ADVANCING FRAILTY CARE IN THE COMMUNITY COLLABORATIVE

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

A 23-month Quality Improvement Collaborative

PARTICIPATING TEAMS

Canadian Foundation for Healthcare Improvement
Fondation canadienne pour l'amélioration des services de santé

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) improves the care of older adults living with frailty and supports their families and caregivers. We 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.

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VANCOUVER ISLAND HEALTH AUTHORITY, BC

Lead Organization	Island Health
Target Population and Scope	Patients over 75 years of age with a frailty score of 4-6 on the Clinical Frailty Scale (CFS).

The Ladysmith Family Practice Clinic – Frailty Linkages and Improved Outcomes for Seniors

Island Health aims to implement the Fraser Health CARES model into the Ladysmith Family Practice Clinic, with the intention that in the future this process will be scaled out the model in other Patient Medical Homes in the Cowichan area of Vancouver Island. An in-practice nurse will work with the primary care team to perform a new standardized electronic comprehensive geriatric assessment (eGCA) for adults over 75 years of age who score 4-6 on the CFS. The eCGA will produce an electronic frailty index. Each patient and their chosen caregivers (e.g. family or friend) will then co-develop their plan of care related to their goals of care with their primary care clinician.

FRASER HEALTH AUTHORITY, ABORIGINAL HEALTH, BC

Lead Organization	Fraser Health, Indigenous (First Nations, Inuit, and Métis) Health
Partner Organization	Fraser Region Aboriginal Friendship Center Association
Target Population and Scope	Those who are 65 years of age or older and are eligible for frailty screening and self-identify as First Nations, Inuit, and Métis.

This team intends to connect Indigenous patients who are 65 years of age (or older) to culturally safe community-based interventions and provide tools to allow them to continue to self-manage their health after the program. This project will utilize a holistic approach in care plan development for First Nations, Inuit, and Métis elders which will include spiritual, emotional, mental, physical, and traditional approaches as evidenced by an inclusion care plan.

FRASER HEALTH AUTHORITY, BURNABY, BC

Lead Organization	Fraser Health Authority, Burnaby Division of Family Practice
Partner Organization	Burnaby NGOs
Target Population and Scope	Patients 75 years of age or older will be systematically screened for frailty and those who score 4-6 on the Clinical Frailty Scale (CFS) will complete a comprehensive geriatric assessment. Adults over 65 years of age are screened for frailty if clinical signs and symptoms warrant.

Improving Frailty Status in Seniors in the Burnaby Community

Utilizing the CARES model and EMR based electronic Comprehensive Geriatric Assessment (efi-CGA) tool, this project will support multidisciplinary care planning and Social Prescribing through integration and collaboration between the primary care provider, Fraser Health Authority CARES LPN, and a Senior Community Connector, who will provide tailored interventions to minimize and prevent social isolation. Patients will be followed by their Primary Care Provider and supported in their self-management goals throughout the program so they will be able to better maintain or improve their frailty status (measured by CFS and the frailty index).

FRASER HEALTH AUTHORITY, JIM PATTISON, BC

Lead Organization	Fraser Health Authority, Primary Care Clinic, Jim Pattison Outpatient Care and Surgery Centre
Partner Organization	Non-Governmental Organization (NGO)
Target Population and Scope	Patients 75 years of age or older who score between 3-6 on the Clinical Frailty Scale (CFS). Adults 65-75 years of age will also be assessed for frailty if clinical signs and symptoms warrant it.

Advancing Frailty Care in the Community Collaborative

Jim Pattison Fraser Health Authority seeks to test and adapt the CARES model of frailty care. Qualifying participants will undergo a Comprehensive Geriatric Assessment by a designated Licensed Practical Nurse. Tailored interventions, developed in collaboration with patients and significant others, will be supported by a senior community connector, a multi-disciplinary team, and an NGO still to be determined.

ALBERTA HEALTH SERVICES-NORTH ZONE, AB

Lead Organization	Seniors Health, North Zone, Alberta Health Services
Target Population and Scope	Home Care clients with a risk for frailty (score of > 4 on the Clinical Frailty Scale (CFS)).

INPACT (Implementation of a Nurse Practitioner Assess, Consult and Treat) model in AHS NZ

Drawing on the learnings from the COACH PEI Innovation and their use of nurse practitioners (NP) in the community setting, AHS North Zone continuing care programs are implementing new nurse practitioner roles who can facilitate a collaborative approach, and client/family specific care planning / interventions, that can enhance frailty care in the home and designated supportive living settings. Interventions can leverage informal and other community-based resources, helping clients to remain living in their community setting. It is anticipated that NPs will be a valuable resource toward improving patient outcomes, patient satisfaction, and supporting care teams in the provision of safe and quality patient care.

SAGE SENIORS ASSOCIATION, AB

Lead Organization	Sage Seniors Association in Collaboration with Athabasca University
Partner Organization	Sage Seniors Association, Edmonton; Edmonton Oliver Primary Care Network, Seniors' Community Hub; and Glenrose Rehabilitation Hospital
Target Population and Scope	All patients 65 years and older who score 4-6 on the Clinical Frailty Scale (CFS).

BuilDing Resilience And RespondinG tO SeNior FraiLtY (DRAGONFLY)

Sage Seniors will use a modified version of the Seniors Community Hub intervention and existing systems in place to address three core elements of practice change: frailty identification, geriatric assessment and tailored intervention. Using a combination of both the CFS and Vulnerability/ Resiliency assessment, this project will identify opportunities for interventions that will seek to decrease vulnerability and increase resilience. After the tailored intervention(s) are implemented, the primary care providers will reassess the patient's CFS score at three, six and 12 months.

SOUTHERN ALBERTA HIV CLINIC, ALBERTA HEALTH SERVICES, AB

Lead Organization	Alberta Health Services
Partner Organization	Southern Alberta HIV Clinic, Sheldon M. Chumir Health Center, Kerby Centre and HIV Community Link, Calgary, Alberta
Target Population and Scope	Patients 50 years and older, living with HIV and receiving HIV care at the Southern Alberta HIV Clinic.

Platinum Navigation: A Clinical Care Pathway for Frail Older Adults Living with HIV

The Southern Alberta Clinic will implement a clinical care pathway for frail, older adults living with HIV to implement routine, annual frailty assessments for all patients 50 years and older. Patients will be assessed at each visit using the Clinical Frailty Scale (CFS) with those identified as vulnerable/frail by a score of 4 or above being further assessed for conditions commonly associated with frailty. The project will also focus on improvements in quality of life; caregiver burden; falls and impaired gait or balance; medication review including number and type of non-antiretroviral medications; unintentional weight loss; loneliness; and subjective cognitive decline.

THE ALEX (ALEXANDRA COMMUNITY HEALTH CENTRE), AB

Lead Organization	The Alex (Alexandra Community Health Centre)
Partner Organization	Calgary West Central Primary Care Network and Carya (formerly Calgary Family Services)
Target Population and Scope	Patients of the Alex Seniors Health Center who are aged 65 years and older and score 4 or above on the Clinical Frailty Scale (CFS).

Screening for Frailty in Low-income, Socially-isolated Older Adults with Complex Health Conditions ("Frailty Project")

The Alex Community Health Centre includes a Seniors Health Centre that provides comprehensive health and social care to low-income, socially-isolated seniors with complex health issues. The Frailty Project will determine if assessing low-income, socially-isolated seniors for frailty helps to ensure that they receive additional health and social services and if such services improve self-reported health, quality of life, and social isolation. For patients scoring 4 or above on the CFS, a referral will be offered to allied health professionals, health specialists, and/or social programming provided by the Alex or by partner agencies. Assessment tools for frailty, self-reported health, social isolation, and quality of life will be incorporated in to the Alex's social database system to link patients with health and social services.

SASKATCHEWAN HEALTH AUTHORITY, SK

Lead Organization	Primary Health Care Network 5 – Saskatchewan Health Authority
Partnering Organizations	Cypress Regional Hospital – Swift Current and Associate Family Physicians Clinic
Target Population and Scope	Patients 75 years and older identified through: Wellness Clinics Home Care – Swift Current, Associate Family Physicians Clinic, and other program areas as possible (e.g., Therapies, Home Care).

Frailty Assessment by Collaborative Teams in SHA Network 5 (FACT-5) - Assessment and Management of Frail Older Adults in Swift Current, Saskatchewan

This project combines features of the CARES model and C5-75 Programs and takes an interdisciplinary, team based, patient- and family-centered approach. Level 1 screening will be offered to older adults attending any Swift Current Wellness Clinic who identify as having a physician at Associate Family Physicians. In addition, screening will be offered through the physician clinic, as well as through other program areas that have capacity (i.e. Home Care, Therapies). If the patient screens positive, a level 2 assessment at a separate scheduled visit will be recommended. If the patient screens negative, they will still be offered preventative educational materials and information on resources in the community.

WINNIPEG REGIONAL HEALTH AUTHORITY, MB

Lead Organization	Winnipeg Regional Health Authority (WRHA)
Partnering Organizations	WRHA Integrated Palliative, Primary and Home Health Services, Elemental Professional Health Centre – Fee for Service Physician at 1600 Pembina Highway Winnipeg, ACCESS Fort Garry – WRHA Primary Care Clinic, WRHA Rehabilitation, Healthy Aging & Seniors Care, A & O: Support Services for Older Adults, Shared Health, Interlake Eastern Regional Health Authority, and Patient and Caregiver Advisors
Target Population and Scope	Patients of Elemental Clinic and Access Fort Garry who are 65 years and older and live within the WRHA region.

Addressing Frailty with Community Collaborative Teams

Adapting the CARES Model, WRHA will have two primary care sites (Elemental Clinic and ACCESS Fort Gary) that will use electronic medical records (EMR) to identify adults 65 years and older to be screen for frailty. Primary care providers will use the Clinical Frailty Scale (CFS) to assess the level of frailty. Individuals scoring 1-3 on the CFS will not undergo further assessment but will inform discussion around health promotion and illness prevention. Individuals scoring 4-6 on the CFS will have further assessment using the Edmonton Frailty Scale to identify domains of frailty that may require additional community supports. Those with high scores 7-9 may be directed to Geriatric Program Assessment Team, the geriatric clinic, or other regional supports such as palliative care for comprehensive assessment. Based on the assessment and the patient's goals, the primary care team, patient and caregivers will jointly develop a personalized care plan as well as help to connect clients to appropriate resources.

CENTRE FOR FAMILY MEDICINE, ON

Lead Organization	Centre for Family Medicine Family Health Team
Partnering Organizations	Canadian Mental Health Association Waterloo Wellington, Schlegel Research Institute for Aging, and Waterloo-Wellington Specialized Geriatric Services
Target Population and Scope	The Centre for Family Medicine will include all persons being assessed in four Multi-specialty INterprofessional Team (MINT) Memory Clinics within the project timeframe who are 65 years of age and older who consent to participate.

Expanding C5-75: Primary Care Screening for Frailty in Older Adults with Cognitive Impairment

The Centre for Family Medicine will extend the C5-75 program to systematically screen for frailty in older adults who have memory concerns. Dementia reduces the person's ability to self-manage co-existing chronic conditions; the ability to self-manage is key to maintaining the stability of conditions such as heart failure, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and falls. Early identification of frailty in people who are cognitively impaired offers the opportunity to identify those at the highest risk of poor outcomes and target pro-active primary care interventions accordingly. Therefore, this project will adapt and integrate the C5-75 program into 4 Multi-specialty INterprofessional Team (MINT) Memory Clinics.

NEW VISION FAMILY HEALTH TEAM, ON

Lead Organization	New Vision Family Health Team
Partnering Organizations	eHealth Centre for Excellence, Waterloo Wellington Local Health Integration Network, Grand River Hospital, St. Mary's General Hospital, Canadian Mental Health Association Waterloo Wellington, and Specialized Geriatric Services IGSW program
Target Population and Scope	All senior patients of the New Vision Family Health Team aged 65 years and older.

Enhanced Complex Care Program

New Vision Family Health Team will use a shared care program led by nurse practitioners who will work with nurses, a clinical pharmacist, the patient's family doctor and a geriatrician. Case finding will be done using the Assessment Urgency Algorithm with those identified undergoing an assessment that is based on the Canadian Geriatric Society 5M approach, with the program acting as the main point of access to primary care. The team will also be working to standardize the comprehensive assessment by using the interRAI Self-reported Check Up instrument. The project seeks to improve patient-centered outcomes and reduce health service use for frailty primary care patients with multiple complex chronic conditions and geriatric syndrome. The project also seeks to strengthen community partnerships, including home care and community services and hospitals to improve care transitions, EMS to promote appropriate ER diversion, and promote eConsults by Specialists.

CHAMPLAIN CARE NETWORK, ON

Lead Organization	Bruyère Research Institute and the Department of Family Medicine, University of Ottawa
Partnering Organizations	Bruyère Continuing Care, Bruyère Research Institute, The Ottawa Hospital Research Institute, Hôpital Montfort, Ontario eConsult Centre of Excellence, Ottawa Practice Enhancement Network (OPEN), Ottawa Public Health, Perley and Rideau Veterans' Health Centre, Regional Geriatrics Program of Eastern Ontario, The Ottawa Hospital, The Ottawa Hospital, The Ottawa Hospital, Riverside, University of Ottawa, Winchester District Memorial Hospital
Target Population and Scope	Each pilot clinic will identify its own target population and scope.

Champlain Care Network Frailty Collaborative

Hosted by the University of Ottawa Department of Family Medicine and Bruyère Research Institute, a network of partnering organizations will act as a hub, overseeing improvement projects in four pilot clinics (Family First Health Team, Greenboro Family Medicine Centre, Centretown Community Health Centre, and Somerset West Community Health Centre) and support the staggered roll out in the other clinics. Each pilot clinic will develop an improvement project that meets the needs of their patient population – the screening tools, geriatric assessments and interventions will all be based on the needs, preferences and resources of the individual clinics. The network will provide opportunities for the clinics to exchange experiences to keep learning and informing implementation through Plan, Do, Study, Act (PDSA) cycles. The network will also facilitate meetings with the participating clinics in order to the develop recommendations for a common approach for frailty assessment and interventions.

WAWA FAMILY HEALTH TEAM, ON

Lead Organization	Wawa Family Health Team (WFHT)
Partnering Organizations	Wawa Senior Goose Club Drop-in Centre, Fenlon's Pharmacy, Canadian Red Cross, Alzheimer's Society, Home and Community Care North East Local Health Integration Network, and Lady Dunn Health Centre
Target Population and Scope	All rostered patients 75 years and older.

Helping Hands Here for You

Using a combination of Frailty or "Wellness" screening (based on COACH model) and the C5-75 hand grip and gait speed measurement system we are going to screen our patients 75 years and older. The providers will assess each patient seen and will ask where the patient feels their initial assessment scoring is. The patients within the 4-6 or vulnerable to moderately frail will be referred on for the quantitate screen by additional WFHT staff.

All patients and caregivers will be connected to available services and resources in their community to assist them in remaining in their homes longer and improve their quality of life.

Past the project completion, early identification will become standard practice within our clinic.

GATEWAY COMMUNITY HEALTH CENTRE, ON

Lead Organization	Gateway Community Health Centre
Partnering Organizations	Canadian Association of Community Health Centres
Target Population and Scope	Gateway Community Health Centre rostered patients 65 years and older for screening. Patients who score 4-6 on the Clinical Frailty Scale (CFS) will be eligible for system navigation.

System Navigation as a Primary Care Model for Improving Care for Older People with Frailty and Supporting their Family/Friend Caregivers

Gateway's proposed initiative will build on Gateway Community Health Centre's (GCHC) System Navigation Model to advance frailty identification and assessment and improve outcomes. System navigation offers a single point of contact addressing medical and social needs for the patient and family reducing duplication of services. The system navigator (SN) supports frail patients through a Coordinated Care Plan (CCP). The development of the CCP with the SN is through the patient's perspective, to identify their personal health and wellbeing goals and priorities. The SNs are bringing care for patients closer to home, by providing the right care at the right time, in the right place. GCHC will also implement the caregiver strain index for patients who have support through a caregiver. The project will allow GCHC to leverage quality improvement and change management approaches.

EXTRA-MURAL PROGRAM, NB

Lead Organization	EM/ANB
Partnering Organizations	Medavie Health Services New Brunswick, Horizon Health Network – McAdam Health Centre and Saint Mary's Health Centre.
Target Population and Scope	Patients 65 years and older who: • Have a high level of suspicion of frailty (for example, unintentional weight loss, incontinence, delirium, dementia, declining functional status, immobility, recent falls, polypharmacy, social isolation and caregiver stress) and are identified through a case finding approach. Patients are then screened for frailty using the Clinical Frailty Scale (CFS). • Are high users of the system – current EMP patients who visit the ED ≥ 3 visits a quarter and ≥3 hospitalizations a year

FRAILTY NB

The Extra-Mural Program (EMP) team will enhance capacity to partner with primary care providers, patients and caregivers in the primary care setting to apply evidence-based innovations (specifically the C5-75 and COACH tools) as well as a comprehensive frailty assessment in populations 65 years and older with a confirmed CFS of 6 or above.

The key innovation the team has put in place is an RN Case Manager for patients identified as at risk for poor outcomes based on frailty. Patients scoring 6 or above on the CFS would be eligible for the RN Case Manager intervention.

WESTERN – EASTERN HEALTH, NL

Lead Organization	Western Health
Partnering Organizations	Eastern Health (also piloting the project) and Central Health
Target Population and Scope	Patients 65 years and older who screen 4-6 on the Clinical Frailty Scale (CFS) and consent to a referral to the Community Support Program.

Frail Older Adult Community Care Initiative (FOCI)

Western Health's project is focused on four clinics located in the Eastern Health and Western Health authority regions. Screening will be conducted by a License Practical Nurse (LPN) who will administer the CFS to patients aged 65 years and older. Patients who score 4-6 on the CFS will be referred to the Community Support Program (CSP). After referral, patients will receive a comprehensive assessment via the RAI-HC by a case manager in consultation with a social worker. Care planning will engage other interdisciplinary team members as appropriate including physiotherapy, occupational therapy, pharmacy, recreation therapy as well as the patient and caregiver.