CARES: Community Action & Resources Empowering Seniors

A Model for Early Frailty Assessment and Management in Primary Care

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Problem Statement

- Early-frail seniors are becoming more frail unnecessarily

Imagine a frailty management plan that:
- Supports GPs with enhanced assessment
- Increases seniors’ self management
- Supports research
Evidenced Based Aim

To proactively delay frailty in early frail seniors:

- **Periodic comprehensive geriatric assessments** (CGA) are associated with better health outcomes for the pre-frail senior (Beswick et al., 2008).

- Augment health assessments to enhance seniors natural protective factors with **wellness planning and coaching** (Wang et al., 2014).

- Primary care providers are ideally situated to incorporate proactive and best practices in their daily clinical work (Lacas et al., 2012).
The CARES 4-Step Model for Frailty Prevention in Primary Care

**Active Case Finding for At Risk Seniors**
- Primary care team identify “at risk” senior in community
- Selection criteria: Rockwood CFS 3-6 and chronic disease management issues.

**Comprehensive Geriatric Assessment & Frailty Indexing (eFI-CGA)**
- A Comprehensive Geriatric Assessment (eFI-CGA) is completed by Physician & Nurse in the EMR.
- Frailty Index supports individualized care planning.

**Wellness Summary/Community Referral**
- A summary of the CGA is shared with the patient and a referral to a community health coach is made as part of the senior’s Wellness Plan.

**Intervention: Health Coaching**
- Senior receives over-the-phone health coaching for up to 6 months to address frailty: nutrition, exercise and social engagement.
- eFI-CGA repeated at 6 months to review impact of coaching.

**Benefits & Outcomes of CARES**
- 1. Seniors age well; risk for frailty decreased.
- 2. Reduce acute & ED utilization.
- 3. Enhance provider experience.
- 4. Delay admission to residential care.

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**Early Assessment and Frailty Management Process**
Frailty Prevention and CARES Program: Benefits for the Physicians, Patients and the Community

What are the benefits to physicians/nurse practitioners?
• Enhanced access to frailty education.
• Evidence-based frailty assessment tool in EMR.
• Improved sensitivity in measurement of frailty with access to CGA and Frailty Index.
• Ability to track and monitor frailty over time with Frailty Index (FI).
• In-office support to complete eFI-CGA and assist with care planning.

What are the benefits to patients?
• Reassurance of a comprehensive frailty assessment.
• Ability to participate in wellness planning.
• Opportunity to develop self management capacity.
• Support and navigation of community resources
• Evidenced based health aging approach that decreases their chance for frailty in the future

What are the benefits to the community?
• More seniors with wellness plans that are engaging with community partners to stay healthy and active.
• Reduced number of seniors with frailty.
• Reduced admissions to hospital/residential care.
• Provide a model for early frailty assessment and frailty prevention for at risk seniors.
• Build capacity between primary care settings, patients and Self-Management BC to prevent frailty

How will Fraser Health support this work?
• Provide education on frailty and use of eFI-CGA.
• Implementation support for eFI-CGA tools into clinic EMR.
• Provide in-office support for completion of eFI-CGA
• Provide seniors with take-home Wellness Plans and information on healthy ageing and frailty prevention
• Follow up with seniors for evaluation
• Support with the primary care patient medical home model through joint practice

Improved seniors’ health and quality of life in later years

[Diagram showing the interconnection between Physicians, Patients, and Community, highlighting the flow of benefits and support.]
The Pathway to Deploying CARES in Primary Care

Outcomes:
- Improved frailty assessment & monitoring tool for physicians
- Improved patient health & self management capacity

Oct 2017

- DoFP agrees to proceed
- Identify willing clinics
- Project team meets physician
- Establish legal agreement
- Identify willing clinics
- Project team Installs eFI-CGA
- RN begins eFI-CGA assessment
- Physician recruits 10 patients
- Frailty education for physicians
- Physician finishes eFI-CGA & reviews with patient
- Project team Installs eFI-CGA
- Patient care planning
- Patient Coaching
- 12 month follow up assessment
- Share data
- Evaluation
Frailty Assessment Tools

Nurse Administered Tools:
- Montreal Cognitive Assessment (MoCA) - Nasreddine, Z. (2003) or
- Mini-Cog - Borson (2016)
- Five Times Sit to Stand Test - Guralnik (2000)
- Delegated eCGA sections

Physician Administered Tools:
- Community Comprehensive Geriatric Assessment (CCGA) - Geriatric Medicine Research, Dalhousie University (2016)

Medical Office Assistant
- Faxes coaching referral form to Self-Management BC
CARES and CI HR Research

- CI HR funding to test reliability and validity of electronic CGA
- Funding for physician participation and patient participation
- Research Protocol supported by education with Dr. Ken Rockwood from Dalhousie
- Research protocol outline provided
What is the Self-Management Health Coach program?
- It is a three month telephone program that supports participants to identify health goals and develop a plan to manage their health conditions.
- A coach works with participants one-to-one through weekly telephone support.

Who developed the program?
- The program was developed by the University of Victoria, Institute on Aging & Lifelong Health.
- It is considered a best practice program in self-management.

What does it cost to participate?
- It is FREE to participants.
- The program is funded by the Ministry of Health and delivered through Self-Management BC; a Patients as Partners Initiative administered by the University of Victoria.

Why we choose to partner with Self-Management BC?
- Provides evidence based programs that demonstrate improvements in health.
- Links health assessments with community based programs that enhance participants “protective factors”.

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Results: Success of CARES Work to Date

Results reported are based on 39 CARES participants who completed the Comprehensive Geriatric Assessment at both the baseline and 6-month follow-up periods.

- **30% increase**
  - Walking independently
  - **Baseline:** 27
  - **6 Month Follow Up:** 35

- **67% increase**
  - Exercising frequently
  - **Baseline:** 15
  - **6 Month Follow Up:** 25

- **29% increase**
  - Balance within normal limits
  - **Baseline:** 21
  - **6 Month Follow Up:** 27

- **19% increase**
  - No supports needed
  - **Baseline:** 32
  - **6 Month Follow Up:** 38

- **59% increase**
  - Health attitude
  - **Baseline:** 17
  - **6 Month Follow Up:** 27

- **11% increase**
  - Socially engaged
  - **Baseline:** 28
  - **6 Month Follow Up:** 31

There was a statistically significant **decrease in the frailty index (FI) score** in seniors participating in CARES.

**0.032** decrease from baseline to 6 month follow up

Equivalent to 2 less health problems at follow up