Falls & Bone Health and Frailty: Tracers for Integrated Care

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International Foundation for Integrated Care

IFIC is a non-profit members’ network that crosses organisational and professional boundaries to bring people together to advance the science, knowledge and adoption of integrated care policy and practice.

The Foundation seeks to achieve this through the development and exchange of ideas among academics, researchers, managers, clinicians, policy makers and users and carers of services throughout the World.
+2 HEALTHY LIFE YEARS by 2020
A triple win for Europe

- A1: Adherence and medication
- A2: Falls prevention
- A3: Frailty
- B3: Integrated care
- C2: Independent living
- D4: Smart cities and communities
# World Report on Ageing and Health

<table>
<thead>
<tr>
<th>Conventional care models</th>
<th>Older person centred and integrated care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focuses on a health condition (or conditions)</td>
<td>Focuses on people and their goals</td>
</tr>
<tr>
<td>Goal is disease management or cure</td>
<td>Goal is maximizing intrinsic capacity</td>
</tr>
<tr>
<td>Older person regarded as a passive recipient of care</td>
<td>Older person is an active participant in care planning and self-management</td>
</tr>
<tr>
<td>Care is fragmented across conditions, health workers, settings and life course</td>
<td>Care is integrated across conditions, health workers, settings and life course</td>
</tr>
<tr>
<td>Links with health care and long-term care are limited or non-existent</td>
<td>Links with health care and long-term care exist and are strong</td>
</tr>
<tr>
<td>Ageing is considered to be a pathological state</td>
<td>Ageing is considered to be a normal and valued part of the life course</td>
</tr>
<tr>
<td>Period</td>
<td>High and stable capacity</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
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<tr>
<td>Risks and challenges</td>
<td>Risk behaviours, emerging NCDs</td>
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### Goals

- **Build and maintain capacity and resilience**
- **Reverse, stop or slow the loss of capacity**
- **Compensate for loss of capacity**

### Responses

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<th>Period</th>
<th>High and stable capacity</th>
<th>Declining capacity</th>
<th>Significant loss of capacity</th>
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<td>Risks and challenges</td>
<td>Risk behaviours, emerging NCDs</td>
<td>Falling mobility, sarcopenia, frailty, cognitive impairment or dementia, sensory impairments</td>
<td>Difficulty performing basic tasks, pain and suffering caused by advanced chronic conditions</td>
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</table>

#### Build and maintain capacity and resilience
- Reduce risk factors and encourage healthy behaviours
- Early detection and management of chronic diseases
- Build resilience through capacity-enhancing behaviours, strengthening personal skills and building relationships

#### Reverse, stop or slow the loss of capacity
- Implement multicomponent programmes delivered at primary health-care level
- Treat the underlining causes of declines in capacity
- Maintain muscle mass and bone density through exercise and nutrition

#### Compensate for loss of capacity
- Interventions to recover and maintain intrinsic capacity
- Care and support to compensate for losses in capacity and ensure dignity
- Rapid access to acute care
- Palliative and end-of-life care
ICOPE

• Improve MSK function and vitality
• Prevent cognitive impairment; promote psychological wellbeing
• Prevent falls
• Maintain sensory capacity
• Manage age associated conditions
• Support caregivers
Frailty is a progressive age-related decline in physiological systems that results in decreased reserves of intrinsic capacity, which confers extreme vulnerability to stressors and increases the risk of a range of adverse health outcomes (WHO 2015).

Early identification and intervention can reverse / delay the trajectory

<table>
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<th>Robust</th>
<th>Pre-Frail or Frail</th>
<th>Functional Limitation</th>
<th>Disability</th>
<th>Dependency</th>
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<td><img src="image1.jpg" alt="Robust Image" /></td>
<td><img src="image2.jpg" alt="Pre-Frail or Frail Image" /></td>
<td><img src="image3.jpg" alt="Functional Limitation Image" /></td>
<td><img src="image4.jpg" alt="Disability Image" /></td>
<td><img src="image5.jpg" alt="Dependency Image" /></td>
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Prevention and Early Intervention

Let's put more effort into 'prevention'

Was there more that could have been done up THERE?
ADVANTAGE JA
A comprehensive approach to promote a disability-free Advanced age in Europe:

- Policy Joint Action: Jan 2017 – Dec 2019
- 22 Member States and 33 organisations
- Co-funded by the EU and the Member States.

www.advantageja.eu
IMPLEMENTATION PHASES

Phase I (2017)
State of the Art evidence review, analysis and SoAR reports

Phase II (2018)
Survey of MS status on frailty, developing and testing a common European model to prevent and manage frailty

Phase III (2019)
draft final documents, debate with MSs, final framework and policy recommendations.
ADVANTAGE JA work packages

- (Coordination WP1+ Dissemination WP2+ Evaluation WP3)
- Knowing frailty at an individual level WP4
- Knowing frailty at a population level WP5
- Treating/approaching frailty at an individual level WP6
- Models of care to prevent, delay or treat frailty WP7
- Extending and expanding knowledge on frailty WP8

Develop ‘Frailty Prevention Approach’ (FPA) and build consensus on addressing Frailty in Europe
Preventing Frailty

• Start active ageing recommendations at mid life
• Assess risk for malnutrition using the Mini Nutritional Assessment
• Promote a Mediterranean diet /daily protein >1-1.2 g per kg
• Target BMI < 30
• Low intensity exercise (endurance, flexibility, balance, resistance training) in sessions of 30 to 45 minutes, three times per week.
• Vitamin D supplement if increased risk for falls / fracture
Identifying Frailty

Opportunistic screening in patients over 70 years using tools that are:

- Quick to administer (taking no more than 10 minutes to complete).
- Do not require special equipment.
- Have been validated and are meant for screening
Frailty levels of patients attending falls prevention & management services in Aberdeen City HSCP
27.11.17 - 1.12.17 (n=159)

Score on Clinical Frailty Scale

Thanks to Rosie Cooper, Falls Lead, Aberdeen HSCP
Managing Frailty

✓ Comprehensive Geriatric Assessment
✓ Care planning and tailored MDT interventions
✓ Telehealth and telecare solutions
✓ Falls prevention interventions
✓ Tools to reduce inappropriate polypharmacy
Integrated Care for Frailty

- a single entry point – generally in Primary Care
- simple screening tools in all settings
- comprehensive assessment and individualised care plans
- tailored interventions by MDT – at home and in hospital
- case management and coordination across providers
- effective transitions across teams / care settings
- information sharing and technology enabled care
- policies and procedures for eligibility and care delivery

Journal of Integrated Care, 2018; 18(2): 1, 1–4. DOI: https://doi.org/10.5334/ijic.4156
Reshaping Care Programme

Preventative and anticipatory care
- Build social networks and opportunities for participation
- Early diagnosis of dementia
- Prevention of falls and fractures
- Information and support for self-management and self-directed support
- Prediction of risk of recurrent admissions
- Anticipatory care planning
- Suitable and varied housing and housing support
- Support for carers

Proactive care and Support at home
- Responsive, flexible, self-directed home care
- Integrated case/care management
- Carer support
- Rapid access to equipment
- Timely adaptations, including housing adaptations
- Telehealthcare

Effective care at times of transition
- Reablement and rehabilitation
- Specialist clinical advice for community teams
- NHS24, SAS and out-of-hours access ACPs
- Range of intermediate care alternatives to emergency admission
- Responsive and flexible palliative care
- Medicines management
- Access to range of housing options
- Support for carers

Hospital and care home(s)
- Urgent triage to identify frail older people
- Early assessment and rehab in the appropriate specialist unit
- Prevention and treatment of delirium
- Effective and timely discharge home or transfer to intermediate care
- Medicine reconciliation and reviews
- Specialist clinical support for care homes
- Carers as equal partners

Enablers
Outcomes-focused assessment
- Co-production
- Technology, eHealth and data-sharing
- Workforce development, skill mix and integrated working
- Organization development and improvement support
- Information and evaluation
- Commissioning and integration resource framework

Ayrshire and Arran Vision

New Models of Care for Older People and People with Complex Care Needs

- Your Community
  - Community Connectors
  - Carer support
  - Lunch Clubs
  - Befriending
  - Local Activities
  - Third Sector
  - Independent Sector

- Support for end of life or palliative care
- Dementia friendly

Practice Attached Team
- District Nurses
- CPNs
- Pharmacists
- Community Connectors
- Social Workers

Practice Aligned Team
- Care at Home
- ICES
- Community Ward
- Hospital at Home
- AHPs
- Advanced Nurse Practitioners
- Care of Elderly Physicians
- Old Age Psychiatrists
- Palliative / End of life care

- Rehabilitation and Intermediate Care
- Community Hospitals
- Combined Assessment Unit
- Complex Care Team
- Care Home
- Liaison

- Equipment & Adaptions
- Technology Enabled Care
France: PAERPA

**WHAT HAS BEEN DONE**

**PAERPA FRAMEWORK**

- A unique phone number
- A single organization accessible for professionals, patients and caregivers
  - Healthcare network
  - Social & medical-social actors
  - MAIA
  - CLIC
- New roles and responsibilities
- An information system, aiming for interoperability with existing software

**Needs** ➔ **Diagnostics** ➔ **Roadmaps**
PAERPA Process

Elderly people & caregivers

Local professionals

Close Clinical coordination

Missions:
- Evaluate elderly
- Develop Personalized Health Plan (PHP)
- Update the PHP

Requests

Transmission of PHP

Local Coordination

Missions:
- Information & orientation
- Support to local professionals
- According expertise, healthcare, social & medical-social services

CLIC
Centre local d’information et coordination

Healthcare network

Health center

Multidisciplinary Healthcare House

MAIA Pilotes MAIA

Social & medical-social actors
Italy - Sun Frail Model

Health and Social Care Services

Secondary care
- geriatricians, specialists, ...

Primary care
- general practitioners, nurses, social workers, ...

Community
- associations, pharmacy, clubs, churches, gyms, ...

possible pathways
- diagnosis
- secondary prevention
- therapy
- referral

bio-medical response

possible pathways
- identification - referral
- primary prevention and promotion (physical activity, nutrition, ...)
- social activation (voluntary work, informatic literacy, sport, ...)
- individual, family, collective response

social response
Spain: Falls and Frailty

**Intervention algorithm** -

- An individual aged 70 and over attending PHC
  - Barthel Test
    - Barthel > 90
    - Barthel < 90
  - Frailty screening
    - SPPB battery ≥ 10 p.
    - SPPB battery < 10 p.

- Non suitable for the programme

- Autonomous non-frail
  - Determine falls risk
  - Low risk of falls
  - High risk of falls

- Multifactorial intervention on falls prevention:
  - Physical activity programme + medication review + home risks

- Advice on regular physical activity, as part of a comprehensive healthy lifestyle counselling

- Referral criteria to specialise hospital resources (geriatric medicine whenever possible)

* Preferable framed in a multidimensional assessment (comprehensive geriatric assessment (CGA))
Integrated Care Framework

10-Step Integrated Care Framework for Older Persons

1. Establish Governance Structures

2. Undertake Population Planning for Older Persons
   - Frailty Prevalence
     - 11% Severely Frail (Very High Risk)
     - 21% Moderate Frailty (High Risk)
     - 36% Mild Frailty (At risk)
     - 32% Fit (Minimal risk)
   
   Pott, O Haltonr, A (2017) Risk stratification based on frailty prevalence. Titia, Irish Longitudinal study on aging, TIO

3. Map Local Care Resources

4. Develop Services & Care Pathways
   - Rehabilitation
   - Ambulatory Day Care
   - Acute Care
   - Nursing Homes
   - Dementia
   - Falls etc.

5. Develop New Ways of Working
   - New roles including case management approach for long term complex needs
   - In-reach and outreach

6. Develop Multidisciplinary Teamwork & Create Clinical Network Hub
   - Co-ordination between care providers

7. Person-centred Care Planning & Service Delivery

8. Supports to Live Well
   - Enable older persons to live well in the community
     - Community Transport
     - Social Activities
     - Home modifications & handy person
     - Medication Management
     - Shopping
     - Harness Technology
     - Support Carers
     - Information & Advice

9. Enablers
   - Develop workforce
   - Align finance
   - Information systems

10. Monitor & Evaluate
    - Track service developments
    - Measure outcomes
    - Staff and service user experience
Integrated Care Matters

- **Webinar Series and Topic Resources**
  www.integratedcarefoundation.org/scotland

- **Special Interest Groups (SIGs)** hosted on IFIC website:
  - Polypharmacy and Adherence
  - Intermediate Care
  - Palliative & End of Life Care
  - Self Management and Co-production
  - Frailty

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Thank You
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