INNOVATION PROFILE

COMMUNITY ACTION AND RESOURCES EMPOWERING SENIORS (CARES) PROGRAM

FRASER HEALTH AUTHORITY, BC

CARES

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Better health. Best in health care.

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

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. CFN does 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.

OVERVIEW

The Community Actions and Resources Empowering Seniors (CARES) is a primary healthcare, upstream intervention intended to decrease the downstream impact of frailty on acute care and emergency resources. Using a phased approach, CARES combines regular assessments by primary care providers with wellness coaching from trained volunteers. The aim is to support seniors to age well and live a higher quality of life within their community for longer.

CARES was established in 2014 as an inter-provincial initiative between Fraser Health Authority, Nova Scotia Health Authority and Shannex Inc. through the Canadian Foundation for Healthcare Improvement's EXTRA Executive Training Program. The project focused on supporting patients in assisted living. Following EXTRA, Fraser Health Authority continued building on the CARES program with a focus on the primary care setting. Fraser Health Authority partnered with electronic medical records (EMR) providers Intrahealth Canada Ltd., Telus Health Wolf EMR and Divisions of Family Practice, to further enhance the CARES program – introducing as a part of routine care – an Electronic Frailty Index Comprehensive Geriatric Assessment (eFI-CGA) tool that measures the frailty index through ongoing periodic geriatric assessments.

The CARES program, specifically the Self-Management Health Coach program, is an established partnership between primary care and community partners developed and implemented by the University of Victoria, Institute on Aging and Lifelong Health. Funded by BC's Ministry of Health, the program is free. Based on successful models of social prescribing in the UK, and in partnership with the United Way, CARES recently introduced a new community support service for seniors. This new service is being trialed in three communities and involves general practitioners (GPs) and nurse practitioners (NPs) being able to prescribe for at-risk seniors, access to a "Seniors' Community Connector" resource. This social prescribing "Seniors' Community Connector" resource position supports seniors to better identify and connect with local resources. The Seniors' Community Connector is situated in non-profit community seniors' resource centres and is free to all seniors. United Way funding has allowed the creation of a Seniors' Community Connector in all Fraser Health Authority communities and will continue over the next three years (2019-2022).

TARGET GROUP FOR THE INNOVATION

- **People aged 65-85 years (and by exception):**
  - Living at home or in assisted living within the catchment community with a Rockwood Clinical Frailty Scale (CFS) score between 3 (Managing Well) to 6 (Moderately Frail)
  - Emerging chronic health issues or other risk factors for frailty (e.g., COPD, dementia, chronic heart failure)
  - Recent event (e.g., a fall, hospitalization, social event) decreasing the risk for the senior to remain independent.

TRAINING REQUIRED TO SUPPORT THE PROGRAM

The CARES team and their associated group of experts provide in-person training to GPs and NPs on the advantages of early frailty identification and the value of care planning that utilizes community-based resources to enhance the senior's self-management capacity. Training also addresses the value of using an evidenced-based tool, such as the eFI-CGA, to identify the frailty index and frailty risk of seniors. Clinicians are educated on how to use the eFI-CGA tool and its benefits to care planning. Lastly, primary care clinics are educated in social prescribing models and how to connect with free health coaches and Seniors' Community Connectors in their communities. CARES has also produced multiple video resources for both patient and clinician education on the CARES model and has published several articles on the CARES model.

APPROACHES TO INTERVENTIONS

Intervention	Approaches
1. Frailty Identification	• Primary care practitioners (PCPs) who are engaged in the CARES program identify clients through active case finding. • Those screened who score between 3 and 6 on the CFS and who are deemed "at risk" by the PCP during an office visit or other trigger to the PCP, then complete a geriatric assessment. **Time to complete screening:** 5 minutes. **Method of documentation:** The CFS is completed and entered in an EMR. **Resources:** The Rockwood CFS tool. **Licensing:** The CFS is publicly available in English for not-for-profit organizations' use and requires the signing of a user agreement. **Providers Involved:** PCP, NP, primary care team in clinic or in Primary Care Network.
2. Geriatric Assessment	• Those who score between 3 and 6 on the CFS and are identified as "at risk" are then booked for a subsequent visit for a geriatric assessment by a multidisciplinary primary care team (Physician, NP, office registered nurse/licensed practical nurse). • The assessment tool used by CARES is a CARES-developed electronic Frailty Index based on the Comprehensive Geriatric Assessment (CGA) – this tool is known as the eFI-CGA and replaces the paper-based assessment form, automatically calculating a frailty index, a sensitive and predictive measurement of frailty, never before made available to care providers in their office settings. The primary care physician clicks a button to populate the CGA with patient information, completes the assessment and then, with another click, generates a frailty index.[2]

	2. Geriatric Assessment	**Time to complete the eFI-CGA:** 30 minutes. **Method of documentation:** The eFI-CGA is integrated in the EMR and recorded therein. **Resources:** A computer with the eFI-CGA embedded in it. **Licensing:** The eFI-CGA is publicly available in English. Providers Involved: PCP and NP (and in some communities, Fraser Health Authority allied health professionals within the primary care network).
	3. Tailored Intervention	• Based on the results of the eFI-CGA, the PCP and client, together, determine a wellness plan that supports the senior's self-management of care. • A key component of the CARES program is the PCP's referral of their clients to either the Self-Management Health Coach Program, a phone-based coaching service offered by a partner organization (Self-Management BC) or to a free community-based Seniors' Community Connector program situated in a local senior's centre. • In the Self-Management Health Coach program, seniors are matched with trained volunteer community health coaches and engage in weekly 30-minute telephone conversations with them over three to six months. During this period, the provision of support and implementation of coaching strategies enhance the senior's self-management capacity and adoption of health protective behaviours, such as engaging in exercise and healthy eating. • In the Seniors' Community Connector program, seniors are matched with a community navigator who can introduce them to resources in their community that will enhance their health. The community navigator also supports seniors in staying engaged with the resources over time.
	4. Person and Family-Centred Care	• A summary of the eFI-CGA result is shared with the patient to make them aware of their status and to help inform discussions around the patient's wellness plan. • Some communities have a dedicated program that supports family members in providing care which can be accessed during intake/assessment by the seniors community navigator.
	5. Collaborative Care	• CARES assists with frailty education of physicians and their adoption of the eFI-CGA into their EMRs. The eFI-CGA is available to any care provider using the Intrahealth Profile or the Telus Health Wolf EMR System. This tool provides an increased geriatric competency for primary care providers (physician or NP) and ideally situates them to incorporate proactive and best practices into their daily clinical work.[3] • PCPs also have access to CARES' visiting NPs and Fraser Health Authority's allied health professionals to assist with geriatric health assessments and data entry (e.g. Montreal Cognitive Assessment, Mini-Cog, Five Times Sit to Stand Test).

	6. Community Supports	• Frailty assessment is best completed in a team-based setting with a strategic connection of PCPs to community programs. • Frailty assessment results are used to create a patient wellness plan to identify goals most important to the patient that will enhance their health and quality of life.[4] • A telephone-based health coach is paired with the patient to track their progress over three to six months, developing the senior's self-management capacity while providing education and facilitating connections to resources in the community. At the end of the six months, the assessment is repeated and compared to baseline. • In addition to coaching through the Self-Management Health Coach Program, CARES has also partnered with the United Way to situate a designated expert in each of the Fraser Health Authority communities to act as a senior's community navigator, to link seniors with relevant community programs and supports. • The health coach will monitor the patient's ability to self-manage and if necessary, will continue supporting them in remaining connected to community resources.
Overarching Principles		Approaches
7.	Quality Improvement, Change Management and Evaluation, and System Level Change	• The CARES team used their project to test the reliability and validity of the eFI-CGA tool for early frailty assessment in seniors in primary, community and residential care settings. • Electronic versions of the comprehensive geriatric assessment enable health providers to enter data and obtain a calculated frailty index score at the time and point of care. As an added benefit, patients can view their scores. • The CARES program includes clinicians, scientists with expertise in aging and frailty, statistical and database scientists, clinical knowledge users, patient representatives and decision makers. Access to existing datasets in their health information systems allows for the calculation of the eFI-CGA scores for seniors in different healthcare settings (e.g. primary, residential and acute care). CARES analyzes retrospective and prospective datasets in order to map and test the psychometric properties of the eFI-CGA tool.

OUTCOMES ACHIEVED

The CARES program has achieved beneficial results in all four Quadruple Aim areas:

✔ Seniors age well and risk for frailty decreases	✔ Reduce acute care and emergency department utilization
✔ Enhance patient and caregiver experience	✔ Enhanced health care provider experience

CARES demonstrates that the progression of frailty in seniors can be proactively delayed with proper assessment and care planning. The physical health of at-risk seniors for frailty can be improved through active coaching which supports improved access to exercise, nutrition and social engagement resources. Over the six-month period, CARES helped increase physical activity in pre-frail seniors (e.g. 30% increase in walking independently and 67% increase in exercising frequently). Seniors also reported considerable improvements in their well-being and quality of life (e.g. 59% reported an increase in their health attitude and 11% increase in feeling socially engaged). Analysis found there was a statistically significant decrease in the seniors' frailty index scores. On average, the seniors' frailty index score from the baseline CGA to the six-month post-CGA decreased by 3%, which is equivalent to having two fewer health deficits in their profiles. Additionally, 38% of participants had an improved frailty status at the six-month assessments.

Benefits to physicians and NPs include:

✔ Enhanced access to frailty education	✔ Improved sensitivity in measurement of frailty with access to CGA and Frailty Index
✔ Having an evidence-based frailty assessment tool in EMRs	✔ Ability to track and monitor frailty over time with Frailty Index, and in-office support of RN/Clinical Nurse Specialist to complete the eFI-CGA and assist with care planning

LESSONS LEARNED

- Embedding the CGA into electronic medical records with the ability to calculate eFI-CGA scores at point of service may be more efficient to primary care teams, more effective for tracking and evaluation, and more feasible than paper-based CGAs. At Fraser Health Authority, the CGA is now included in the electronic medical records, allowing general practitioners who participate in the CARES program to access the eFI-CGA scores of their patients at point of service. Future studies need to test whether this could lead to improved care for seniors.
- Completing the CGA using a multi-disciplinary approach provides a great opportunity to address comprehensive patient care and coaching through team-based care in primary care settings.
- Health coaching works best for motivated patients interested in learning more about their healthcare management, as well as those interested in assuming more responsibility in the management of their care. Coaching is not as well suited for non-motivated patients.

- Patients may be frailer, as assessed by the eFI-CGA, than their primary care providers think.
- CARES has demonstrated that it is feasible to assess frailty in community-dwelling older adults using both an eFI-CGA and a CFS, and that the implemented interventions might mitigate the adverse effects of frailty. Analysis of the CARES initiative showed that the eFI-CGA was more responsive to changes - compared to the CFS, and that the program worked best for patients with higher frailty scores. Even so, other factors, such as age and gender, did not seem to be important with respect to who might demonstrate a better response to CARES interventions.

SELECT RESOURCES ON THE CARES INNOVATION:

- CARES Professional Resource
- CARES Program CFN Award and Story Board
- CARES featured in the Vancouver Sun's Conversations that Matter
- Published article in Medical & Clinical Reviews: *Using an Electronic Comprehensive Geriatric Assessment and Health Coaching to Prevent Frailty in Primary Care: The CARES Model*

REFERENCES

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