Family First
Family Health Team

An Interdisciplinary, Proactive Frailty Screening and Assessment Program to Enhance the Care of Elderly Patients

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INTRODUCTION

1 in 4 community dwelling older adults over the age of 65 are living with frailty.[1]

Frailty: "A state of vulnerability where the body does not have the ability to cope with minor illnesses that would normally have minimal impact on a healthy individual".[2]

In Canada, the population aged 65 and older is projected to rise from 20% to as high as 32% over the next 40 years.[3]

CIHI initiative: This program developed from a collaborative initiative with Healthcare Excellence Canada and the Canadian Frailty Network. The "Advancing Frailty Care in the Community" initiative tasked teams with identifying and supporting the frail population in their community.[2,4]

Frailty Program: The FHT's existing eldercare program was transformed into a systematic method to identify community dwelling older adults at risk for frailty and to mitigate these risks using existing clinic programs and community resources.

METHODS

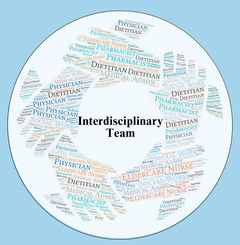
- Active patients ≥ 75 years old at Family First Family Health Team are invited to complete a screening questionnaire with a family member or caregiver via email or by phone.[5]

The InterRAI Assessment Urgency Algorithm (AUA) predicts individual frailty risk by assessing:[6]

- ADLS
- Shortness of breath
- Self-reported health
- Caregiver burden
- Instability of conditions
- Mood
- Nutrition

- Additionally, three questions evaluating changes in the patient's memory, exercise level, and frequency of falls were added based on findings from Bruyere Research Institute.[5]

- The EQ-5D scale assesses five areas of health: mobility, self-care, usual activities, pain/discomfort, and anxiety /depression. Patients rate their health from 0-100 providing a quantitative measure reflecting their own judgement.[7]



METHODS CON'T

Nine physicians' practices were individually screened for eligible patients using a step-wise approach. Results were reviewed and adjustments made to improve efficiency, including enlisting reception staff to distribute surveys.

AUA results are triaged based on frailty risk:
AUA score 1-2: low risk
AUA score 3-4: medium risk
AUA score 5-6: high risk

Intake Assessment:

- Patients who score ≥3 on the AUA screen or report memory changes, decreased exercise, or recent falls are offered a frailty intake assessment with the Eldercare RN.
- During the intake assessment, the nurse and patient discuss screening results, current supports in place, and necessity for a comprehensive frailty assessment.

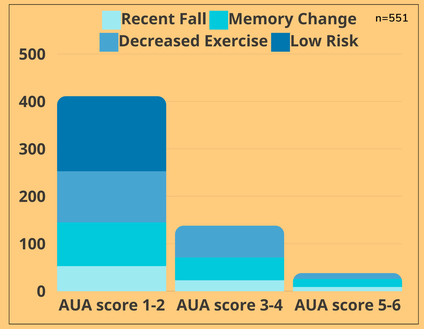
Comprehensive Frailty Assessment:

- If appropriate, patients are invited for an in depth assessment of overall health, function, and social capacities.
- A personalized care plan is developed to optimize health and quality of life, including referrals to other healthcare providers at the FHT and community resources.

RESULTS

1. Screening

Of the 1017 patients invited to complete the AUA questionnaire, 551 responses were received.



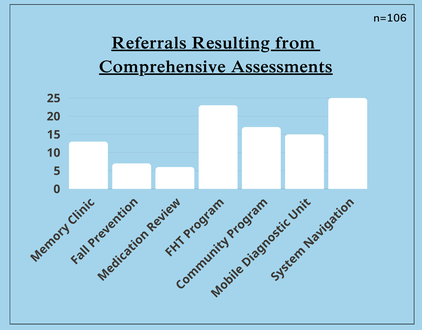
2. Intake Assessment

256 patients screened mod-high risk for frailty and completed an intake assessment.

FOLLOW UPS AND REFERRALS

3. Comprehensive Frailty Assessment

106 patients were referred for a comprehensive frailty assessment



Follow up appointments are offered at three month intervals. Patients are discharged from the Frailty Program when sufficient supports and referrals are in place.

CURRENT AND FUTURE DIRECTION

Step #1 - Completion of initial screen for remaining physicians' practices at Family First Family Health Team.
Step #2 - Re-screen patients at ages 80, 82, and then annually after age 85.
Step #3 - Integrate into existing care pathways and/or create new care pathways with the Archipel OHT and community partners.
Step #4 - Annual re-evaluation of program with a Quality Improvement lens to ensure the needs of this growing demographic are met.
Please note: Family First FHO Physician referrals are accepted directly into the program for patients at risk for frailty.

DISCUSSION & CONCLUSIONS

1. Proactive screening and assessment of frailty identifies more at risk patients, increasing timely access to clinic resources and raising awareness of community programs tailored for frail older adults.
2. Only 24% of patients who completed a comprehensive frailty assessment required their physician's involvement, which helps avoid adding to physicians' time burdens.
3. 25% of patients screened benefited from a referral to additional health prevention programs, including system navigation with the Eldercare RN, FHT programs, and community resources.
5. The Frailty Program works cohesively with our well established Memory Clinic and our Primary Care Mobile Diagnostic Unit (MDU).

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