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## POSTER ABSTRACT

# Implementing a new model in primary care for older Canadians living with frailty

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Jacobi Elliott<sup>1</sup>, Joanie Sims-Gould<sup>2</sup>, Susie Gregg<sup>1</sup>, Anik Giguere<sup>3</sup>, Sara Mallinson<sup>4</sup>, Kenneth Rockwood<sup>5</sup>, Paul Stolee<sup>1</sup>

1: University of Waterloo, Canada;

2: University of British Columbia;

3: Universite Laval, Canada;

4: University of Calgary, Canada;

5: Dalhousie University, Canada

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**Background:** Effective models for complex patients in primary care require appropriate targeting, engagement of patients and caregivers, and coordination with other services (McCarthy et al., 2015). A large national project, funded by the Canadian Frailty Network, aims to co-design and implement a model in primary care that includes risk-stratification, patient engagement and care coordination techniques for older Canadians living with frailty. This presentation focuses on the process of implementing the intervention in primary care sites in Canada.

**Methods:** Grounded in frameworks for implementation, the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009) and The Behaviour Change Wheel (BCW; Michie et al., 2011), researchers worked with eight primary care sites (urban and rural) in three Canadian provinces. Project implementation was completed in two phases. Pre-implementation: individual and focus group interviews with providers (n=35) and older adults (n=8) were conducted to understand current care practices and plan for implementation. Intervention was co-designed with staff and older adults. Implementation: Researchers worked with primary care sites to train staff and support implementation. Monitoring of the implementation process included Interviews with providers (n=15) and field notes. Data were analyzed using directed coding, following the CFIR and BCW.

**Results:** A number of learnings emerged during the implementation phases. Buy-in was required from the entire team as well as management. Team members provided meaningful information to guide implementation, which contributed to a sense of ownership of the process. It was important that intervention components were tailored to the needs at each site. Ongoing and frequent discussions with the team was necessary to support successful implementation. Scheduling meetings and training sessions for staff was challenging due to the length of time away from direct patient care.

**Discussion/Conclusion:** A new primary care model for complex patients that included risk-screening, care coordination, patient engagement and shared decision-making, was implemented in eight primary care sites. Lessons from this project will be used to guide future implementation of similar interventions in other primary care sites.

**Lessons learned:** Implementation of a complex intervention takes time. A significant amount of time should be dedicated to the pre-implementation phase for appropriate co-development of resources. Implementation planning should be done in partnership with primary care providers to increase buy-in and older adults.

**Limitations:** This project was only completed in team-based primary care settings.

**Suggestions for future research:** This work was completed in team-based settings and involved non-physician roles to carry out the intervention. More work is needed to understand how this model would need to be adapted in other primary care settings.

**References:**

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