LEARNING FROM INNOVATION: A UNIQUE APPROACH TO FRAILTY CARE IN THE COMMUNITY

THE CHALLENGE: FRAILTY IN CANADA
Frailty is a condition of reduced function and health in older individuals. Frailty makes patients more susceptible to large declines in health from minor illnesses like flus or falls, and makes patients more likely to be hospitalized, need long-term care, or die.¹

COLLABORATION FROM ACROSS CANADA: FOUR INNOVATIONS
The Canadian Foundation for Healthcare Improvement and the Canadian Frailty Network have collaborated with four frailty innovators and designed the Advancing Frailty Care in Community collaborative.

THE OPPORTUNITY: THE COLLABORATIVE
The Advancing Frailty Care in the Community (AFCC) Collaborative assists healthcare organizations across Canada to improve care for frail older adults and support their caregivers. This work takes place within the primary and/or home care setting and is a collaboration between the Canadian Foundation for Healthcare Improvement and the Canadian Frailty Network. Seventeen teams across Canada are participating in the collaborative.

A cross-analysis of the four frailty innovations identified seven common interventions that are foundational for advancing frailty care in primary care in Canada, and are used as the basis of the AFCC collaborative approach. The collaborative teams receive coaching and support on how to implement all seven intervention areas, within their frailty initiatives from innovators of the four profiled frailty innovations. Individual team approaches to each intervention vary based on local contexts.

STRATEGY FOR CHANGE: COLLABORATIVE GOALS
Support teams to implement frailty-related innovations in primary care
Improve care and quality of life
Spread frailty innovations in primary care

DIFFERENT APPROACHES, COMMON CORE MEASURES
All teams are collecting data on a common set of core measures that correspond to IHI’s Quadruple Aim, based on the AFCC logic model and adhere to the MMMMD (meaningful, minimal and manageable dataset) directive. All teams will be expected to report on:

Number of patients reached
Percent of patients whose frailty decreased or remained the same
Experience of care
Hospitalizations and emergency room visits

HOW WILL WE KNOW THE CHANGE IS AN IMPROVEMENT?
Outcomes:
- Increased access to frailty care
- Enhanced engagement of family/friend caregivers
- Increased capacity for frailty care amongst primary care providers
- Increased collaboration within primary care practices
- Increased provision of evidence informed frailty interventions in primary care settings
- Increased coordination/integration of care between primary care and community-based healthcare providers, services and agencies
- Improved health and well-being
- Enabling environment for evidence-informed frailty care and quality improvement
- Improved quality of care

- Maintained or reduced use of acute care services by frail older adults
- Delayed entry to long-term care
- Improved provider experience
- The innovations spread to other primary care clinics and communities
- Quality improvement, monitoring and evaluation used in other interventions

2. Ibid.