

EVIDENCE >> INSIGHT >> ACTION

Addressing Nutritional Risk Among Older Adults in Ontario

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

About citizen panels

A citizen panel is an innovative way to seek public input on high-priority issues. Each panel brings together 10-14 citizens from all walks of life. Panel members share their ideas and experiences on an issue, and learn from research evidence and from the views of others. The discussions of a citizen panel can reveal new understandings about an issue and spark insights about how it should be addressed.

About this summary

On January 24, 2015, the McMaster Health Forum convened a citizen panel on how to address nutritional risk among older adults in Ontario. The purpose of the panel was to guide the efforts of policymakers, managers and professional leaders who make decisions about our health system. This summary highlights the views and experiences of panel participants about:

- the underlying problem;
- three possible options to address the problem; and
- potential barriers and facilitators to implement these options.

The citizen panel did not aim for consensus. However, the summary describes areas of common ground and differences of opinions among participants and (where possible) identifies the values underlying different positions.

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Summary of the panel

Participants discussed challenges related to addressing nutritional risk among older adults in Ontario. During the deliberations, the following seven challenges were raised: 1) nutrition-related challenges have deep roots going beyond the health system (e.g., a lack of public awareness and knowledge regarding nutrition-related issues, a growing disconnect between food consumption and food production, a lack of economic security for older adults, and a lack of compassion towards older adults); 2) changing the eating habits of older adults is difficult; 3) many older adults are not actively seeking nutrition-related information and advice, but those who are have difficulty getting information and advice that they can trust; 4) older adults at high nutritional risk are often socially isolated; 5) many older adults and their informal/family caregivers don't know about existing programs and services; 6) current health-system arrangements complicate matters further; and 7) long-term planning at the system level appears limited.

Participants reflected on three options (among many) for addressing nutritional risk among older adults in Ontario: strengthening older adults' capacity to make healthier nutritional choices (option 1); improving the identification and support of older adults at high nutritional risk (option 2); and enhancing the coordination, integration and monitoring of services for older adults at nutritional risk (option 3). Several values-related themes emerged during the discussion about these options, with two emerging with some consistency: 1) compassion towards older adults; and 2) fairness (priority should be given to the most vulnerable older adults, and efforts must bridge the gap in services across different population groups – e.g. children versus seniors).

When turning to potential barriers to addressing nutritional risk among older adults in Ontario, participants focused on two sets of barriers to moving forward: 1) societal barriers (i.e., attitudes towards aging and older adults); and 2) system barriers (i.e., the current health system being bureaucratic and siloed). Participants then turned to two key factors that could facilitate efforts to bring about change: 1) making family physicians the most responsible practitioners with the overall responsibility for directing and coordinating the care and management of older adults at nutritional risk; and 2) redirecting our efforts to reach the most vulnerable older adults.



“I realized just how far reaching the problem was.”

Discussing the problem: What are the most important challenges to addressing nutritional risk among older adults?

Panel participants began by reviewing the findings from the pre-circulated citizen brief, which highlighted what is known about the underlying problem – shortfalls in the care and support available to older adults at nutritional risk in Ontario – and its causes. They individually and collectively focused on seven challenges in particular:

- nutrition-related challenges have deep roots going beyond the health system;
- changing the eating habits of older adults is difficult;
- many older adults are not actively seeking nutrition-related information and advice, but those who are have difficulty getting information and advice that they can trust;
- older adults at high nutritional risk are often socially isolated;
- many older adults and their informal/family caregivers don't know about existing programs and services;
- current health-system arrangements complicate matters further; and
- long-term planning at the system level appears limited.

We review each of these challenges in turn on page three.

Nutritional-related challenges have deep roots going beyond the health system

Discussions initially focused on the wide range of factors having an impact on older adults' nutrition, many of which go well beyond the health system. One participant said that, after reading the pre-circulated citizen brief, he “realized just how far reaching the problem was.” Participants generally agreed that fundamental changes are required to address key facets of the problem, including but not limited to: 1) a general lack of public awareness and knowledge regarding nutrition-related issues; 2) a growing disconnect between food consumption and food production; 3) a lack of economic security for older adults; and 4) a lack of compassion towards older adults. These challenges are further discussed below.

Several participants pointed out that there was a general lack of public awareness and knowledge around nutrition-related issues. As one participant said: “I don't think most of us, regardless of age group, know what the best nutrition is.” This was seen as particularly challenging since many older adults are suffering from multiple chronic health conditions, which may be caused or worsened by poor nutritional choices.

A few participants pointed out that such a lack of public awareness and knowledge was connected to another challenge: the growing

Box 1: Key features of the citizen panel

The citizen panel about addressing nutritional risk among older adults in Ontario had the following 11 features:

1. it addressed a high-priority issue in Ontario;
2. it provided an opportunity to discuss different features of the problem;
3. it provided an opportunity to discuss three options for addressing the problem;
4. it provided an opportunity to discuss key implementation considerations (e.g., barriers);
5. it provided an opportunity to talk about who might do what differently;
6. it was informed by a pre-circulated, plain-language brief;
7. it involved a facilitator to assist with the discussions;
8. it brought together citizens affected by the problem or by future decisions related to the problem;
9. it aimed for fair representation among the diversity of citizens involved in or affected by the problem;
10. it aimed for open and frank discussions that will preserve the anonymity of participants; and
11. it aimed to find both common ground and differences of opinions.

disconnect between food consumption and food production. These participants indicated that we need to better understand what we eat and where it comes from, which would empower us to collectively advocate for healthier food and ultimately make healthier nutritional choices.

Participants also discussed at length the need to strengthen the economic security of older adults to ensure that they have the capacity to buy nutritional food, which they often perceive as more expensive. “If you want real food, it costs you an arm and a leg.” This discussion highlighted that many older adults have to make difficult choices between paying for their meals, their medications, their rent, their utilities and other essential services. For some participants, addressing nutritional risk among older adults cannot be achieved without a real commitment to reinforce the social safety net for older adults in the province.

Participants generally agreed about the lack of compassion towards older adults, despite frequent and highly publicized stories of neglect and abuse. They indicated that these negative attitudes were fuelled by changes in family structures and values (i.e., people increasingly turning to the government to provide care and support to their elders), and by stereotypical depictions of aging. Several participants complained that older adults are too often being depicted as a ‘burden’ or as ‘disposable.’ As one participant said: “Children are cute and families are wonderful. But when you look at seniors, they’re messy. Nothing is neat, clean or cute about seniors.... We’re treating seniors very differently than anyone else.” A second participant claimed that there was a lack of respect for older adults and this needed to change. “We have to build a culture where there is respect for seniors.” Another participant provided a different perspective and argued that older adults are increasingly depicted in an overtly positive way in advertising. “The way the media portrays a stereotypic image of a senior creates the image that every senior is living a wonderful life, wealthy, and happy, and having a great time at the golf course.” Despite these different perspectives, participants generally agreed that such stereotypical depictions (either negative or positive) contributed to trivializing serious problems facing many older adults in the province, including social isolation, economic insecurity, declining health, and nutritional challenges.

Changing the eating habits of older adults is difficult

Participants generally agreed that it is difficult to change older adults’ eating habits, even if they may be at nutritional risk. Many expressed scepticism towards initiatives to change the behaviours of older adults via food literacy interventions. One participant said: “I’m Italian. My father thought that if you eat enough bread and cheese you were healthy. No amount of education will change that. You need to start young.” A second participant claimed that

such initiatives might be a “bandage solution” to a deeply rooted problem. Yet, a few participants were encouraged by outreach initiatives to improve the knowledge and skills of older adults regarding food and nutrition, but felt that such initiatives needed to be carefully designed to meet the needs of older adults, by focusing on long-term interventions that break social isolation (rather than rapid learning curriculums).

Many older adults are not actively seeking nutrition-related information and advice, but those who are have difficulty getting information and advice that they can trust

Participants indicated that many older adults (or their informal/family caregivers) are not actively seeking nutrition-related information and advice, most likely because of a lack of awareness and knowledge about nutrition-related problems. However, those who are have difficulty getting information and advice that they can trust. This challenge was fuelled by: 1) existing health information sources that are not fully designed to meet the specific needs of older adults (both in terms of format and content); 2) many older adults experiencing information overload; and 3) many healthcare providers seeming to have poor training in nutrition. These issues are further discussed below.

Box 2: Profile of panel participants

The citizen panel aimed for fair representation among the diversity of citizens likely to be affected by the problem. We provide below a brief profile of panel participants:

- **How many participants?**

11

- **Where were they from?**

Region covered by the Hamilton Niagara Haldimand Brant Local Health Integration Network

- **How old were they?**

45-64 (8), 65 and older (3)

- **Were they men, or women?**

Men (6) and women (5)

- **What was the educational level of participants?**

One participant completed elementary school, three completed high school, two completed community college, four completed a bachelor’s degree, and one completed post-graduate training

- **What was the work status of participants?**

Two participants were self-employed, four working full-time, and five retired

- **What was the income level of participants?**

One participant earned less than \$20,000, two between \$20,000 and \$40,000, five between \$40,000 and \$60,000, one more than \$80,000, and two preferred not to disclose their income

- **How were they recruited?**

Selected based on explicit criteria from the AskingCanadians™ panel

First, several participants indicated that existing health information sources were not fully designed to meet the specific needs of older adults. They pointed out that information seems to be increasingly disseminated via online resources or by telephone, but that many older adults do not have access to a computer, or have visual and hearing impairments making it difficult to access such information. Some participants also emphasized that the complex care needs of older adults was making it even more complicated to find relevant information, especially in the context of older adults living with multiple chronic health conditions (e.g., Alzheimer's disease, conditions that make it difficult to chew and swallow food, and diabetes), as well as multiple treatments or drug regimens that may interact with their food intake. One participant who acted as a family caregiver indicated being at a loss when seeking nutrition-related information and advice. "[My mother] has diabetes and I don't understand it. I don't really know what to do or how to go about it." A second participant said that existing nutrition resources that are well known to the public (e.g., Canada's Food Guide) appear to be designed for families with young children. "I've only focused on nutrition value for my kids, and not for my parents. Canada's Food Guide and things like that focus on kids, not older adults." A third participant expressed disappointment towards what they perceived as the limited scope of the EatRight Ontario's toll-free line, since the work of registered dietitians appeared to be limited to providing general nutrition and disease-prevention information. "Dietitians need to be reactive to patient needs. They go by a set of criteria laid out that they think is for all people, but not listening to the patient needs, which leads to more problems."

Second, a few participants indicated that those actively seeking nutrition-related information are often experiencing information overload. As one participant said: "My wife had a surgery three years ago. Since then, our diet has changed drastically. When we go to the [inter]net for information, there is too much information and conflicting information." A few participants acknowledged that it was particularly difficult to identify what information is reliable, particularly in a context where so many sources are not entirely transparent and could potentially be biased towards corporations with a financial interest in particular food choices.

Third, there was a general perception among participants that many healthcare providers (with the exception of registered dietitians) have poor training in nutrition. Several participants recalled receiving conflicting information and advice about nutrition from healthcare providers, particularly in relation to their chronic health conditions (e.g., what to eat or what to avoid, when to eat, and food-drug interactions). One participant talked about his personal experience with his family physician. "[My family physician told me

that you can] eat as much fruit as you want because it's natural sugar. And a few months later, she told me something different. Is professional advice reliable?" This story resonated with other participants who shared similar stories about receiving poor nutritional advice from healthcare providers. Some participants were also under the impression that physicians were more inclined to lean towards prescription drugs to address a health problem, instead of trying to address the problem from a nutritional perspective (e.g., treating high blood pressure with a pill, rather than addressing the high salt content in the food consumed by a patient). Such experiences fuelled the perception that many healthcare providers have poor training in nutrition, or that trying to address such deeply rooted problems were too complicated. These experiences also nourished a deep scepticism of medical knowledge and authority regarding nutrition.

Older adults at high nutritional risk are often socially isolated

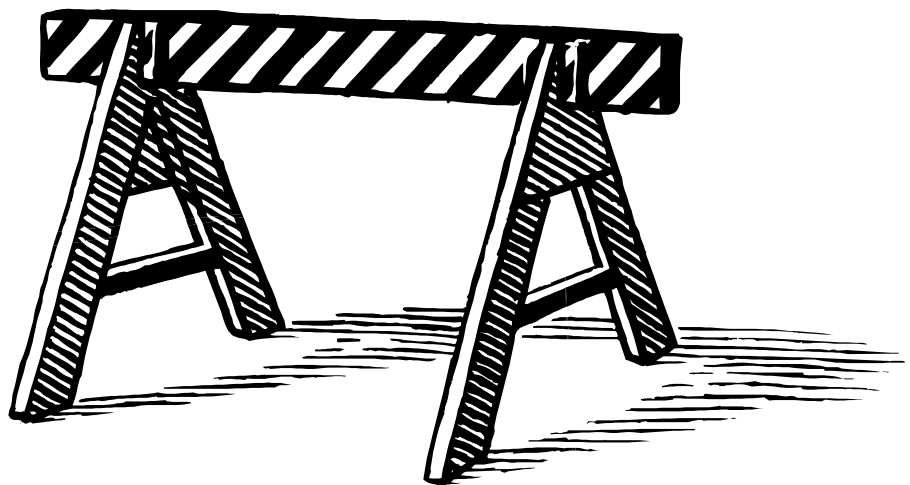
Participants generally agreed that older adults at high nutritional risk are often socially isolated and vulnerable. Finding ways to reach out to those who are socially isolated was a great source of concern for participants. As one participant indicated: "How do you get to those who are isolated? Nobody knows that they're isolated, because they're isolated." A second participant was concerned that such situations would become even more the norm with changing family structures. "If you don't have a family, you don't have anyone."

Participants acknowledged that it is particularly difficult to actively seek out these older adults since they are often reluctant to acknowledge that they are at risk, do not want to be perceived as a burden, are concerned that their personal freedom may be compromised if they received formal support, or are unable to express their needs. As one participant said: "This is a group that grew up during a difficult time. They're not going to ask for help. [They have grown] used to making do. They don't like attention placed on them. They do not advocate for themselves."

Many older adults and their informal/family caregivers don't know about existing programs and services

Another set of challenges raised by participants was the lack of public awareness about existing programs and services that could address nutritional risk among older adults. Many expressed being at a loss when faced with the mosaic of programs and services (some offered by the health system, while others are delivered by community-based organizations or faith-based organizations), many of which appeared fragmented and limited in scope. Several participants indicated that they were unsure about what programs and services were available for community-dwelling older adults, but there was a general perception that existing programs and services (particularly home visiting services) were insufficient to meet the growing needs of older adults. One participant specified that personal support workers could provide invaluable home care services, but that they would require greater training to fully incorporate nutrition-related care in their scope of activities.

Some participants called for much greater public awareness campaigns about these programs and services, as well as more proactive strategies to connect older adults in need with these programs and services. An example of promising programs and services highlighted by one participant was the health-promotion program for seniors delivered by the Hamilton Urban Core Community Health Centre. This organization is offering weekly group activities designed to reduce social isolation and support high-risk older adults. This initiative was seen as particularly relevant to identify vulnerable older adults at nutritional risk, and then to connect them with the programs and services they need.



Current health-system arrangements complicate matters further

Participants emphasized that current health-system arrangements make it difficult to address nutritional risk among older adults. Participants generally agreed that the health system is not fully integrated. While current health-system arrangements may be sufficient for acute illnesses, they do not appear to be effective in meeting the complex care needs of older adults. As a participant pointed out: “The average infant is not a complex case, but the average senior is a complex case.” A few participants pointed out that current payment arrangements, particularly the fee-for-service remuneration model for physicians, do not seem to be conducive to the delivery of comprehensive and integrated care. As one participant said: “How many times have we heard - *Just one issue at a time, please.*”

Long-term planning at the system level appears limited

While participants acknowledged that health-system leaders seem to be increasingly paying attention to the challenges of supporting the rapidly growing and aging population, many were upset that long-term planning at the system level still appears to be limited. Referring to the impact of the aging population on the health system, one participant pointed out: “It’s not a surprise. It’s not a tsunami. It’s a glacier. You knew it was coming.” This resonated with other participants who called for greater public engagement to “educate the government” about the challenges facing the aging population (including nutrition-related challenges), but also to facilitate and trigger change in the health system.





“It is a friendship issue as much as a taxpayer issue.”

Discussing the options:

How can we address the problem?

After discussing the challenges that together constitute the problem, participants were invited to reflect on three options (among potentially many) for addressing nutritional risk among older adults in Ontario:

- 1) strengthening older adults’ capacity to make healthier nutritional choices;
- 2) improving the identification and support of older adults at high nutritional risk; and
- 3) enhancing the coordination, integration and monitoring of services for older adults at nutritional risk.

Several values-related themes emerged during the discussion about these options, with two emerging with some consistency: 1) compassion towards older adults; and 2) fairness (priority must be given to the most vulnerable older adults, and efforts must bridge the gap in services across different population groups – e.g. children versus seniors). We review the themes that emerged for each option in more detail below.

Option 1 – Strengthening older adults’ capacity to make healthier nutritional choices

The discussion about the first option focused on strengthening older adults’ capacity (or the capacity of their informal and family caregivers) to make healthier nutritional choices. This option might include (but is not limited to):

- providing information about nutrition;
- supporting nutrition-related behaviour change; and
- developing nutrition-related skills.

Six values-related themes emerged during the discussion about option 1:

- based on data and evidence (our efforts must be aligned with what is known about the most vulnerable groups);
- compassion (towards older adults);
- fairness (priority should be given to vulnerable older adults);
- accessibility (interventions should focus on improving access to food, not just access to information);
- attuned to the diversity of needs of multiple audiences (e.g., interventions should be culturally sensitive, written in plain language, and designed for older adults with visual and hearing impairments); and
- trust (both in the reliability of the information provided, and in the organizations behind such initiatives).

Participants had mixed views about this option. While it may be a worthy objective to help people make healthier nutritional choices, this option may have three potential flaws: 1) this option does not seem to target those at nutritional risk; 2) the issue is not just about increasing access to information, but also (and perhaps more importantly) about increasing access to food; and 3) trying to change the nutritional behaviours of older adults is very difficult.

Turning to the first of these potential flaws -- this option does not seem to target those at nutritional risk -- some participants noted that the available research evidence shows that nutrition-related problems disproportionately affect certain groups in Canada, such as older women, older adults suffering from depression and older adults who are socially isolated. Thus, many participants perceived option 1 as targeting older adults who are “healthy-ish” and well-off, rather than those who are the most vulnerable. Many participants claimed that we should be more compassionate and fair, and consequently prioritize our efforts towards the most vulnerable groups. One participant emphasized that compassion should be at the heart of our approach to address the problem. “It is a friendship issue as much as a taxpayer issue.”

Moving to the second potential flaw, several participants pointed out that the big issue is not so much about increasing access to information to help older adults make healthier nutritional choices. For these participants, the fundamental challenge of many vulnerable older adults is to improve access to food.

Finally, several participants reiterated the difficulty of overcoming someone’s eating habits that have developed over 70-80 years. They pointed out that you couldn’t simply distribute written material and expect that people will read and adhere to information and advice. A few participants questioned

Box 3: Key messages about option 1

- Participants had mixed views about this option.
- Six values-related themes emerged during the discussion about option 1:
 - based on data and evidence (our efforts must be aligned with what is known about the most vulnerable groups);
 - compassion (towards older adults);
 - fairness (priority should be given to vulnerable older adults);
 - accessibility (interventions should focus on improving access to food, not just access to information);
 - attuned to the diversity of needs of multiple audiences (e.g., interventions should be culturally sensitive, written in plain language, and designed for older adults with visual and hearing impairments); and
 - trust (both in the reliability of the information provided and in the organizations behind such initiatives).



whether interventions to re-educate older adults could ever work, and even whether current older adults may be a lost generation and that we should instead focus education efforts on younger generations.

Despite their reservations and questions about option 1, participants pointed out that interventions to strengthen older adults' capacity to make healthier nutritional choices should be carefully designed and attuned to the needs of different audiences. More specifically, they pointed out seven key characteristics for these interventions: 1) they must be fully accessible without any financial barriers; 2) they must be culturally sensitive given the increasingly diverse Ontario population (both in terms of language and food culture); 3) they must be accessible to someone with a grade-5 reading level; 4) they must be designed for older adults with visual and hearing impairments (e.g., not tiny print on food packages); 5) they must cultivate a sense of belonging and social interaction; 6) they must be hands-on and practical interventions (e.g., cooking classes); and 7) they must be delivered over a long period of time instead of being one-off interventions.

The issue of trust emerged consistently during the discussion about option 1, both in terms of the reliability of the information provided, and about 'who should be behind' such initiatives. Participants generally agreed that interventions to strengthen older adults' capacity to make healthier nutritional choices may be seen as more trustworthy and promising if they are delivered by community groups, which are typically more deeply rooted in the community and could nurture a sense of mutual responsibility towards addressing nutritional risk among older adults.

Option 2 – Improving the identification and support of older adults at high nutritional risk

The discussion about the second option examined how we can improve the identification and support of older adults who are at high nutritional risk, in order to prevent or mitigate the health risks associated with poor nutrition. This option might include (but is not limited to):

- supporting the use of a validated screening tool in all care settings (i.e., home and community care, primary care, acute care and long-term care);
- training and supporting physicians, nurse practitioners and nurses in all care settings to support older adults identified as being at high nutritional risk, and to recognize the need for referrals to dietitians; and

- expanding the role of dietitians within primary care, including in Family Health Teams and Community Health Centres, as well as in other primary-care settings where physician or nurse practitioner referrals are often required.

Four values-related themes emerged during the discussion that were identified as being important for guiding efforts to improve the identification and support of older adults who are at high nutritional risk:

- compassion (towards vulnerable older adults at nutritional risk);
- responsibility (to report and refer older adults at nutritional risk);
- autonomy (of older adults); and
- privacy (of older adults).

Participants generally supported option 2, but most of the discussion focused on the role of the public, as opposed to healthcare providers, in identifying and supporting older adults at nutritional risk. Participants agreed that this option should be guided by compassion towards older adults who are the most vulnerable and socially isolated. Some participants indicated that we desperately need to encourage a “buddy system” to proactively and frequently check on socially isolated older adults to identify those who may be at nutritional risk. Others emphasized the need to have regular scheduled check-ups for vulnerable older adults, similar to those for children (referred to by participants as “healthy baby” check-ups). Applying such a model to vulnerable older adults could

Box 4: Key messages about option 2

- Participants generally supported option 2, but most of the discussion focused on the role of the public, as opposed to healthcare providers, in identifying and supporting older adults at nutritional risk.
- Four values-related themes emerged during the discussion that were identified as being important for guiding efforts to improve the identification and support of older adults who are at high nutritional risk:
 - compassion (towards vulnerable older adults at nutritional risk);
 - responsibility (to report and refer older adults at nutritional risk);
 - autonomy (of older adults); and
 - privacy (of older adults).



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facilitate the screening process to identify those at nutritional risk and proactively prevent nutrition-related problems.

Participants also indicated that we have a collective responsibility towards vulnerable older adults, and that we should be held accountable for their well being. They suggested that we collectively have the responsibility to report (or refer) any older adult who may be at nutritional risk, whether they may be family members, friends or neighbours. Some participants questioned whether the general public had the capacity to do this, especially since access to many healthcare programs and services appear to be strictly controlled by ‘gatekeepers.’ One participant pointed out that Community Care Access Centers (CCACs) in the province are advertising that “anyone can make a referral,” but many participants indicated that the general public is largely unaware of this. Thus, they called for CCACs to pursue efforts to raise public awareness about this. Others called for social marketing campaign, like Bell’s “Let’s Talk” campaign to promote a national conversation about mental illness. Such initiatives could raise awareness about the older adult population facing nutrition-related problems, and could make it a social imperative to bring about change. This would empower the public to play a more proactive role in the identification and referral of older adults at nutritional risk.

Participants also discussed the responsibility of healthcare providers to report and refer older adults at nutritional risk. Discussion essentially focused on strategies targeting healthcare providers to ensure that they would proactively screen older adults and make sure that those at high nutritional risk are referred to a registered dietitian. While some participants suggested strategies to build the capacity of healthcare providers to recognize those at nutritional risk (e.g., improvements to medical curricula), others called for much more coercive strategies to enforce this (e.g., imposing criminal liability on healthcare providers for negligence if they ignore the nutritional needs of a patient or fail to recognize that a patient is at nutritional risk).

Participants debated the ethical tensions between our responsibility to proactively report (or refer) older adults at nutritional risk, and the need to respect their autonomy and privacy. While many participants claimed that it was “in their best interests,” others were concerned that some older adults could perceive this as a serious breach of their privacy and as compromising their autonomy. Therefore, they called for the need to carefully weigh the potential benefits and unintended consequences of such a proactive approach.

Option 3 – Enhancing the coordination, integration and monitoring of services for older adults at nutritional risk

The discussion focused on enhancing the coordination, integration and monitoring of services for older adults at nutritional risk. In other words, this option aims to improve how the different parts of the health system (e.g., home and community care, primary care, acute care, and long-term care) might address the needs of older adults at nutritional risk, as well as their informal and family caregivers. This option might include (but is not limited to):

- enhancing the coordination and integration of services in Ontario’s health system to better address the needs of older adults at nutritional risk, with services requiring greater coordination and integration including those provided through:
 - 14 Community Care Access Centres (e.g. visiting health professional services, personal care and support, and homemaking),
 - 184 Family Health Teams, 75 Community Health Centres, 25 Nurse Practitioner-Led Clinics, and 644 not-for-profit community support services,
 - 145 hospitals, and
 - more than 630 long-term care facilities;
- monitoring the implementation of nutrition services in all care settings and evaluating their impact; and
- increasing the accessibility to dietitian services in all care settings.

Two values-related themes emerged during the discussion that were identified as being important for guiding efforts to enhance the coordination, integration and monitoring of services for older adults at nutritional risk:

- fairness (in the coordination, integration and monitoring of services across different population groups); and
- collaboration (among patients, providers and organizations within the health system).

Participants also supported option 3, but grappled with the most promising way to make the different parts of the system work together to provide care and support to older adults at nutritional risk. Several participants called for greater fairness in the coordination, integration and monitoring of services across different population groups. These participants were concerned about the gap between child care and senior care, and expected the same level of care for both. Some participants highlighted “healthy

baby” check-ups and the Ontario Early Years Centres as models for child care that could be applied to older adults. Such models would allow older adults and their informal/family caregivers to have regular interactions with healthcare providers, get information about programs and services that are available for older adults at nutritional risk, and talk with other older adults and caregivers in the community.

Several participants also emphasized the need for greater collaboration among patients, providers and organizations within the health system. Such collaboration could be fuelled by different types of interventions, including (but not limited to): 1) the implementation of centralized electronic health records to help share patient information across healthcare providers and organizations; 2) the designation of the family physician as the most responsible practitioner with the overall responsibility for directing and coordinating the care and management of older adults at nutritional risk; 3) the introduction of multidisciplinary clinic appointments with both traditional primary care providers (e.g., family physicians and nurses) and registered dietitians (as one participant indicated: “it’s hard enough getting my mother out of the house in the first place”); and 4) the implementation of a system to follow-up with community-dwelling older adults (and their informal/family caregivers) when they are discharged.

Box 5: Key messages about option 3

- Participants also supported option 3, but grappled with the most promising way to make the different parts of the system work together to provide care and support to older adults at nutritional risk.
- Two values-related themes were identified as being important for guiding efforts to enhance the coordination, integration and monitoring of services for older adults at nutritional risk:
 - fairness (in the coordination, integration and monitoring of services across different population groups); and
 - collaboration (among patients, providers and organizations within the health system).





“Go to the vulnerable people rather than having them come to you.”

Discussing the implementation considerations: What are the potential barriers and facilitators to implementing these options?

After discussing the three options (among many) for addressing nutritional risk among older adults in Ontario, participants examined potential barriers and facilitators for moving forward.

Participants focused on two sets of barriers to moving forward: 1) societal barriers; and 2) system barriers. First, several participants emphasized that fundamental social changes were necessary to ensure that we collectively take care of the well being of older adults, but this would most likely be difficult to achieve. As one participant said: “[We need to] make sure seniors have the care and respect they deserve for building our country.” Second, several participants emphasized the need to achieve a more holistic health system, but to do so we needed to “get rid of the bureaucracy” and “get rid of the silos.”

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Participants then turned to two key factors that could facilitate efforts to address nutritional risk among older adults in Ontario. First, since the public generally considers family doctors as their first point of contact with the health system, they should be the practitioners with the overall responsibility for directing and coordinating the care and management of older adults at nutritional risk. Efforts should be made to better train and support family physicians to provide nutritional advice and to recognize the need for a referral to registered dietitians. Empowering family physicians to become the most responsible practitioner was perceived as the most promising way to implement a comprehensive and holistic approach to health and wellness. Second, participants in general agreed about the need to redirect efforts of the public and health-system stakeholders to reach out to older adults, particularly those most vulnerable. As one participant said, to successfully address nutritional risk among older adults, it was essential to invest in outreach activities. “Go to the vulnerable people rather than having them come to you.”



Acknowledgments

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Funding

The citizen brief and the citizen panel it was prepared to inform were funded by McMaster University's Labarge Optimal Aging Initiative and by the Government of Ontario (through a Ministry of Health and Long-Term Care Health System Research Fund grant entitled Harnessing Evidence and Values for Health System Excellence). The McMaster Health Forum receives both financial and in-kind support from McMaster University. The views expressed in the panel summary are the views of panel participants and should not be taken to represent the views of the Government of Ontario, McMaster University, McMaster University's Labarge Optimal Aging Initiative, or the authors of the panel summary.

Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the panel summary. The funder reviewed a draft panel summary, but the authors had final decision-making authority about what appeared in the panel summary.

Acknowledgements

The authors wish to thank the entire McMaster Health Forum team for support with project coordination, as well as for the production of this panel summary. The authors also wish to thank Carolyn Canfield, a member of our Citizen Panel Program Advisory Group, for taking notes during the panel. We are especially grateful to all the participants of the citizen panel for sharing their views and experiences on this pressing health system issue.

Citation

Gauvin FP, Mahendren M, Lavis JN. Panel Summary: Addressing Nutritional Risk Among Older Adults in Ontario. Hamilton, Canada: McMaster Health Forum, 24 January 2015.

ISSN

2368-2116 (Print)

2368-2124 (Online)



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