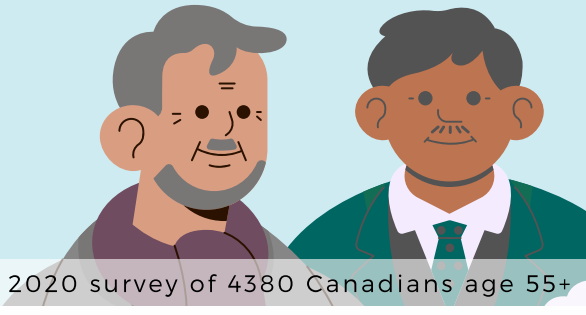
43% of all older Canadians engaged in care discussions

Women more likely to have had care discussions, prior to and since the pandemic outbreak

Documents since pandemic outbreak



LGB persons more likely to have revised or completed ACP documents



Lesbian, gay, and bisexual (LGB)

Findings from Fall 2020 survey of 4380 Canadians age 55+

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SUMMARY AND RECOMMENDATIONS

COVID-19 poses the greatest risk to older adults, in particular those with pre-existing medical conditions. Little, however, is known about how COVID-19 may be affecting sub-groups within the older population. Are some coping better than others? Has it stimulated some more than others to think about their future care needs and preferences? These were questions addressed in an online survey that ran from August 10-October 10, 2020. A large and fairly representative sample of 4380 Canadians aged 55+ told us about their perceived current as compared to pre-pandemic physical and mental health and lifestyle, and about their actions and discussions about future healthcare before and since COVID-19 started. In analyzing the data we first looked at trends in the sample as a whole, then addressed questions about differences as a function of age grouping (55-64, 65-74, 75+), gender, and sexual orientation. Below we begin by summarizing key findings as a function of age; key findings by gender and sexual orientation follow, and subsequently we offer recommendations along these lines.

Age Groups

Contrary to our expectations, the youngest group in our sample (i.e., those between the ages of 55 and 64) appear to have experienced more detrimental effects of the pandemic and paradoxically, to have engaged less in mitigation efforts than older respondents. For example, these younger-older adults were more likely than those older to have reported changes in health, as well as more COVID-19 symptoms and other medical conditions for which they did not seek help. This younger group was similarly more likely to report changes in family income/employment and in stress and family discord; to a smaller degree, they were also more likely to report changes in access to food and to mental healthcare. This group was also more likely to report negative emotions “at least some of the time” (e.g., feeling depressed, lonely, anxious, and sad). At the same time, this younger group was less likely to report that they wear masks and social distance “most of the time.” They were less likely to call upon others for support (especially other relatives, close friends and neighbours) and they were less likely to have completed ACP documents and to have had discussions with loved ones about the care they would prefer in a health crisis prior to the start of the pandemic.

Gender

A pattern of higher stress responses may be seen among the women compared to the men of our sample, accompanied, however, by more prosocial behaviours. That is, the women of the sample were more likely, than were men, to report changes across many of the domains assessed in the Coronavirus Impact Scale: routines, stress and discord in family, support access, medical and mental healthcare access, and access to food. Relative to men, women reported that they live

with a greater number of chronic conditions, were more likely to report that their health has gotten worse, that they exercised less, and that they experienced health conditions for which they did not seek medical attention. Perhaps as a result, more women than men reported negative emotions “at least some of the time”. On the other hand, women were more likely than were men to report wearing masks and social distancing “most of the time.” Women were also more likely to have completed ACP documents and to have had discussions about care options both before and since the pandemic outbreak.

Sexual Orientation

The LGB persons in our sample appear to be taking the virus and mitigation efforts more seriously than heterosexual persons and, similar to the pattern of results for women, to have engaged in more prosocial and health enhancing behaviours. LGB persons were more likely to wear masks and social distance “most of the time”; they were more likely to exercise more since the pandemic outbreak. LGB persons were ten times more likely to have experienced HIV/AIDS and, perhaps accordingly, were more likely to agree with statements that having experienced a previous pandemic they felt like they have “been here before,” “felt prepared,” and “felt the need to act.” At the same time, LGB persons were more likely to report feeling depressed, anxious, and sad, were more likely to report changes in health (both positive and negative) and more likely to experience changes in medical and mental healthcare access. LGB persons live with a greater number of chronic conditions than heterosexual persons. They reported that they were more likely to call upon close friends for short term and long term support (and less likely to call upon other relatives—with whom older LGB persons have historically had complicated and often disturbed relations). They were also more likely to call upon social service providers and to have no one on whom to call. LGB were also more likely to have completed ACP documents and to have had care discussions prior to and after the COVID-19 outbreak. This counterbalancing of current stress from the pandemic (and from ongoing stigma) with proactive responses to present health disparities and future healthcare needs may contain lessons for other marginalized/minority groups.

For example, the ACP efforts of LGB persons, more numerous and broader than their heterosexual peers, may be seen as one such positive, productive response to the stress. In this group, the most likely to be chosen is a friend rather than biological kin, expanding our thinking of instrumental and key relationships relevant to ACP. However, while the LGB group were more likely than heterosexual respondents to seek out formal care providers when needed, a key finding of this survey was how few respondents overall (only 180 or 4% of the 4380) had held care discussions with their physician.

Recommendations

The key findings suggest a series of targeted recommendations:

- While the emphasis on combatting social isolation and loneliness among all seniors that has been exacerbated by COVID-19 pandemic mitigation efforts is vital, the attention of policy makers, service providers and the general public needs also to be drawn to the unique stresses experienced by younger older adults. More than those in the 65+ age range, the day-to-day lives of the 55-64 age group have been disrupted – especially among those still in the paid labour force. Forced by the pandemic to work from home, or not to work at all, raises the specter of family discord (as reported). This is reflected in the following quote:

> **"My son had to move back into my home. However, he does not take responsibility for living in the home. He does not wash the dishes after dinner, and he does not take out the trash. I am very unhappy. He does not pay rent and does not provide money for meals... I always go out because I don't want to see my son"** 55-year-old heterosexual woman

- As younger respondents are less likely to follow COVID-19 protocols, compared to older respondents, a public education campaign on virus safety measures targeting places they commonly frequent (e.g. gyms, restaurants, bars, transit stations, workplaces), may be useful to increase compliance. There is also a need to recognize and address the concerns of this group about COVID-19 mitigation policies, reflected in the quote below:

> **"Every time I see someone in a mask I almost have a panic attack. They closed the whole world for nothing more than the common cold..."** 55-year-old heterosexual woman

- More women than men have been exercising less since the pandemic outbreak, in part because the venues they prefer are closed. Mass media may be used to promote COVID-safe physical activities in order to reduce the physical health burden of sedentary behaviour but need also to take into account the social outlet that group exercise provides for many older women. It's fun and fitness, not just fitness that needs to be fostered. Such promotions would also help to address the higher levels of stress expressed by women.
- LGB respondents who have had previous pandemic experience, particularly with the HIV/AIDS pandemic, should be encouraged and supported to reach out to their community and beyond with stories of survival and resilience – i.e., serve as exemplars, role models and mentors; and communicate strategies upon which current advocacy measures, policies and programs can be modelled.

Recommendations

In addition to these recommendations based on trends in our research, there are startling findings across our three variables of interest that call for attention and intervention.

- Address the physician-patient ACP communication gap from both sides of the equation – doctors and patients. This could be accomplished through media campaigns to encourage and facilitate communication targeted by professional groups (e.g., Doctors of BC, Ontario College of Family Physicians) to their members being conducted simultaneously with or in partnership with campaigns conducted by local and/or national seniors' organizations (e.g. CARP)
- Encourage Canadians to plan ahead. Even as 60% of our sample had completed a will, all other ACP documents about which we asked were completed by fewer than 40%–and as low as 18% (for an Advance Directive). COVID-19 has emphasized the unpredictability of life; it is a careful balance between raising awareness of the steps needed to survive the pandemic, while also encouraging people to plan realistically for infirmity and end of life care post-COVID.

KEY FINDINGS

COVID-19 Experiences & Advance Care Planning among Older Canadians

Sexual Orientation

Age Group

Gender

LGB respondents more likely to have taken COVID-19 public health measures more seriously

as compared to heterosexual respondents

Women more likely to have taken a harder hit in their routines, stress and available support since COVID-19

as compared to men

Younger old adults (55-64) less likely to wear masks or social distance

as compared to older respondents (65+)

LGB with previous pandemic experience, more likely to agree that since COVID-19 they:

- have been here before
- felt prepared
- felt the need to act

Women were also more likely to comply with public health measures

In wearing masks, social distancing and socializing with others

Younger age group (55 - 64) more likely to have seen negative changes in income and discord at home

This age group also more likely to experience negative emotions e.g. depression, anxiety and stress, at least some of the time.

LGB more likely to have completed ACP documents and have had discussions regarding future care

both prior to and since the pandemic

LGB: Lesbian, gay, and bisexual

Findings from Fall 2020 survey of 4380 Canadians age 55+

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REFERENCES

1. Public Health Agency of Canada. Vulnerable populations and COVID-19. Updated October 1, 2020. Accessed January 17, 2021. https://www.canada.ca/en/public-health/services/publications/diseases-conditions/vulnerable-populations-covid-19.html

2. Brotman S, Ryan B, Cormier R. The health and social service needs of gay and lesbian elders and their families in Canada. *The Gerontologis*t. 2003;43(2):192-202. doi:10.1093/geront/43.2.192

3. Fredriksen-Goldsen KI, Emlet CA, Kim H-J, et al. The physical and mental health of lesbian, gay male, and bisexual (LGB) older adults: the role of key health indicators and risk and protective factors. *The Gerontologist*. 2013;53(4):664-675. doi:10.1093/geront/gns123

4. de Vries B. Stigma and LGBT aging: negative and positive marginality. In: Orel NA, Fruhauf CA, eds. *The Lives of LGBT Older Adults: Understanding challenges and resilience*. APA; 2015:55-72.

5. de Vries B, Mason AM, Quam J, Acquaviva K. State recognition of same-sex relationships and preparations for end of life among lesbian and gay boomers. *Sex Res Soc Policy*. 2009;6(1):90-101. doi:10.1007/BF03165990

6. Fredriksen-Goldsen KI, Simoni JM, Kim H-J, et al. The Health Equity Promotion Model: Reconceptualization of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Disparities. *Am J Orthopsychiatry*. 2014;84(6):653-663. doi:10.1037/ort0000030

7. Smith A, Anderson M. Social Media Use 2018: Demographics and Statistics. March 1, 2018. Accessed January 17, 2021. https://www.pewresearch.org/internet/2018/03/01/social-media-use-in-2018/

8. Statistics Canada. Population and Dwelling Count Highlight Tables, 2016 Census. Government of Canada. Published 2017. Accessed January 17, 2021. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/pd-pl/Table.cfm?Lang=Eng&T=101&S=50&O=A

9. Statistics Canada. Census Profile, 2016 Census - Quebec [Province] and Canada [Country]. Government of Canada. Published 2017. Accessed January 17, 2021. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

10. Statistics Canada. Population Centre and Rural Area Classification 2016. Government of Canada. Published 2017. Accessed January 17, 2021. https://www.statcan.gc.ca/eng/subjects/standard/pcrac/2016/introduction

11. Statistics Canada. Dictionary, Census of Population, 2016 Population centre (POPCTR). Government of Canada. Published 2017. Accessed January 17, 2021. https://www12.statcan.gc.ca/census-recensement/2016/ref/dict/geo049a-eng.cfm

12. Canadian Internet Registration Authority. Canada's Internet Factbook 2020. Canadian Internet Registration Authority (CIRA). Published 2020. Accessed January 17, 2021. https://www.cira.ca/node/8796

13. Yoon H, Jang Y, Vaughan PW, Garcia M. Older Adults' Internet Use for Health Information: Digital Divide by Race/Ethnicity and Socioeconomic Status. *J Appl Gerontol*. 2020;39(1):105-110. doi:10.1177/0733464818770772

14. Statistics Canada. Education Highlight Tables, 2016 Census. Government of Canada. Published 2017. Accessed January 17, 2021. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/edu-sco/Table.cfm?Lang=E

15. Statistics Canada. Census Profile, 2016 Census - Canada [Country] and Canada [Country]. Government of Canada. Published 2017. Accessed January 17, 2021. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E

16. Statistics Canada. Aboriginal Population Profile, 2016 Census. Government of Canada. Published 2017. Accessed January 17, 2021. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/abpopprof/index.cfm?Lang=E

REFERENCES

17. Clement J. U.S. Facebook usage frequency by ethnicity 2018. Statista. Published 2019. Accessed January 18, 2021. https://www.statista.com/statistics/653029/frequency-usage-facebook-usa-ethnicity/

18. Statistics Canada. 2011 National Household Survey: Data tables – Religion. Government of Canada. Published 2013. Accessed January 20, 2021. https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/dt-td/Rp-eng.cfm?LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GID=0&GK=0&GRP=0&PID=105399&PRID=0&PTYPE=105277&S=0&SHOWALL=0&SUB=0&Temporal=2013&THEME=95&VID=0

19. Employment and Social Development. Social isolation of seniors: A focus on LGBTQ seniors in Canada. Government of Canada. Published 2018. Accessed January 17, 2021. https://www.canada.ca/en/employment-social-development/corporate/seniors/forum/social-isolation-lgbtq.html#h2.5-h3.2

20. Statistics Canada. Same-sex couples and sexual orientation... by the numbers. Government of Canada. Published 2015. Accessed January 17, 2021. https://www.statcan.gc.ca/eng/dai/smr08/2015/smr08_203_2015

21. Statistics Canada. 2016 Census of Canada: Data tables – Age (in Single Years) and Average Age (127) and Sex (3) for the Population of Canada, Provinces and Territories, Census Divisions, Census Subdivisions and Dissemination Areas, 2016 Census. Government of Canada. Published 2017. Accessed January 17, 2021. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Index-eng.cfm

22. Carlson KB. New poll reveals landscape of gay Canada | National Post. National Post. https://nationalpost.com/news/canada/the-true-north-lgbt-new-poll-reveals-landscape-of-gay-canada. Published 2012. Accessed January 17, 2021.

23. Clement J. Canada Facebook users by gender 2020. Statista. Accessed January 17, 2021. https://www.statista.com/statistics/649520/facebook-user-share-in-canada/

24. McKinnon M. 2019 Report: Social Media Use in Canada. CanadiansInternet.com. https://canadiansinternet.com/2019-report-social-media-use-canada/. Published 2019. Accessed January 17, 2021.

25. Giblon R, Bauer GR. Health care availability, quality, and unmet need: a comparison of transgender and cisgender residents of Ontario, Canada. *BMC Health Serv Res*. 2017;17(1):283. doi:10.1186/s12913-017-2226-z

26. Statistics Canada. Data tables, 2016 Census - Marital Status (13), Age (16) and Sex (3) for the Population 15 Years and Over of Canada, Provinces and Territories and Census Metropolitan Areas, 1996 to 2016 Censuses. Government of Canada. Published 2017. Accessed January 17, 2021. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Index-eng.cfm

27. Taylor E. Is Canada's lesbian, gay, and bisexual and transgender community worth pursuing? Marketing Mag. Published 2012. Accessed January 17, 2021. http://marketingmag.ca/wp-content/uploads/2012/06/LastQ_LGBT.pdf

28. Statistics Canada. Labour Highlight Tables, 2016 Census. Government of Canada. Published 2017. Accessed January 17, 2021. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/lab-tra/index-eng.cfm

29. Statistics Canada Catalogue no. 98-312-X2011003. Living arrangements of seniors. Government of Canada. Accessed January 18, 2021. https://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/98-312-x2011003_4-eng.cfm

30. MetLife Mature Market Institute. Still Out, Still Aging. The MetLife Study of Lesbian, Gay, Bisexual, and Transgender Baby Boomers. Mature Market Institute; 2010.

31. Wassersug RJ, Lyons A, Duncan D, Dowsett GW, Pitts M. Diagnostic and outcome differences between heterosexual and nonheterosexual men treated for prostate cancer. *Urology*. 2013;82(3):565-571. doi:10.1016/j.urology.2013.04.022

REFERENCES

32. Global Health 5050. The COVID-19 Sex-Disaggregated Data Tracker. Updated January 11, 2021. Accessed January 17, 2021. https://globalhealth5050.org/the-sex-gender-and-covid-19-project/

33. Public Health Agency of Canada. Coronavirus disease (COVID-19): Measures to reduce COVID-19 in your community. Government of Canada. Published 2020. Accessed January 17, 2021. https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevention-risks/measures-reduce-community.html

34. Stoddard J, Kaufman J. Coronavirus Impact Scale. Published 2020. Accessed January 17, 2021. https://www.nlm.nih.gov/dr2/Coronavirus_Impact_Scale.pdf

35. Hall G, Laddu DR, Phillips SA, Lavie CJ, Arena R. A tale of two pandemics: How will COVID-19 and global trends in physical inactivity and sedentary behavior affect one another? *Prog Cardiovasc Dis*. Published online April 8, 2020. doi:10.1016/j.pcad.2020.04.005

36. Wong CW, Tsai A, Jonas JB, et al. Digital Screen Time During the COVID-19 Pandemic: Risk for a Further Myopia Boom? *Am J Ophthalmol*. 2021;223:333-337. doi:10.1016/j.ajo.2020.07.034

37. van Uffelen JGZ, Khan A, Burton NW. Gender differences in physical activity motivators and context preferences: a population-based study in people in their sixties. *BMC Public Health*. 2017;17(1):624. doi:10.1186/s12889-017-4540-0

38. (US) Centers for Disease Control and Prevention. 1918 Pandemic (H1N1 virus) | Pandemic Influenza (Flu). Published 2019. Accessed January 17, 2021. https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html

39. (US) Centers for Disease Control and Prevention. CDC FACT SHEET: HIV Among Gay and Bisexual Men. Accessed January 17, 2021. https://www.cdc.gov/NCHHSTP/newsroom/docs/factsheets/cdc-msm-508.pdf

40. Wight RG, LeBlanc AJ, de Vries B, Detels R. Stress and Mental Health Among Midlife and Older Gay-Identified Men. *Am J Public Health*. 2012;102(3):503-510. doi:10.2105/AJPH.2011.300384

41. Santini ZI, Jose PE, Cornwell EY, et al. Social disconnectedness, perceived isolation, and symptoms of depression and anxiety among older Americans (NSHAP): a longitudinal mediation analysis. *Lancet Public Health*. 2020;5:e62-70. doi:10.1016/S2468-2667(19)30230-0

42. Evandrou M, Falkingham J, Qin M, Vlachantoni A. Older and 'staying at home' during lockdown: informal care receipt during the COVID-19 pandemic amongst people aged 70 and over in the UK. Published online June 23, 2020. doi:10.31235/osf.io/962dy

43. Saltzman LY, Hansel TC, Bordnick PS. Loneliness, isolation, and social support factors in post-COVID-19 mental health. *Psychol Trauma Theory Res Pract Policy*. 2020;12(S1):S55-S57. doi:10.1037/tra0000703

44. Sudore RL, Lum HD, You JJ, et al. Defining Advance Care Planning for Adults: A Consensus Definition from a Multidisciplinary Delphi Panel. *J Pain Symptom Manage*. 2017;53(5):821-832.e1. doi:10.1016/j.jpainsymman.2016.12.331

45. Howard M, Bernard C, Tan A, Slaven M, Klein D, Heyland DK. Advance care planning. *Can Fam Physician*. 2015;61(8):663-665.

46. (US) Centers for Disease Control and Prevention. COVID-19 and Your Health - Older Adults. Published 2020. Accessed January 17, 2021. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html

47. de Vries B, Gutman G, Humble Á, et al. End-of-Life Preparations Among LGBT Older Canadian Adults: The Missing Conversations. *Int J Aging Hum Dev*. 2019;88(4):358-379. doi:10.1177/0091415019836738

48. Teixeira AA, Hanvey L, Tayler C, Barwich D, Baxter S, Heyland DK. What do Canadians think of advanced care planning? Findings from an online opinion poll. *BMJ Support Palliat Care*. 2015;5(1):40-47. doi:10.1136/bmjspcare-2013-000473

OUR TEAM

Gloria Gutman, Ph.D., developed the Gerontology Research Centre and Department of Gerontology at Simon Fraser University (SFU) and was director of both from 1982-2005. Currently, she is a Research Associate and Professor Emerita at SFU. Her awards and honours include the Order of British Columbia, an LLD (honoris causa) from the University of Western Ontario, a Queen Elizabeth II Diamond Jubilee medal and the Order of Canada, the country's highest civilian honour, for her work "as an international authority in the field of gerontology". She is author/editor of 23 books. Her research interests include seniors' housing, long-term care, health promotion, gerontechnology, prevention of elder abuse, advance care planning, and disaster mitigation.

Brian de Vries, Ph.D., is Adjunct Professor of Gerontology at Simon Fraser University and Professor Emeritus of Gerontology at San Francisco State University; he received his Ph.D. from the University of British Columbia in 1988. He is a Fellow of the Gerontological Society of America, past Board member of the American Society on Aging and former co-Chair of the LGBT Aging Issues Network constituent group, and was appointed to the Institute of Medicine's Board on the Health of Select Populations Committee. Dr. de Vries has co-edited several professional journals and academic books; he has authored or co-authored over 125 journal articles and book chapters (with funding from national agencies, associations and organizations). His research has focused on the social and psychological well-being of midlife and older LGBT persons, friendship, and end-of-life issues.

Robert Beringer, DSocSci., is a Research Consultant and has worked as a gerontologist and researcher for 10 years. In 2019 he completed his doctoral dissertation focused on The Experience of Older Gay Men Living in Non-Metropolitan British Columbia. Prior to this dissertation, Robert published and presented research on gerontechnology, aging-in-place, and Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Two-Spirit (LGBTQI2S) aging. He is also a Canadian Health Systems Impact Post-Doctoral Fellow working in collaboration with Victoria Hospice to Evaluate and Optimize LGBTQI2S Engagement with Hospice and Palliative Care in the Island Health Region of British Columbia.

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Paneet Gill, BSc, is an undergraduate Kinesiology and Gerontology student at Simon Fraser University. She joined the iCAN-Diversity Access Team in July 2020 and currently works as a research assistant for the Gerontology Research Centre, under Dr. Gloria Gutman. She has previously worked on a project addressing the impacts of social isolation in older adults for the Health Change Lab at Simon Fraser University; in her studies she is interested in health promotion strategies for healthy ageing, and ethnocultural experiences and disparities in aging. Paneet also works for the Generation Health Program with the YMCA of Greater Vancouver.