

THE ECOSYSTEM OF EVIDENCE

Navigating the future
of the ecosystem of evidence

Artificial intelligence and digital transformation
in research and healthcare

11th EBHC International Conference
Taormina, 21st – 24th October 2026

#EBHC2026

Developing a peer-led telephone intervention for older adults that would slow down and/or prevent the progression of frailty

Effectiveness of peer coaches

Patrick McGowan PhD
Faculty of Health
U of Victoria, BC, Canada

30th 1996-2026 GIMBE EVIDENCE FOR HEALTH

International Society for Evidence-Based Health Care

Background and aims

Background

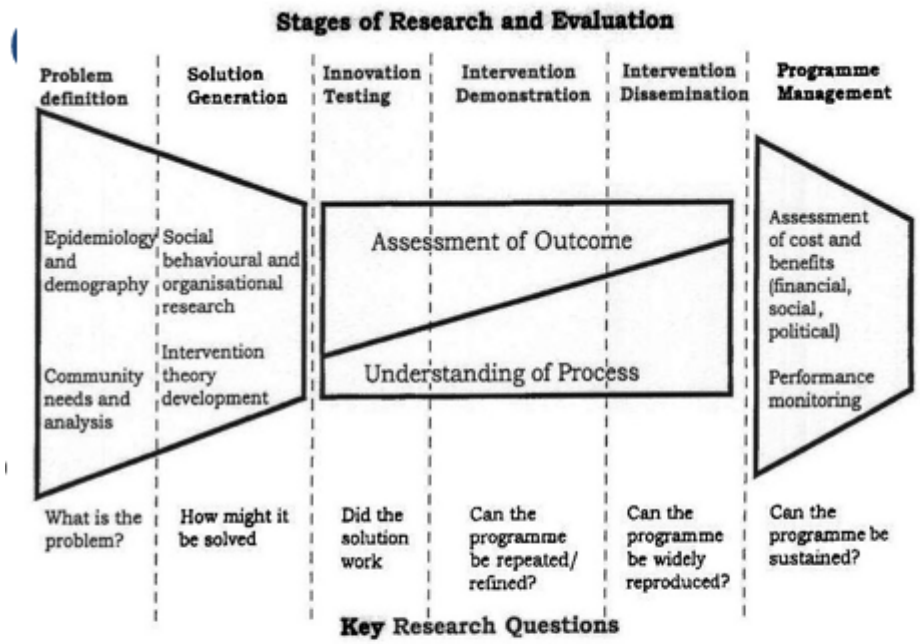
Aging population, biological and social changes increase risk of chronic conditions and functional loss leading to frailty. Older adults with frailty are more vulnerable to minor stressors, take longer to recover from illness (increase costs), and have difficulty participating in daily activities.

There are few community-based inexpensive interventions that assist older adults concerned with becoming frail.

Aim

To develop and evaluate effectiveness of a telephone peer-coach program to assist older adults manage chronic conditions and slow down and /or prevent progression of frailty.

Methods



(Nutbeam D. 1998)

Study 1 – 2017 longitudinal study (n=115)
Study 2 – 2021 RCT with 170 seniors
Study 3 – 2023 waitlist control design N-128

3 Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

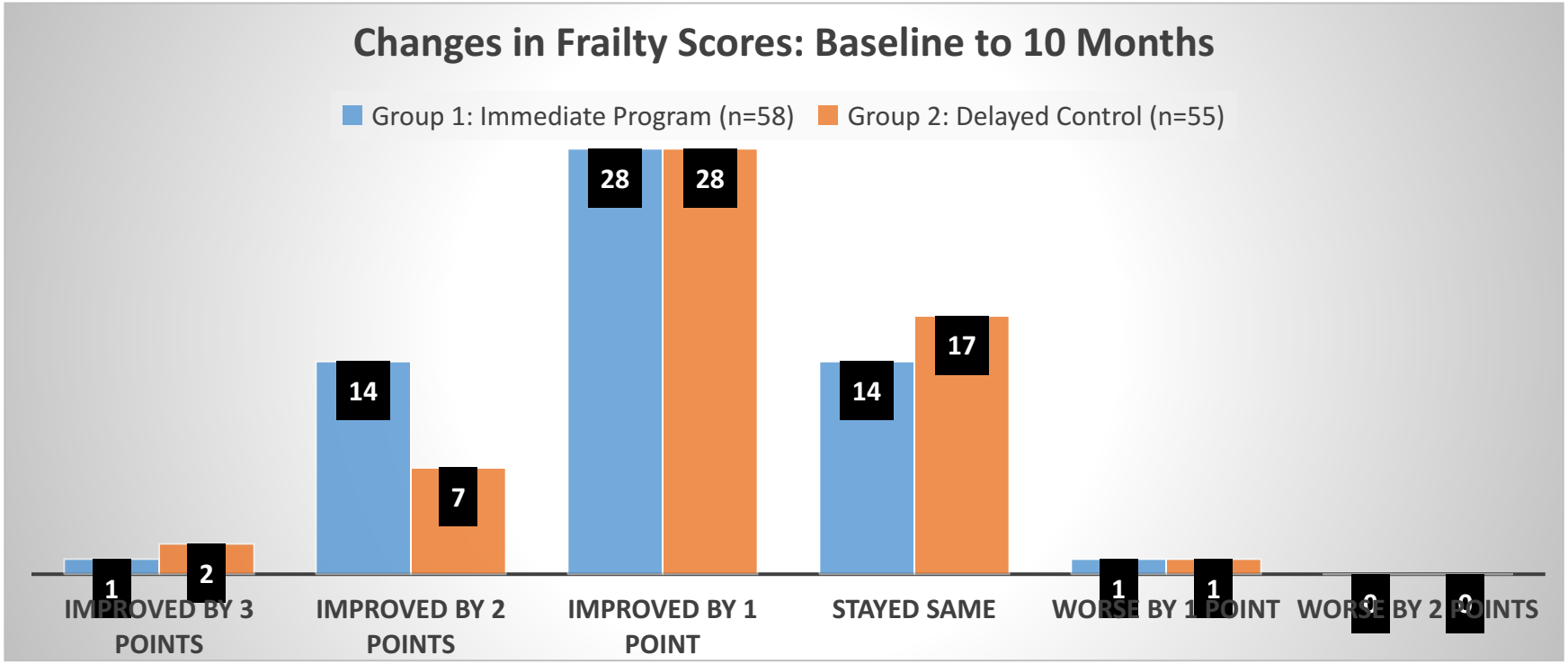
4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



Results



- **70.8% (80 of all 113) participants who completed the program IMPROVED frailty score**
- **27.4% (31 or 113) participants remained at the same frailty level**
- **only 2 (1.8%) participants scored worse (by one point)**

Limits and conclusions

Limits

Relative heterogeneity of the sample resulting in low statistical power to detect a significant interaction effect. The precision of the clinical frailty scores may not be quite exact, and a one-point change could easily be within a random and/or measurement error or even simply based on how the participant was feeling during the particular time period when they were assessed.

Conclusion

Formal assessment of frailty in a clinician's office is a highly time-consuming process, and one that is not likely to be adopted by general practitioners. The results of the intervention described in this study offer modest evidence that an inexpensive Frailty Self-Management Program led by peer coaches for 45 minutes a week over 13 weeks and based on the Canadian Frailty AVOID strategy can benefit older adults experiencing frailty.

The program now receives ongoing funding from the Provincial Ministry of Health.