IMPROVING CARE FOR OLDER PEOPLE WITH FRAILTY AND SUPPORTING THEIR FAMILY/FRIEND CAREGIVERS

A 23-month Quality Improvement Collaborative

Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

About the Canadian Foundation for Healthcare Improvement

The Canadian Foundation for Healthcare Improvement supports partners to accelerate the identification, spread and scale of proven healthcare innovations. We work shoulder-to-shoulder with you to improve health and care for everyone in Canada. CFHI is a not-for-profit organization funded by Health Canada.

About the Canadian Frailty Network

The Canadian Frailty Network (CFN) will improve the care of older adults living with frailty and support their families and caregiver. We will do this by increasing recognition and assessment of frailty, increasing evidence for decision making, advancing evidence-based changes to care, educating the next generation of care providers, and by engaging with other adults and caregivers.

The views expressed herein do not necessarily represent the views of Health Canada.

CALL FOR APPLICATIONS

WHO SHOULD APPLY?

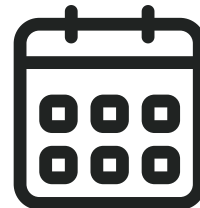
Two types of improvement teams - a network or a single institution - based in **primary care**

BENEFITS

- Implementation seed funding
- Expert faculty and coaches
- Cross-team learning
- Evaluation guidance
- QI tools

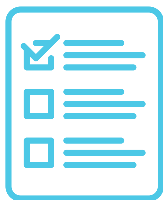
...and more!

TIMELINES



Date	Event
JUNE 18 2019	Call Launch
JUNE 24 2019	Informational Webinar
AUGUST 21 2019	Call Closes

ACTIVITIES & DELIVERABLES



- In-person workshops
- Webinars
- Coaching
- Online learning
- Peer-to-peer

...and more!

WHAT IS THE OPPORTUNITY?

Drive rapid adoption of proven innovations

To **improve care and quality of life** for older people living with frailty and **to support** their family/friend caregivers

APPLY NOW!

1: Read Call for Applications

2: Attend the webinar

3: Request an application form

4: Submit application by August 21, 2019

TABLE OF CONTENTS

EXECUTIVE SUMMARY 5
THE CHALLENGE 7
THE INNOVATIONS 8
THE INTERVENTION 10
MEASURING FOR QUALITY IMPROVEMENT 11
BENEFITS OF JOINING THE AFCC COLLABORATIVE 13
ACTIVITIES AND DELIVERABLES 14
AFCC COLLABORATIVE CURRICULUM HIGHLIGHTS AND KEY DATES* 15
WHO SHOULD APPLY? 16
ASSEMBLE YOUR IMPROVEMENT TEAM 17
ETHICS 19
COLLABORATION AGREEMENT 19
CONSENT TO USE FRAILTY IDENTIFICATION TOOLS 19
HOW TO APPLY 20
CONTACT 20
REFERENCES 21

EXECUTIVE SUMMARY

To improve care for older people with frailty and support their caregivers, the Canadian Foundation for Healthcare Improvement and Canadian Frailty Network invite you to join the Advancing Frailty Care in the Community (AFCC) Collaborative. This initiative will help you enhance your capacity to partner with patients and family/friend caregivers to improve the identification, assessment and implementation of tailored evidence-informed interventions that address frailty in primary care. Whether your organization already has clearly established approaches for older people with frailty or is looking to develop some for the first time, our goal is to help you deliver more improvement, for more people, that lasts.

As the Canadian population ages, there is an urgent need and a tremendous opportunity to improve care and quality of life for older people living with frailty and to support their family/friend caregivers. These caregivers are often the family and friends of older people, with more than two million Canadians[1] providing care to family members because of age-related needs. 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,[4] 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.

This 23-month collaborative, taking place between November 2019 and September 2021, is based on some of the top frailty innovations from the 2018 CFN Frailty Matters Innovation Showcase. These applied innovations were presented by practitioners and experts across Canada and have been selected to be spread further across the country through this collaborative.

Using a quality improvement (QI) approach in a primary care setting, teams will systematically identify and assess frailty in populations 75 years of age and over, with opportunistic screening for those 65 and over. Teams will then implement customized care plans for those who are frail, in partnership with their caregivers, towards slowing the progression of frailty and maintaining or enhancing quality of life.

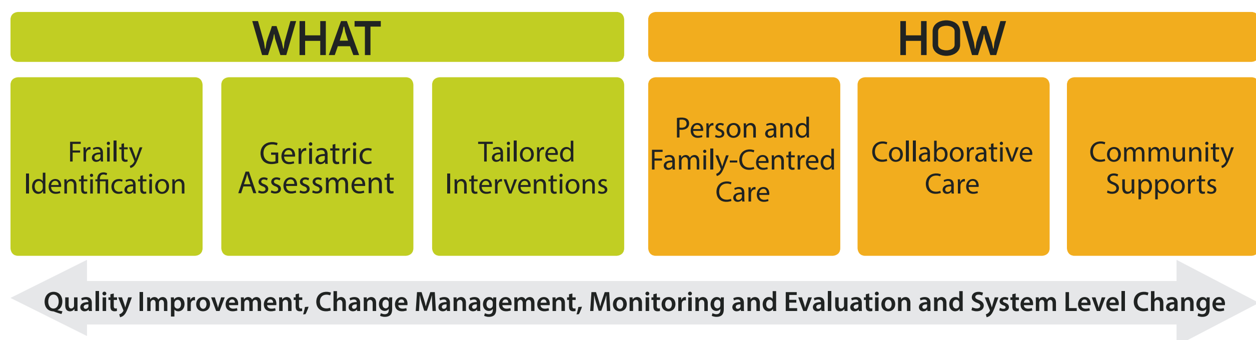
This collaborative will use an all-teach-all-learn approach, with numerous peer-to-peer networking opportunities, measurement and evaluation support and access to a network of expert faculty and coaches. It will provide up to **$1,000,000** in implementation seed funding support **shared across** up to 20 interdisciplinary teams. This amount will be divided and distributed based on demonstrated needs of each team during the application process.

Through this process CFHI and CFN aim to:

- Support teams to implement the AFCC Collaborative intervention areas. *See Figure 1.*
- Improve quality of life for older adults presenting to primary care who score 4-6 (vulnerable to moderately frail) on the Clinical Frailty Scale.
- Support capacity development for QI, change management and leadership, particularly as it relates to spreading and sustaining frailty-related improvements

Teams will test and adapt evidence-informed innovations (or portions thereof) that address each of the seven areas below: Frailty Identification; Geriatric Assessment; Tailored Interventions; Person and Family Centred-Care; Collaborative Care; Community Supports; and Quality Improvement.

Figure 1. AFCC Collaborative High Level Interventions and Approaches (more detail in Figure 2, below)



The deadline to apply is August 21, 2019.

THE CHALLENGE

Frailty is a state of increased vulnerability resulting from reduced reserve and loss of function across multiple systems reducing the ability to cope with normal or minor stressors.

The burden of frailty in Canada is steadily growing, especially in older Canadians. Today, over one million Canadians are medically frail. In 10 years, well over two million Canadians may be living with frailty. Frailty is linked to higher consumption of healthcare resources.

While frailty may occur throughout the lifespan, a large proportion of those who are living with frailty are aged 65 and over. Of the $253.5 billion spent on healthcare annually in Canada (11.3% of GDP), 45% is spent on people aged over 65, although they only account for 17% of the total population.[5]

Many interventions, including those we will work to spread in this Collaborative, have shown measurable progress in improving the health and wellbeing of older adults and advancing frailty care within a primary care setting, while positively impacting health system utilization.

To help address these growing challenges and support older people in Canada living with frailty together with their family/friend caregivers, the Canadian Foundation for Healthcare Improvement (CFHI) and the Canadian Frailty Network (CFN) invite you to join the ***Advancing Frailty Care in the Community (AFCC) Collaborative***.

This initiative will support up to 20 interdisciplinary teams from across Canada from November 2019 to September 2021. Using a Quality Improvement (QI) approach, teams will enhance their capacity to consistently partner with patients and caregivers to apply **frailty identification** and **assessment** in populations 75 years of age and over, with opportunistic screening for those 65 and over, in a **primary care setting**. Teams will then implement **tailored, evidence-informed interventions** to collaboratively care for those who score 4-6 a (vulnerable to moderately frail) on the Clinical Frailty Scale – in partnership with their family/friend caregivers – to **slow the progression of frailty and maintain or enhance their quality of life**. After the Collaborative, teams are expected to continue to spread their work beyond their initial intervention site(s). The Collaborative will provide teams with learning opportunities supported by CFN, CFHI, peers, and experts in the field through in-person workshops, webinars, coaching and other modalities.

THE INNOVATIONS

The AFCC Collaborative will support teams to implement practice change interventions (see Figure 2.) to improve the care and quality of life of those living with frailty, and those who support them. Participants will be guided by the experience and expertise of some of the top frailty innovations from CFN's 2018 Frailty Matters Innovation Showcase, which teams can draw from and adapt to their own setting. These innovations are:

- **COACH Program,** Prince Edward Island

  The COACH Program provides frail Island seniors with in-home support for their complex health needs. The program is led by a specialized, interdisciplinary team of healthcare professionals who support frail seniors to live at home longer and return home from hospital sooner. The team works with three partner programs – Home Care, Primary Care and the provincial Geriatric Program. The COACH team provides direct client care at home, on a timely basis, in an effort to predict and prevent (or proactively manage), health crises when they occur and ideally decrease the need for emergency services or admission to hospital. The team encourages advanced care planning and access to community support, with the goal of improved quality care for older adults living with frailty. System utilization data from the COACH pilot demonstrated decreases in hospital inpatient stays by two thirds, emergency visits by one third and primary care visits by one half. COACH clients are better able to self-manage and make informed decisions that positively impact their quality of life at home and, when necessary, support smoother transitions to and from acute care or long-term care.

  PEI's COACH program provides a patient-centred alternative to going to the emergency department and ensures that older adults improve their ability to self-manage their health (including caregiver support) and feel better equipped to make choices that have a positive impact on their quality of life. Program participants also showed one-third fewer emergency department visits and a 50% reduction in primary care visits.

- **The Senior's Community Hub (SCH)**, Edmonton Alberta

  The overarching goal of SCH is to transform primary care into a central hub to better meet the dynamic health and social needs of older adults with frailty and their family/friend caregivers. The objectives are to: maintain and enhance seniors' health and wellness; build integrated primary healthcare centred on the goals and priorities of older adults; develop effective information sharing between patients, care providers and settings; provide community-based support to family/friend caregivers to prevent or alleviate caregiver burden; and foster long-term sustainability in the primary care setting. The SCH builds capacity in primary care by mobilizing available Primary Care Network resources, proactively supporting older adults and their family/friend caregivers in maintaining their intrinsic capacity, strengthening their resilience, and, ultimately, mitigating frailty.

- **[CARES: Early Frailty Identification and Prevention Strategy]**, Fraser Health Authority, British Columbia

  CARES (Community Action and Resources Empowering Seniors) partners with primary care providers, family physicians and nurse practitioners to proactively identify vulnerable seniors at risk for frailty. Based in research, CARES supports early frailty assessment in the primary care clinic by using an electronic comprehensive geriatric assessment (eFI-CGA) able to generate a frailty index at point of service. CARES empower seniors by addressing frailty early, then supporting the collaborative development of a personalized care plan to connect seniors to community-based resources that enable them to live longer in their community. CARES offer seniors access to community based free health coaches and social prescribing resources to keep them engaged, active and connected to helpful resources. CARES is part of a CIHR research grant that seeks to establish the reliability and validity of the eFI-CGA.

Co-developing a personalized care plan through BC's CARES program helped participants improve their frailty status within six months. ***"A lot of the times, people go to the emergency room because they don't know what to do, they don't have an option."[6]***

- **[C5-75: Case-findings for Complex Chronic Conditions in Persons 75+]**, Centre for Family Medicine Family Health Team, Ontario

  C5-75 is a program designed to screen for frailty and its associated conditions which can be systematically implemented into regular family practice with minimum training and equipment. Using a quick validated screen for frailty involving gait speed and hand grip, the program identifies frail older adults at higher risk for health destabilization. These individuals are then screened for conditions known to worsen, or be worsened by, frailty, such as falls, high fracture risk, unstable heart failure and COPD, dementia, urinary incontinence and inappropriate medication use. Annual systematic screening, typically performed annually by nursing staff, can be implemented into most family practice settings. The orientation is to proactively identify unrecognized or sub-optimally treated co-existing conditions and to target appropriate interventions with the goal of averting medical crises that result in ED use, hospitalization and early transition into long term care. The C5-75 program aims to help older adults with frailty to continue to live in the community with best quality of life for as long as possible.

Improvement teams designing and implementing their frailty interventions as part of the AFCC Collaborative will ensure that they are testing, adopting and tracking some of the approaches drawn from the above four programs within each of the seven intervention areas: Frailty Identification, Geriatric Assessment, Tailored Intervention, Person and Family Centred-Care, Collaborative Care, Community Supports and Quality Improvement. Figure 2, below, provides examples of approaches Collaborative teams will test within each intervention area.

THE INTERVENTION

Each Collaborative team will implement each of the seven interventions listed below in Figure 2. They will do this by applying one or more of the listed approaches per intervention. For example, all teams will work on frailty identification (Intervention 1) and may choose to use the CFS as their preferred method to complete this step. Those at risk will then undergo a geriatric assessment (Intervention 2), by using a selected approach such as the Frailty Index.

Teams must also track the progress of their work using the below noted Core Measures (Figure 3), which will be collected on a monthly basis, evaluated for improvement and will be reported quarterly to CFHI and shared with other Collaborative teams (as helpful/appropriate).

Figure 2. Intervention Areas, Expanded

	Intervention (teams will address all listed)	Approaches (teams to select at least one)

WHAT	1. Frailty Identification	Teams will support the identified patient population through:
		• Screeing - Adults 75 years and older are systematically screened for frailty
		• Case Finding - Adults 65 years and older are assessed for frailty if clinical signs and symptoms warrant
		• Teams will assess older adults identified via screening or case finding through geriatric screening. Two tools are suggested; if another tool is preferred, this should be specified upon application:
		  • Clinical Frailty Scale (CFS)[7] or
		  • Hand Grip Strength[8] and Gait Speed with a determined cut-off point

	2. Geriatric Assessment	• Those who are deemed to be vulnerable (4) or above undergo a thorough deficit assessment (e.g. through the Frailty Index, Edmonton Scale, the RAI, or geriatric assessment, if available). • Patients will be reassessed within 6 months, and 12 months.
	3. Tailored Intervention	• Using a shared decision-making approach, older adults identified as vulnerable/frail who subsequently undergo a thorough assessment will work with the care team to develop a person-centred care plan that reflects the patient's values and goals. • The person-centred care plan may include: advance care planning, in-home support, remote coaching, nutrition counselling, etc.

HOW	4. Person and Family-Centred Care	• Personalized patient care goals and education. • Family/caregiver assessment and support
	5. Collaborative Care	• The patient and their caregiver(s) are a part of the care team and will be part of the shared decision-making process. • Implementation will involve a collaborative care approach with timely sharing of information between providers, across sectors, community supports and with patients and their family members. • Competency based education, as necessary, for providers, patients and caregivers. • Implementation of the care plan could involve a case manager who works with team members and available community supports, and may or may not involve a self-management coach.
	6. Community Supports	• The collaborative care team will reach beyond the bounds of the health system and will involve available community support services which will be documented and used as part of the Collaborative. • Self-Management coaching
Overarching Principles		Approaches
7. Quality Improvement, Change Management and Evaluation, and System Level Change		• Leveraging QI and change management approaches to ensure the rapid testing, implementation and sustainability of the interventions. • Measurement and evaluation of the work to ensure that it is making a positive impact on the identified population of older people living with frailty and their caregivers, and is used to illuminate areas for improvement and additional work.

MEASURING FOR QUALITY IMPROVEMENT

All teams will collect and submit data to reflect a set of common process, outcome, and balancing measures that align with the seven core AFCC interventions described in Figure 2 above. The core measures for the AFCC Collaborative are described broadly and present a mix of patient-reported, clinician-reported and carer-reported measures. These measures will be further operationalized based on input from teams selected to participate in the Collaborative. Selected teams will be asked to populate a measurement and data submission plan at the start of their initiative to help inform the Collaborative measurement curriculum and collective learning. In addition to the core measures that are specified in Figure 3, teams are asked to include other indicators they will use to track and measure success of their initiative.

At a minimum, measures will be collected by teams on a monthly basis and reported to CFHI on a quarterly basis. Please note that while you will be asked to follow a cohort of patients through the duration of the Collaborative to assess their frailty progression, we will NOT request or accept patient level data, and all submitted data should be anonymized and in aggregate form. Through curriculum content, tools, coaching and potential partnerships, CFHI will work with teams to support meaningful, manageable and efficient data collection, reporting and evaluation.

Figure 3. Core Measures of the AFCC Collaborative

Core Measures of the AFCC Collaborative	
Outcome Measures	
1	Change in patient frailty status/level (e.g. CFS Frailty score)
2	Caregiver burden/(di)stress
3	Patient-reported quality of life
Process Measures	
4	Number of people going through each stage of the intervention: • Number of patients identified as living with frailty (as identified with a CFS score, gait speed and hand grip strength) • Percentage of patients who consent/agree to be assessed for frailty • Number of personalized/individualized care plans developed • Number of patient and assessments completed (at baseline, 6-months and 12-months follow-up) • Number of caregiver assessments completed • Number and type of referrals to community programs or services and/or patients receiving self-management coaching (expected to be recorded in personalized care plans)
5	Number of emergency department (ED) visits and hospitalizations for targeted patients • Please note that CFHI is looking to support the capture of this data with a partner organization, and teams would not be expected to track this information themselves.*
Balancing Measures	
6	Provider (primary care providers, allied health professional, etc.) reported satistifaction with intervention
7	Patient and caregiver reported satisfaction with intervention

*If confirmed, more information will be provided on the steps needed by teams to allow this partner organization to track ED and hospital use

BENEFITS OF JOINING THE AFCC COLLABORATIVE

Teams will learn and apply patient- and caregiver-centred care, QI methodology, and measurement to ensure the rapid, successful and sustainable design and implementation of their work improving care for older Canadians with frailty, together with those who support them.

Great support when implementing such a huge change.

- Former collaborative team member

CFHI experts are hugely beneficial and necessary for this initiative. All that I have had contact with have been helpful.

- Former collaborative team member

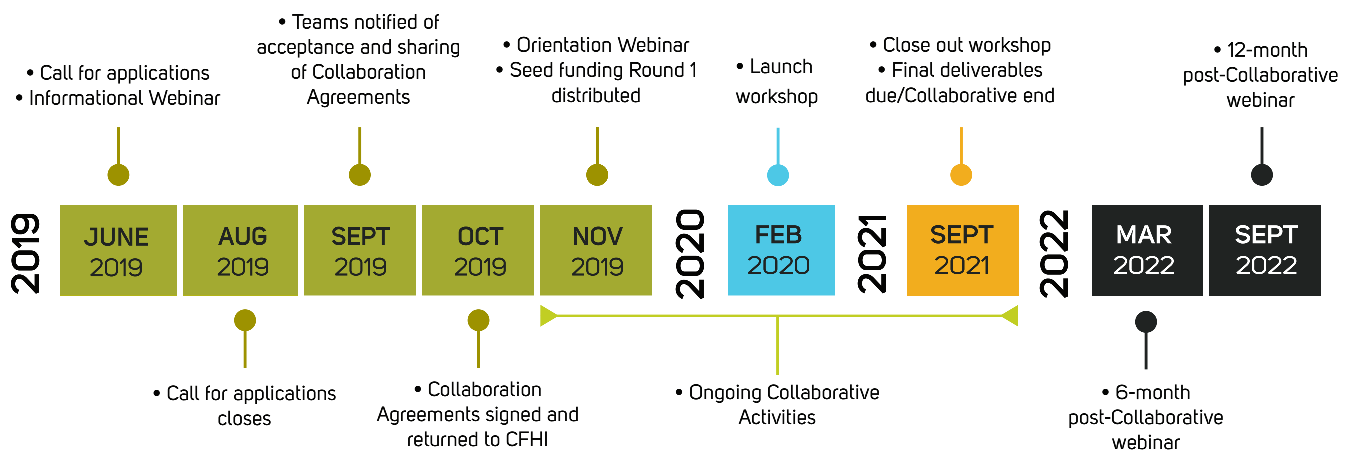
Improvement teams will also have access to a range of valuable resources including:

- **Funding support to kickstart sustainable improvement**
  - Seed funding of up to $1,000,000 shared across up to 20 teams to support implementation, based on demonstrated need and anticipated reach
- **Coaching and expert implementation guidance**
  - Access to a network of expert faculty and coaches - clinicians, administrators, patient advisors and others who are experienced in designing, implementing and evaluating frailty care services and improving quality of care
  - Optional monthly distance team coaching by expert faculty to ensure a rapid pace for testing change and troubleshooting
- **Education**
  - Flexible curriculum that's responsive to iterative learning needs of Collaborative teams
  - Webinars focused on key practice changes, patient engagement, QI, and change management
  - In-person workshop(s) to foster cross-team learning
- **Improvement methodology and tools**
  - Access to learning tools and activities through an online learning platform
- **All-teach, all-learn, adult learning environment**
  - Peer-to-peer networking and exchange across Canada
- **Measurement and evaluation guidance and tools that fosters sustainable improvement**
- **Other opportunities based on team needs and available resources,** e.g. team site visits

ACTIVITIES AND DELIVERABLES

The general structure of the AFCC Collaborative:

- **Webinars:** Regular (approximately every two months) interactive webinars, over the course of the Collaborative that delve into relevant topics on both practice change and QI to support the implementation of the work.
- **Workshops:** Two in-person workshops, attended by several members of each team for peer-to-peer learning and knowledge development (held in February 2020 and September 2021), and may additionally include site visits.
- **Coaching calls:** Between individual teams and context experts, available for each team for up to one hour per month (based on teams' need and interest) to ensure a rapid pace for testing change and to troubleshoot any barriers encountered.
- **Affinity webinars:** Webinars open to all team members focused on specific themes of interest will be held as needed and attendance will be optional.
- **Online learning tools and activities:** Available via a secure document repository.



- Content and Measurement webinars held approximately every two months.
- As needed: Coaching Calls (up to one hour per month)
- As needed: Affinity Calls

AFCC COLLABORATIVE CURRICULUM HIGHLIGHTS AND KEY DATES*

Using an adult-learning approach, the AFCC Collaborative will set teams up for success as they move from testing to implementation, and ultimately to spread of their initiative, while fostering team-building skills and a QI foundation. Curriculum topics will focus on the elements needed to allow improvements to be sustained long-term, while promoting networking and exchange within the entire Collaborative. Collaborative activities will include:

CALL FOR APPLICATIONS	Call for applications launched	June 18, 2019
	Informational webinar	June 24, 2019
	Call for applications closes	August 21, 2019
	Teams notified of acceptance and sharing of Collaboration Agreements	Week of September 30, 2019

PLANNING AND START-UP	Collaboration Agreements signed and returned to CFHI	October 28, 2019
	Orientation Webinar	November 19, 2019
	Seed funding round 1 distributed	November 21, 2019

ADAPTING, TESTING AND REFINING THE INNOVATION	Content webinars will focus on topics relevant to: • QI change management • Patient identification and frailty assessment • Interdisciplinary team support and case management • Person centred care; personalized care plans • Policy change • Planning for long-term success • Measurement and evaluation	Content and Measurement webinars held approximately every two months
		February 2020 Launch Workshop
		September 2021 Close Out Workshop
		As Needed: Coaching Calls (up to one hour per month)
		As Needed: Affinity Calls

POST-COLLABORATIVE	Final deliverables due/ collaborative end	September 2021
	6-month post-collaborative webinar	March 2022
	12-month post-collaborative webinar	September 2022

**Dates and topics subject to change. All webinars begin at noon Eastern Time*

WHO SHOULD APPLY?

Two types of improvement teams – **a network team** or **a single institution** – based in primary care will be considered for this Collaborative. A network team may include, but not be limited to regional health authorities and similar organizations; government organizations and agencies; academic health sciences centres; community hospitals; primary care practices; physician groups; and community organizations (such as Aboriginal Health Access Centres or Community Health Centres). A single institution may be, for example, a primary care practice with a large, clearly identified elderly patient population, or a network of several primary care provider practices unified by an institutional framework, or shared goal.

Applying organizations may wish to reach beyond their usual boundaries to develop multi-stakeholder partnerships. These partnerships could include healthcare organizations and groups such as social service agencies, local governments, disease-based agencies, public health departments, educational institutions, civic agencies, and non-profit or volunteer organizations focused on improving healthcare. These partners, if available, should expressly commit to participate in this work.

All applying teams should have at least 16% of their patient roster represented by those 65 years of age or older.

Additionally:

- Healthcare providers and/or organizations delivering publicly funded primary care services are encouraged to apply
- Providers in Canadian northern and/or remote communities are encouraged to apply.
- Providers in First Nations, Inuit and Métis communities are encouraged to apply.
- Applying organizations must demonstrate readiness and commitment to test, implement or scale frailty identification, assessment and management in their jurisdictions or beyond.
- Applicants must have explicit, active support from their senior leadership.
- Applicants must have a clearly defined patient population (including estimated number of patients) they wish to reach in a primary care setting through the duration of the Collaborative.

Teams accepted in the Collaborative should demonstrate they have considered how their initiative can be spread and scaled beyond their initial intervention site(s) in future and how they are or will be involving patients and family/friend caregivers as partners and integral members of their teams.

In addition to the above eligibility criteria, CFHI reserves the right to ensure the Collaborative contains teams that reflect a mix of settings, geographies and populations.

ASSEMBLE YOUR IMPROVEMENT TEAM

Teams accepted into the Collaborative will be comprised (at a minimum) of the following team members/roles (for both network and single institution teams). Please note that team members may fulfill more than one role – for example, the Team Lead and QI Advisor could be the same person – but the application should clearly show that this person has adequate time to manage multiple roles. It is recommended that the Team Lead does not also undertake the Measurement Lead role, as these are the two most demanding roles in terms of time commitment and should be carried out by two different people.

- An **Executive Sponsor –** often the CEO or senior leader in the organization – who will provide leadership and executive endorsement and support.
  - During the Collaborative, the Executive Sponsor will ensure the improvement team has regularly scheduled access to the senior executive team; protected time for the work; and support for, and active engagement in, the organizational or policy change dimensions. Senior management (including a clinical or administrative lead) will support and be accountable for the overall direction, implementation and management of the initiative.
  - Teams should report to their Executive Sponsor on at least a quarterly basis, and the Executive Sponsor is welcome and encouraged to join Collaborative activities.
- A **Team Lead** (or co-leads) who can demonstrate the allocated time, resources and accountability to:
  - Coordinate and oversee the day-to-day activities of development and execution of the project implementation.
  - Be the key coordinator and motivator of the team. This person is often a project manager, rather than a care provider. Care providers interested in being a team lead, are encouraged to consider co-leading with a non-care provider to ensure adequate balance between their daily work role and the team lead role for the Collaborative.
  - Plan for and provide guidance and oversight of the initiative to ensure milestones are met.
  - Serve as main point of contact for CFHI and the Executive Sponsor.
  - Be accountable for the design, implementation, and evaluation of the initiative.
  - Be responsible for all internal network communications (e.g., internal updates).
  - Ensure regular and ongoing communication with staff, patients, caregivers and relevant committees/councils.
  - Lead and coordinate necessary activities with staff, leadership, patients and caregivers.
- A **Patient and/or Family/Friend Caregiver Advisor** who has experience and expertise as a service-user or supporting a service user within the healthcare organization and who will advise the team on patient-centred approaches to care, including patient co-design. Patient and family/friend caregiver advisors will be integral members of the improvement team – attending meetings, identifying needs and solutions, testing ideas, and evaluating outcomes. As well, this role may service as a liaison between the initiative and other patients and caregivers/councils within the organizations and support broader engagement practices throughout the initiative.

- An **Evaluation and Measurement Lead** who will support the tracking of results over time. Common definitions and indicators will be used across teams, informed by Evaluation and Measurement Leads, who will also supply anonymized data at baseline, throughout and post-Collaborative to allow for progress reporting and sharing across sites as required.
- A **Primary Care Provider Champion,** who will be or work with the Team Lead, provide practical support and feedback on the intervention, and ensure the primary care provider perspective is considered throughout, including alignment with the Patient's Medical Home model.
- An **Allied Health Champion,** who will work with the Team Lead, provide practical support and feedback on the intervention, and ensure the Allied Health perspective is considered throughout the improvement project.

Teams are encouraged to consider additional team members with expertise in the following roles, or having such people available for as-needed consultation:

- A **Quality Improvement Advisor** with knowledge, skills and experience in applying QI methodology and supporting teams on improvement initiatives.
- **Broader community organizations** (e.g., community pharmacy, seniors' organizations) **and/or a Local Region Advisor,** to ensure the broader context, and all available support services (within the facility and community) and leveraged and engaged by the team.
- **Information Technology Advisor**, if the team is altering existing technology platforms (e.g. to include a new assessment scale) this person would provide technical support and guidance to the team. Depending on the complexity of the change, this person may need to be a core team member.
- **Policy (e.g., Payer) Advisor,** to ensure that the administrative/payment perspective is integrated into the work, and to provide financial guidance to the team as necessary.

ETHICS

It is the responsibility of each organization applying to participate in the AFCC Collaborative to determine if ethics approval from a research ethics board is required. Organizations should identify if the nature of the improvement project will require ethics board approval at the application stage. If applicable, plans to attain ethics approval must be described and factored into the timeline of the proposed improvement project. Tri-Council Policy Statement (TCPS2) governs requirements pertaining to research ethics in Canada, distinguishes quality improvement and research, and advises when seeking ethics approval is required. Article 2.5: "Quality assurance and quality improvement studies, program evaluation activities, and performance reviews, or testing within normal educational requirements when used exclusively for assessment, management or improvement purposes, do not constitute research for the purposes of this Policy, and do not fall within the scope of [research ethics board] review." For more information, please consult the Tri-Council Policy Statement : Ethical Conduct for Research Involving Humans (2014), the Tri-Agency Framework: Responsible Conduct of Research (2016), TCPS: Section 6: Research Involving Aboriginal Peoples and First Nations Principles of OCAP™ (ownership, control, access, and possession).

CONFLICT OF INTEREST

By completing the expression of commitment, the organization and team members confirm that they have reviewed and understood CFHI's Conflict of Interest Policy, including the rules regarding the eligibility of CFHI employees, directors, registrants and agents. Organizations from which any members of CFHI's Board of Directors, or Foundation agents or employees, receive remuneration are eligible to apply to this competition. Applicants must fully disclose any relationship with current members of CFHI's Board of Directors.

COLLABORATION AGREEMENT

Organizations invited to join the AFCC Collaborative will be asked to sign a Collaboration Agreement (CA). The CA outlines the program's commitments and expectations. Further details about the CA will be provided to teams requesting an application form. Ongoing funding will be dependent on active participation and meeting co-designed objectives throughout the Collaborative.

CONSENT TO USE FRAILTY IDENTIFICATION TOOLS

If teams select to use the Clinical Frailty Scale, it is publicly available for not-for-profit use and requires the signing of a user agreement. This agreement can be provided by and returned to Sharri Fay at Sherri.Fay@nshealth.ca at Dalhousie University and the Nova Scotia Health Authority.

If teams choose to implement C5-75, please note that this tool is copyrighted. If used, the copyright must be acknowledged. If any changes are made to the tool, teams must work with Linda Lee and Tejal Patel to gain permission to revise. Please contact Lindsay Donaldson, Research and Evaluation Manager, Centre for Family Medicine Family Heath Team at Lindsay.donaldson@family-medicine.ca to receive the acknowledgment and the tool.

HOW TO APPLY

STEP 1: Read the AFCC Call for Applications and attend the Informational Webinar on the AFCC Collaborative.

Informational Webinar: Learn more about the AFCC Collaborative at our informational webinar on June 24, 2019 from 12:00 - 1:00 p.m. ET. Recording of the webinar will be available on CFHI's website following.

STEP 2: Email Christine (Kirby) Kirvan at christine.kirvan@cfhi-fcass.ca to request an application form. Teams can also request a free coaching call with CFHI staff before submitting their application.

STEP 3: Submit a completed application no later than August 21, 2019 (11:59 p.m. ET) to christine.kirvan@cfhi-fcass.ca. Applications may be submitted in English or in French.

CONTACT

For more information about the AFCC Collaborative, or if you have additional questions, please email:

Christine (Kirby) Kirvan
Improvement Lead, CFHI
christine.kirvan@cfhi-fcass.ca

REFERENCES

1. Canadian Frailty Network. (n.d.). Frailty Matters. Retrieved from https://www.cfn-nce.ca/frailty-matters/

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. Canadian Institute for Health Information. (n.d.). Health spending. Retrieved from https://www.cihi.ca/en/health-spending

6. CBC News. (2019). Could New Brunswick adopt P.E.I. program that keeps 'frail seniors' at home longer? Retrieved from https://www.cbc.ca/news/canada/new-brunswick/coach-program-pei-senior-care-overcrowded-hospitals-1.4975908

7. Dalhousie University. (n.d.). Clinical Frailty Scale. Retrieved from https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html

8. Lee, L., Patel, T., Costa, A., Bryce, E., Hillier, L. M., Slonim, K., Molnar, F. (2017). Screening for frailty in primary care: Accuracy of gait speed and hand-grip strength. Canadian family physician Medecin de famille canadien, 63(1), e51–e57.