USING AN ELECTRONIC COMPREHENSIVE GERIATRIC ASSESSMENT AND HEALTH COACHING TO PREVENT FRAILTY IN PRIMARY CARE: THE CARES MODEL

PROJECT DESCRIPTION

In almost every country in the world, the proportion of seniors 65 years and over is growing faster than any other age group. By 2031 in Canada, seniors will account for 22.8% of the population. Additionally in BC, the average annual cost of health care per person is $2,000 for people aged 50-64, $4072 for ages 65-74, and $11,834 for those aged 75+. This rapid and disproportionately aging population predisposed to frailty is placing increasing pressure on an already over-burdened healthcare system (Park et al, 2014). It is reported that many seniors with multiple health issues spend the last decade of their life suffering from the impact of frailty on their health (Morley et. al, 2013). Evidence suggests that the early identification of frailty in the senior population can mitigate or prevent subsequent health decline (Wang et. al, 2014). This has particular importance in primary care settings, where acute medical events typically addressed by primary care clinicians, could result in adverse health consequences for the individual (Lacas & Rockwood, 2012). However, frailty prevention has not been widely integrated as a standard of primary care in British Columbia.

In 2016, the Fraser Health Authority addressed this need by piloting a novel project aimed at reducing the impact of frailty on 'at risk' seniors, led by a steering committee that included patient voices. The Community Action and Resources Empowering Seniors (CARES) program is a four-step evidence-based initiative that combines an electronic Frailty Index & Comprehensive Geriatric Assessment (eFI-CGA) and health coaching to addresses frailty in a holistic and proactive way (Park et al, 2014).

First, primary care providers identify and assess 'at-risk' seniors using a Clinical Frailty Scale (Rockwood et. al, 2005) and the eFI-CGA tool. Next, the primary care team will work with senior participants to inform an individualized care plan to enhance their health and quality of life. Then, community collaborators (such as Seniors Come Share Society, Caregivers BC, and United Way) will provide support to the seniors in managing their care plan. In BC, telephone health coaches are provided for free to seniors through Self-Management BC.

WHAT YOU NEED TO KNOW

IMPACT & OUTCOMES

Short Term Benefits

Seniors:

- Improved awareness for seniors of their health status, increased self-management and health promotion opportunities and ability to manage chronic health issues.
- Enhanced self-management capacity and utilization of community-based supports; reduction of reliance on care team.

Physicians:

- Improved accuracy, reliability and sensitivity in measurement of frailty in seniors.
- Enhanced education for primary care providers in frailty, an evidence-based frailty assessment tool and a reliable health coaching community-based partnership to support the adoption of health protective factors in their patient's education.

Fraser Health/Community:

- Improved augmentation of health protective factors to address preventable components of frailty (social, physical, mental, nutrition, etc.).
- Improved determination of multifactorial interventions to frailty such as health coaching; can be used to address frailty in a better way (I.e. address preventable components including reducing meds, improving housing, increasing exercise, etc.)

Long Term Benefits

Seniors:

- Improved seniors' health and quality of life in later years.
- Supporting seniors in aging well in their community settings
- Educated seniors as informed partners in the self-management of their health care; greater connection to community support agencies.

Physicians:

- Reduced costs of care and increase sustainability of the health system.
- Reduced avoidable admissions to acute care and premature admission to residential care systems.
- Reduced unnecessary emergency room visits.
- Ability to track and monitor frailty index over time.

Fraser Health/Community:

- Standardized approach to assessing and managing seniors in primary care.
- Increased support for primary care providers through team-based approach to managing at risk seniors.
- Increased capacity development through physician partnership with community seniors' connectors to help identify acceptable programs for exercise, socialization, and other supports (I.e. Self-Management BC).
- Contribution to a body of knowledge that informs research and best practice in senior care.

NEXT STEPS

The pilot evaluation of CARES demonstrated a statistically significant decrease in the eFI-CGA scores of participants, amongst other benefits that impact the care of seniors (as seen on the figures on Page 2). Subsequently, Fraser Health has collaborated with Divisions of Family Practice, Self-Management BC, and other local primary care clinics to spread the CARES model into additional community settings. Having demonstrated positive impacts on seniors, health care systems, and community networks, CARES is now seeking opportunities for collaboration with partners across British Columbia.