

The Canadian Frailty Priority Setting Partnership: Research Priorities for Older Adults Living with Frailty



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ABSTRACT

Background

Patient engagement in research priority-setting is intended to democratize research and increase impact. The objectives of the Canadian Frailty Priority Setting Partnership (PSP) were to engage people with lived or clinical experience of frailty, and produce a list of research priorities related to care, support, and treatment of older adults living with frailty.

Methods

The Canadian Frailty PSP was supported by the Canadian Frailty Network, coordinated by researchers in Toronto, Ontario and followed the methods of the James Lind Alliance, which included establishing a Steering Group, inviting partner organizations, gathering questions related to care, support and treatment of older adults living with frailty, processing the data and prioritizing the questions.

Results

In the initial survey, 799 submissions were provided by 389 individuals and groups. The 647 questions that were within scope were categorized, merged, and summarized,

then checked against research evidence, creating a list of 41 unanswered questions. Prioritization took place in two stages: first, 146 individuals and groups participated in survey and their responses short-listed 22 questions; and second, an in-person workshop was held on September 26, 2017 in Toronto, Ontario where these 22 questions were discussed and ranked.

Conclusion

Researchers and research funders can use these results to inform their agendas for research on frailty. Strategies are needed for involving those with lived experience of frailty in research.

Key words: frailty, research, patient engagement, patient and public involvement, research priorities

INTRODUCTION

Frailty is a state of increased vulnerability to adverse outcomes.^(1,2) It increases with age and is associated with consequences at the individual and societal level.⁽³⁾ While frailty has emerged as an important health and care concept among researchers and clinicians working with older adults, there is still debate about the best operational definition and evidence is still emerging on ways to recognize, evaluate, and manage frailty.⁽⁴⁻⁸⁾

Research on frailty presents challenges, including that older adults living with frailty may not self-identify and people with lived or clinical experience of frailty (i.e., older adults, friends, family and caregivers, and care providers) are typically not involved in the research process, leaving important gaps in current knowledge.⁽⁹⁾ For research priority-setting, involving those with lived or clinical experience has the potential advantages of democratizing allocation of research resources and increasing impact.⁽¹⁰⁾ The James Lind Alliance (JLA) offers an established approach to involving patients, caregivers, and clinicians in developing shared research priorities through Priority Setting Partnerships (PSPs).^(11,12)

The objectives of the Canadian Frailty PSP were to engage people with lived or clinical experience of frailty, and to produce a list of research priorities related to the care, support, and treatment of older adults living with frailty. Ultimately, the objective was to stimulate more research in these priority areas and, in doing so, improve the health and care of older adults living with frailty.

METHODS

The Canadian Frailty PSP followed the methods of the JLA, a non-profit initiative supported by the National Institute for Health Research (UK) which has facilitated roughly 80 PSPs that involve patients, carers and health and social care providers in developing shared research priorities. The JLA methods are available online (<http://www.jla.nihr.ac.uk/jla-guidebook/>) and described in brief here, as applied to the Canadian Frailty PSP. Research Ethics Board approval was obtained through the University Health Network.

1. Establish Steering Group

A 17-person Steering Group, which included people with lived or clinical experience of frailty, researchers, and the Senior JLA Adviser, was established to oversee and advise the Canadian Frailty PSP. The Steering Group met monthly (October 2016 to August 2017), by teleconference.

2. Invite Partner Organizations

Organizations that represent, serve or advocate for older adults or their care providers were identified through the Steering Group and Canadian Frailty Network (CFN) and asked to join as partner organizations. Partner organizations (see Appendix A) assisted by promoting surveys, identifying workshop participants, and disseminating results.

3. Gather Questions About Frailty

An open survey was conducted between March and June 2017, inviting people with lived or clinical experience of frailty to submit their questions about care, support, and treatment of older adults living with frailty. The survey was available in English and French, online (<https://www.limesurvey.org/>) and in paper format. The survey was

adapted from previous PSPs with project-specific modifications, including to incorporate feedback from a consultation with Seniors Helping as Research Partners.⁽¹³⁾

The survey had three sections: Section One asked respondents to submit their questions about care, support, and treatment of older adults living with frailty as free text; Section Two collected demographic information; and Section Three invited respondents to participate in the prioritization process by submitting their contact information. In order to protect the privacy of respondents, Section Three data were collected and stored separately from the rest of the data, thus precluding any linkage or description of those who initially agreed to take part in this step. Completion of the survey was taken as implied consent. To align with the objective of the study—to produce a list of research priorities related to the care, support, and treatment of older adults living with frailty—frailty was explicitly defined in the survey, based on the CFN website description,⁽¹⁴⁾ as:

“What is frailty?”

We usually associate frailty with noticeable losses in a person’s physical, mental or social functioning. Frailty is a health state continuum ranging from fit to very frail, involving multiple health problems and often associated with getting older. Frailty can result from a range of diseases and conditions where even fairly minor health events can trigger major changes in a person’s health status.”

In addition to assistance from partner organizations, Steering Group members assisted with distributing the survey, community newspaper ads were run in Canadian cities (Edmonton, Winnipeg, Montreal, Mississauga, and Surrey), and paper surveys were mailed to older adults in the Seniors Helping Advance Research Excellence group.⁽¹⁵⁾ Partner organizations were encouraged to promote the survey by means that were relevant to their community (e.g., social media, website, newsletter). There was no formal sampling frame for the survey, and thus, no reportable response rate.

4 Process the Data

Online survey data were downloaded into a spreadsheet and data from paper surveys were entered in this format. Only surveys with a response in Section One (questions about frailty) were included. Section One submissions were analyzed by the research team and one Steering Group member, who extracted information on population, intervention/exposure, control/comparison, and outcome (PICO) elements wherever possible. Submissions that were out of scope (i.e., not directly related to care, support, and treatment of older adults living with frailty) or could not be formulated into a question were excluded. The remaining questions were categorized, merged, and summarized as indicative questions. Questions that addressed

a single domain of frailty (i.e., physical, mental or social functioning alone) were combined with questions that addressed frailty overall. To keep the list to a manageable size, questions that were asked only once were also excluded. Indicative questions were checked against research evidence. An Information Specialist searched Medline (Medline in Process and other non-indexed citations, ePubs and Medline Daily), Cochrane Database of Systematic Reviews, and Database of Abstracts of Reviews of Effects, to identify reviews related to frailty in older adults published between January 2014 and June 2017, limited to English, French or German language (see Appendix B). Titles and abstracts were reviewed and indicative questions were removed if a relevant, published, review indicated adequate evidence. The list of indicative questions was reviewed by the Steering Group before prioritization.

5 Prioritize the Questions

Interim Prioritization

A second survey was conducted between July and mid-September 2017, again inviting participation from Canadians with experience of frailty and available in English and French, online and via paper format. Individuals who provided their contact information in the first survey were contacted and others were invited to join through partner organizations. Respondents reviewed the indicative questions and identified their own top 10 priorities (unranked), then provided demographic information.

The frequency each question was selected was tabulated. In an attempt to balance input from persons with lived and clinical experience of frailty, stratified ranked lists were created to ensure both groups' priorities were brought forward.

Final Prioritization

An in-person workshop, chaired and facilitated by the JLA Senior Advisor, was held in Toronto on September 26, 2017 to discuss and rank the short-listed questions. The final workshop followed the adapted Nominal Group Technique, as described by JLA. This involved small and large group discussions and ranking of questions, with participant types mixed to ensure a balance of patient, caregiver, and clinician experience. All participants had the opportunity to share their top and bottom priorities before the ranking began, in order to understand each other's perspectives. Consensus was mainly reached through discussion, with decisions put to a vote if required. Independent facilitators ensured that no single voice dominated and that everyone had a chance to have their say. All participants agreed to a basic ground rule of respecting different opinions, and compromise was acknowledged.

Participants included older adults, friends, family and caregivers of older adults, as well as health and social care providers. Some Steering Group members (those with lived or clinical experience of frailty) participated, and researchers

attended as observers. Written consent was obtained from participants and travel expenses were reimbursed. Assistance with travel arrangements was offered, including for an accompanying person for older adults. The workshop was held in an accessible venue, close to public transit. The workshop format was adapted to encourage involvement of older adults (e.g., larger-font materials, longer break, and smaller group discussions). A member of the research team also worked with one of the older adults to discuss the questions before the workshop and record comments.

RESULTS

Table 1 describes the 389 and 146 individuals and groups who submitted their questions about frailty and participated in the interim prioritization, respectively. Figure 1 summarizes the flow of data, beginning with the 799 submissions that were provided by 389 individuals and groups from across Canada. These submissions were summarized and checked to create the list of 41 indicative questions (provided in Appendix C) which were then narrowed down during the interim prioritization to 22 questions for discussion at the final prioritization workshop, where the top 10 ranked priorities were decided.

Subsequent to the interim prioritization survey, after reviewing the stratified ranked lists, one question was added to the list of questions for the workshop to ensure that both groups' priorities (top 14 ranked questions) were discussed. There were 21 participants at the workshop (from British Columbia, Alberta, Ontario, Quebec, New Brunswick, and Nova Scotia); 9 represented lived experience and 12 represented clinical experience, but many participants referred to dual roles (e.g., older adults and clinicians with family caregiving experience). The top 10 ranked research priorities are listed in Table 2 and the complete ranked list of 22 questions is available online: <http://www.jla.nihr.ac.uk/priority-setting-partnerships/frailty-canada/top-10-priorities.htm>

DISCUSSION

The Canadian Frailty PSP was the first JLA PSP to engage those with lived or clinical experience of frailty in setting shared priorities for research. The priorities highlight issues related to the health, wellbeing, and care of older adults living with frailty and their family/caregivers, and include questions related to social determinants of health.

The results complement a recent review which examined literature on frailty in acute care and consulted a panel of experts for research recommendations.⁽¹⁶⁾ Despite incomplete overlap in scope, both the review and the Canadian Frailty PSP highlight the clinical utility of frailty detection, interventions to safely avoid hospitalization, and frailty prevention as priorities for research. Notably, the review also emphasized the importance of involving patients and family in research.

Certain limitations must be considered in interpreting these results. First, the data show that the process reached

TABLE 1.
Description of Canadian Frailty Priority Setting Partnership survey respondents

	<i>Initial Survey</i> (n=389)		<i>Interim Prioritization</i> (n=146)	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Are you completing this questionnaire alone or as a pair or group?				
Alone	379	97.4%	141	96.6%
As a pair or group	4	1.0%	1	0.7%
Not specified	6	1.5%	4	2.7%
Which of the following best describes you? Check all that apply.				
Older adult concerned about frailty (i.e., experiencing noticeable losses in health and/or physical, mental or social functioning)	52	13.4%	6	4.1%
Older adult with no direct experience of frailty, but interested in it	52	13.4%	10	6.8%
Partner, relative or friend of a frail older adult	82	21.1%	25	17.1%
Caregiver or former caregiver of a frail older adult	72	18.5%	29	19.9%
Health and/or social care provider, current profession:	273	70.2%	112	76.7%
<i>Dietitian</i>	67	17.2%	48	32.9%
<i>Nurse</i>	55	14.1%	18	12.3%
<i>Occupational therapist</i>	8	2.1%	6	4.1%
<i>Pharmacist</i>	10	2.6%	9	6.2%
<i>Physician</i>	89	22.9%	10	6.8%
<i>Physiotherapist</i>	9	2.3%	3	2.1%
<i>Personal support worker, care aide or community health worker</i>	4	1.0%	0	0.0%
<i>Recreation therapist</i>	11	2.8%	4	2.7%
<i>Social worker</i>	6	1.5%	4	2.7%
<i>Other</i>	26	6.7%	11	7.5%
Which part of Canada do you live in? Check all that apply.				
Alberta	59	15.2%	13	8.9%
British Columbia	56	14.4%	17	11.6%
Manitoba	13	3.3%	8	5.5%
New Brunswick	7	1.8%	9	6.2%
Newfoundland and Labrador	3	0.8%	1	0.7%
Northwest Territories	0	0.0%	1	0.7%
Nova Scotia	12	3.1%	6	4.1%
Nunavut	0	0.0%	0	0.0%
Ontario	208	53.5%	81	55.5%
Prince Edward Island	2	0.5%	1	0.7%
Quebec	25	6.4%	7	4.8%
Saskatchewan	2	0.5%	1	0.7%
Yukon	0	0.0%	0	0.0%
What are your ethnic or cultural origins? Check all that apply.				
North American Aboriginal	5	1.3%	3	2.1%
Other North American (e.g., Canadian or American)	238	61.2%	81	55.5%
European	135	34.7%	50	34.2%
Caribbean	1	0.3%	1	0.7%
Latin, Central or South American	1	0.3%	1	0.7%
African	3	0.8%	1	0.7%
Oceania (e.g., Australian)	1	0.3%	0	0.0%
Asian (e.g., Middle Eastern, South, East and Southeast Asian)	21	5.4%	7	4.8%
Prefer not to say	11	2.8%	6	4.1%

TABLE 1. Continued

	<i>Initial Survey (n=389)</i>		<i>Interim Prioritization (n=146)</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
What is the highest certificate, diploma or degree that you have completed?				
Less than high school diploma or its equivalent	0	0.0%	0	0.0%
High school diploma or a high school equivalency certificate	18	4.6%	2	1.4%
Post-secondary certificate or diploma (including college, CEGEP or trades)	39	10.0%	8	5.5%
University degree	314	80.7%	126	86.3%
Prefer not to say/not specified	18	4.6%	10	6.8%
How do you identify?				
Male	66	17.0%	12	8.2%
Female	304	78.1%	125	85.6%
Other	0	0.0%	0	0.0%
Prefer not to say/not specified	19	4.9%	9	6.2%
In what year were you born?				
1920-1939	47	12.1%	4	2.7%
1940-1959	121	31.1%	39	26.7%
1960-1979	125	32.1%	56	38.4%
1980-1999	71	18.3%	30	20.5%
Prefer not to say/not specified	25	6.4%	17	11.6%
Do you receive the Guaranteed Income Supplement?				
Yes	10	2.6%	2	1.4%
No	172	44.2%	52	35.6%
Prefer not to say/not specified	2	0.5%	1	0.7%
Not applicable (question not posed to health and social care providers unless also identified lived experience)	205	52.7%	91	62.3%

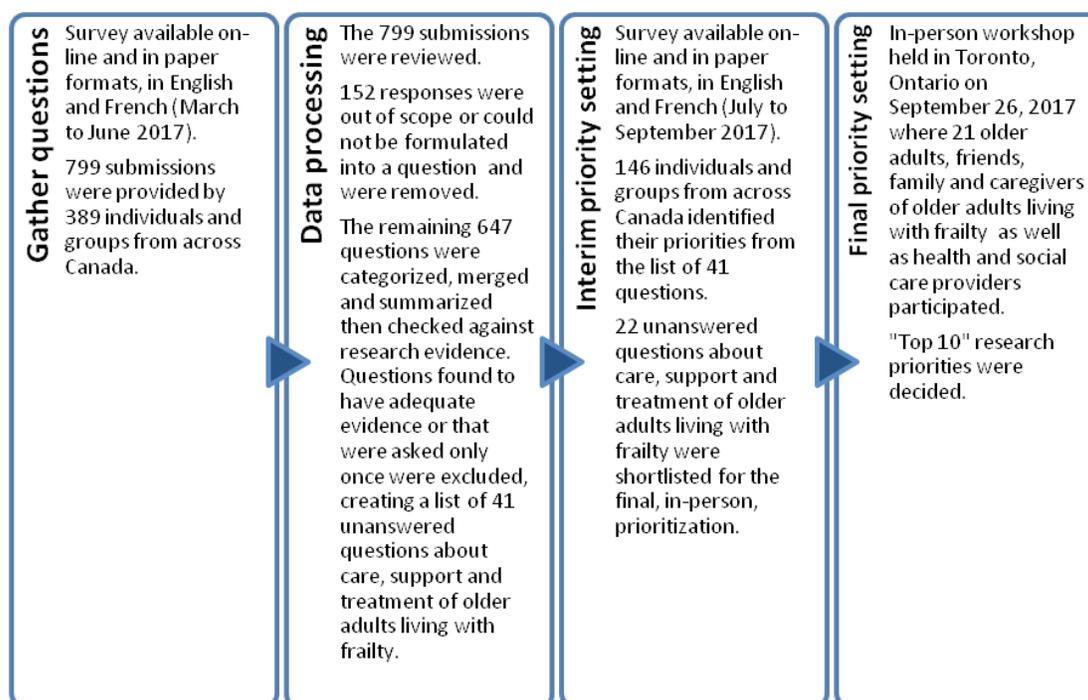


FIGURE 1. Summary of the data from the Canadian Frailty Priority Setting Partnership

TABLE 2.

Top 10 priorities for frailty research from the Canadian Frailty Priority Setting Partnership

1. How can the health system be organized to provide integrated/coordinated care that would better meet the health and social care needs of older adults living with frailty and their family/caregivers?
2. How can care, services and treatments be tailored to meet the needs of older adults living with frailty who are isolated and/or without family/caregiver support or advocates?
3. What is the impact of community- and home-based services, programs and resources in preventing and managing frailty (including slowing progression and/or minimizing the impact of frailty)?
4. What are the costs and benefits of alternative models of housing, including multigenerational or shared living, for older adults living with frailty?
5. What would help avoid unnecessary hospitalizations and emergency department visits for older adults living with frailty?
6. What frailty-related attitudes, skills and knowledge should health and social care providers have? What are effective ways of improving attitudes and providing skills and knowledge about frailty for health and social care providers?
7. What would help older adults living with frailty and their family/caregivers recognize when living at home is no longer viable?
8. What are effective ways of supporting family/caregivers of older adults living with frailty to maintain their own health and wellbeing and/or that of older adults living with frailty?
9. How can frailty measures be used by health care practitioners, older adults and family/caregivers to inform treatment and care decisions?
10. What is the impact of exercise and physical activity (including type, duration and intensity) in preventing and managing frailty (including slowing progression and/or minimizing the impact of frailty)?

only a subset of Canadians with experience in frailty (i.e., those that participated were mainly women, more than half were from Ontario, nearly all had European or North American ethnic or cultural origins, and most had a university degree), and results are not representative of groups and individuals with specific needs. Second, obtaining responses from older adults who self-identified as frail was challenging. Aside from the barriers that frailty may pose for participation,⁽⁹⁾ many who meet criteria for frailty will

not perceive themselves as frail,⁽¹⁷⁾ and the term will have a negative connotation for some.⁽¹⁸⁾ Coupled with the apparent divergent meanings of frailty in different contexts, the term “frailty” may have been a barrier for involving older adults and establishing a common understanding for those involved. In other words, when engaging older adults, the process itself was likely biased towards a healthier population, but asking respondents to self-identify as frail may well have had the opposite effect and, together, these phenomena no doubt impacted the final results. Yet, there are important reasons for engaging those with lived experience in research, and these limitations reiterate that strategies are needed for engaging older adults living with frailty in research and to demonstrate the benefits of this engagement.^(9,12)

The Canadian Frailty PSP results offer researchers and research funders an opportunity to incorporate perspectives of those with lived and clinical experience of frailty. The themes are wide-ranging, in that they can be addressed through diverse research approaches and methods. Still, the results of the Canadian Frailty PSP are not intended as the only priorities to inform the frailty research agenda, and further work is needed to engage older adults and others with experience of frailty across the research process.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that no conflicts of interest exist.

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APPENDICES

Appendix A: List of Partner Organizations

Canadian Frailty Priority Setting Partnership Partner Organizations

Alberta Continuing Care Association	Community Health Nurses of Canada
The Arthritis Society	Denominational Health Association
BC Care Providers Association	Geriatric Education & Research in Aging Sciences (GERAS)
Canadian Academy of Geriatric Psychiatry	GTA Rehab Network
Canadian Association for Rural & Remote Nursing	Heart & Stroke Foundation of Canada
Canadian Association of Critical Care Nurses	Hypertension Canada
Canadian Association of Occupational Therapists	The Kidney Foundation of Canada
Canadian Association of Social Workers	Leukemia & Lymphoma Society of Canada
The Canadian Cancer Survivor Network	Lung Association
Canadian Geriatrics Society	National Association of Federal Retirees
Canadian Hospice Palliative Care Association	National Initiative for the Care of the Elderly (NICE)
The Canadian Orthopedic Foundation	New Brunswick Association of Nursing Homes
Canadian Society of Consultant Pharmacists	The North East Specialized Geriatric Centre
Canadian Society of Hospital Pharmacists	Older Women's Network (Ontario) Inc.
Canadian Society of Palliative Care Physicians	Ontario Long Term Care Association
Canadian Society of Respiratory Therapists	Ontario Respiratory Care Society
Canadian Therapeutic Recreation Association	Public Health Physicians of Canada
Clinical Nurse Specialist Association of Canada	Speech-Language and Audiology Canada
Community Care Access Centre (CCAC)-Central East	The 519 Church Street Community Centre
Community Care Access Centre (CCAC)-Central West	The College of Family Physicians of Canada
Community Care Access Centre (CCAC)- Hamilton Niagara Haldimand Brant	Trent Centre for Aging & Society

Appendix B: Literature Search Strategy

Database: Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) <1946 to Present>

1. Frail Elderly/
2. frail*.tw,kw,kf.
3. exp aged/ or “aged, 80 and over”/
4. Geriatrics/
5. (geriatri* or gerontol* or elder? or elderly or senior* or senescen* or septuagenarian* or octogenarian* or nonagenarian* or pensioner*).tw,kw,kf.
6. ((old* or aged* or ag?ing) adj2 (adult* or people or patient* or person* or women or men or individual*)).tw,kw,kf.
7. 3 or 4 or 5 or 6
8. 1 or (2 and 7)
9. meta-analysis.pt.
10. meta-analysis/ or systematic review/ or meta-analysis as topic/ or “meta analysis (topic)”/ or “systematic review (topic)”/ or exp technology assessment, biomedical/
11. ((systematic* adj3 (review* or overview*)) or (methodologic* adj3 (review* or overview*)) or (scoping* adj3 (review* or overview*))).tw,kf,kw.
12. ((quantitative adj3 (review* or overview* or synthes*)) or (research adj3 (integrati* or overview*))).tw,kf,kw.
13. ((integrative adj3 (review* or overview*)) or (collaborative adj3 (review* or overview*)) or (pool* adj3 analy*)).tw,kf,kw.
14. (data synthes* or data extraction* or data abstraction*).tw,kf,kw.
15. (handsearch* or hand search*).tw,kf,kw.
16. (met analy* or metanaly*).tw,kf,kw.
17. (meta regression* or metaregression*).tw,kf,kw.
18. (meta-analy* or metaanaly* or systematic review*).mp,hw.
19. (medline or cochrane or pubmed or medlars or embase or cinahl).tw,hw.
20. (cochrane or evidence report).jw.
21. or/9-20
22. 8 and 21
23. (eng or fre or ger).lg.
24. 22 and 23
25. limit 24 to yr=”2014 -Current”
26. remove duplicates from 25

Database: EBM Reviews - Cochrane Database of Systematic Reviews <2005 to June 20, 2017>

1. frail*.ti,ab.
2. (geriatri* or gerontol* or elder? or elderly or senior* or senescen* or septuagenarian* or octogenarian* or nonagenarian* or pensioner*).ti,ab.
3. ((old* or aged* or ag?ing) adj2 (adult* or people or patient* or person* or women or men or individual*)).ti,ab.
4. 1 and (2 or 3)
5. limit 4 to full systematic reviews
6. limit 5 to last 4 years

Database: EBM Reviews - Database of Abstracts of Reviews of Effects <1st Quarter 2016>

1. frail*.af.
2. (geriatri* or gerontol* or elder? or elderly or senior* or senescen* or septuagenarian* or octogenarian* or nonagenarian* or pensioner*).af.
3. ((old* or aged* or ag?ing) adj2 (adult* or people or patient* or person* or women or men or individual*)).af.
4. 1 and (2 or 3)
5. “2014”.do.
6. 4 and 5

Appendix C: Long List of Indicative Questions

Complete list of 41 indicative questions from the Canadian Frailty Priority Setting Partnership

1. What would ensure that frail older adults and their family/caregivers are aware of community-based services (including care provided at home)?
2. What would ensure that frail older adults and their family/caregivers have access to appropriate community-based services (including care provided at home)?
3. What are the costs and benefits of alternative models of housing, including multigenerational or shared living, for frail older adults?
4. How can the health system be organized to provide integrated/coordinated care that would better meet the health and social care needs of frail older adults and their family/caregivers?
5. What would help older adults and their family/caregivers identify individualized treatment and care goals and plan for future care needs?
6. What are effective ways of supporting family/caregivers of frail older adults to maintain their own health and wellbeing and/or that of frail older adults?
7. What would enable the creation of age-friendly communities that would better support frail older adults?
8. What frailty-related attitudes, skills and knowledge should health and social care providers have? What are effective ways of improving attitudes and providing skills and knowledge about frailty for health and social care providers?
9. What are effective ways of providing clear and accurate information and education about frailty to older adults and their family/caregivers?
10. What are effective ways of educating the general public about frailty (including prevention)?
11. What are effective ways of preventing elder abuse of frail older adults?
12. What would improve end of life care for frail older adults and their family/caregivers?
13. How can frailty measures be used by health care practitioners, older adults and family/caregivers to inform treatment and care decisions?
14. What is the best screening tool for identifying frailty in different clinical settings (including primary care, hospital and home care)?
15. How can frailty screening tool(s) be implemented in different clinical settings?
16. What would help avoid unnecessary hospitalizations and emergency department visits for frail older adults?
17. How can inpatient and emergency department care and design be optimized for frail older adults?
18. What would improve care, health and quality of life for frail older adults living in long-term care homes?
19. What would help frail older adults to maintain their independence?
20. What would help frail older adults meet their transportation needs?
21. What explains the relationship between frailty and cognitive impairment or dementia?

22. How can prescribing be optimized for frail older adults?
23. In what ways does de-prescribing (decreasing or stopping medications) reduce the negative impacts of polypharmacy (simultaneous use of multiple drugs) in frail older adults?
24. What are effective approaches to de-prescribing (decreasing or stopping medications) in frail older adults?
25. How can care, services and treatments be tailored to meet the needs of frail older adults who are isolated and/or without family/caregiver support or advocates?
26. How can care, services and treatments be tailored to meet the needs of frail older adults with cognitive impairment or dementia?
27. What would help frail older adults to continue living safely in their own home or living environment of choice?
28. What would help frail older adults and their family/caregivers recognize when living at home is no longer viable?
29. How does being labelled frail by clinicians impact older adults and their access to care?
30. How do societal attitudes and perceptions about frailty impact older adults? What are effective ways of improving societal attitudes and perceptions associated with frailty?
31. What is the impact of therapeutic recreation in preventing and managing frailty (including slowing progression and/or minimizing the impact of frailty)?
32. What is the impact of technology in managing frailty (including slowing progression and/or minimizing the impact of frailty)?
33. What is the impact of rehabilitation services in preventing and managing frailty (including slowing progression and/or minimizing the impact of frailty)?
34. What is the impact of diet and nutrition in preventing and managing frailty (including slowing progression and/or minimizing the impact of frailty)?
35. What is the impact of exercise and physical activity (including type, duration and intensity) in preventing and managing frailty (including slowing progression and/or minimizing the impact of frailty)?
36. What is the impact of community- and home-based services, programs and resources in preventing and managing frailty (including slowing progression and/or minimizing the impact of frailty)?
37. What is the impact of medications in preventing and managing frailty (including slowing progression and/or minimizing the impact of frailty)?
38. What are effective ways of assessing and ensuring adequate diet and nutrition for frail older adults?
39. What are effective ways of assessing and reducing risk of falls for frail older adults?
40. What are effective approaches to reducing unnecessary care for frail older adults?
41. What are effective approaches to motivating frail older adults to remain active (including in rehabilitation activities)?