About the information

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Developed in partnership
Managing frailty

Cano, A et al. (2016) FOCUS: Frailty management optimisation through EIPAHA commitments and utilisation of stakeholders’ input – an innovative European project in elderly care, Family Medicine & Primary Care Review, 18(3), pp.373-376

The goal of FOCUS, which stands for Frailty Management Optimization through EIPAHA Commitments and Utilization of Stakeholders’ Input, is to reduce the burden of frailty in Europe. The partners are working on advancing knowledge of frailty detection, assessment, and management, including biological, clinical, cognitive and psychosocial markers, in order to change the paradigm of frailty care from acute intervention to prevention. FOCUS partners are working on ways to integrate the best available evidence from frailty-related screening tools, epidemiological and interventional studies into the care of frail people and their quality of life.


Frailty is associated with adverse health outcomes, but its association with hospital healthcare costs has not been analyzed. The main objective was to estimate the adjusted annual costs and use of hospital healthcare resources in frail older adults compared to non frail ones.


Because of the dynamic nature of frailty, prospective epidemiological data are essential to calibrate an adequate public health response. Well-designed prospective studies of frailty are necessary. To facilitate comparison across studies and over time, incidence should be estimated in person-time rate. Analyses of factors associated with the development of frailty are needed to identify high-risk groups.


The recognition of frailty as a long-term condition is not merely a semantic issue—a wide range of benefits can be anticipated. Primary care-based registers for frailty could be established and chronic disease models applied systematically for co-ordinated and person-centred preventative and proactive care. A team approach is a key component of long-term condition management, incorporating support, follow-up and behaviour change interventions that go beyond the scope of a traditional medical approach.

The authors used a web-based mixed methods survey to explore the health of frail older adults enrolled in a home-based primary care program in Vancouver, Canada. Despite high levels of co-morbidity and functional dependence, 50 per cent rated their health as good, very good, or excellent. Results suggest that greater focus on symptom management, and supporting social contact, may improve frail seniors’ health.


Although frailty is common among community-dwelling older adults, its prevalence in Europe and how this varies between countries is unclear. A systematic review and meta-analysis of literature on frailty prevalence in 22 European countries involved in the Joint Action ADVANTAGE was conducted. The considerable and significant heterogeneity found warrants the development of common methodological approaches to provide accurate and comparable frailty prevalence estimates at population-level.


The technology making use of ICT solution is beginning to significantly support patients with frailty syndrome in everyday life, improving the standard of their lives. This study looks at results from the CareWell and WRP® pilot projects, which introduced wearable technologies to a group of older people in the Lower Silesian Province. Results indicate a decrease in the GDS index for patients in the intervention group, which may support the implementation of CareWell and WRP® services. Analysis of user satisfaction shows that people participating in the projects are satisfied and would like to continue using new services and new solutions.


Demographic ageing is one of the most serious challenges that Europe is currently facing. Older people are at greatest risk of becoming frail and developing disability, which will ultimately impact on the wellbeing of the individuals and on the sustainability of healthcare systems. However, frailty is not an inevitable consequence of ageing, it can be prevented and treated to foster a longer and healthier life. To this end, the Joint Action (JA) ADVANTAGE, has prepared the State of the Art on Frailty Report, which will support frailty as a public health priority and inform future planning of frailty prevention and management.
**Integrated care**

**Boult, C et al. (2013)** *A matched-pair cluster-randomized trial of guided care for high-risk older patients*, *Journal of general internal medicine*, 28(5), pp.612-621

Patients at risk for generating high health care expenditures often receive fragmented, low-quality, inefficient health care. Guided Care is designed to provide proactive, coordinated, comprehensive care for such patients. Guided Care improves high-risk older patients’ ratings of the quality of their care, and it reduces their use of home care, but it does not appear to improve their functional health.

**Dubuc, N et al. (2013)** *Development of integrated care pathways: toward a care management system to meet the needs of frail and disabled community-dwelling older people*, *International Journal of Integrated Care*, 13, pp.e017

The home care and services provided to older adults with the same needs are often inadequate and highly varied. Integrated care pathways (ICPs) can resolve these issues. The aim of this study was to develop the content of ICPs to follow-up frail and disabled community-dwelling older people. Once computerized, these ICPs will facilitate the exchange of information as well as the clinical decision-making process with a perspective to adequately matching the needs of an individual person with resources that delay or slow the progression of frailty and disability.

**Ghosh, A et al. (2014)** *Evaluating PACE: A review of the literature*, Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Mathematica Policy Research (website)

The Program of All-Inclusive Care for the Elderly (PACE) provides coordinated acute and long-term care services to nursing home (NH) eligible seniors in the community. Based on a comprehensive review of existing evaluations of PACE, this paper brings together available evidence on the effect of PACE on several key outcomes of interest.

**Goodman, C et al. (2012)** *A study of the effectiveness of interprofessional working for community dwelling older people*, NIHR NETSCC: Project report (pdf)

Effective interprofessional working for community-dwelling older people with complex, multiple and ongoing needs is more likely to occur when three key features are present: 1) a functioning link with wider primary care services, 2) a system of communication and evaluation that allows review and input from the older person and family carers, and 3) the presence of a recognised key worker.

This paper describes work by the ADVANTAGE Joint Action (JA), co-funded by the European Union and 22 Member States, to develop a common European approach to the prevention and management of frailty. The authors reflect on the emerging evidence and experience of implementing integrated care for frailty, and invite readers to participate in ongoing dialogue on this topic through the ADVANTAGE JA website and IFIC Academy activities.

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Integrated Care Programme for Older Persons (ICP OP) (2018) Dublin: Health and Safety Executive (website)

The Integrated Care Programme for Older Persons (ICPOP) improves the life of older persons by providing access to integrated care and support that is planned around their needs and choices, supporting them to live well in their own homes and communities.

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Multimorbidity and frailty are highly prevalent and emerging conditions. Contrary to patients’ and primary care providers’ perceptions, multimorbidity does not necessarily imply the onset of frailty. Patients presenting with these complex conditions often have special and unmet clinical needs, requiring an adaptation of traditional care organization and services.

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Improving integration in care requires many components. However, local barriers and facilitators need to be considered. Changes are expected to occur slowly and are more likely to be successful where elements of integrated care are well incorporated into local settings.

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The goal of this analysis is to identify important lessons for policy makers and service providers to enable better design, implementation and spread of successful integrated care models. Case managers or care coordinators who support patient-centred collaborative care are key to successful integration in all our cases as are policies that provide funds and support for local initiatives that allow for bottom-up innovation. However, more robust and systematic evaluation of these initiatives is needed to clarify the ‘business case’ for integrated health and social care and to ensure successful generalization of local successes.
Case management

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(7), pp.818–832

Despite the fact that over the years several (good-quality) studies have been performed to estimate the value of comprehensive care for multimorbid and/or frail patients, evidence for their effectiveness remains insufficient. More good-quality studies and/or studies allowing meta-analysis are needed to determine which specific target groups at what moment will benefit from comprehensive care. Moreover, evaluation studies could improve by using more appropriate outcome measures, e.g. measures that relate to patient-defined (personal) goals of care.

Hopper, L et al. (2018) Case management approaches to support integrated care for older adults, Integrated Care Programme, Older Persons (ICP OP) (pdf)

Case management involves collaborative and multidisciplinary approaches to organising and coordinating care for the individual. It typically comprises of case finding, needs assessment, care planning, care coordination and case closure. Its strength lies in its flexibility and adaptability to a variety of health care settings, but the absence of a clear definition and the existence of numerous overlapping case management models makes evaluation and model comparison very difficult.

Huntley, AL et al. (2013) Is case management effective in reducing the risk of unplanned hospital admissions for older people? A systematic review and meta-analysis, Family practice, 30(3), pp.266-275

Case management is a collaborative practice involving coordination of care by a range of health professionals, both within the community and at the interface of primary and secondary care. It has been promoted as a way of reducing unplanned admissions in older people. The identified trials included a range of case management interventions. Nine of the 11 trials showed no reduction of unplanned hospital admissions with case management compared with the same with usual care.


This was the first meta-analytic review which examined the effects of case management on a wide range of outcomes and considered also the effects of key moderators. Current results do not support case management as an effective model, especially concerning reduction of secondary care use or total costs. This article looks at reasons for lack of effect and highlight key research questions for the future.