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]

FRAILTY AFFECTS 1.5 MILLION CANADIANS TODAY[2]

FRAILTY WILL AFFECT 2 MILLION CANADIANS BY 2030[3]

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.

C5-75: Case-finding for Complex Chronic Conditions in persons 75+, is based at the Centre for Family Medicine Family Health Team in Kitchener, Waterloo, and Wellesley, Ontario, and aims to systematically identifies and better manages frailty for all adults aged 75+ in primary care.

Seniors' Community Hub based in Edmonton, Alberta is an integrated, interprofessional, shared-care geriatric program within the Edmonton Oliver Primary Care Network.

COACH Program (Caring for Older Adults in Community and at Home), based in Prince Edward Island, provides direct client care at home for older adults living with frailty, delivered by an integrated interdisciplinary team led by a geriatric nurse practitioner.

CARES (Community Action and Resources Empowering Seniors) based in Fraser Health Authority in British Columbia is a primary care model for early identification and geriatric assessment of seniors "at risk" for frailty, and provides a community-based health coaching intervention.

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.

WHAT

- Frailty Identification
- Geriatric Assessment
- Tailored Interventions

HOW

- Person and Family-Centred Care
- Collaborative Care
- Community Supports

Quality Improvement, Change Management, Monitoring and Evaluation and System Level Change

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 MMMD (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:

SHORT-TERM

- Increased access to frailty care
- Enhanced engagement of family/friend caregivers
- Enhanced self-management of frailty and/or health
- Increased capacity for frailty care amongst primary care providers
- Increased collaboration within primary care practices

INTERMEDIATE

- 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

LONG-TERM

- 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

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Endnotes

1 Research on Aging, Policies and Practice. (June 2018). A profile of caregivers of older adults (65+). [Website] https://rapp.ualberta.ca/wp-content/uploads/sites/49/2018/09/Profile-of-Carers-of-Older-Adults-65-Infographic_2018-06-20.pdf
2 Ibid.
3 Ibid.

Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

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