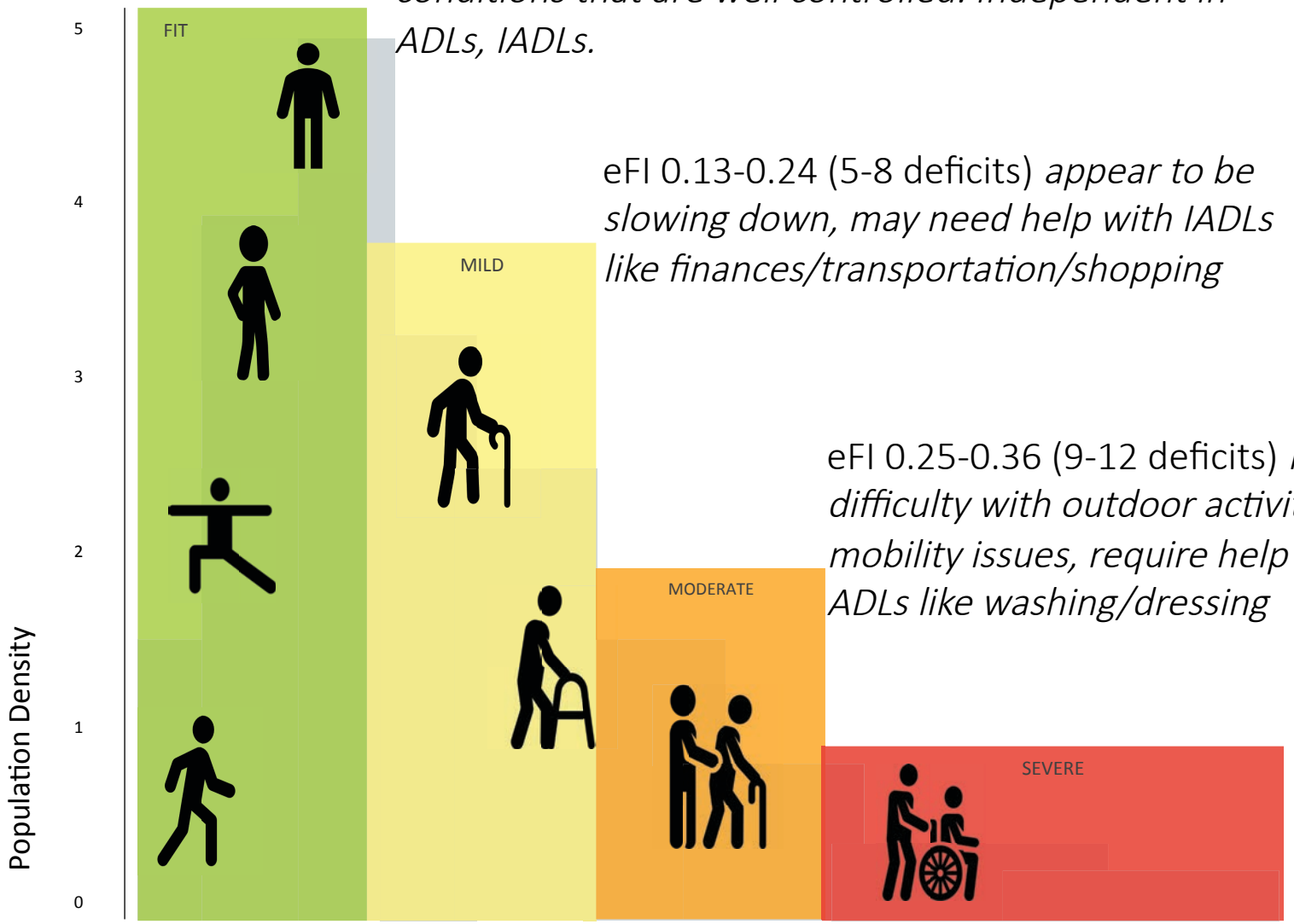


eFI 0-0.12 (<5 deficits)- *none to few chronic conditions that are well controlled. Independent in ADLs, IADLs.*

→Healthy Ageing Programs

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

→Supported Self-Management

eFI 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

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

→EoL / Palliative Care

Seniors' COMMUNITY HUB

Structured Process of Care

STEP 1

FRAILTY IDENTIFICATION
Case finding and risk stratification

STEP 2

FRAILTY ASSESSMENT
Multi-domain assessment to define components of frailty

STEP 3

FRAILTY MANAGEMENT
Addressing components of frailty

Education of Healthcare Workforce

- Curriculum on interprofessional core competencies and principles of geriatric care;
- Toolkit & Skills session on case finding tools, conducting multi-domain assessment, and care planning.

Patient & Caregiver Empowerment

- Patients and families engaged as partners in design, delivery, and evaluation of care;
- Patient & Family Advisory Board;
- Clinic environment to enhance patient experience.

Partnership in Care

- Integrating care with social and community support services;
- Health Technology as a partner (e.g. clinical support triggers in EMR, automate frailty index);
- Clinical, Academic & Intersectoral bridges (Strategic clinical networks; Researchers, Smart City Challenge).

Metrics

- Building consistency of care processes and measurement to improve capacity to collect, analyze and use data.
- Patient-oriented, provider and health system measures

Outcomes

Outcomes

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

Results

88 PATIENTS

Females 53

Males 28

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

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

MARITAL STATUS
Married 46
Divorced 5
Single 8
Widowed 28
Unknown 1

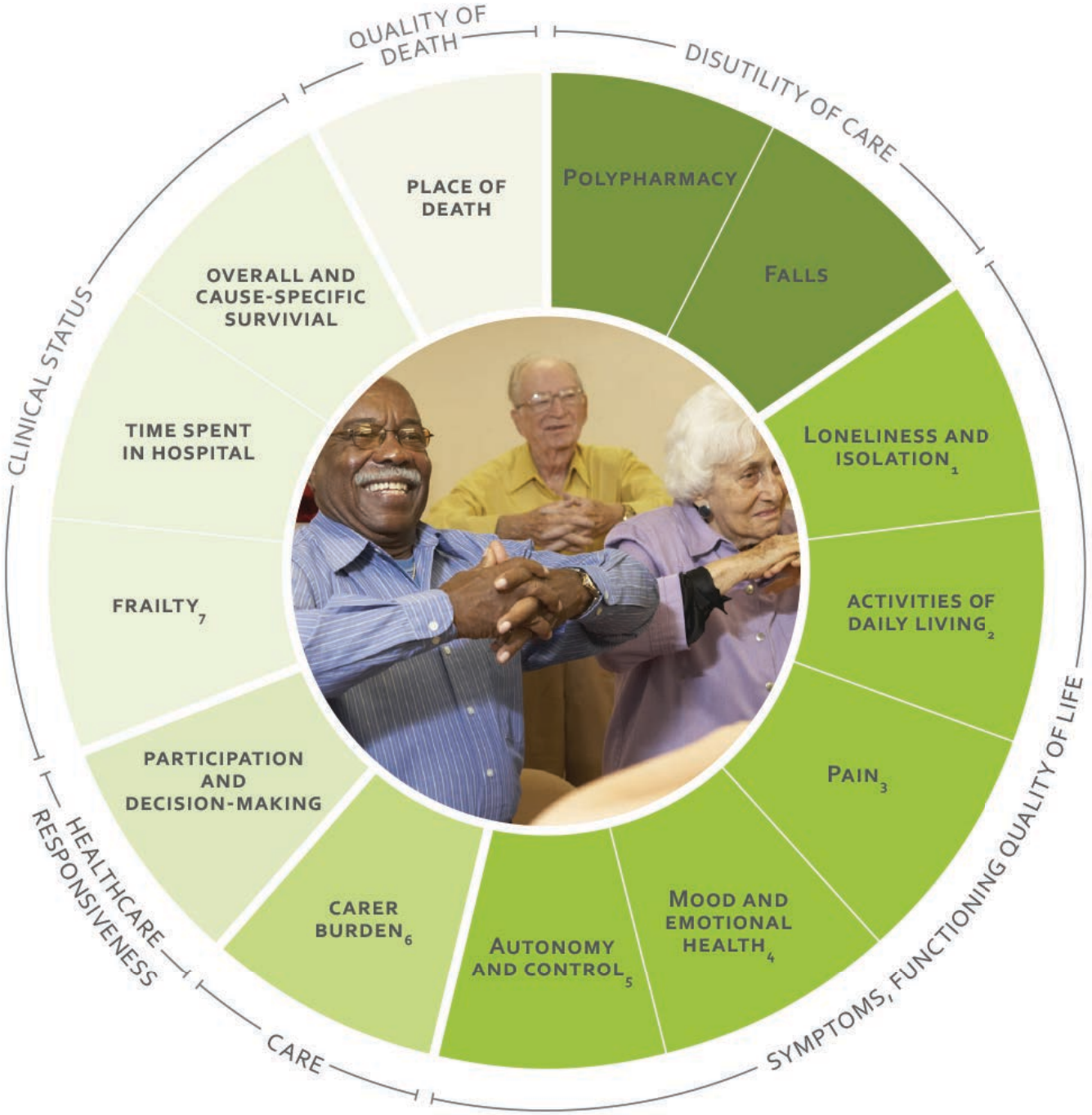
AVG NO. of MEDS
9 Medications

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

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

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

“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

“I am very happy, and I feel listened to.”

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

“… 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.”

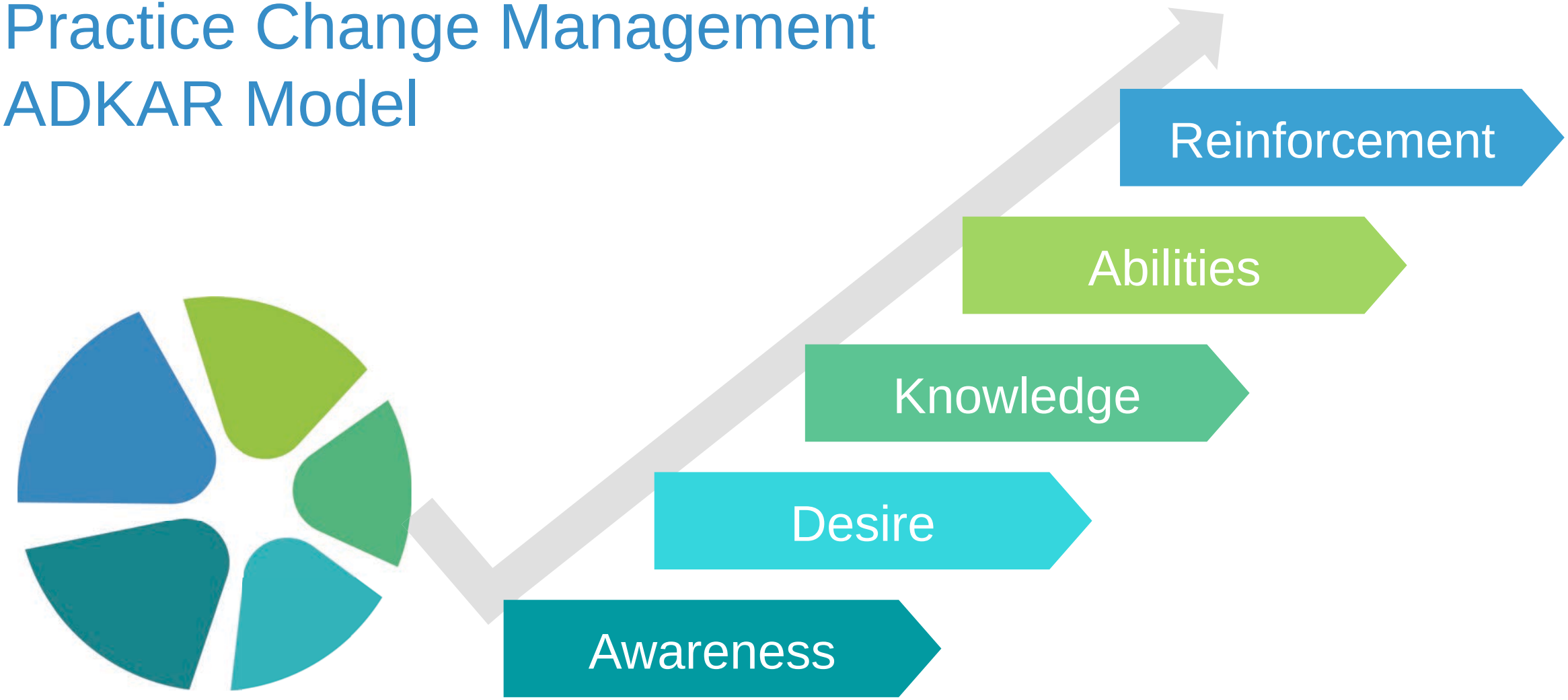
“We have helped patients and their caregivers in a variety of ways from providing emotional support, assisting physicians with obtaining diagnoses, linking to community programs such as home care, reducing medications and finding suitable housing.”

“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.”

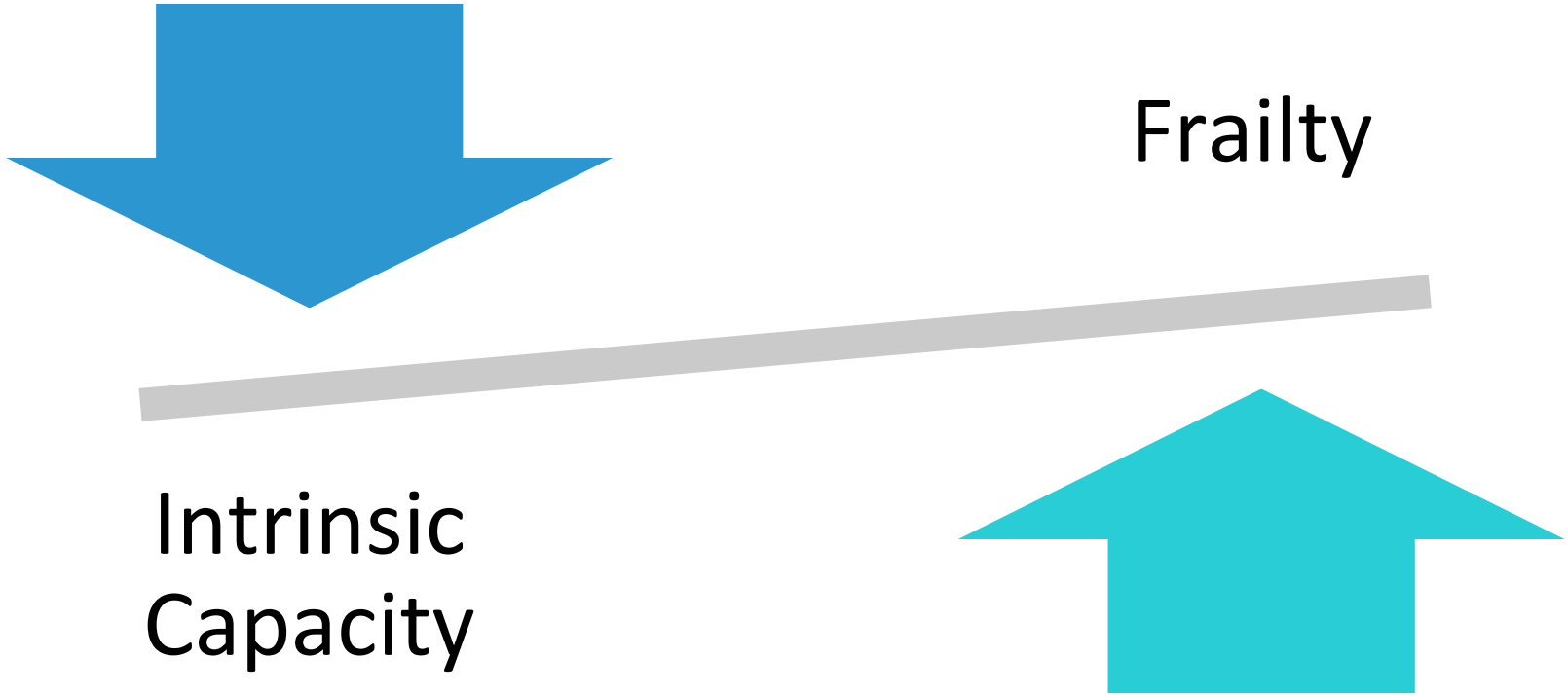
Challenges & Recommendations

Adding More to Primary Care
“My Bucket is Full”

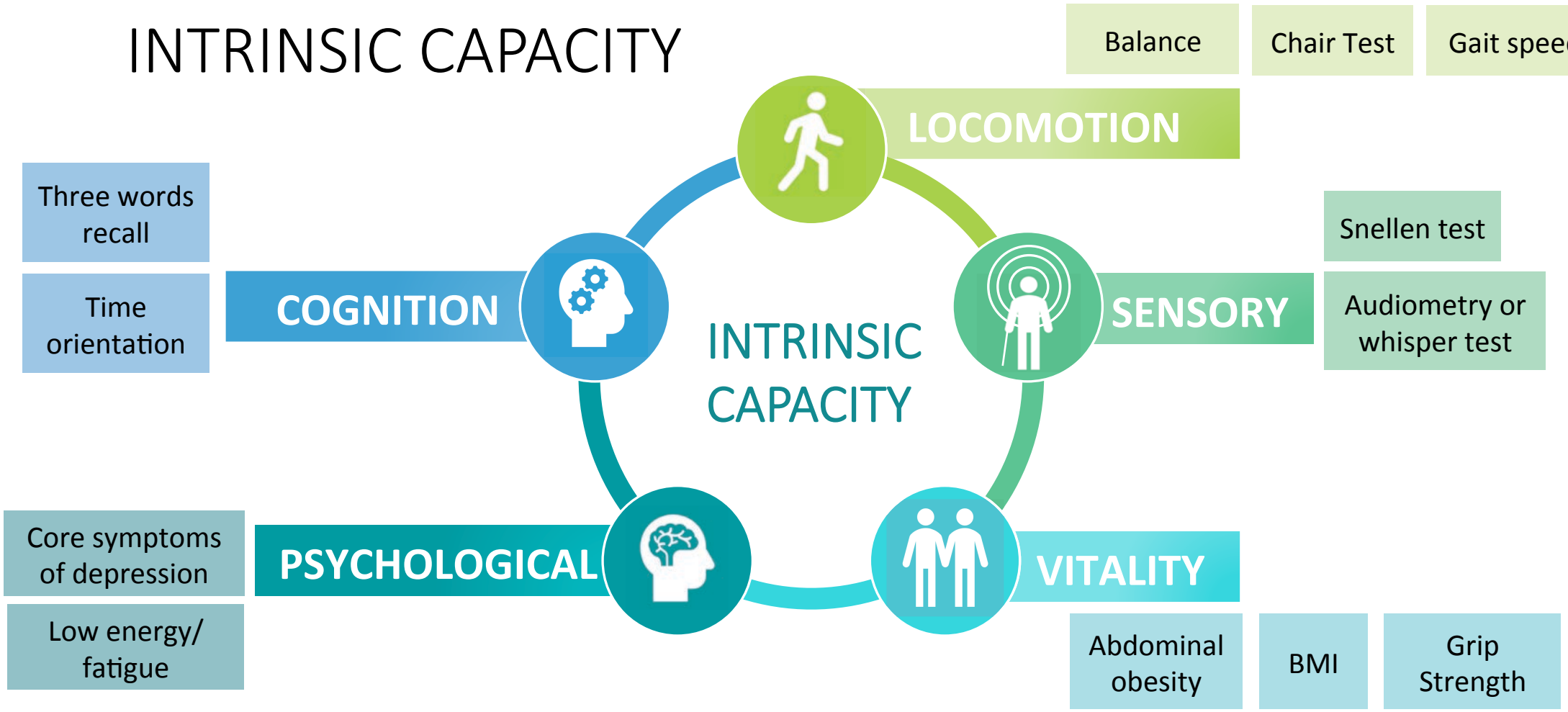
Practice Change Management
ADKAR Model



Acceptance of “frailty”



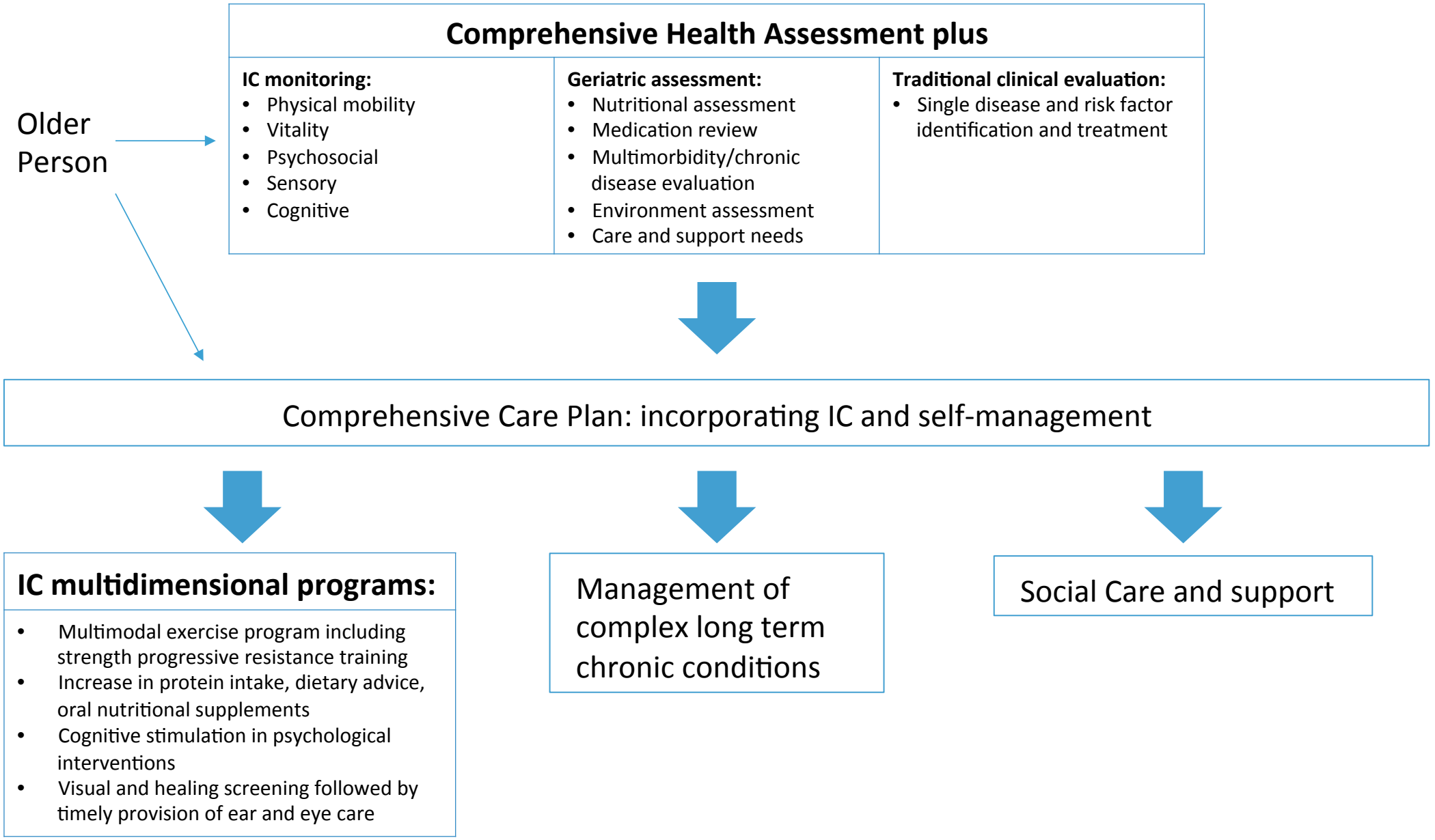
ASSESSMENT OF INTRINSIC CAPACITY



Hôpitaux de Toulouse

Toulouse GÉRONTOPÔLE

WHO - Collaborative Centre for Frailty, Clinical Research and Geriatric Training



Operationalising the concept of intrinsic capacity in clinical setting.
WHO Clinical consortium on healthy ageing November 21-22, 2017.

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