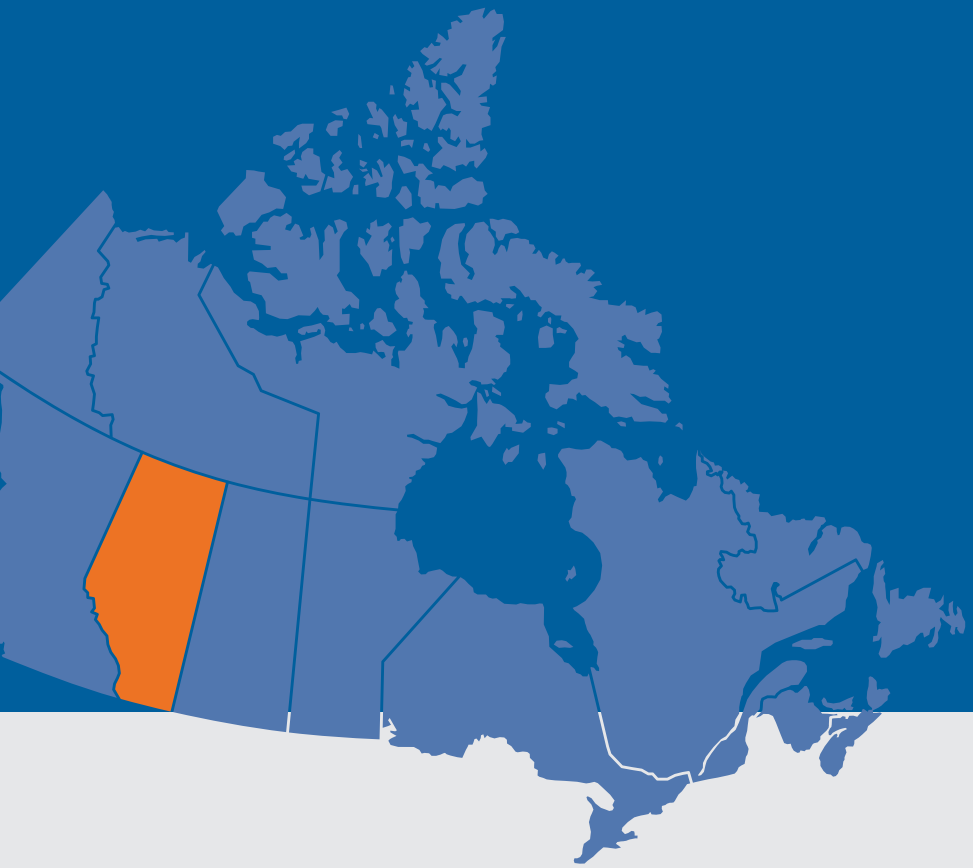

Improving the health outcomes of older adults living with frailty

Primary care implementation guide for providers in Alberta

Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

Acknowledgements:

Our team is grateful to the Canadian Frailty Network for the funding and the opportunity to undertake this project. We are thankful to the staff, researchers, and students who contributed to the information in this document. We are also thankful to the over 40 partner organizations who supported this work.

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Letter from the Principal Investigators

We've known for a long time that our population is getting older. Currently, 16% of the Canadian population is over 65, and this population accounts for nearly half of total health care spending.[1]

One reason for this is that, along with age, often comes the risk of frailty, a medical condition of reduced function and health in older individuals.

In 2020, 1.6 million Canadians 65 years old or older were living with frailty. By 2030, we expect that number to rise to roughly 2.5 million.

Clearly, something needs to be done, not only for the health system as a whole, but for these millions of Canadians who are living with frailty, sometimes unknowingly, and their caregivers.

To improve the health and quality of life of older Canadians, preventing age-related issues and identifying early indications of health problems is the first step. Primary care professionals are a trusted resource for most patients and their caregivers, and play an important role in providing timely supports, so that manageable concerns don't spiral out of control.

Above all, health care providers must actively engage older patients and their caregivers as partners in their care.

This implementation guide was born out of an applied research project—*Transforming primary care for older Canadians living with frailty*—funded through a Transformative Grant from the Canadian Frailty Network (CFN). The systematic approach of identifying older patients who are at risk of or living in the early phase of frailty —using a quick screening tool, applying engagement and shared decision-making tools, and coordinating referrals to community-based services—was tested with the support of primary care clinics in three provinces (Quebec, Ontario, Alberta) to assess the viability of this approach in multiple primary care settings.

It is meant to be a starting point for you as a primary care provider, in the hopes that it helps you improve the health of the older adults in your practice. If we work together, health care providers, older adults, researchers and collaborators from across Canada can transform primary care for older Canadians.

If you have any questions on how to implement our approach after reading this guide, please don't hesitate to reach out to us or the team directly.

All the best,

Dr. Sara Mallinson, Principal Investigator
Adjunct Assistant Professor, Department of Community Health Sciences, University of Calgary

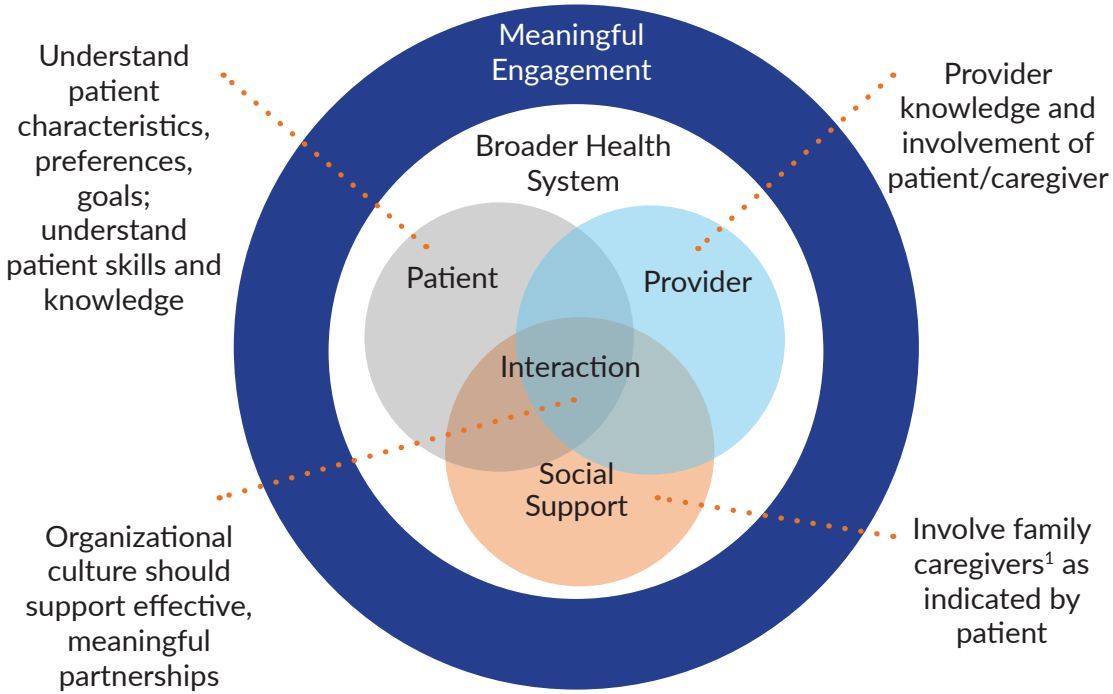
Dr. Paul Stolee, Principal Investigator
Professor, School of Public Health Sciences, University of Waterloo

[1] https://www.cfn-nce.ca/frailty-matters/

Why primary care?

The Canadian Frailty Network defines frailty as a medical condition of reduced function and health in older individuals. As our population ages, more and more older adults are considered frail every year. As a trusted resource for most patients and their caregivers, family doctors, nurse practitioners and other primary care professionals play an important role as partners in their care.

- Primary care provides an opportunity for proactive, preventive, coordinated and integrated care, reaching the most people, as early as possible.
- Primary care can improve the well-being and quality of life of patients and their caregivers. At the same time, it can have an impact on the rest of the health system by directing older adults to the appropriate services early, and preventing emergency situations.
- Primary care is the front door to the health care system and primary care professionals are in the best position to offer preventive care to our growing older adult population. This can help address the fact that, as the Canadian Frailty Network reports, 46% of health care spending is generated from the 16% of our population who are over 65 years old.



The Change Foundation's broad definition of family caregivers is family members, friends or neighbours who provide care for someone without pay. We refer to them as caregivers in this document.

[1] https://ontariocaregiver.ca/wp-content/uploads/2019/12/Spotlight-on-ontarios-caregivers-2019_EN.pdf

Image reference on p. 6

Implementing this approach in your primary care setting

The research team created an approach, using a variety of models—with input from primary care professionals and in collaboration with patients and caregivers—to help you care for your older patients (70+).

Managing chronic conditions in a primary care practice isn't easy:

- Primary care professionals have competing demands on their time.
- Chronic conditions come with a greater administrative burden.
- The system wasn't designed to care for people living with complex health issues.
- Connecting people to local health and social supports can be time consuming and complex.
- There isn't a one-stop place to find relevant social and community services to support patients.
- Patients, caregivers, and health care providers struggle to find the information and the time to build effective care partnerships.

Taking into consideration all these challenges, an interdisciplinary research team designed and tested an approach to assist primary care professionals as they work to improve the health, social and economic outcomes for older patients. This guide can help primary care clinics implement this approach in their own setting.

There are three main steps to this approach, which are underpinned by proven tools and technology supports:

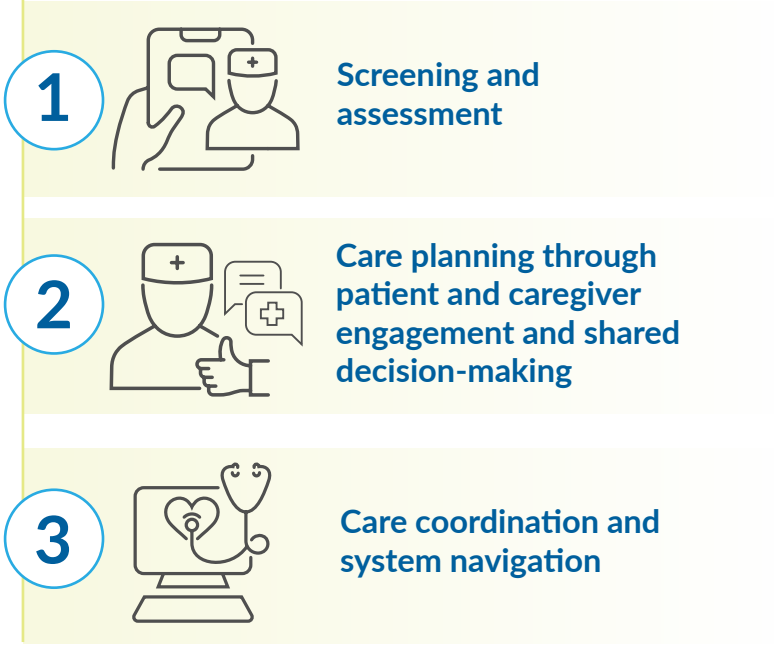


Image from p. 5: Elliott J, McNeil H, Ashbourne J, Huson K, Boscart V, Stolee P. Engaging Older Adults in Health Care Decision-Making: A Realist Synthesis. Patient. 2016 Oct;9(5):383-93. doi: 10.1007/s40271-016-0168-x. PMID: 27048393; PMCID: PMC5021754.

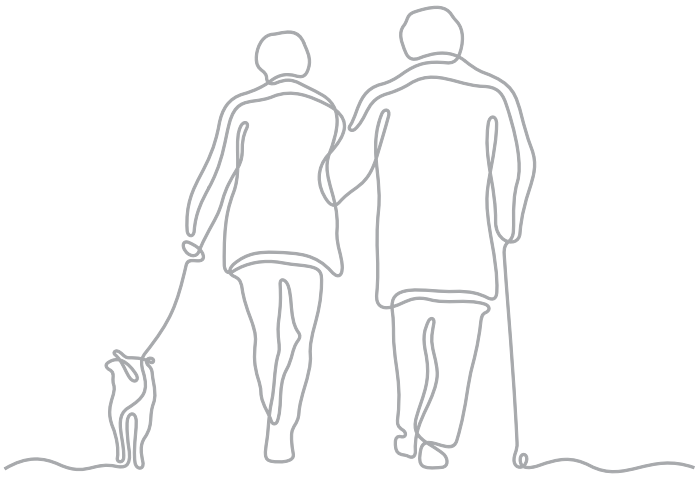
Step 1: Screening and assessment

Although you may know your patients well and have a longstanding relationship with them, digging a little deeper can often help you learn something new, catch something earlier, or make connections you hadn't noticed before.

Screening and assessment tools

- Possible tools: interRAI Preliminary Screener (AUA), Pictoral Fit Frailty Scale, Clinical Frailty Scale
  - Determine which screener works in your electronic medical record (EMR) and/or primary care clinic[1]

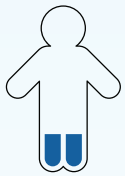
[1]interRAI code available to integrate into Practice Solutions, MedAccess, OCEAN by requesting permission from interRAI Canada.



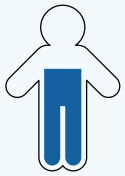
Example: Screening and assessment tool

The interRAI Preliminary Screener (AUA) is a quick and simple tool to answer the question: *Is this patient likely to benefit from further assessment and intervention?*

- Seven topics in the screener: cognitive skills, 4 activities of daily living, dyspnea, self-rated health, unstable condition, self-reported mood, caregiver status.
- The Assessment Urgency Algorithm (AUA) converts responses into an urgency scale ranging from 1-6.



1 & 2: Low risk
Wait & monitor: Referral to self-management and social supports including fitness program, transportation, home visiting, etc.



3 & 4: Moderate risk
Community support services program referrals: Home and community care support services; Day programs, etc.

5 & 6: High risk
Specialized geriatric services and other home and community care programming as needed.

If your patient has a high AUA score, further intervention is likely needed* as your patient may have:

- Higher risk of adverse outcomes.
- Mild to severe cognitive impairment.
- Medium to high medication complexity and frailty.
- Depression.
- Challenges in self-care or other tasks of daily living.

Like any tool, the interRAI Preliminary Screener (AUA) has its limitations. Use your skilled interview abilities and apply your professional judgment to determine if your patient requires follow-up. In discussion with the patient and their caregiver, you can make the right decision.

For example, a person with a fracture may score high, but both you and your patient know that their limitations are temporary.

**This tool does not replace a health professional's clinical judgment.*

Step 2: Care planning through patient and caregiver engagement and shared decision making

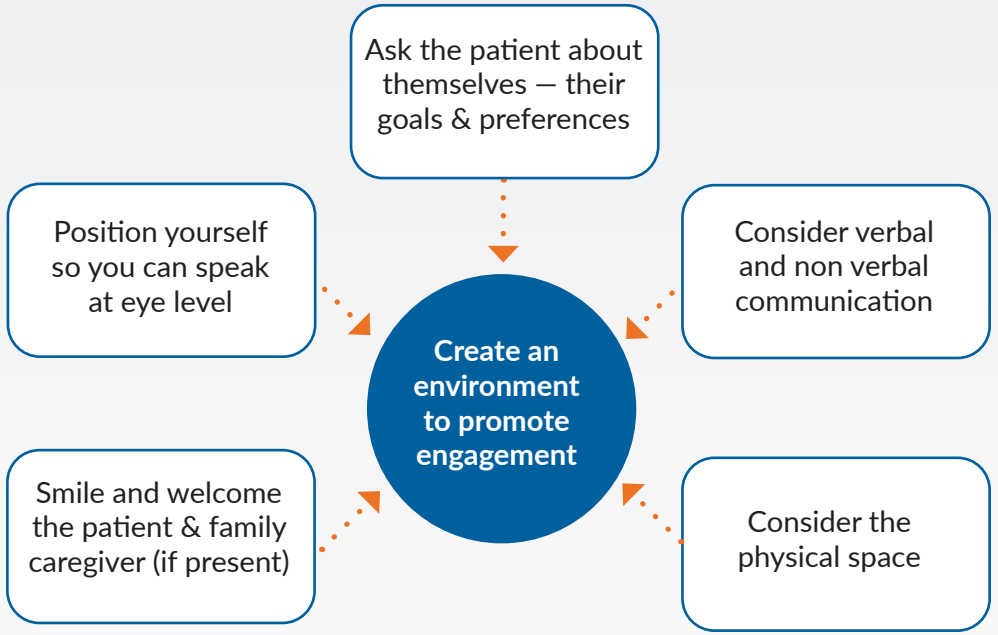
Patients and caregivers should be partners in decision making and care planning. Research shows that when patients and caregivers are engaged, health outcomes are better, patients and providers have better experiences, and there is better care planning.

Decision Boxes (DBs)—see page 9 for more information—facilitate patient/caregiver engagement during clinical decision making. These documents support shared decision making between the health care professional and patient and/or caregiver. The Decision Boxes:

- Are developed in plain language.
- Are based on the best available scientific evidence.
- Describe all the options to limit frailty risks, their benefits, harms, and practical issues.
- Guide patients and their caregivers in identifying what's important to them, and help them choose options that align with their goals and priorities.

Example: Patient/caregiver engagement

Here are things you already know about creating a supportive environment to talk with patients and caregivers when making choices about care options and supports.



Five Decision Boxes

Decision Boxes, often referred to as decision aids, are available for primary care professionals to use with older adults, using a shared decision making approach.

Maintaining independence in daily activities

- Present the evidence for options to maintain independence, along with the potential benefits and harms for each:
  - Physical activity tailored to older adults
  - Yoga
  - Rehabilitation or occupational therapy at home
  - Self-management programs (support to care for yourself better)
  - Smart homes
  - Brain exercises
  - Wait and monitor

Mild problems with thinking or memory

- Present the evidence for options to maintain or improve mental capacity, along with the potential benefits and harms for each activity:
  - Brain exercises
  - Physical activity tailored to older adults
  - Brain exercises on the computer
  - Wait and monitor

Depression

- Present the evidence for options to mitigate depression, along with the potential benefits and harms for each activity:
  - Light therapy
  - Massage therapy
  - Psychotherapy
  - Physical activity tailored to older adults
  - Antidepressants
  - Wait and monitor

Stress in caregivers

- Present the evidence for options for stress reduction, along with the potential benefits and harms for each activity:
  - Physical activity
  - Psychoeducation
  - Support groups
  - Respite care
  - Psychotherapy
  - Wait and monitor

Malnutrition

- Present the evidence for options to mitigate malnutrition and limit weight loss, along with the potential benefits and harms for each activity:
  - Oral nutritional supplements
  - Meals on Wheels
  - Nutritional counselling & oral nutritional supplements
  - Wait and monitor

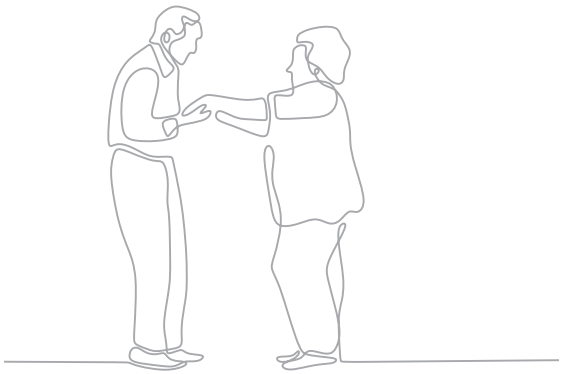
Step 3: Care coordination and system navigation

Providing knowledge of, and access to, community programs to patients, caregivers and providers can help lead to important conversations about supports and care.

Once you've determined what support the patient and/or caregiver can benefit from through the results of the assessment and discussions, you can use these digital platforms to see what is available in their community.

In Alberta, there are a few platforms that you can use:

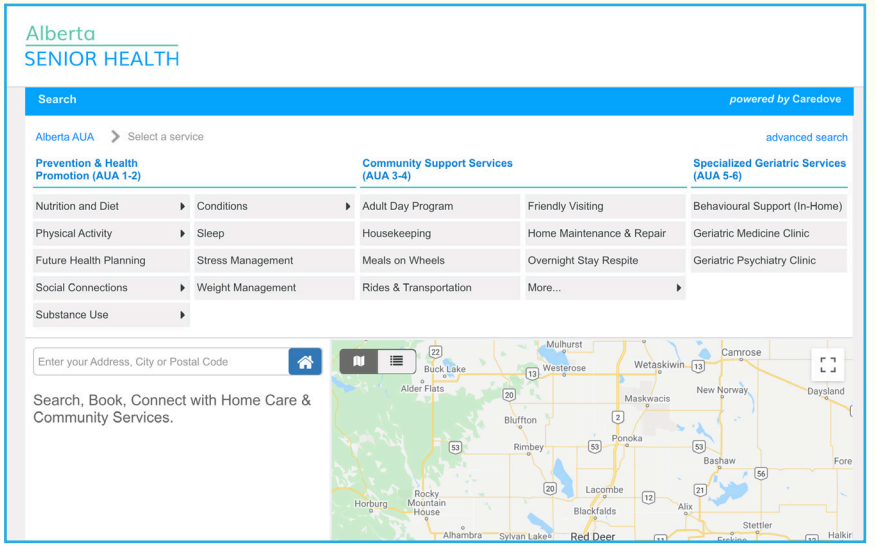
- 211 Alberta
- Caredove Alberta (Red Deer and Sherwood Park)
- Carya (Calgary)
- Inform Alberta
- Services listed and available through municipalities



Example: Using technology to support system navigation

Caredove step-by-step

- Enter patient's full address
- Based on results identified through Caredove, provide referrals to the patient and/or care partner
- Caredove has a help centre



Ready to implement in your primary care setting?

This primary care approach is about improving patient experiences, health outcomes and quality of life for older adults living with, or at risk of, frailty. This practice change may align with your quality improvement priorities and/or could be included in your Quality Improvement Plan.

As your primary care team considers this approach, begin by setting up a Working Group that can collaborate on the planning and support the practice change implementation. The Working Group should oversee the development of a project plan and a supporting communications plan. Remember to consider what change management strategies might be needed to ensure success.

Working Group members can include representatives of those who need to support implementation or who will be using and/or benefitting from the new approach. For example, a primary care practitioner, other clinical representation, IT support, patient and/or caregiver, administrative staff, etc.

To support planning and implementation, we've created:

- An implementation worksheet (Appendix A)
- A step-by-step implementation plan checklist (Appendix B)
- Three sample models (Appendix C)

Here are the steps to follow to implement this approach/structure:

1. Determine the best approach, based on the example models (Appendix C), to administer the screening tool:

- In-clinic: by providers
- Telephone: before the appointment
- Self-report: on a tablet, in the waiting room
- Online appointment: downloadable by anyone

2. Determine which team member (e.g., Designated Clinician) will work through the Decision Boxes with the patient/caregiver, if any of these conditions are identified:

- Malnutrition
- Maintaining independence in daily activities
- Mild problems with thinking or memory
- Depression
- Stress in caregivers

3. Select which platform you will use to connect to available health, community and social services (e.g., Caredove, thehealthline.ca):

- Determine which team member (e.g., Designated Clinician) will spend time with the patient/caregiver to identify appropriate services, and make referrals

4. Staff/team training (approximately 3-4 hour modules, plus some additional online training):

- Decide the best strategies to implement the tools with your team
- Identify the best time for training, based on team member availability
  - For 3-hour training
    - Overview of screening tool, Caredove and patient/caregiver engagement/involvement & using a shared decision making approach
    - Case study examples
    - Role playing, to further embed training concepts
    - Translation of knowledge to practice
    - Hands on use of referral platform, to explore the platform/tool with real examples
  - For additional 1-hour online training
    - Shared decision making – supportive training

5. Determine your approach to measurement and/or evaluation:

- How will your team know if this approach is making a difference for older adults living with frailty?
- Consider whether to take a detailed evaluation approach or by tracking specific indicators (e.g., number of referrals to geriatric specialists or number of patients scoring high on frailty tool)

PRINT

Considerations to customize implementation in your primary care setting

- **What are the team functions required to successfully implement all (or elements of) your preferred approach, for example:**

  Who will administer preliminary screening?

  Who will distribute and review the Decision Boxes with the older adult?

  Who will follow-up on community services and referrals?

- **Can the screener be embedded into your EMR?**
  YES ☐ NO ☐ TBD ☐

  Are there technical barriers or issues that need to be considered, such as cost?

- **Is internet reliable, or should the clinic introduce downloaded fillable documents for screeners and referrals?**

  If so, who will create the paper/downloadable version?

- **Do you need a new configuration of your physical space to implement any part of this approach?**

  If so, who will make sure these changes happen?

Appendix B: Step-by-step implementation plan checklist

Designated clinicians (DC) are selected based on the clinic or primary care office. A DC can include, but is not limited to, Doctors, Nurses, Nurse Practitioners, Social Workers, Pharmacists, Occupational Therapists, Physiotherapists.

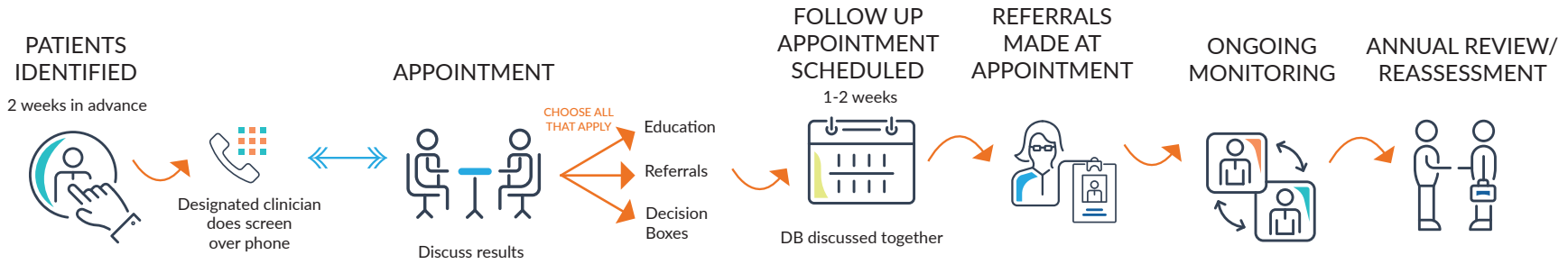
Step	Action	Details
1	**Select screener**	Review the available screening tools (e.g., interRAI Preliminary Screener (AUA), Clinical Frailty Scale), and select the tool that is best suited for your clinic. Seek permission to use the tool, as needed. For the purposes of this checklist, the selected screener is the interRAI Preliminary Screener (AUA).*
2	**Set-up screener**	Build Screener into EMR or database; ensure a seamless process for adding it to the patient's record.
3	**Identify patients over 70 years old**	SELECT ONE: 1. Designated staff member identifies patients with upcoming appointments who need to complete screener, and flags these patients in the patient record or other system set up within the clinic (see options for administration in step 4). 2. Designated clinician identifies patients over 70 years old who have upcoming appointments (done weekly or monthly) to administer screener over the phone in advance of in-person appointment. 3. Designated clinician proactively identifies patients over 70 years old who are due for a wellness check.
4	**Screening and assessment**	SELECT ONE: 1. Pre-appointment screening done over the phone by designated clinician up to 2 weeks prior to upcoming appointment. Designated clinician discusses results of screener with patient and/or caregiver at the appointment. 2. Phone screening proactively done with all eligible patients over 70 years old. Designated clinician discusses results of screener with patient and/or caregiver, and either determines no follow up is needed, schedules a follow up appointment and/or identifies Decision Boxes to be administered at a follow up appointment. 3. Screener completed independently by patient in waiting room on tablet, when the patient arrives for their appointment (even if the appointment is not related to aging or frailty concerns). Designated clinician discusses results of screener with patient and/or caregiver. 4. Primary care practitioner completes the screener with the patient (and caregiver) in a clinic room as part of the appointment (even if the appointment is not related to aging or frailty concern).

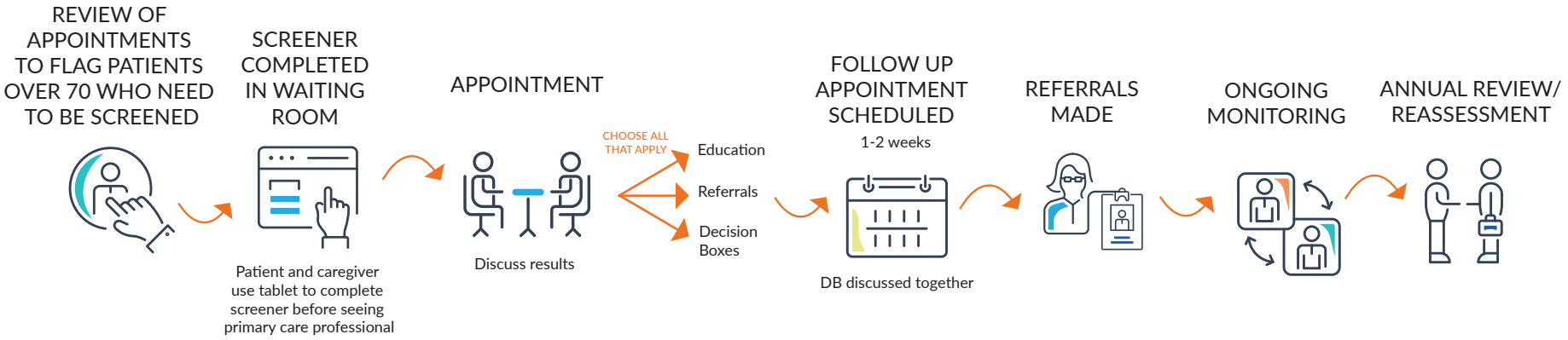
* Alternative tools include: Pictoral Fit Frailty Scale, Clinical Frailty Scale. Please note, these tools were not tested in this approach as part of this research study.

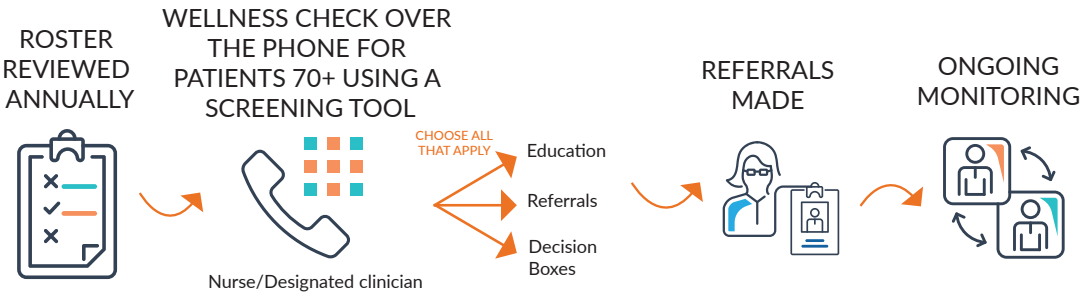
Appendix B: Step-by-step implementation plan checklist

Step	Action	Details
5	**Care planning and shared decision making with patient and caregiver**	SELECT BASED ON RISK LEVEL (example based on interRAI Preliminary Screener (AUA)): 1. AUA risk level 1 & 2 (low risk): using clinical judgment, discuss self-management and/or education, and discuss Decision Boxes, if appropriate; reassess in 1-year or earlier if there are major changes with the patient. 2. AUA risk level 3 & 4 (moderate risk): using clinical judgment and screener results, discuss results and suggest referrals and/or further assessment with patient and/or caregiver. 3. AUA risk level 3 & 4 (moderate risk): using clinical judgment and screener results, discuss results, suggest referrals and/or further assessment with patient and/or caregiver. Recommend Decision Boxes to complete together (clinician and patient) at current appointment (time permitting), or at a follow-up appointment. 4. AUA risk level 5 & 6 (high risk): using clinical judgment and screener results, discuss results and suggest referrals and/or further assessment with patient and/or caregiver. 5. AUA risk level 5 & 6 (high risk): using clinical judgment and screener results, discuss results, suggest referrals and/or further assessment with patient and/or caregiver. Recommend Decision Boxes to complete together (clinician and patient) at current appointment (time permitting), or at a follow-up appointment.
6	**Care coordination and system navigation**	SELECT ALL THAT APPLY: 1. Designated clinician makes recommendations for self-management and/or education. 2. Designated clinician makes referrals for further assessment by home and community care, community support service or services known to primary care professionals. 3. Designated clinician makes referrals directly through Caredove or through other provincial resources (e.g., thehealthline.ca, 211) for community support services or home care. 4. Physician makes referral to specialized geriatric services (those requiring a physician's signature).
7	**Ongoing monitoring**	Frequency determined by primary care practitioner.

Appendix C: Three sample models







About the Canadian Frailty Network

Canadian Frailty Network is funded by the Government of Canada's Networks of Centres of Excellence (NCE) program. As a research network, CFN collaborates with industry, health care, academic, non-governmental organizations and private partners to improve the care of older adults living with frailty, and support their families and caregivers. CFN does this by increasing frailty recognition and assessment, creating evidence to inform decision making from the bedside to policymaking, training the next generation of care professionals and scientists, and mobilizing knowledge to catalyze improvements in Canada's health and social care systems.

Visit: www.cfn-nce.ca

Recognizing Partners and Collaborators

It takes a village. Thanks to all our partners and collaborators who believe in improved care for older adults.

Notes

Notes

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