

Aging at Home: Concerns of Community-Dwelling Older People and Their Interest in Seeking Local Resources and Services

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Article

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Abstract

Objectives: This cross-sectional study examinee health and social concerns among community-dwelling older people, the resources they sought, and factors related to these concerns.

Methods: A convenience sample of 222 Nova Scotians aged 65 or over completed a semi-structured interview using the ACT® Assess, which assess 53 common health and social issues across six domains. Each item was linked to a database of corresponding local resources.

Findings: Over 40% of participants reported loneliness, moderate or greater pain, sleep problems, and/or bereavement – all within the Mental Health domain. However, only 32% sought Mental Health resources, compared to over 60% who sought resources for Accommodation and Finances. Participants receiving care showed greater challenges in activities of daily living and mobility.

Discussion: Findings suggest a high level of concern, even among a relatively healthy sample, and indicate a progression of concerns from psychosocial and home maintenance issues to mobility and functional challenges.

Abrégé

Contexte: Les investissements dans les services à domicile et communautaires permettent aux personnes âgées de demeurer plus longtemps dans leur milieu de vie. Toutefois, les services prioritaires à financer demeurent mal définis.

Objectif: Examiner les préoccupations de santé et sociales des aînés vivant dans la communauté, les ressources recherchées et les facteurs associés à ces préoccupations.

Méthodes: Un échantillon de convenance de 222 Néo-Écossais âgés de 65 ans et plus a participé à une entrevue semi-structurée utilisant l'outil ACT® Assess, qui évalue 53 problèmes de santé et sociaux répartis en six domaines. Chaque problème était associé à une base de données de ressources locales pertinentes.

Résultats: Plus de 40 % des participants ont signalé de la solitude, une douleur modérée ou plus intense, des troubles du sommeil ou un deuil. Malgré cela, seulement 32 % ont recherché des ressources en santé mentale, comparativement à plus de 60 % pour le logement et les finances. Les personnes recevant des soins présentaient davantage de difficultés liées à la mobilité et aux activités de la vie quotidienne.

Conclusion: Les résultats révèlent un niveau élevé de préoccupations et suggèrent une progression des enjeux psychosociaux vers des limitations fonctionnelles et de mobilité.

Background

In 2024, 7.8 million Canadians (19%) were aged 65 years or older (Statistics Canada, 2024a). Because older people receive health care that costs approximately 4.4 times more than younger cohorts, their care constitutes nearly 50% of total health expenditure (Gibbard, 2018). As the number of older people is projected to increase through 2075, at the fastest rate of any age group (Statistics Canada, 2025), costs will continue to grow. Investing in home and community services to help older people age well and remain at home is known to reduce expensive acute and long-term care demands (National Seniors Council, 2024). For example, a 2024 Canadian Institute for Health Information (CIHI) report estimated that 1 in 10 residents newly admitted to a long-term care facility could have remained at home if sufficient supports and services were in place (CIHI, 2024). Given that nearly all older Canadians express a preference to age in place (Sinha, 2020), this type of investment also holds strong public support.

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Governments and community agencies are responding in several ways. For example, comprehensive geriatric assessments (CGAs) serve individuals at risk of functional decline or during a health crisis using a medical lens; social prescribing (SP) initiatives link individuals to non-medical supports within the community to tackle social determinants of health; and community-based needs assessments (CBNAs) facilitate public and private sectors to design or tailor health and social programs based on communities' aggregated needs. The *ACTing Collectively* project was a proof-of-concept study that combined components of CGAs, SP, and CBNAs. A structured interview, the ACT[®] Assess, identified participating older peoples' concerns and a linked resource dataset was used to offer a choice of local health and social services and resources. Aggregating answers elevated their voices to inform public and community policies and service planning.

CGAs, now the gold standard in geriatric settings, are widely used in primary and community-based care (Kshatri et al., 2025; Parker et al., 2018). These multidimensional assessments inform multidisciplinary, integrated care plans designed to address older peoples' concerns (Parker et al., 2018), especially when older people transition between health care settings, following a health crisis, or with increasing frailty or disability (Morrisby et al., 2018). An umbrella review of systematic reviews found that the use of CGAs in community settings significantly reduced mortality and long-term care admission among general and frail older people (Ambagtsheer et al., 2023).

SP is a phenomenon of global interest, intended to leverage the known, positive impact of social factors, such as appropriate housing, financial security, and transportation, and combat negative conditions such as social isolation (Morse et al., 2022). Using a deliberate and individualized process to connect people to community-based resources or activities, SP builds social support, strengthens trust in service, and improves clients' mental health and ability to manage chronic conditions (Bhatti et al., 2021), and is an effective approach for people experiencing social isolation and loneliness (Paquet et al., 2023).

CBNAs aggregate and synthesize community-level data to inform community organizations, local service providers, and policy makers about programs and services needed and sought by residents (Ravaghi et al., 2023). These assessments aggregate and analyze individual responses to make community-level recommendations so that concerns extend beyond individuals themselves and reach organizational, social, and policy levels, ultimately helping older people to live well at home (National Seniors Council, 2024).

Each of these three initiatives have weaknesses. First, CGAs and CBNAs often focus on health care and home services (e.g. home maintenance, basic activities of daily living, medical care) and overlook psychological concerns or social determinants of health, such as loneliness, finances, transportation, and accommodations (Beran, 2015). Second, many CBNAs are based on census or institutional data or input from caregivers, health care providers, and service managers (Ravaghi et al., 2023). Thus, older peoples' needs are indirectly, rather than directly heard. Third, while some CGAs, SP initiatives, and CBNAs collect information directly from older people, there is evidence that individuals are likely to avoid, decline to respond to, or provide vague responses to sensitive, challenging, or difficult topics, such as incontinence, bereavement, and elder abuse, especially in open-ended interviewing contexts (Silverio et al., 2022). Fourth, all these initiatives tend to follow traditional views of older people as passive service receivers, with less attention paid to how they actively seek community resources to age in place. Interestingly, while older people identify barriers to aging in place, they may not always take action to reduce those

barriers. In one study, older people sought resources for less than 25% of their unmet needs (Walters et al., 2001). A more recent study also reported discrepancies in expressed concerns and prioritized areas for action while managing chronic conditions, such as taking medications and distress in health-related problems (Hessler et al., 2019).

Studies explicitly examining older peoples' proactive interest in local resources to prevent or address concerns related to living or aging in place are scarce. Yet, past studies examining perceived barriers to remaining at home, unmet needs, and areas requiring assistance shed some light on common concerns and associated factors. For example, home improvement and maintenance, mobility, and safety at home are the most expressed barriers for older people who wish to remain living at home (Brim et al., 2021). Heavy and light housework were the most frequently unmet needs reported in a large-scale New Zealand survey (Wilkinson-Meyers et al., 2014). Older people with greater need for assistance and more unmet needs were more likely to experience mobility difficulty, be a care provider, and/or be female (Wilkinson-Meyers et al., 2014). Home maintenance concerns were also closely associated with financial concerns, especially for those who were older, female, had greater care needs, had lower income or financial means, or were living alone/had never been married (Fret et al., 2020). A Canadian national survey found that 41% of adults aged 50 years or older are at risk of being socially isolated and 58% are experiencing loneliness (Iciasczyk et al., 2024). While women are more likely to experience loneliness, higher education and better income security are protective factors for social isolation and loneliness (Bull et al., 2023).

Therefore, the overall goals of the *ACTing Collectively* project were to describe older peoples' health and social concerns at the community level, to identify those concerns for which they seek resources (prioritized concerns), and to identify potential gaps in local resources. This paper reports on the first two goals. Specific objectives of this paper are to:

- describe the extent and type of health and social concerns expressed by community-dwelling older people living in three Nova Scotian communities,
- describe the extent and types of concerns for which they prioritized resources, and
- identify the underlying personal factors related to the number, type, and prioritization of concerns for which to seek resources.

Methods

Study design

The *ACTing Collectively* project was a proof-of-concept, cross-sectional study using a convenience sample. The project was approved by the Nova Scotia Health Research Ethics Board. All requirements to protect participants' privacy and confidentiality were followed. The *Strengthening the Reporting of Observational Studies in Epidemiology* (STROBE) statement guided reporting (Von Elm et al., 2007).

Setting

The study took place in three communities (one regional municipality and two rural counties) in Nova Scotia, one of the four Atlantic Canadian provinces. In 2021, older people in these three areas accounted for over 25% of the population of the three counties (Statistics Canada, 2024a). The level of economic dependency, situational vulnerability, and health care costs in these areas was higher

than the provincial averages (Kephart et al., 2016; Statistics Canada, 2024b). In Canada, access to primary care providers (i.e. family physicians and nurse practitioners), who are the first point of contact for people in need of non-urgent care or referral, is publicly funded for residents (with few exceptions) via provincial health insurance. However, between July 2023 and October 2024, approximately 13% of Nova Scotians were on the 'Need a Family Practice Registry' (Nova Scotia Health, 2024), complicating access to health care resources for a large number of people. In Nova Scotia, a virtual care option, functioning like a walk-in clinic, was available to those without a primary care provider. In addition to primary care, the province operates two free telephone information services – '211', which provides information on non-commercial formal and informal resources, and '811', which provides health advice. Each participating community expressed interest in and then agreed to participate in the project; a local community coordinator was assigned to assist with recruitment, attend regular project meetings, and provide the researchers with local knowledge and connections.

Participants

Participants were recruited by community coordinators, via seniors' groups, local, municipal, and provincial health and social care organizations. Flyers, infographics, and articles in newsletters distributed or posted on social media and in local public venues (e.g. libraries, seniors' clubs) were also used. During the participant recruitment period, a monthly project newsletter was sent to interested organizations and individuals to encourage ongoing recruitment. Local community coordinators recruited potential participants through word-of-mouth and via organized, in-person community events. Newspaper articles and local television and radio interviews about the study supplemented recruitment efforts. Participants were encouraged to disseminate information about the project to eligible family members and friends. Based on advice from the community coordinators, recruitment materials emphasized the opportunity to plan for the future, learn about local resources, and help the community learn about the needs of older people (Boutilier et al., 2025).

Individuals were eligible to participate if they (1) were aged 65 years or older and lived independently (community-dwelling), (2) lived in one of the three collaborating communities, and (3) were able to understand and speak English or French. The exclusion criteria meant that individuals with (1) cognitive or psychological impairments preventing comprehension of the assessment questions (assessed by the ability to follow instructions), or (2) who were living in a long-term care facility. Family members could answer the assessment questions on behalf of participants who met the eligibility criteria if communication barriers, such as hearing impairment, prevented their participation.

Interested individuals contacted the research team to confirm their eligibility and provide informed, voluntary consent. Next, they selected their preferred assessment method (in-person, telephone, or online via Zoom for Healthcare) and appointments were scheduled with trained assessors.

Instruments

ACT[®] Assess

The ACT[®] Assess (Age Care Technologies, 2025) includes a semi-structured interview of 56 short questions with a locally curated database of resources linked to each question. Questions are asked in a conversational manner to ease participants' anxiety or embarrassment and increase their willingness to respond to sensitive

topics. The questions identify older peoples' concerns across six domains: Looking After Yourself, Getting Around, Safety and Relationships, Accommodation and Finances, Mental Health, and Staying Healthy. Response options range from two to five and responses are entered into the digital platform by the assessors in real-time. Participants can 'skip the question' if desired. Brief narrative responses can also be recorded in the digital ACT[®] Assess platform; however, these qualitative data are not reported in this paper.

Upon answering and entering responses to all 56 questions, ACT[®] Assess automatically generates a list of all concerns (defined as a problem, worry, or negative situation) raised during the interview. Participants are given the opportunity to select or 'prioritize' any of these concerns to review local resources from the database linked to each concern. Upon viewing and discussing available resources, participants select resources of interest to populate an Individualized Action Plan summarizing their prioritized concerns and chosen resources. There are no limits on the number of prioritized concerns or resources selected. Resources chosen are not reported in this paper.

Sociodemographic characteristics and chronic conditions

Participants' sociodemographic characteristics, and the number and perceived impact of their chronic conditions were collected by the assessor, then entered into an electronic form using software (i.e. Opinio) supported by the researchers' institution.

Data collection

Participant recruitment was carried out and assessment/interview data were collected between October 2022 and May 2024. The ACT[®] Assess was administered by trained assessors, including members of the research team, community coordinators, and local volunteers with varying backgrounds. Assessors required sufficient digital literacy to use the ACT[®] platform, and all had experience working with older people. Assessors from rural areas and those who spoke the local Acadian French dialect increased the capacity to reach and assess participants with this background. All assessors received manuals developed by the research team and completed synchronous Zoom training sessions developed by the research team, supplemented by ACT[®] training tools. The training sessions included assessment simulations. Assessors signed confidentiality agreements upon completion of training and before conducting assessments.

Statistical analysis

Participants' sociodemographic and health-related characteristics were summarized using means (standard deviation [SD] and range) for continuous variables, and number (percentage, %) for dichotomous or categorical variables. The count of concerns and prioritized concerns, as well as the percentage of concerns prioritized in each ACT[®] Assess domain and in total, were calculated; the mean (SD) or median (inter-quartile range, IQR) are reported as appropriate. Item-based descriptive analysis was done to highlight items with the most and least concerns or prioritized concerns raised by participants.

Age was the only continuous sociodemographic variable; others were categorized. Gender was dichotomized as 'male' or 'female' (no participant chose 'other gender'); education as 'completed less than secondary education' or 'completed postsecondary education or higher'; marital status into 'married' or 'single, separated,

divorced, or widowed'; and living arrangement into 'living alone' or 'living with others'. Ethnicity was based on self-identification and dichotomized as 'European' or 'not European' (yes or no). 'Providing care to others' and 'receiving care from others' were binary variables with yes or no responses. Two variables related to chronic conditions were categorized into three groups. Number of chronic conditions was grouped as 'no chronic condition', '1 condition', or '2 or more conditions'. The impact of chronic conditions was categorized as 'no impact to a little bit of impact', 'moderate impact', or 'quite a bit to extreme impact'. Finally, data from these two questions were used to create a combined, four-category variable, called 'number and impact of chronic condition(s)'. The three 'impact' categories were supplemented by a fourth category accounting for participants without a chronic condition. Integrated data from the two related variables reduced collinearity issues and overcame the problem of missing data on 'impact of chronic condition' for those without chronic conditions.

Four ACT[®] Assess questions, all in the Mental Health domain, were recoded or removed from the analysis. Pain was defined as a concern if rated as 'moderate or worse' ($n = 106$, 48% of participants). 'Mild pain' was regrouped with 'no pain'. This was based on literature that shows that pain of moderate or greater severity has adverse effects on older people (Shega et al., 2013). Three other ACT[®] Assess questions, included to screen for cognitive ability (for example, 'what is today's date?'), were excluded from the analysis because they do not capture self-assessed concerns. A separate ACT[®] question asking participants to self-assess their memory was retained. With the three screening questions removed, and pain recoded, the total number of potential concerns was 53.

To examine differences in the number of concerns and prioritized concerns across domains, parametric analysis of variance (ANOVA) or nonparametric Kruskal-Wallis H test was used as appropriate. Pairwise post-hoc analysis using Bonferroni correction was then calculated; adjusted p -values are reported.

Participant characteristics associated with the total number of concerns/prioritized concerns at both aggregated and domain levels were identified using a two-step analysis. First, correlated personal and health-related characteristics for each outcome (i.e. number of concerns and prioritized concerns in total and by domain, and the percentage of concerns prioritized) were identified using univariate analysis. A p -value ≤ 0.25 was considered sufficient to select potential predictive factors for inclusion in the multivariate models (Chowdhury & Turin, 2020). Second, generalized linear models (GLMs) with Poisson loglinear or negative binomial log link function were applied to identify which of the included predictive factors were significantly associated with the outcomes, controlling for other associated variables in the models. These GLMs were chosen to handle the counted outcomes that were not normally distributed. The choice of Poisson loglinear or negative binomial regression was determined by dispersion (Schober & Vetter, 2021). Models for prioritized concerns only included participants with at least one concern identified in the relevant domain because prioritized concerns were only selected from the previously raised concerns.

A high proportion (35%) of missing data for age affected analysis of four domain scores (i.e. concerns in Getting Around and Staying Healthy, and prioritized concerns in Looking After Yourself and Safety and Relationships). These missing data were considered missing at random. Multiple imputations using the multivariate imputation by chained equations (MICE) were used to impute age for analysis of these four outcomes. Other missing values in the predictive variables (all <5% of the sample and missing

completely at random) were not imputed and all the GLMs were done with complete cases to reduce bias introduced by cross data imputation (Sterne et al., 2009). To resolve the collinearity issue between marital status and living arrangements (Spearman's $\rho = .855$, $p < .001$), the regression model with the variable generating higher pseudo-R square value was retained. The main effects of each predictive variable were examined; their exponential coefficient and 95% confidence intervals are reported. The significance level was $p = .05$. Deviance residual plots were used to examine the model fit.

One personal factor, 'receiving care from others', was specifically examined to gauge the concerns raised by older people perceived to rely, at least to some extent, on care from others. 'Receiving care from others' was left to the interpretation of the respondents, therefore, the nature of this support (paid or unpaid for example) was not known. These concerns were identified using chi-square test or Fisher's exact test by cross tabulating the two binary variables: receiving care (Y/N) and raised as a concern (Y/N) for each of the 53 items. To compare differences in the concerned items between older people who received care from others and those who did not, the total number of concerns from all the items that were significantly associated with receiving care were calculated for each group.

Statistical analyses were completed using the IBM SPSS version 29 and R 4.4.2 with MICE, MASS packages.

Results

Participants' sociodemographic characteristics and chronic conditions

Over the recruitment period, 288 individuals expressed interest; 66 later declined or did not participate in the assessment, resulting in 222 enrolled participants (Table 1). The mean age was 75.8 years old ($SD = 6.0$, range = 65–93 years old); about 74% were female and 69% had completed postsecondary education or higher. Around one in five participants (20%) were providing care to others and one in eight (13%) were receiving care. Among the 169 participants (78%) with at least one chronic condition, 63% ($n = 106$) reported moderate to extreme impact on their everyday life, representing 48% of the total sample (Table 1).

Overall number of concerns and those prioritized for resource selection

In total, 1,824 concerns were identified by 221 participants; only one participant identified no concerns (Table 2). Participants reported an average of 8.2 concerns ($SD = 5.0$, median = 7.5, $IQR = 4$ –11, range = 0–26). Thirty-two percent of the concerns ($n = 581$) were in the Mental Health domain (Table 2, Column B), with an average of 83 people registering concerns per question in this domain (Table 2, Column C). By comparison, the Staying Healthy domain, the domain with the second highest number of concerns, registered only 23.5% of the overall concerns ($n = 428$ concerns) with an average of 36 people raising concerns per question. The Accommodation and Finances domain registered the fewest concerns with only 8.3% ($n = 151$) of the total, though the number of people reporting concerns per question ($n = 38$) was similar to other domains. Average concerns raised in the Mental Health domain were significantly higher than those in the Looking After Yourself domain (Kruskal-Wallis H test = 28.04, Bonferroni

Table 1. Sociodemographic and health-related characteristics of participants (n = 222)

Participant characteristics	Number (%)
Age (n = 145)	
Mean (SD)	75.84 (5.98)
65–74 years old	65 (45%)
75 years old or more	80 (55%)
Sex	
Male	58 (26%)
Female	164 (74%)
Education level	
Completed less than secondary education	68 (31%)
Completed postsecondary education or higher	154 (69%)
Marital status	
Married	112 (50%)
Single, separated, divorced, or widowed (not married)	110 (50%)
Living arrangement	
Living alone	95 (43%)
Living with others	127 (57%)
Ethnicity (multiple responses possible)	
European	177 (81%)
Acadian	51 (23%)
Indigenous	7 (3%)
Others	7 (3%)
Providing care to others (n = 213)	
Yes	45 (21%)
No	168 (79%)
Receiving care from others	
Yes	28 (13%)
No	194 (87%)
Number of chronic conditions (n = 218)	
0	48 (22%)
1	89 (41%)
2 or more	81 (37%)
Number and impact of chronic conditions (n = 217)	
No chronic condition	48 (22%)
No impact to a little bit of impact	63 (29%)
Moderate impact	45 (21%)
Quite a bit to extreme impact	61 (28%)

adjusted $p = .001$) and the Safety and Relationships domain ($H = 26.55$, $p = .013$), but not higher than other domains.

When asked to select and prioritize concerns to learn about resources, one-fifth of the participants (44/222) prioritized no concerns at all (Table 2). The remaining 178 participants (80.2%) prioritized 645 concerns (mean = 3.6 per participant, SD = 3.0, median = 3, IQR = 2–4, range = 1–23). The greatest number of prioritized concerns were again concentrated in the Mental Health

domain with 187 of 645 (29.0%) prioritized concerns falling in this domain (Table 2, Column D), followed by the Staying Healthy domain (20.5%, $n = 132$). There were no statistically significant differences in the number of prioritized concerns across domains.

A different story was found, however, when the proportion of people with concerns, rather than the proportion of total participants, was examined. Only 32.1% of concerns in the Mental Health domain were prioritized compared to between 30.8% and 60.9% in other domains (Table 2, Column F). Over 60% of the participants with concerns in the Accommodation and Finances domain were interested in learning about corresponding resources, 1.6–2.0 times higher than other domains (30.8%–37.9%).

Common concerns and highly prioritized concerns

A more granular analysis was possible by looking at item-level responses. Seventeen of the 53 items (32.1%) posed concerns for at least 20% of participants (Figure 1). Of these, the four most common concerns (reported by over 40% of participants) were in the Mental Health domain: loneliness (48.6%), bodily pain of a moderate or greater severity (47.7%), sleep problems (47.3%), and bereavement (43.7%). Other frequent concerns were spread across the other five domains, though there were slightly more concerns identified in the Staying Healthy domain than the other four. Interestingly, 16 of the remaining 36 potential concerns (44.4%) were concerns for 5% or fewer participants ($n < 12$). The majority of these 16 items fell in the Looking After Yourself domain (7 items), followed by the Safety and Relationships domain (4 items).

When prioritizing concerns to identify resources, one specific item stood out – financial benefits and allowances. Of participants with this concern, 87% prioritized it, a stark contrast to other highly prioritized concerns, including bodily pain (48.1%), weight control (43.5%), house maintenance (41.4%), and foot problems (40.8%) (Figure 2). Notably, no single ACT® Assess domain dominated prioritized selections, but bereavement was the least prioritized concern, selected by only 12.4% of those who reported it as a concern.

The relationship between participant factors, concerns, and prioritized concerns

Personal factors associated with concerns and prioritized concerns identified using univariate analysis are presented in Tables 3 and 4. ‘Not being married’, ‘receiving care from others’, and reporting ‘greater impact of chronic conditions’ were associated with having both more concerns and prioritized concerns. Having a ‘greater number of chronic conditions’, ‘greater impact of the conditions’, and ‘receiving care from others’ were positively associated with having more concerns in almost all ACT® domains. ‘Receiving care from others’ was also significantly associated with prioritized concerns in the five ACT® domains. No other participant characteristics (i.e. age, gender, education level, living arrangement, ethnicity, providing care or not) were consistently associated with concerns or prioritized concerns by domain.

Results of the GLMs demonstrated that, after controlling for all other associated characteristics, ‘not being married’ (i.e. single, separated, or widowed), ‘receiving care from others’, and ‘having moderate or greater impact of chronic conditions’ were associated with more total concerns (Table 5: $p < .05$ = significantly related; $p < .08$ = marginally related). Analysis at the domain level showed that older people experiencing ‘quite a bit to extreme impact of

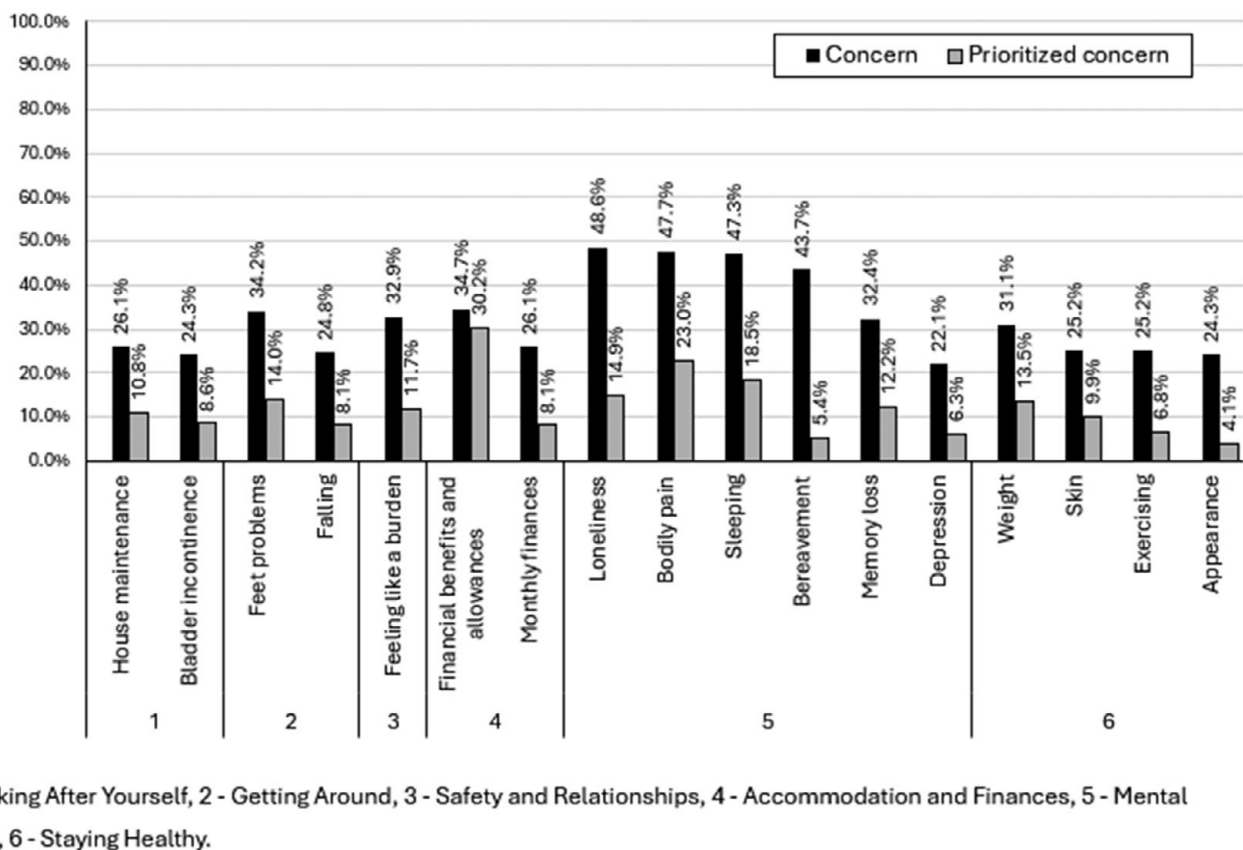
Table 2. Descriptive statistics of concerns and prioritized concerns of older people by six ACT* Assess domains and overall total (n = 222)

ACT* Assess domains	Number of questions (A)	Median (IQR), range of concerns	Total number (%) of concerns raised (B)	Mean (SD) concerns raised per question (C) = (B) / (A)	Median (IQR), range of prioritized concerns	Total number (%) of prioritized concerns (D)	Mean (SD) prioritized concerns per question (E) = (D) / (A)	Sample percentage of concerns prioritized (F) = (D) / (B)	Mean (SD) individual percentage of concerns prioritized
Looking After Yourself	14	2 (0–2), 0–8	264 (14.5%)	18.9 (19.0) ¹	0 (0–1), 0–7	100 (15.5%)	7.1 (7.9)	37.9%	40.1% (43.7)
Getting Around	8	1 (0–1), 0–7	233 (12.8%)	29.1 (24.5)	0 (0–0), 0–5	74 (11.5%)	9.3 (10.3)	31.8%	32.0% (42.2)
Safety and Relationships	8	0 (0–1), 0–4	167 (9.2%)	20.9 (22.8) ²	0 (0–0), 0–4	60 (9.3%)	7.5 (8.4)	35.9%	34.3% (44.7)
Accommodation and Finances	4	1 (0–1), 0–3	151 (8.3%)	37.8 (35.2)	0 (0–1), 0–3	92 (14.3%)	23.0 (30.2)	60.9%	60.8% (43.5)
Mental Health	7	2 (1–4), 0–7	581 (31.9%)	83.0 (27.8) ^{1,2}	0 (0–1), 0–6	187 (29.0%)	26.7 (115.9)	32.1%	30.4% (38.9)
Staying Healthy	12	2 (1–4), 0–7	428 (23.5%)	35.7 (19.7)	0 (0–1), 0–3	132 (20.5%)	11.0 (8.6)	30.8%	23.6% (50.0)
Total	53	7.5 (4–11), 0–26	1824 (100.0%)	34.4 (30.0)	2 (1–4), 0–23	645 (100.0%)	12.2 (13.6)	35.4%	35.7% (29.4)

Abbreviations: SD = standard deviation; IQR = interquartile range.

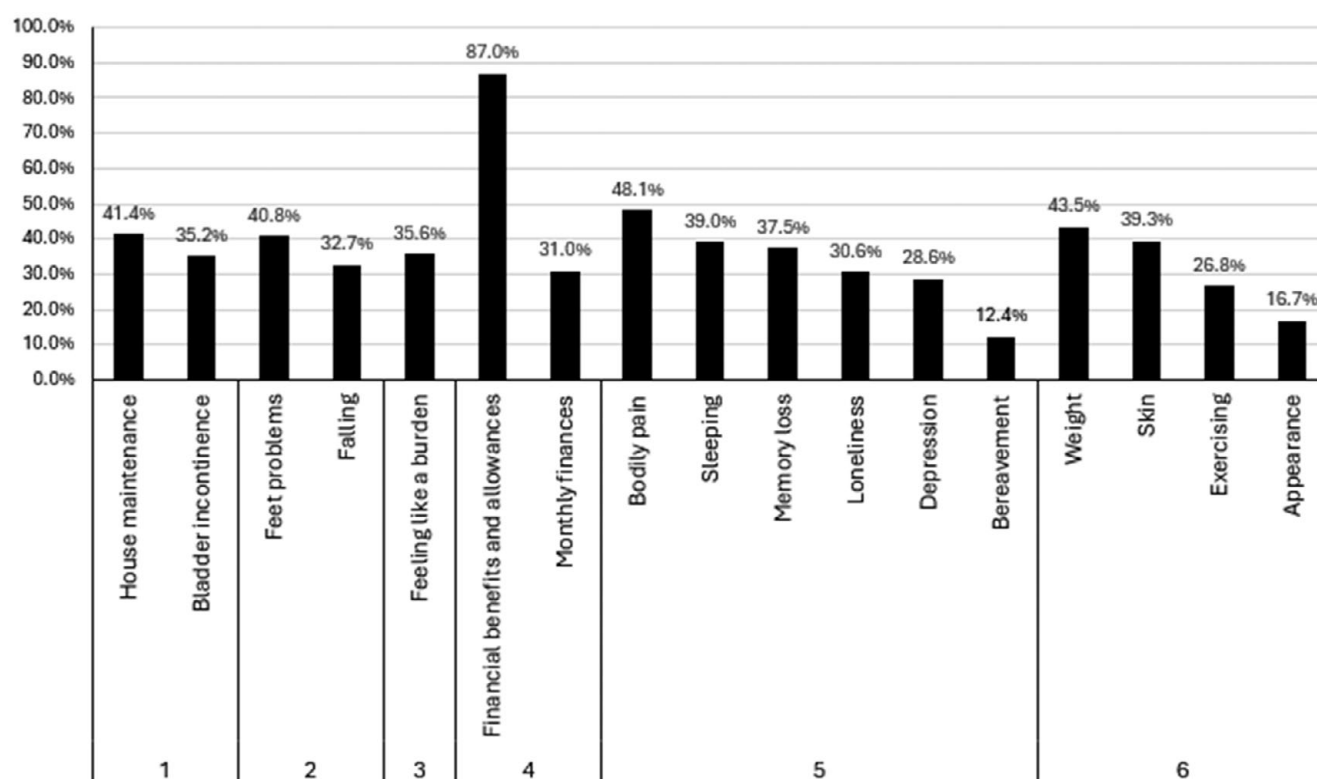
¹Statistically significant difference between Looking After Yourself and Mental Health domains using the Kruskal-Wallis test and post hoc Bonferroni pairwise comparison.

²Statistically significant difference between Safety and Relationship and Mental Health domains using the Kruskal-Wallis test and post hoc Bonferroni pairwise comparison.

**Figure 1.** Concerns identified by 20% or more of the total participants and percentage of participants who prioritized these concerns (n=222).

conditions' had about five more concerns in the Staying Healthy domain compared to those who 'do not have any chronic condition' ($\text{Exp}(B) = 5.01$, 95% CI = 2.95–8.53, $p < .001$). People reporting 'quite a bit to extreme impact of conditions' and who were 'receiving care from others' were likely to have two more concerns in the Looking After Yourself and Getting Around domains (Exp

(B) = 2.07–2.95, 95% CI = 1.38–4.13, $ps < .001$). 'Not being married' was associated with more concerns in the Mental Health and Staying Healthy domains ($\text{Exp}(B) = 1.37$ –1.89, 95% CI = 1.16–2.70, $ps < .001$). Interestingly, the only personal characteristic related to the total number of concerns in the Accommodation and Finances domain was 'living alone', but the effect on the



1 - Looking After Yourself, 2 - Getting Around, 3 - Safety and Relationships, 4 - Accommodation and Finances, 5 - Mental Health, 6 - Staying Healthy.

Figure 2. Prioritized concerns as a percentage of those who identified a concern (only concerns identified by 20% or more of participants are shown).

Table 3. Concerns: Univariate association between participant characteristics and concerns by total number and by domain (only significant values of $p = .25$ are shown)

Participant characteristics	Concerns, test statistic (p -value)					
	Total	1	2	3	4	5
Age ($n = 145$) ¹			.132 (.115)			-.164 (.048)
Gender ²						1.341 (.180)
Education level ²		-1.763 (.078)	-1.216 (.224)		-1.806 (.071)	
Marital status ²	2.811 (.005)			1.645 (0.100)	3.207 (.001)	3.657 (<.001)
Living arrangement ²	-2.162 (.031)	1.503 (.133)			-3.352 (<.001)	-3.309 (<.001)
Receiving care ²	5.220 (<.001)	5.291 (<.001)	6.117 (<.001)	2.464 (.014)		1.219 (.223)
Providing care ($n = 213$) ²			-1.410 (.159)	1.240 (.215)		
Number and impact of chronic conditions ($n = 217$) ³	68.245 (<.001)	40.405 (<.001)	27.509 (<.001)	10.71 (.013)	4.537 (.209)	34.052 (<.001)

Statistical tests: ¹Spearman's rho (p), ²Mann-Whitney U Standardized Test Statistic (p), ³Kruskal-Wallis Test Statistic (p)

Note: 1 ACT* Assess domains – Looking After Yourself, 2 – Getting Around, 3 – Safety and Relationships, 4 – Accommodation and Finances, 5 – Mental Health, 6 – Staying Healthy.

number of concerns was not strong ($\text{Exp}(B) = 0.61$, 95% CI = 0.44–0.85, $p = .003$).

In addition to being associated with the total number of concerns, 'receiving care from others' was significantly or marginally associated with five domains. It was not related to the count of concerns in the Mental Health (e.g. loneliness, bodily pain, sleeping, bereavement, memory loss, depression) domain or the Accommodation and Finances domain.

Far fewer associations were found between participant characteristics and their prioritized concerns (Table 6). Older people reporting 'quite a bit to extreme' impact of their chronic conditions were more likely to have a higher number of prioritized concerns ($\text{Exp}(B) = 1.81$, 95% CI = 1.24–2.64, $p = .002$). At the domain level, only two clear associations emerged. Older people 'receiving care from others' were more likely to prioritize resources for Getting Around ($\text{Exp}(B) = 1.54$, 95% CI = 1.07–2.27, $p = .022$), but not in

Table 4. Prioritized concerns: Univariate association between participant characteristics and prioritized concerns by total number and by ACT[®] Assess domains (only significant values of $p = .25$ are shown)

Personal factors	Prioritized concerns, test statistic (p -value)						% prioritized concerns (n = 221)
	Total (n = 221)	1 (n = 128)	2 (n = 127)	3 (n = 108)	4 (n = 113)	5 (n = 201)	6 (n = 183)
Age (n = 145) ¹		.188 (.078)		-.311 (.010)	-.180 (.104)		-.130 (.157)
Marital status ²	1.542 (.123)	-2.451 (.014)					1.642 (.101)
Living arrangement ²		2.378 (.017)					
European					1.464 (.143)		-1.351 (.177)
Receiving care ²	1.202 (.229)		1.626 (.104)	-1.836 (.066)	-1.219 (.223)	1.415 (.157)	-1.504 (.133)
Providing care (n = 213) ²			-1.264 (.206)				
Number and impact of chronic conditions (n = 217) ³	17.204 (<.001)					8.699 (.034)	

Statistical tests: ¹Spearman's rho (p), ²Mann-Whitney U Standardized Test Statistic (p), ³Kruskal-Wallis Test Statistic (p)

Note: 1 – ACT[®] Assess: Looking After Yourself, 2 – Getting Around, 3 – Safety and Relationships, 4 – Accommodation and Finances, 5 – Mental Health, 6 – Staying Healthy.

other domains. Interestingly, 'not being married' was significantly associated with fewer prioritized concerns and less interest in finding resources in the Looking After Yourself domain, yet the effect was not strong ($\text{Exp}(B) = 0.47$, 95% CI = 0.30–0.75, $p = .002$).

Twenty-eight participants (13%) reported that they were 'receiving care from others'. Twenty ACT[®] items (37.7%) were associated with receiving care. Among individuals receiving care, 52.6% of their total concerns were raised in these 20 items (203/386), compared to only 34.0% by those not receiving care (489/1438). Most of these concerns were in the Looking After Yourself (7/20, 35.0%) and Getting Around domains (5/20, 25%) and 9 out of 20 were concerns identified by less than 10% of all participants (22 participants). Thus, older people receiving care had distinct concerns related to activities of daily living and mobility that were rarely a concern of their peers.

Discussion

This study aimed to identify concerns of community-dwelling older people and their interest in learning about local services and resources to address those concerns. Three key findings emerged. First, almost all participants reported at least one concern, including those who were relatively healthy, financially secure, and well-educated. Concerns related to mental health were by far the most common, exceeding concerns related to daily functioning, mobility, safety, housing, and finances. Second, while a substantial proportion of participants reported concerns in the Mental Health domain – particularly loneliness, pain, sleep problems, and bereavement – many did not prioritize these for resource exploration. In contrast, financial benefits and allowances (within the Accommodation and Finances domain), though less frequently reported as a concern, were highly prioritized: 87% of those with this concern sought resources. Third, regression models identified only a few personal factors associated with the number and type of concerns, or interest in resources. 'Not being married', 'receiving care from others', and experiencing 'greater impact from chronic conditions' were significantly associated with higher numbers of concerns. These same characteristics also predicted domain-specific interest in resources – for example, those receiving care were more likely to prioritize supports for mobility.

The semi-structured, conversational nature of the ACT[®] Assess likely contributed to the high rate of concerns reported. Its design enabled participants to share their situation in non-confrontational, flexible terms – worries, difficulties, or need for assistance – allowing a wide capture of issues related to both health and social determinants of health that are often missing in assessments of older people (Kshatri *et al.*, 2025). This is a notable strength of the assessment and may explain the breadth of concerns reported.

Of the 222 participants, 221 reported at least one concern – on average, more than eight per person. This represents a substantial level of concern, especially given this study's relatively conservative, well-resourced and healthy volunteer sample. The high frequency of concerns, however, does align with a 2019 study in primary care where participants (mean age of 55.4 years), when asked about 12 self-management problems, selected an average of six (50%) problems (Hessler *et al.*, 2019). The present sample, largely composed of women, those with postsecondary education, and people of European descent, likely underrepresents more vulnerable populations in the community, given the communities where participants were recruited have high levels of economic dependency and situational vulnerability (Kephart *et al.*, 2016; Statistics Canada, 2024b). This suggests that the true level of concern in the broader population may be even higher.

The prominence of mental health concerns in this study reflects wider societal trends. Loneliness, bereavement, and sleep difficulties are well-documented challenges in later life and have been exacerbated by the COVID-19 pandemic (Bull *et al.*, 2023; Teichman *et al.*, 2024). Data collection in this study began approximately seven months after local public health restrictions on social contact due to COVID-19 ended. Though physical or bodily pain is not often considered a mental health concern, it is included in the ACT[®] Assess Mental Health domain. Bodily pain was highly prevalent among respondents and is known to impact quality of life and mood (Shega *et al.*, 2013). While these concerns were frequently reported, participants were less likely to seek resources to address them – particularly in the case of bereavement, where only 12% of those with concerns pursued additional resources. These findings could reflect stigma around mental health that manifests as reluctance to seek help or having low expectations for the success of interventions (Sickel *et al.*, 2014).

Table 5. Concerns: Factors predicting total number of concerns and concerns by domain (n = 222)

	Total concerns		Looking After Yourself		Getting Around		Safety and Relationships	
	exp(β) (95% CI)	p	exp(β) (95% CI)	p	exp(β) (95% CI)	p	exp(β) (95% CI)	p
Education level (Reference = Lower than secondary education)								
Secondary education or higher			.750 (.563, 1.002)	.050*				
Marital status (Reference = Married)								
Single, separated, widowed	1.296 (1.143, 1.469)	<.001					1.401 (.989, 1.996)	.059*
Receiving care (Reference = Not receiving care)								
Receiving care	1.543 (1.296, 1.838)	<.001	2.399 (1.719, 3.337)	<.001	2.946 (2.100, 4.133)	<.001	1.484 (.944, 2.285)	.078*
Number and impact of chronic conditions (Reference = No chronic condition)								
None to a little bit impact	1.026 (.849, 1.240)	.793	.769 (.474, 1.247)	.286	1.342 (.799, 2.253)	.265	1.053 (.611, 1.846)	.854
Moderate impact	1.386 (1.138, 1.688)	.001	1.667 (1.071, 2.620)	.026	1.444 (.836, 2.494)	.186	1.439 (.827, 2.541)	.202
Quite a bit to extreme impact	1.944 (1.620, 2.334)	<.001	2.071 (1.377, 3.168)	<.001	2.374 (1.453, 3.877)	<.001	1.871 (1.133, 3.183)	.017
Pseudo-R squared	0.389		0.277		0.295		0.083	
Note	Negative binomial Remove 'living arrangement'		Negative binomial		Negative binomial, age imputed		Negative binomial	
	Accommodation and Finances		Mental Health		Staying Healthy			
	exp(β) (95% CI)	p	exp(β) (95% CI)	p	exp(B) (95% CI)	p		
Marital status (Reference = Married)								
Single, separated, widowed					1.373 (1.161, 1.628)	<.001	1.885 (1.314, 2.704)	<.001
Living arrangement (Reference = Living alone)								
Living with others		.613 (.443, .845)		.003				
Receiving care (Reference = Not receiving care)								
Receiving care							1.643 (.936, 2.888)	.008
Number and impact of chronic conditions (Reference = No chronic condition)								
None to a little bit impact					1.099 (.849, 1.428)	.476	0.949 (0.575, 1.567)	.838
Moderate impact					1.391 (1.064, 1.821)	.016	1.581 (0.902, 2.770)	.109
Quite a bit to extreme impact					1.853 (1.455, 2.376)	<.001	5.012 (2.947, 8.525)	<.001
Pseudo-R squared		0.065			0.193		0.298	
Note	Poisson, remove 'marital status'		Poisson, remove 'living arrangement'		Poisson, age imputed			

* These personal factors are marginally associated with the ACT* Assess domains ($p = 0.50\text{--}0.80$). CI = confidence interval. exp(β) = exponent of the regression coefficient or adjust incident rate ratio.

Table 6. Prioritized concerns: Factors predicting total number and concerns by domain

	Total prioritized concerns (n = 221)		Looking After Yourself (n = 128)		Getting Around (n = 127)		Safety and Relationships (n = 108)	
	exp(β) (95% CI)	p	exp(β) (95% CI)	p	exp(β) (95% CI)	p	exp(β) (95% CI)	p
Age							.975 (.951, 1.000)	.050*
Marital status (Reference = Married)								
Single, separated, widowed			.472 (.295, .754)	.002				
Receiving care (Reference = Not receiving care)								
Receiving care					1.554 (1.071, 2.256)	.022		
Number and impact of chronic conditions (Reference = No chronic condition)								
None to a little bit impact	.962 (.661, 1.399)	.840						
Moderate impact	1.365 (.920, 2.027)	.121						
Quite a bit to extreme impact	1.809 (1.241, 2.643)	.002						
Pseudo-R squared	0.081		0.093		0.051		0.057	
Note	Negative binomial	Negative binomial, age imputed, remove 'living arrangement'			Poisson		Poisson, age imputed	
	Accommodation and Finances (n = 113)		Mental Health (n = 204)		Staying Healthy (n = 183)		Percentage of prioritized concerns (n = 222)	
	exp(B) (95% CI)	p	exp(B) (95% CI)	p	exp(B) (95% CI)	p	exp(B) (95% CI)	p
Number and impact of chronic conditions (Reference = No chronic condition)								
None to a little bit impact			.599 (.347, 1.026)	.062*				
Moderate impact			.942 (.552, 1.608)	.827				
Quite a bit to extreme impact			1.144 (.697, 1.892)	.593				
Pseudo-R squared	0.061		0.039		0.020		0.012	
Note	Poisson		Negative binomial		Poisson		Poisson	

* These personal factors are associated or marginally associated with the ACT* domains (p = 0.50–0.80). CI = Confidence Interval. exp(β) = exponent of the regression coefficient or adjust incident rate ratio.

Indeed, this study demonstrated that acknowledging a concern did not equate to an interest in pursuing resources to manage them. This study found that only one-third of concerns were prioritized by participants. How participants determined which concerns would be prioritized was not always clear. While some concerns were very common, few older people chose to look for resources. Other concerns were not as common, but when identified, a large proportion of older people were interested in learning about resources. For example, less than 5% of participants ($n < 12$) reported concerns related to 13 questions in the domains of Accommodation and Finances, Looking After Yourself, and Safety and Relationships (out of 26 questions, 50%). Even though concerns in these domains were not common, older people who had these concerns were likely to prioritize them and ask for resources. Participants' comments shed some light on the reasons. Some participants had already received adequate assistance through formal (e.g. family doctor, health care professionals) or informal (e.g. family members, neighbors) channels. Others expressed satisfaction with their existing management strategies or considered certain issues to be a normal part of aging. In some cases, previous negative experiences or low expectations of services may have deterred them from seeking alternatives. Other reasons known to alter interest in finding resources are related to health literacy, health beliefs, and trust and expectations of the system (Levesque et al., 2013).

The high frequency of concerns in the Mental Health domain, but the reluctance to prioritize these concerns creates a dilemma for community agencies and policy makers. This is consistent with previous research in primary care, where patients frequently identified distress managing their health problems (> two-thirds of the sample) but rarely prioritized them for discussion (18%) or action (2.6%) (Hessler et al., 2019). With a high number of concerns, but a reluctance to speak up or take action, new strategies to prevent decline and increase individuals' desire to seek resources and support are needed. Raising awareness of available resources, reducing stigma, and improving perceptions of service usefulness may help close this gap.

The Levesque et al. (2013) access framework offers a useful lens to examine factors that affect how people access health and social care services. Using the terms supply and demand in five key dimensions, the model suggests ways that health care services can be designed to increase patient access (i.e. supply-side). Enhancing older peoples' ability to recognize their concerns as legitimate, understand where and how to access resources, and feel empowered to act may increase their motivation to and engagement in seeking services (i.e. demand-side). This framework has been used in several empirical studies that show the importance of reducing system barriers and offering timely and affordable services to facilitate actions to address concerns (Mohd Rosnu et al., 2022; Pass et al., 2019). Analyzing the facilitators and barriers using Levesque's conceptual model may enhance the understanding of why some resources (e.g. mental health programs/services) are underutilized. This type of analysis, however, was beyond the scope of this study and is recommended as a valuable future research direction.

Another important finding relates to the predictable difference in type of concern based on self-assessed receipt of care from others. While most participants raised issues related to mental health, mobility, or safety, those receiving care were more likely to report challenges with self-care and daily functioning – concerns more typical of individuals at higher risk for institutionalization (Chyr et al., 2020). This suggests a possible trajectory: older people

may first experience social, relational, mental health, psychosocial, and environmental concerns, followed by functional decline requiring hands-on assistance. The emerging literature on frailty and social vulnerability also hints at this trajectory. A recent review supports that social factors may accelerate the progression of frailty and its associated negative health effects (Hanlon et al., 2024). Engaging social supports and community services could address this potential progression. Early attention to less tangible but highly prevalent concerns may delay or prevent the need for more intensive care later. This also raises a broader point: while many community-based interventions target physical risks (e.g. fall prevention, nutrition), fewer comprehensively address social and emotional well-being. The findings suggest that investment in upstream supports – such as SP, peer programs, and resource navigation – could have long-term value by helping older people remain at home and in their community.

Several limitations should be acknowledged. First, the sample of convenience likely underrepresents older people with limited mobility, or who are experiencing social isolation. Despite a variety of recruitment strategies, the sample skewed toward women, those with higher education, and those of European descent. Second, the proportion of missing data on the age variable was high but not substantive (Jakobsen et al., 2017). While multiple imputations were used, this still introduces uncertainty. Third, older people in this study were free to self-assess whether they received care from others. No distinction between paid and unpaid care was imposed; doing so may have changed the results but might have also altered older peoples' lived experiences of receiving care. Finally, the Hawthorne effect, which introduces bias as participants can change their behaviour or responses in the research context, may have influenced participants' willingness to prioritize concerns during the assessment, especially given the interactive, conversational format. However, the fact that 20% of participants did not prioritize any concerns suggests that social desirability did not fully drive responses and participants chose concerns for which they were interested in knowing about resources.

Conclusion

Older people living in the community reported an average of eight or more concerns (out of a possible 53 concerns). Over 40% reported mental health concerns related to loneliness, pain, sleep, and bereavement. However, their reluctance to prioritize these concerns creates a dilemma for community agencies and policy makers focused on providing up-stream preventive services and resources. This finding is particularly important given that mental health concerns seem to pre-date concerns related to mobility and self-care. Older people with more chronic conditions, greater impact of health conditions, and those receiving care from others reported more concerns than those with less or milder health conditions. Those receiving care from others demonstrated a distinct pattern of concern. Knowing the concerns and the pattern of those concerns provides insight into how best to assist older people to age in place and underscores the value of initiatives, such as SP and CGAs, in health and social care.

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