ADVANCING THE HEALTH OF OLDER ADULTS IN PRIMARY CARE
The issue
FRAILTY...

• State of Increased Vulnerability to Stressors
• Multidimensional Syndrome
• Predicts Risk for Adverse Outcomes (disability, hospital/ER visits, and death)
• Higher Prevalence in Older ages, Women, and those with Lower SES
• Late presentation of frailty to acute care services
• Fragmentation of care
  - Difficulty navigating
  - Caregiver burnout
  - Long wait times for referrals
• Increased complexity and polypharmacy
• Underutilized Primary Care Network resources
• No standards of practice for frailty identification & management in primary care
Our solution
Integrated Model of Care

Re-Design Care

- Hospital centric → Community based
- Reactive → Proactive, preventative
- Disease oriented → Capacity focused

70-80% of people with long-term conditions

More complex cases

High Risk Cases

High proportion of professional care

Equally shared care

High proportion of self care “guided self care”
Inspire Healthy Aging

Holistic approach to addressing the dynamic needs of those living with frailty & supporting their caregivers
Build on Prior Investment

Disease Management & Nursing
- Chronic Disease Mgmt
- INR & Injections
- Prenatal Nursing Care

Dietitian (Nutrition)
- Healthy Eating 101
- Eating Well the Mediterranean Way
- Cooking with Beans
- Cooking for One
- Healthy Meal Panning
- Label Reading
- Protein & Fibre: Am I Getting Enough?
- Craving Change
- Individual Counselling and Education

Mental Health
- Mental Wellness 101 – Intake Group
- SMART Recovery Addictions Support
- OCD Group Therapy
- Mindful Based Cognitive Therapy (MBCT)
- Anxiety and Depression Group Therapy
- Grief Group Therapy
- Effective Communication
- Insomnia Group
- Craving Change
- Individual Counselling
- Social Work Navigation
- Transitions – Adult Autism Program
<table>
<thead>
<tr>
<th>Kinesiology (Exercise and Active Living)</th>
<th>Pharmacy Services</th>
<th>Referrals &amp; Screening</th>
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<tbody>
<tr>
<td>Active Living 101</td>
<td>Tobacco Cessation</td>
<td>Specialist Referrals</td>
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<tr>
<td>Move Program</td>
<td>Pharmacy Discharge</td>
<td>Patient Health Screening</td>
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<tr>
<td>Edmonton Oliver Lifestyle Program (EOLP)</td>
<td>Individual Counselling</td>
<td>Panel Management</td>
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<tr>
<td>Individual Fitness Counselling and Education</td>
<td>Medication Reconciliation</td>
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<td>Prescription to Get Active</td>
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The innovation
• Community-based
• Interprofessional team approach
• Joint care planning & assessment of care needs
• Case management
• Relational & informational continuity

Social & Community Services/Resources
PCN Team including Geriatric Services
Primary Care Provider
Patient & Family/Friend Caregiver
Structured Process of Care

1. **FRAILTY IDENTIFICATION**
   - Case-finding and risk stratification
   - Valid tool; Time and resource efficient; Risk score
   - Electronic Frailty Index

2. **FRAILTY ASSESSMENT**
   - Multi-domain assessment to define components of frailty
   - Team approach
   - Primary care nurse as case manager

3. **FRAILTY MANAGEMENT**
   - Addressing components of frailty
   - Falls prevention
   - Self management strategies
   - Exercise/nutrition
   - Supportive Care Planning
   - Structured Medication review
   - Community Connections
   - Referral for Comprehensive Geriatric Assessment/COE
Case-finding Innovation - eFI

Electronic Frailty Index from Primary Care Data

36 Deficits (mapped to over 1000 read codes):

- Diseases, Functional Abilities, Disabilities, Labs

Risk Stratifying Tool:

- Fit 0-0.12 (<5 deficits)
- Mild Frailty 0.13-0.24 (5-8 deficits)
- Moderate 0.25-0.36 (9-12 deficits)
- Severe Frailty >0.36 (13+ deficits)

National Implementation in the United Kingdom 1

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Box 1. List of Deficits included in the eFI

<table>
<thead>
<tr>
<th>Deficit</th>
<th>Description</th>
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<tbody>
<tr>
<td>Arthritis</td>
<td>Ischaemic heart disease</td>
</tr>
<tr>
<td>COPD</td>
<td>Respiratory disease</td>
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<tr>
<td>Atrial Fibrillation</td>
<td>Dizziness</td>
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<tr>
<td>Osteoporosis</td>
<td>Falls</td>
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<tr>
<td>Cerebrovascular disease</td>
<td>Memory and cognitive problems</td>
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<tr>
<td>Chronic kidney disease</td>
<td>Weight loss and anorexia</td>
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<tr>
<td>Diabetes</td>
<td>Sleep disturbance</td>
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<tr>
<td>Skin ulcer</td>
<td>Urinary incontinence</td>
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<tr>
<td>Peripheral vascular disease</td>
<td>Polypharmacy</td>
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<tr>
<td>Thyroid Disease</td>
<td>Dyspnea</td>
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<tr>
<td>Foot problems</td>
<td>Activity Limitation</td>
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<tr>
<td>Fraility fracture</td>
<td>Visual impairment</td>
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<tr>
<td>Peptic ulcer</td>
<td>Housebound</td>
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<tr>
<td>Heart failure</td>
<td>Hearing impairment</td>
</tr>
<tr>
<td>Heart valve disease</td>
<td>Requirement for care</td>
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<tr>
<td>Parkinsonism and tremor</td>
<td>Mobility and transfer problems</td>
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<tr>
<td>Hypertension</td>
<td>Social vulnerability</td>
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<tr>
<td>Hypotension/syncope</td>
<td>Anemia and hematinic deficiency</td>
</tr>
</tbody>
</table>
Example panel results using the UK eFI (manual extraction)

- Panel = 835, n(65+) = 62 (7% of the total number)
- Age: mean = 74.2
- Female - 43 (69%)