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

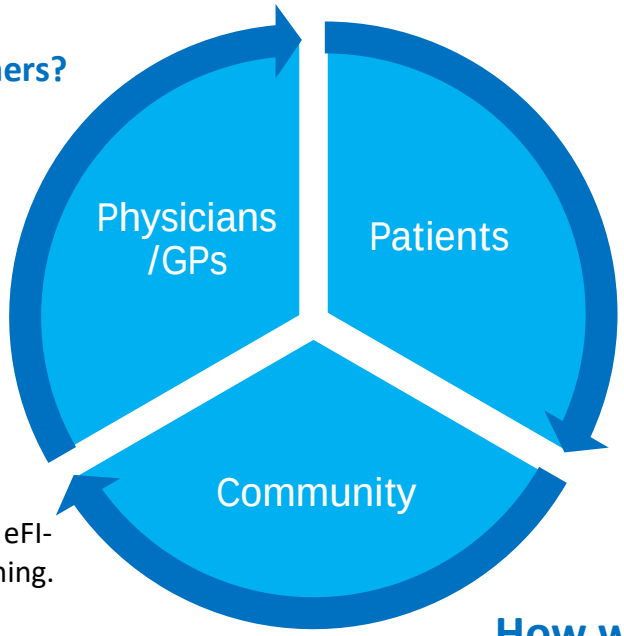
1. Seniors age well; risk for frailty decreased.
2. Reduce acute & ED utilization.
3. Enhance provider experience.
4. Delay admission to residential care.

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

Improved seniors' health and quality of life in later years

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

The Pathway to Deploying CARES in Primary Care

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DoFP agrees to proceed

Identify willing clinics

Project team meets physician

Establish legal agreement

Project team Installs eFI-CGA

Frailty education for physicians

Physician recruits 10 patients

RN begins eFI-CGA assessment

Physician finishes eFI-CGA & reviews with patient

Patient care planning

Patient Coaching

12 month follow up assessment

Share data

Evaluation

Outcomes:

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

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Frailty Assessment Tools

Nurse Administered Tools:

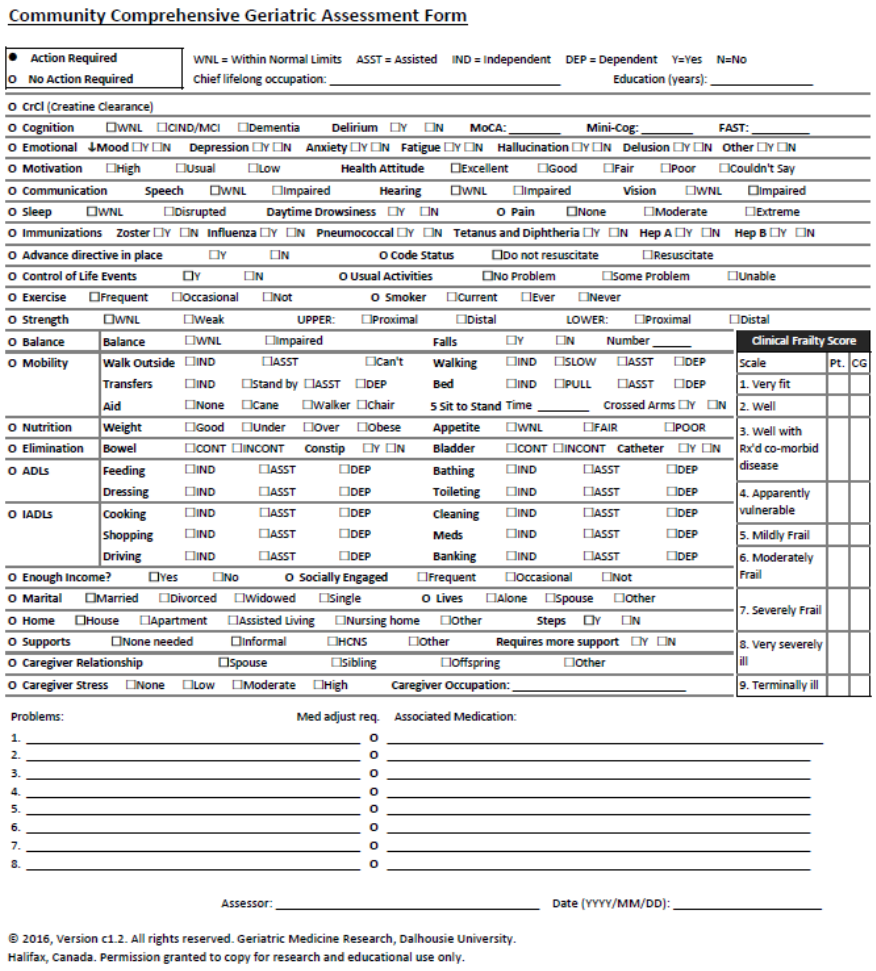
- Montreal Cognitive Assessment (MoCA) - Nasreddine, Z. (2003) **or**
- Mini-Cog – Borson (2016)
- Five Times Sit to Stand Test - Guralnik (2000)
- Delegated eCGA sections

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



Community Comprehensive Geriatric Assessment Form

● Action Required
○ No Action Required

WNL = Within Normal Limits ASST = Assisted IND = Independent DEP = Dependent Y=Yes N=No

Chief lifelong occupation: _____ Education (years): _____

○ CrCl (Creatine Clearance)

○ Cognition ☐WNL ☐CIND/MCI ☐Dementia Delirium ☐Y ☐N MoCA: _____ Mini-Cog: _____ FAST: _____

○ Emotional ↓Mood ☐Y ☐N Depression ☐Y ☐N Anxiety ☐Y ☐N Fatigue ☐Y ☐N Hallucination ☐Y ☐N Delusion ☐Y ☐N Other ☐Y ☐N

○ Motivation ☐High ☐Usual ☐Low Health Attitude ☐Excellent ☐Good ☐Fair ☐Poor ☐Couldn't Say

○ Communication Speech ☐WNL ☐Impaired Hearing ☐WNL ☐Impaired Vision ☐WNL ☐Impaired

○ Sleep ☐WNL ☐Disrupted Daytime Drowsiness ☐Y ☐N ○ Pain ☐None ☐Moderate ☐Extreme

○ Immunizations Zoster ☐Y ☐N Influenza ☐Y ☐N Pneumococcal ☐Y ☐N Tetanus and Diphtheria ☐Y ☐N Hep A ☐Y ☐N Hep B ☐Y ☐N

○ Advance directive in place ☐Y ☐N ○ Code Status ☐Do not resuscitate ☐Resuscitate

○ Control of Life Events ☐Y ☐N ○ Usual Activities ☐No Problem ☐Some Problem ☐Unable

○ Exercise ☐Frequent ☐Occasional ☐Not ○ Smoker ☐Current ☐Ever ☐Never

○ Strength ☐WNL ☐Weak UPPER: ☐Proximal ☐Distal LOWER: ☐Proximal ☐Distal

○ Balance	Balance	☐WNL	☐Impaired		Falls	☐Y	☐N	Number _____	
○ Mobility	Walk Outside	☐IND	☐ASST	☐Can't	Walking	☐IND	☐SLOW	☐ASST	☐DEP
	Transfers	☐IND	☐Stand by ☐ASST	☐DEP	Bed	☐IND	☐PULL	☐ASST	☐DEP
	Aid	☐None	☐Cane	☐Walker ☐Chair	5 Sit to Stand Time _____		Crossed Arms ☐Y		☐N
○ Nutrition	Weight	☐Good	☐Under	☐Over ☐Obese	Appetite	☐WNL	☐FAIR	☐POOR	
○ Elimination	Bowel	☐CONT	☐INCONT	Constip ☐Y ☐N	Bladder	☐CONT	☐INCONT	Catheter ☐Y	☐N
○ ADLs	Feeding	☐IND	☐ASST	☐DEP	Bathing	☐IND	☐ASST	☐DEP	
	Dressing	☐IND	☐ASST	☐DEP	Toileting	☐IND	☐ASST	☐DEP	
○ IADLs	Cooking	☐IND	☐ASST	☐DEP	Cleaning	☐IND	☐ASST	☐DEP	
	Shopping	☐IND	☐ASST	☐DEP	Meds	☐IND	☐ASST	☐DEP	
	Driving	☐IND	☐ASST	☐DEP	Banking	☐IND	☐ASST	☐DEP	

○ Enough Income? ☐Yes ☐No ○ Socially Engaged ☐Frequent ☐Occasional ☐Not

○ Marital ☐Married ☐Divorced ☐Widowed ☐Single ○ Lives ☐Alone ☐Spouse ☐Other

○ Home ☐House ☐Apartment ☐Assisted Living ☐Nursing home ☐Other Steps ☐Y ☐N

○ Supports ☐None needed ☐Informal ☐HCNS ☐Other Requires more support ☐Y ☐N

○ Caregiver Relationship ☐Spouse ☐Sibling ☐Offspring ☐Other

○ Caregiver Stress ☐None ☐Low ☐Moderate ☐High Caregiver Occupation: _____

Clinical Frailty Score

Scale	Pt.	CG
1. Very fit		
2. Well		
3. Well with Rx'd co-morbid disease		
4. Apparently vulnerable		
5. Mildly Frail		
6. Moderately Frail		
7. Severely Frail		
8. Very severely ill		
9. Terminally ill		

Problems: Med adjust req. Associated Medication:

1. _____ ○ _____
2. _____ ○ _____
3. _____ ○ _____
4. _____ ○ _____
5. _____ ○ _____
6. _____ ○ _____
7. _____ ○ _____
8. _____ ○ _____

Assessor: _____ Date (YYYY/MM/DD): _____

CARES and CIHR Research

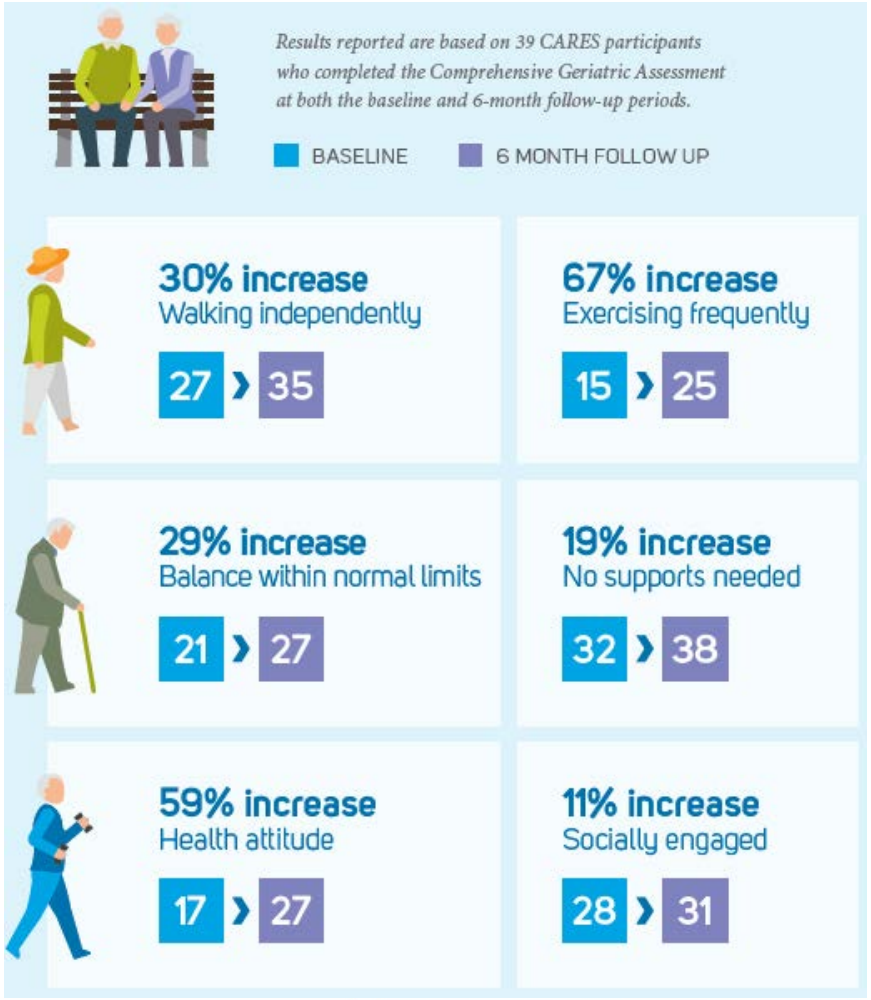
- CIHR funding to test reliability and validity of electronic CGA
- Funding for physician participation and patient participation
- Research Protocol supported by education with Dr. Ken Rockwood from Dalhousie
- Research protocol outline provided

Self-Management British Columbia

- **What is the Self-Management Health Coach program?**
  - It is a three month telephone program that supports participantss 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”.

Results: Success of CARES Work to Date



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

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