Co-funded by
the Health Programme
of the European Union

advantAGE
MANAGING FRAILTY

Title:	**D7.2 European Guide for integrated models of care for frailty**
Work Package Leader:	NHS Lanarkshire
Work Package:	WP7
Author (s):	Anne Hendry, Ana María Carriazo, Eliane Vanhecke, Aaron Liew, Teija Hammar, Olatz Albaina on behalf of Work Package 7 ADVANTAGE Joint Action partners.
Date of submission:	December 2019

This report is part of Joint Action '724099 / ADVANTAGE' which has received funding from the European Union's Health Programme (2014-2020).

Table of contents

Goals

- Analyse the literature to understand the best models of care to prevent or delay progression of frailty and to enable people to live well with frailty.
- Describe good practice examples across the continuum of care and support and consider lessons to transfer and scale up the most comprehensive models of care.
- Analyse the impact and cost effectiveness of integrated care and intermediate care for older adults with frailty.

Main conclusions of the reviews developed by the WP

Frailty is a potentially reversible syndrome that is best managed within an integrated health and social care system, as for chronic disease, and with an enablement and rehabilitation focus to optimise functional ability, particularly at times of transition between home and hospital or care home. There is some evidence of cost-effectiveness and positive outcomes from a coordinated and interdisciplinary approach, particularly where the models of care include:

- Home care, education and support
- Improved transitions of care between hospital and home
- Case management and coordination by an interdisciplinary community team

A systematic review of 18 comprehensive integrated care programmes for people with multimorbidity or frailty reported improved health-related quality of life, function, and satisfaction with care but no reduction in health services utilisation or costs. Seven of nine studies of integrated primary care for frail older people evidenced reduced hospital and/or long-term care utilisation. Key components of an effective integrated model of care are:

- Single entry point in the community, generally in Primary Care, for comprehensive assessment and individualised care plans for older people and their caregivers.
- Use of simple frailty specific screening tools in all care settings.
- Case management.
- Coordination of home support and community services by a continuous partnership between case manager, primary care team and all care providers.
- Multiple interventions (physical, cognitive, social and functional) by an interdisciplinary team, both in hospitals and community, tailored to achieve the outcomes that are important to the individual, increase independence and reduce

the risk of adverse events.

- Effective management of transitions between care teams and settings.
- Electronic information tools and technology enabled care solutions.
- Adoption of clear policies and procedures for service eligibility and care processes.

Intermediate care and transitional care are a broad range of time limited services, from crisis response to support for several weeks or months, that aim to ensure continuity and quality of care and promote recovery at times of a deterioration in health, or when moving between home, hospital or care home. A systematic review of 133 studies of intermediate care and transitional care services for older adults found strong evidence that intermediate care can improve functional outcomes and reduce adverse events, including preventable early readmissions and premature admission to long term care. There is more evidence for intermediate care delivered at home than for bed-based interventions. The impact of transitional care on functional ability, independence and health and social care costs is not clear.

Recommendations to be adopted by European Commission

- Raise awareness in policy leaders of the importance of prevention and management of frailty within an integrated health and social care system
- Create opportunities for MS to collaborate on implementing, twinning and scaling up integrated care approaches to prevent and manage frailty
- Ensure future research calls enable evaluation and comparison of effectiveness of different models of care for frailty in the EU.

Recommendations to be adopted by national/regional authorities

- Ensure models of care to prevent functional decline, frailty and disability address physical, cognitive and psychosocial dimensions within an integrated health and social care system.
- Support providers to deliver coordinated and interdisciplinary care based on person centred comprehensive geriatric assessment and tailored interventions to maximise independence and achieve positive outcomes for individuals, carers and for the system.
- Build capacity for intermediate care services by an interdisciplinary team that links different providers and levels of care in a collaborative network of care and support that includes partners from community and voluntary sectors and has a focus on recovery and rehabilitation at home.
- Consider data from different care providers and settings to understand the impact of

models of care on the system, not just the costs and benefits for health services

Recommendations to be adopted by health and social professionals

- Adopt relational approaches, creative solutions and simple technologies that enable and support older adults, their families and caregivers to be fully involved in care planning, goal setting and monitoring from early stages.
- Apply a person centred and enablement approach and focus on outcomes that matter for the individual, and their caregiver, such as care experience, quality of life, ability to participate in society, and independence and wellbeing.
- Tailor the nature, duration and intensity of multi-dimensional interventions to the needs of the individual, in collaboration with their family and caregivers.

Recommendations to be adopted by older people

- Understand what you can do to stay active and as well as you can be.
- Take an active role in planning your care and support with your professionals
- Expect your care to be well coordinated and provided at the right time and in the best place to achieve the outcomes that are important to you.
- Give feedback on your experience of care to help professionals and authorities understand how to continually improve the model of care

Recommendations to be adopted by the informal caregivers

- Take an active role in planning care for, and with, the person you support.
- Ask care professionals for the information, training and support you need to stay well and able to continue in your caring role.
- Give feedback on your experience as a caregiver to help professionals and authorities understand how to continually improve the model of care

References

Béland F, Hollander MJ (2011). Integrated models of care delivery for the frail elderly: international perspectives. Gaceta Sanitaria,25 Suppl 2:138-46. doi:10.1016/ j.gaceta.2011.09.003

Hopman P et al. (2016). Effectiveness of comprehensive care programs for patients with multiple chronic conditions or frailty: A systematic literature review. Health Policy, 120:818-823. doi: 10.1016/j.healthpol.2016.04.002.

Hendry A, Vanhecke E, Carriazo AM, López-Samaniego L, Espinosa JM, Sezgin D et al. Integrated Care Models for Managing and Preventing Frailty: A Systematic Review for the European Joint Action on Frailty Prevention (ADVANTAGE JA). Transl Med UniSa. 2019 Jan 6;19:5-10. eCollection 2019 Jan-Jun.

Hendry A, Carriazo AM, Vanhecke E, and Rodríguez-Laso A. (2018). Integrated Care: A Collaborative ADVANTAGE for Frailty. International Journal of Integrated Care, 2018; 18(2): 1, 1–4. DOI: https://doi.org/10.5334/ijic.4156

Looman WM, Huijsman R, Fabbricotti IN (2018). The (cost-)effectiveness of preventive, integrated care for community-dwelling frail older people: A systematic review. Health Soc Care Community. 2018;00:1–30. https://doi.org/10.1111/hsc.12571