Healthcare Excellence Canada | Excellence en santé Canada

Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

Addressing Frailty in the Community: connecting to community-based services

Prepared by Cathexis for Healthcare Excellence Canada and the Canadian Frailty Network

About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners to spread innovation, build capability, and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaborations with patients, essential care partners and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence.

HEC focuses on improving care of older adults, bringing care closer to home, and supporting pandemic recovery and resilience – with quality and safety embedded across all our efforts. We are committed to fostering inclusive, culturally safe, and equitable care through engagement with different groups, including patients and essential care partners, First Nations, Métis and Inuit, healthcare workers and more.

Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement. We are an independent, not-for-profit organization funded primarily by Health Canada.

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About this report

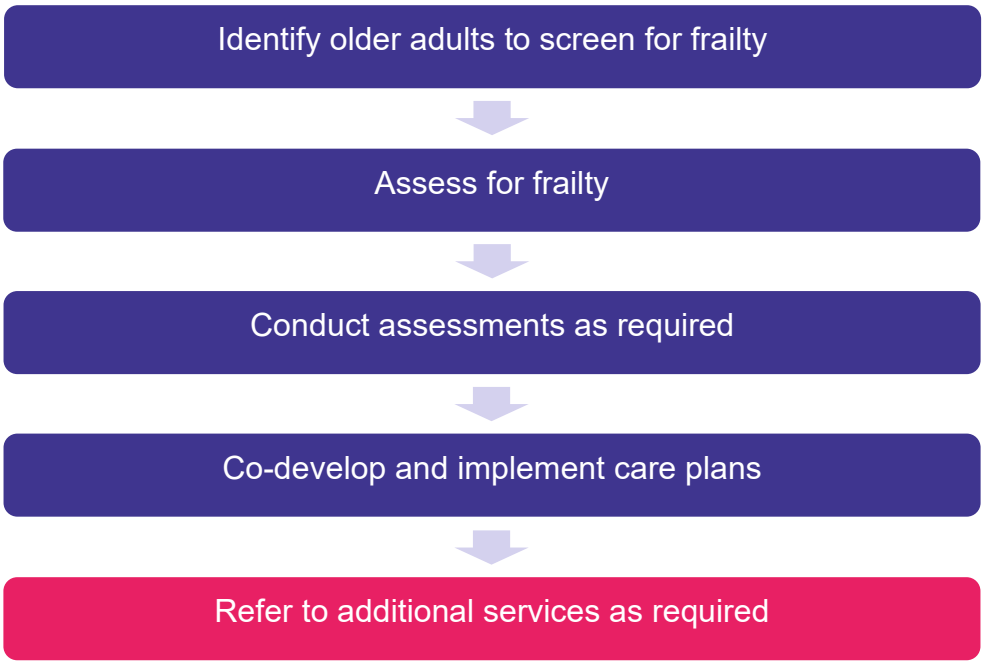
From late 2019 to March 2022, Healthcare Excellence Canada (HEC) and the Canadian Frailty Network (CFN) supported 17 teams from primary care and community settings across Canada through specific initiatives to implement interventions to improve care for older adults with frailty through the Advancing Frailty Care in the Community (AFCC) collaborative.

Participating teams could choose from a menu of evidence-based frailty models or adapt others as appropriate. Regardless of the approach chosen, all followed the same basic care pathway.

The range of variation demonstrates the adaptability of the care pathway to suit many different settings and contexts. This report spotlights some of the variations in how frail older adults were linked to further services, which is the last step in the frailty care pathway. The information was derived from team final reports and interviews with implementation team members.

Despite the variation across the 17 teams, there were commonalities in how frail older adults were linked to additional services. Some teams used a dedicated provider to connect frail older adults and their caregivers with the supports and services they needed (e.g., system navigators, community connectors). In some cases, this person was involved in other parts of the care pathway, in other cases, this was a stand-alone position dedicated to community connections. Some teams made referrals to internal resources, while others referred to a combination of internal and external services. For sites without existing relationships with referral partners, it was a challenge to cultivate some of the relationships that enable referrals to flow smoothly.

Frailty care pathway



Dedicated staff

Community Connectors – Fraser Health Authority (British Columbia)

Three initiatives in British Columbia used dedicated personnel, called “community connectors,” to link frail older adults to additional services. Community connectors were established through the United Way of BC’s Healthy Aging Social Prescribing Program.

Frail older adults in need of social connections are referred to community connectors with a “social prescription” from their healthcare provider. Community connectors meet with patients and offer suggestions to engage them in activities of interest. They conduct a motivational interview with the clients and their caregiver(s) if involved, and they refer them to services in the community including physical activities, nutrition support, caregiver support and/or social engagement.

Community connectors can receive referrals from primary care clinics and assisted living facilities. Some community connectors stay connected with their clients on a regular basis; all do six-week check-ins and provide reports back to the primary care providers. .

Community connectors are knowledgeable about local programs and services and establish relationships with frail older adults, which can help uncover additional needs. This dedicated resource takes the onus off primary care providers to stay “up to date” about frequently changing community-based services.

System Navigators – Gateway Community Health Centre (Ontario)

System navigators were used in a community health centre to support the social and medical needs of frail older adults. Unlike the community connectors, they become involved in the frailty care pathway earlier on once the person is identified as frail and support coordinated care planning.

At Ontario’s Gateway Community Health Centre, for example, the system navigators carry a caseload of about 120 patients. These positions existed prior to the implementation of their AFCC initiative, but were seen as key to optimal service provision.

The system navigators complete a coordinated care plan with the client and can focus on client goals and then support the client to access services or supports in the community. As a community H=health centre, on-site interdisciplinary practitioners are available to support diverse patient needs (respiratory therapist, social worker, community resource worker). However, the system navigators go beyond the traditional referral pathways. They use local service clubs like the Lions Club or Kiwanis to get support and services. They know the service providers and have some of those “back door numbers” they can use to support a client getting services from other programs. Part of their role is to become familiar with the services in the community. The navigators also do periodic check-ins with clients, as often as bi-weekly if needed.

The system navigators go beyond the medical needs of clients and talk to them, for example, about seeing a dietitian, or letting them know about the local Good Food Box program. They look across the social determinants of health to address client needs. The system navigators can take time to build trusting relationships with their clients so that they feel comfortable talking about their full needs.

Linking to in-house services

Many frailty interventions were implemented in team-based care settings where referrals to additional in-house services were part of the existing referral process. For example, the Platinum Navigation program at the Southern Alberta HIV Clinic made referrals to geriatric medicine, pharmacy, dietetics, and social work based on each patient's responses to their standardized assessment. Patients who reported having had a fall, or impaired gait/balance were offered a geriatric medicine referral. Patients who reported taking 10 or more non-antiretroviral medications were offered a pharmacy referral. Those reporting unintentional weight loss were offered a dietitian referral. And those reporting food insecurity, loneliness or interpersonal violence were offered a social work referral.

Interventions implemented in community health centres or family health teams also had on-site interdisciplinary professionals available for referrals. For example, the New Vision Family Health Team in Kitchener, Ontario includes access to doctors, pharmacists, dieticians, social workers, nurse practitioners, registered nurses, and specialists like geriatricians.

Likewise, the frailty intervention implemented at the Sage Seniors Association used all the services and programs offered at Sage. This included appointments with primary care providers and allied health providers (when the clinic was open), including a pharmacist, physiotherapist, mental health therapist, dental hygienist, denturist and footcare specialist. Patients were also provided with access to Sage's social work programs, including help with information and referral, securing housing, accessing financial assistance and benefits, addressing hoarding behaviour, and finding safety from elder abuse and exploitation (including shelter and support).

Similarly, the frailty intervention implemented at The Alex, a senior's health centre (SHC) in Alberta, relied upon in-house services. This included enhanced social support during the pandemic (food, essentials, medications in-person delivery with a visit; telephone outreach and visits), social work (brief supportive counselling, assistance with form completion, tax returns, accessing benefits, maintaining housing), and allied healthcare (foot care, massage, physiotherapy, dietitian, optometry, limited dental due to the pandemic). Social activities were mostly suspended during pandemic, but were offered by a partner organization Carya, located across the street from the SHC.

Linking to in-house and existing referral partners

Some interventions used a combination of internal and external referrals. For example, at the MINT Memory Clinics in Ontario, patients were referred for in-house geriatrician assessments. Patients identified as a fall risk may also be referred to a community falls prevention program. Those identified as socially isolated were referred to an appropriate community program (e.g., adult day program). Those with poor nutrition were referred to a community dietitian or practice setting dietitian, as available. Those with low physical activity were referred to community exercise programs.

Similarity, the Family First Family Health Team in Ottawa, a physician-led family health centre that houses primary care physicians and allied health professionals, made referrals to their in-house practitioners (including a clinical pharmacist) and external partner organizations, where required.

Some of the more traditional primary care clinics referred to their existing list of external partners. For example, the registered nurse involved in the frailty intervention in Ladysmith, BC, conducted additional screening and co-developed care plans that included referrals to known community programs like the Self-Management Program available through University of Victoria, Community Health Services or, if appropriate, to Geriatric Specialty Services.

For frailty interventions implemented in-home care settings, referrals were part of the program. For example, additional services beyond the New Brunswick Extra Mural Program interdisciplinary team could have included Meals on Wheels, the Alzheimer's Society, home support or homemaker services, Social Development - Long Term Care services and assessments, or tours of a Special Care Home. Here, referrals were part of the standard care pathway.

The challenges with system navigation

The New Vision Family Health Team in Ontario employed their nurse practitioner to provide intensive support for patients identified as frail. The Family Health Team had a number of in-house providers to whom referrals could be made, including pharmacists, dieticians, social workers, registered nurses, and specialists like geriatricians. But learning about and navigating additional supports and services beyond the traditional healthcare system was a challenge. The system navigator noted the importance of building and maintaining relationships with community partners to break down siloes and work together to meet the needs of older adults.

What do these spotlights reveal?

For some implementation sites, referrals are part of the standard care pathway (e.g., sites with team-based care, specialty clinics, home care programs, and community-based organizations).

Other implementation sites had specific individuals whose jobs included being knowledgeable about community-based resources and referral sources (e.g., community connectors, system navigators, social workers).

If sites do not have existing positions or in-house interdisciplinary team members, they may consider a new position for a dedicated professional to link individuals to community resources or assigning this role to an existing team member. Those linking frail older adults to programs and services must have a robust understanding of both local health and social services, and sufficient capacity to create and nurture relationships with community partners.