eFl 0-0.12 (<5 deficits)- none to few chronic conditions that are well controlled. Independent in ADLs, IADLs.

Healthy Ageing Programs

eFl 0.13-0.24 (5-8 deficits) appear to be slowing down, may need help with IADLs like finances/transportation/shopping

Supported Self-Management

eFl 0.25-0.36 (9-12 deficits) may have difficulty with outdoor activities, mobility issues, require help with some ADLs like washing/dressing

Care & Support Planning

eFl >0.36 often dependent for personal care, have a range of long term conditions

EoL / Palliative Care
<table>
<thead>
<tr>
<th>Structured Process of Care</th>
<th>Education of Healthcare Workforce</th>
<th>Patient &amp; Caregiver Empowerment</th>
<th>Partnership in Care</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FRAILTY IDENTIFICATION</strong></td>
<td>Curricular content focusing on the identification of frailty.</td>
<td><strong>Patients and families</strong></td>
<td><strong>Integrating care with social and community support services;</strong></td>
<td><strong>Building consistency of care processes and measurement to improve capacity to collect, analyze and use data.</strong></td>
</tr>
<tr>
<td>Case finding and risk stratification</td>
<td></td>
<td>engaged as partners in design, delivery, and evaluation of care;</td>
<td>Health Technology as a partner (e.g. clinical support triggers in EMR, automate frailty index);</td>
<td>Patient-oriented, provider and health system measures</td>
</tr>
<tr>
<td><strong>FRAILTY ASSESSMENT</strong></td>
<td>Toolkit &amp; Skills session on case finding tools, conducting multi-domain assessment, and care planning.</td>
<td><strong>Patient &amp; Family Advisory Board;</strong></td>
<td>Clinical, Academic &amp; Intersectoral bridges (Strategic clinical networks; Researchers, Smart City Challenge).</td>
<td></td>
</tr>
<tr>
<td>Multi-domain assessment to define components of frailty</td>
<td><strong>Clinic environment to enhance patient experience.</strong></td>
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<tr>
<td><strong>FRAILTY MANAGEMENT</strong></td>
<td></td>
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<tr>
<td>Addressing components of frailty</td>
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</tbody>
</table>
Outcomes
## Outcomes

<table>
<thead>
<tr>
<th>Patient-Oriented</th>
<th>Provider</th>
<th>System</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Functional status using SMAF</td>
<td>• Perceptions on collaborative practice</td>
<td>• Number of ER visits</td>
</tr>
<tr>
<td>• Level of frailty (change in index)</td>
<td>• Satisfaction with care provided</td>
<td>• Hospital admission days</td>
</tr>
<tr>
<td>• Appropriateness of meds (START/STOPP)</td>
<td></td>
<td>• Long-term care admission</td>
</tr>
<tr>
<td>• Quality of life using EQ-5D/VAS</td>
<td></td>
<td>• Death</td>
</tr>
<tr>
<td>• Carer burden (Caregiver risk screening tool)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Satisfaction of services provided</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Results
88 Patients

**Females 53**
- Married 46
- Divorced 5
- Single 8
- Widowed 28
- Unknown 1

**Males 28**
- Married 30
- Divorced 5
- Single 8
- Widowed 28
- Unknown 1

**AGE**
- Avg/Mean 81

**EDUCATION**
- Primary (K-9) 16
- Secondary (Gr. 10-12) 39
- Post-Secondary 31
- Unknown 1

**CHRONIC CONDITIONS**
- Average Number 5
- TOP CONDITIONS
  - Arthritis 70
  - Hypertension 59
  - Hyperlipidemia 51
  - Atrial fibrillation 32
  - COPD 25

**MARITAL STATUS**
- Married 30
- Divorced 5
- Single 8
- Widowed 28
- Unknown 1

**AVG NO. of MEDS**
- 9 Medications

**LIVING ACCOMODATION**
- Living Alone 30
- Independent home living 74
- Private Supportive Living 11
- Designated Supportive Living 2
- Other 1

**MAIN REASON PATIENT ASSESSED:**
- Cognition 29
- Falls & mobility 27
- Chronic pain 16
- Depression 15
- Caregiver Burden 10
- Medication Review 10
- Medically complex 9

**Mean eFI Score 0.30**
**Mean FI-CGA 0.35**
The International Consortium for Health Outcomes Measurement (ICHOM)

Available from: http://www.ichom.org/medical-conditions/older-person/
Successes of the program thus far

Improvements in these patient oriented outcomes:
Impact
"I am very happy, and I feel listened to."

"HUB makes me feel more confident about how I can deliver elderly care."

"We have helped patients and their caregivers in a variety of ways from providing emotional support, assisting physicians with obtaining diagnoses, linking to community programs such as home care, reducing medications and finding suitable housing."

"The Seniors’ Community Hub has really helped me with my diabetes… I am really happy with my care, it is helpful for planning and has given me better knowledge."

"Rather than trying to make the patient population fit into their program, they are continuously flexing their initial plan, as they learn more about their patients and their needs…" – citizen advisor

"If it wasn’t for that appointment with the Hub, my dad would be in long-term care … doing nothing with his life."

"… aware of the value that everyone in every position is providing now… from reception to the nursing, to how the EMR is working, to the doctors, everything.. work end-to-end a little bit better in this model."
Challenges & Recommendations
Adding More to Primary Care
“My Bucket is Full”
Practice Change Management
ADKAR Model

Awareness
Desire
Knowledge
Abilities
Reinforcement
Acceptance of “frailty”
ASSESSMENT OF INTRINSIC CAPACITY

- **Locomotion**
  - Balance
  - Chair Test
  - Gait speed

- **Sensory**
  - Snellen test
  - Audiometry or whisper test

- **Cognition**
  - Three words recall
  - Time orientation

- **Psychological**
  - Core symptoms of depression
  - Low energy/fatigue

- **Vitality**
  - Abdominal obesity
  - BMI
  - Grip Strength

**WHO - Collaborative Centre for Frailty, Clinical Research and Geriatric Training**
Comprehensive Health Assessment plus

IC monitoring:
- Physical mobility
- Vitality
- Psychosocial
- Sensory
- Cognitive

Geriatric assessment:
- Nutritional assessment
- Medication review
- Multimorbidity/chronic disease evaluation
- Environment assessment
- Care and support needs

Traditional clinical evaluation:
- Single disease and risk factor identification and treatment

Comprehensive Care Plan: incorporating IC and self-management

IC multidimensional programs:
- Multimodal exercise program including strength progressive resistance training
- Increase in protein intake, dietary advice, oral nutritional supplements
- Cognitive stimulation in psychological interventions
- Visual and healing screening followed by timely provision of ear and eye care

Management of complex long term chronic conditions

Social Care and support

Operationalising the concept of intrinsic capacity in clinical setting.
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