LEARNING FROM INNOVATION:
ENHANCING FRAILTY CARE IN THE COMMUNITY

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The **Advancing Frailty Care in the Community Collaborative** (AFCC) 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. The AFCC collaborative runs from November 2019 to September 2021 and is a collaboration between the Canadian Foundation for Healthcare Improvement (CFHI) and the Canadian Frailty Network (CFN).

Frailty is a condition of reduced function in 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]

Although the emergence of frailty and its progression are not inevitable and pre-determined outcomes of aging, as the population continues to live longer[2] the likelihood of frailty increases, with 25% of Canadians over the age of 65 becoming frail, increasing to more than half in the over 85 age group.[3] With this shift, and greater awareness that this growing population is currently under-recognized and under-served, the time is right to improve the lives of those impacted by frailty and their caregivers, while ensuring older Canadians are getting the right care, closer to home.[4]

Strategy for Change: Collaborative Goals

1. Support teams to implement frailty-related innovations in primary care.
2. Improve care and quality of life for FOAs and support their family/friend caregivers.
3. Build capacity of teams to do quality improvement to spread and sustain frailty-related improvements.

Driving Rapid Adoption

Four frailty innovations from across Canada have collaborated with CFHI and CFN to inform the design of collaborative, driving rapid adoption of evience-informed frailty innovations based in primary and/or home care.

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

The **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.

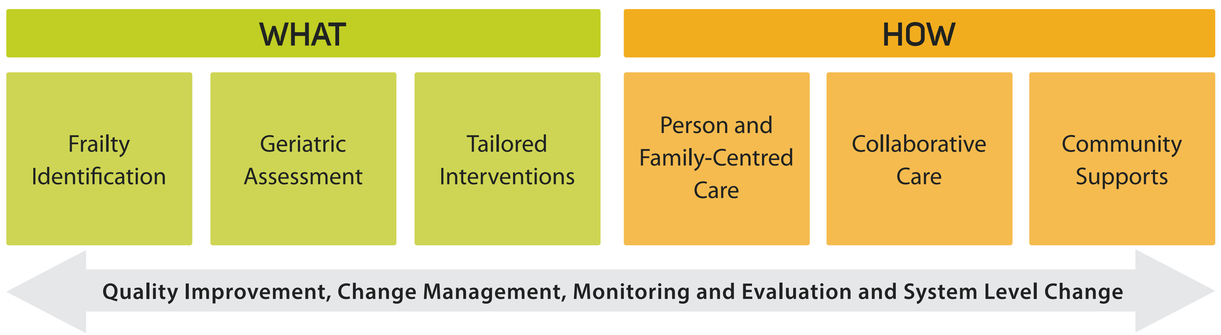
CARES (Community Action and Resources Empowering Seniors) based in Fraser Health Authority in British Columbia is a collaborative, primary care model for early identification and geriatric assessment of seniors "at risk" for frailty, and provides a community-based health coaching intervention.

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 identify and better manage frailty for all adults aged 75+ in primary care.

Drawing on a Suite of Interventions

A cross-analysis of the four frailty innovations identified **seven common interventions** that were foundational for advancing frailty care in primary care in Canada, and are used as the basis of the AFCC collaborative approach. This includes systematically identifying and assessing frailty in populations 75 years of age and over, with opportunistic screening for those 65 and over. Customized care plans are implemented for those who are frail, in partnership with their caregivers, slowing the progression of frailty and maintaining or enhancing quality of life.

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 programs. The profiled frailty innovations are used as real-life examples for how these intervention areas can be applied. Individual team approaches to each intervention vary based on local contexts.



Frailty is estimated to affect **1.5 million** Canadians.
2 million people are expected to be affected **by 2030**.
The majority of frail patients live in a **community setting**.[5]

Common Core Measures

Teams are collecting data on a common set of core measures that correspond to IHI's Quadruple Aim (patient health, patient experience, provider experience, and health system outcomes), the AFCC logic model and adhere to the MMMD directive (meaningful, minimal and manageable dataset). In addition to their own measures, all teams will be expected to report on:

- Change in patient frailty status/level
- Caregiver burden/(di)stress
- Patient-reported quality of life
- Number of persons identified living with frailty
- Percentage of patients who consent/agree to be assessed for frailty
- Number of care plans developed
- Number of patient assessments completed (baseline, 6 and 12 months)
- Number of caregiver assessments completed
- Number and type of referrals to community programs or self-management coaching
- Patient and caregiver reported satisfaction

How Will We Know the Change is an Improvement?

Immediate:

- 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 PCPs
- Increased collaboration within primary care practices

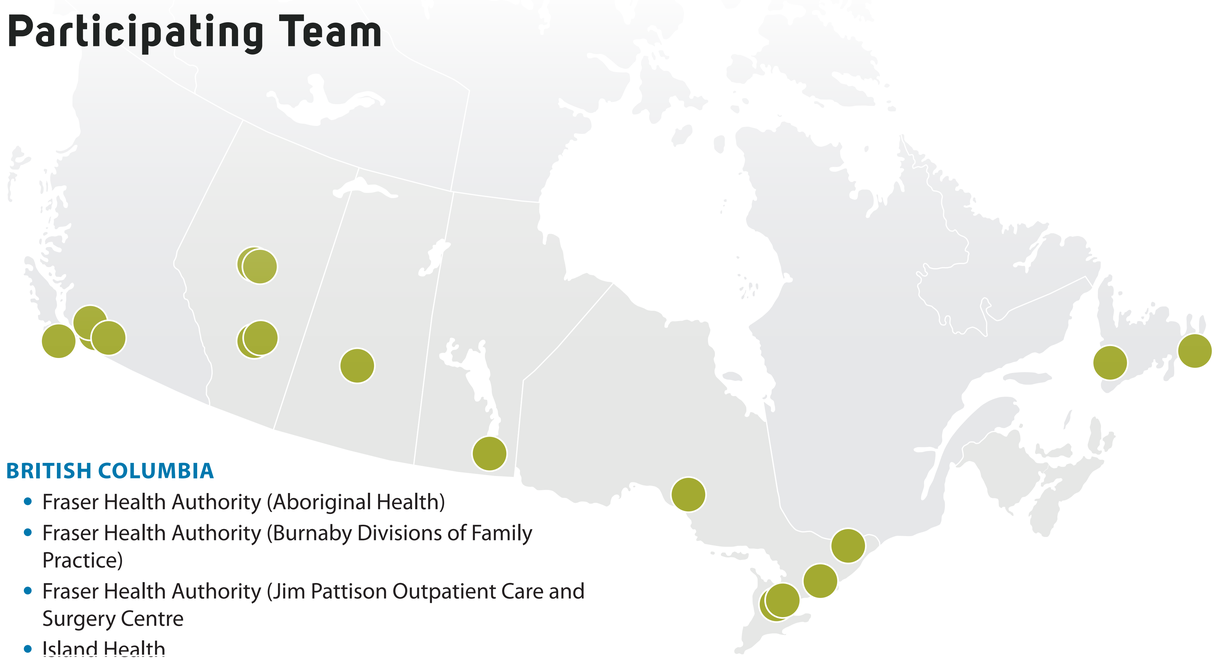
Intermediate:

- Improved health and well-being
- Improved patient experience
- Enabling environment for evidence-based frailty care and quality improvement

Long-Term:

- Maintained quality of life
- Maintained or reduced use of acute care services by frail older adults
- Delayed entry to long-term care
- Improved provider experience

Participating Team



BRITISH COLUMBIA
- Fraser Health Authority (Aboriginal Health)
- Fraser Health Authority (Burnaby Divisions of Family Practice)
- Fraser Health Authority (Jim Pattison Outpatient Care and Surgery Centre
- Island Health

ALBERTA
- Sage Seniors Association
- The Alexandra Community Health Centre
- Alberta Health Services, North Zone
- Alberta Health Services, Calgary Zone, Sourthern Alberta Clinic

SASKATCHEWAN
- Saskatchewan Health Authority

MANITOBA
- Winnipeg Regional Health Authority

ONTARIO
- Centre for Family Medicine Family Health Team
- Gateway Community Health Centre
- New Vision Family Health Team
- Champlain CARE Network Team, University of Ottawa
- Wawa Family Health Team

NEW BRUNSWICK
- Medavie Health Services New Brunswick, Extra Mural Program

NEWFOUNDLAND AND LABRADOR
- Western Health
- Eastern Health

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. Grenier, É. (2017). Canadian seniors now outnumber children for 1st time, 2016 census shows. Retrieved from https://www.cbc.ca/news/politics/2016-census-age-gender-1.4095360
3. Freedman, A., McDougall, L. (2019). Frailty 5 Checklist. Canadian Family Physician, 65 (1) 74-76
4. Canadian Frailty Network. (n.d.). Frailty Matters. Retrieved from https://www.cfn-nce.ca/frailty-matters/
5. 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

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