

Topic Overview

Strengthening Care for Frail Older Adults in Canada

Stakeholder Dialogue

12 October 2016

The McMaster Health Forum convened a stakeholder dialogue on the subject of strengthening care for frail older adults in Canada. With the support of the Canadian Institutes of Health Research (grant number 339657) and McMaster University's Labarge Optimal Aging Initiative, the dialogue brought together 20 participants – 2 policymakers, 7 managers, 3 healthcare professionals, 6 researchers, and 1 patient representative -- from across Canada to examine the problem, options for addressing it, and key implementation considerations.

Deliberation about the problem

Dialogue participants generally agreed with the problem as presented in the brief, which related to challenges in defining and diagnosing frailty, that it affects some Canadians more than others, the complex needs of frail older adults leading to care that is fragmented, and the significant support required from caregivers. They also agreed that while more attention is being placed on frailty and on care for older adults, a number of challenges still remain. Building on this, participants focused on the problem as it relates to four challenges: 1) the health system is not aligned to the needs of frail adults and caregivers; 2) evidence is often not helpful or not sufficient to spur change; 3) no one owns the issue of strengthening care for frail older adults; and 4) there is inadequate recognition of caregivers as a value-added resource to the health system.



The views expressed in the evidence brief and dialogue summary are the views of the authors and should not be taken to represent the views of the funders.





Participants drawn from government, and from health, professional and research organizations gather during a McMaster Health Forum event on 12 October 2016.

Deliberation about an approach

Participants generally agreed with the three elements of a potentially comprehensive approach to addressing the problem that were presented in the evidence brief, but identified several considerations for moving forward with them. For element 1 (engaging in efforts to prevent frailty or prevent the onset for those who are 'pre-frail'), participants indicated that increased integration with public health was necessary, and that broader population-focused interventions are needed to make cities more 'age friendly' and to provide education to promote healthy aging throughout one's lifespan. For element 2 (managing challenges faced by frail older adults), participants identified the need for new models of care that are more patient-centred, suggesting specifically the adoption of intermediate care options (i.e., care in the community beyond the scope of primary care, but designed to avoid admission to hospital or long-term care). In discussing this element participants also supported increased patient engagement and the adoption of technology that can both help to coordinate care across health professionals for frail adults and their caregivers. For element 3, all participants agreed that the current level of supports available for caregivers across the country was insufficient. Participants generally agreed that there should be more communication directed to caregivers to help them self-identify and seek support, however, they had mixed views on what supports should be made available. Participants also agreed that caregivers would benefit from technology that could assist them in providing care.

Deliberation about next steps

Participants identified four types of activities and considerations that need to be the focus moving forward: 1) engaging the public in discussions on their expectations for primary care, and for home and community care for frail older adults; 2) continuing to support and invest in research on frailty, particularly for assessing patient-relevant outcomes for interventions to prevent and manage frailty and support caregivers; 3) create better alignment between the programs and services needed by frail older adults and their caregivers, and the broader health-system arrangements that are needed to support patient-centred and coordinated delivery of those programs and services; and 4) encourage home-care programs to assess caregivers' needs (not just those of patients), and develop valid support choices that can be made widely available to caregivers.

Dialogue deliverables

To learn more about this topic, consult the [evidence brief](#) that was presented to participants before the dialogue, the [summary of the dialogue](#), and view the [interviews with dialogue participants](#).

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