World Health Organization

Restructuring health system for frailty care program in low resourced health care settings

Luis Miguel Gutiérrez Robledo

SALUD
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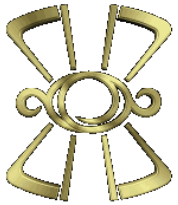

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Por un envejecimiento sano y activo

Discussion topics

- In many countries, primary health care is the first point of contact for health service: perhaps, an ideal place for scaling up care for frail older people.
- Existing health systems are ill- prepared and already struggling to respond to infectious disease and growing NCD epidemics. We will discuss the feasibility and sustainability of organizing care for frail older people at primary health care level in HIC and LAMICs.

Main concerns

DISABILITY PREVENTION

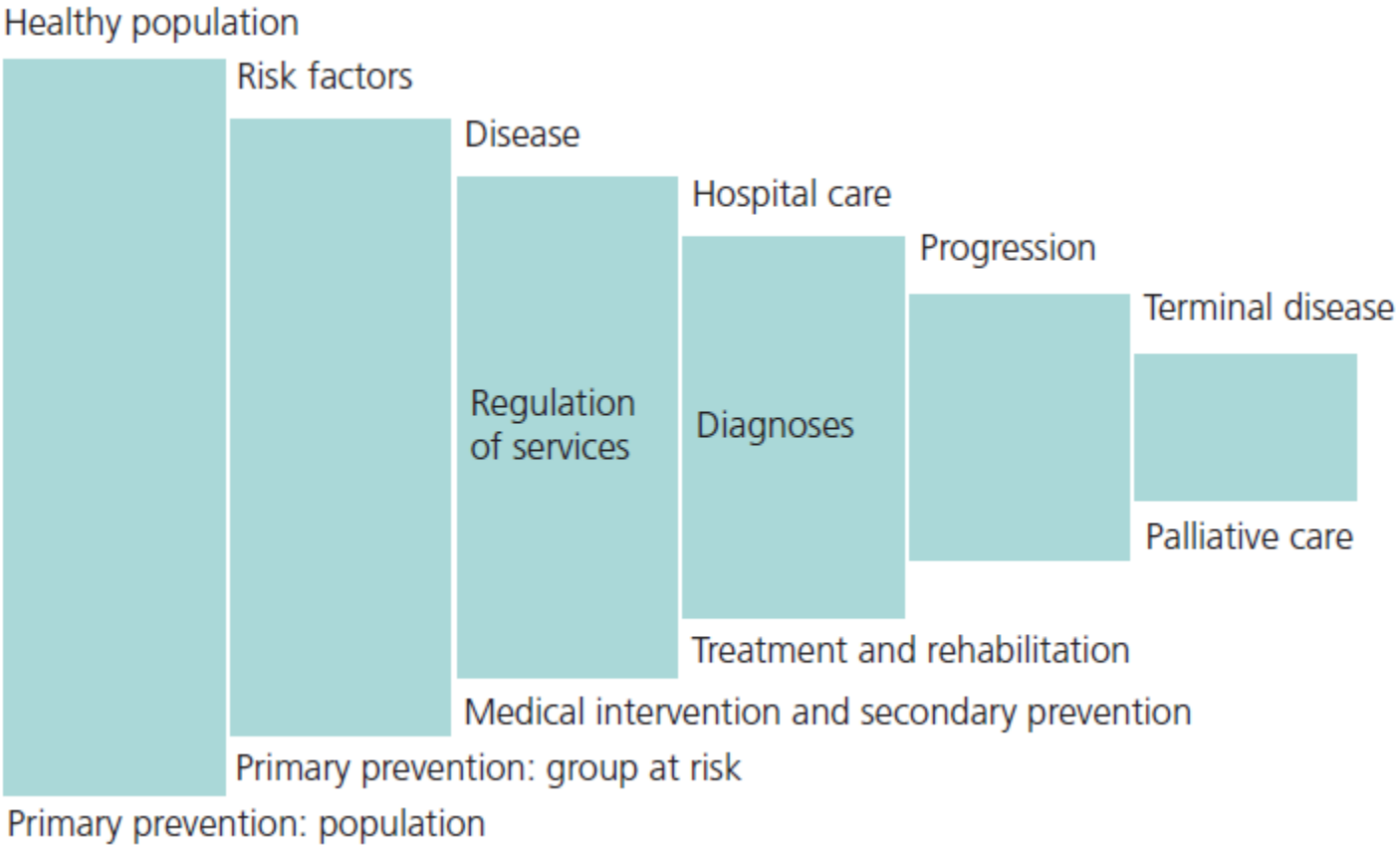
CONCERNS ABOUT RESSOURCE ALLOCATION

RAISING AWARENESS

Principal Aims

- Reduce the prevalence of behaviors that increase the risk of frailty and disability
- Reduce the incidence of frailty and disability and delay their consequences in people who experience them
- Reduce the incidence of other chronic non-communicable conditions in later life that contribute to frailty and disability (Dementia, diabetes, cardiovascular diseases, chronic obstructive pulmonary disease, and some cancers).

Health care integration



Suñol R et al. Towards health care integration: the proposal of an evidence- and management system-based model. *Medicina Clínica*, 1999, 112(suppl 1):97–105.

FRAILTY STAGES AND PUBLIC POLICY GOALS

CLINICAL OBJECTIVES	HEALTHY POPULATION	AT RISK (PRE-FRAILTY)	FRAILTY	DISABLED	END STAGE FRAILTY
SPECIFIC FOR THE STAGE	AVOID RISK STATUS	AVOID FRAILTY DEVELOPMENT	PREVENT ADVERSE OUTCOMES	TRANSITION TO END OF LIFE CARE	PALLIATIVE CARE
KEY CLINICAL INTERVENTIONS	AVOID EXPOSURES	RECOGNIZE AND NEUTRALIZE RISK FACTORS	DETECT AND TREAT	PRESERVE FUNCTION/ SUPPORT THE CAREGIVER	PALLIATIVE CARE AND CAREGIVER SUPPORT
PUBLIC POLICY DOMAINS AND THEIR POTENTIAL IMPACT					
Science and Technology	High	High	High	High	High
Health Care	Minimal	Moderate	Moderate/ high	High	High
Long Term Care				Moderate	High
Public Health	High	Moderate/ high	Low	Low	Minimal

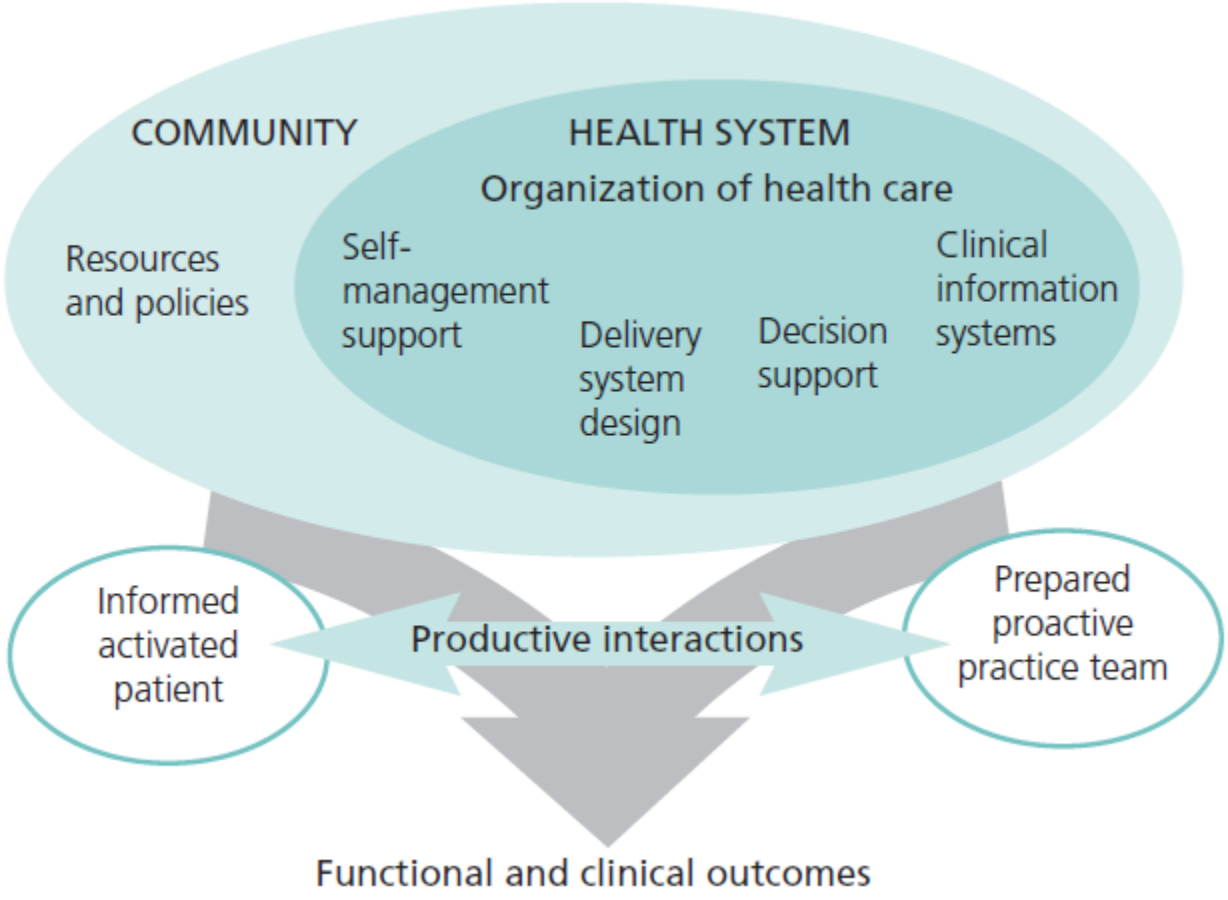
Restructuring the health system for frailty care programs

- Strengthen the primary care level and extend its reach into the community.
- Many frail elders remain living in the community and experience adverse health outcomes out of the sight of the system because they are not detected or cannot access appropriate primary care.
- Enhanced access and achieving universal coverage remain major goals.

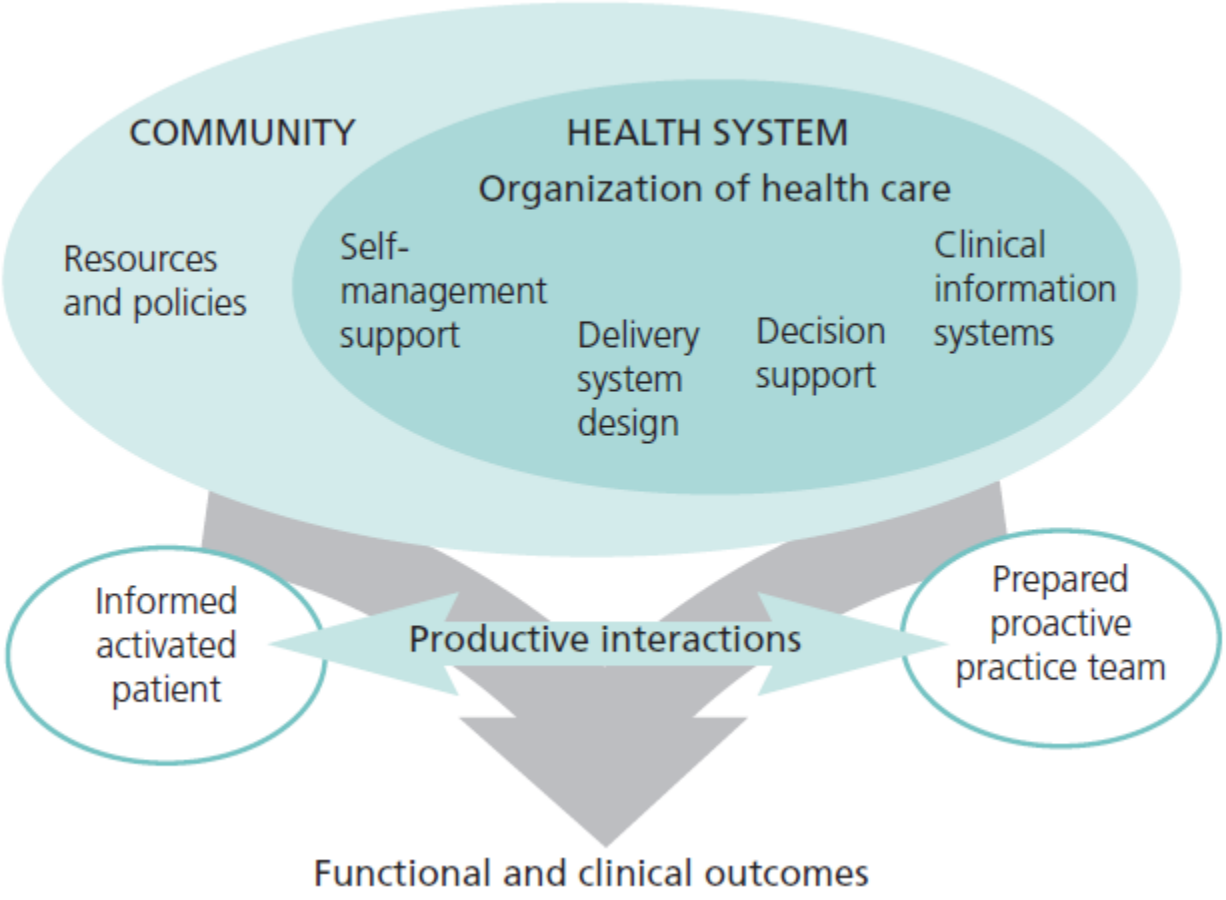
Specific considerations for incorporating frailty care into LAMIC health systems:

- Weak and poorly organized health systems
- Poor gate-keeping function of the primary care setting
- Limited economic resources
- Insufficient and poorly equiped health care facilities
- Lack of properly trained health care professionals
- Need for coordinated health and social care
- Heavy reliance on informal care within the families and other social support networks

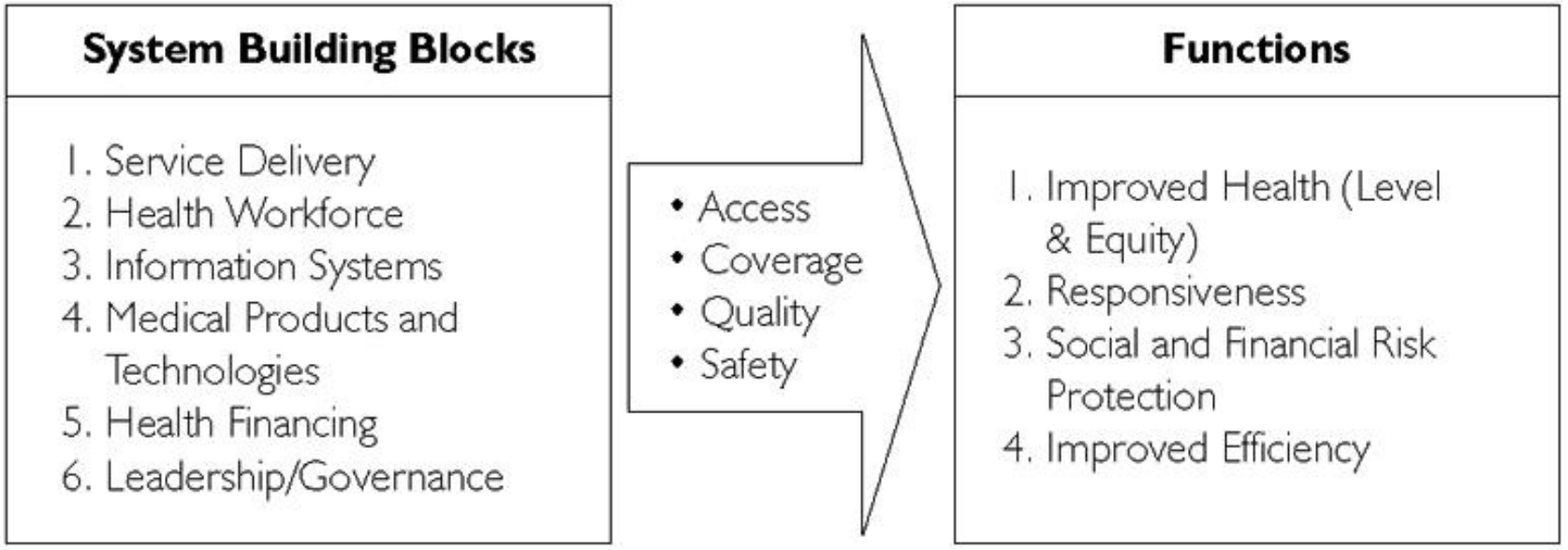
The Chronic Care Model



The Frailty Care Model



WHO building blocks for health system strengthening



Source: WHO 2010b.

The innovative aspects of our model should include:

- integration (health and social services working together);
- substituting skills (using the community workers and/or voluntary sector as case managers);
- substituting the location of care (home- and community-based services);
- segmenting service users into high and lower risk groups; and
- new types of service delivery (tele-health care, case managers visiting people at home).

- surveillance to track trends in long-term conditions and their determinants;
- disease prevention and health promotion to reduce premature morbidity, mortality and disability; and
- health care innovations and effective management strategies tailored to local situations.

Integration of essential care services

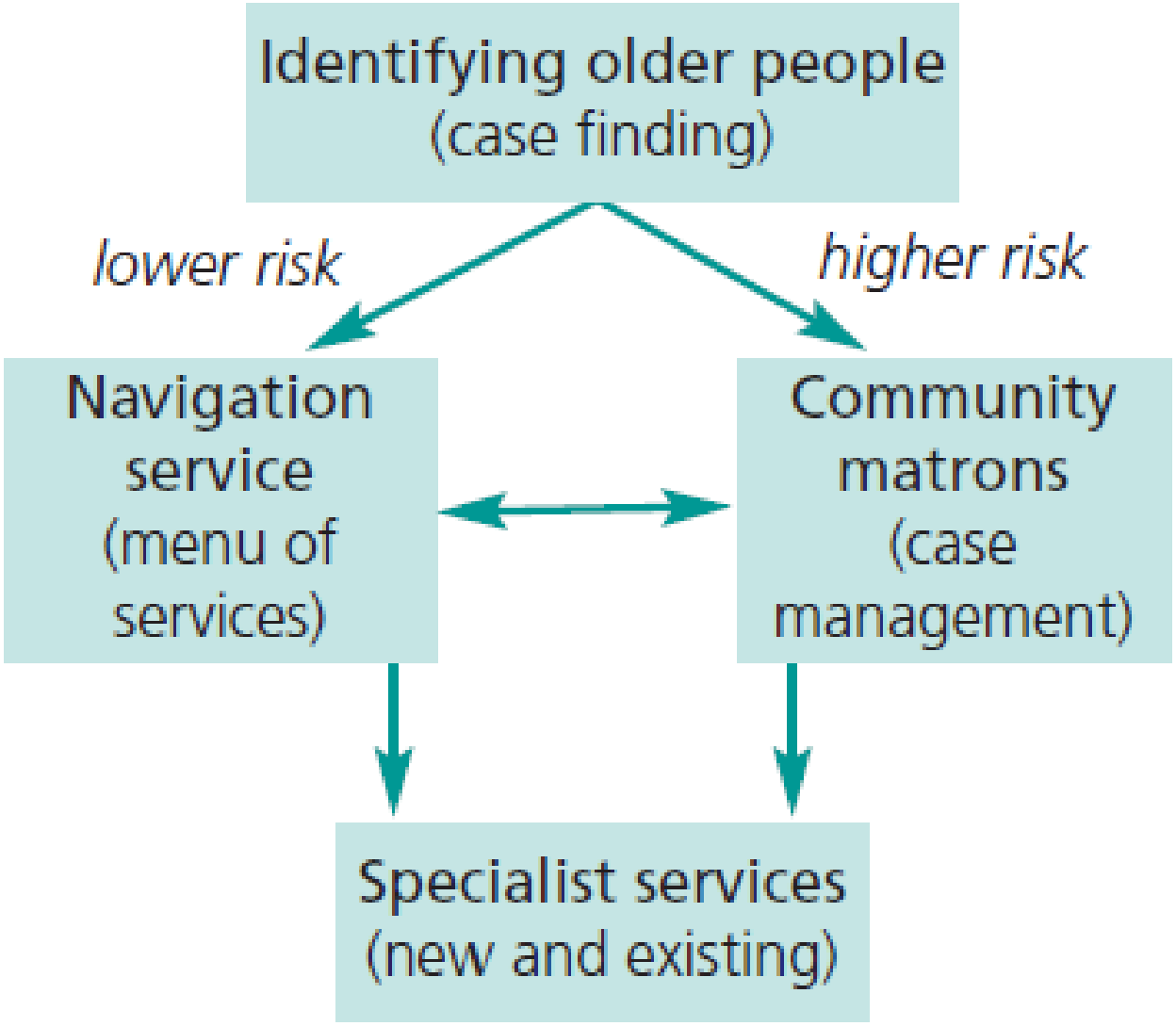
- Nutrition
- Physical therapy
- Dental care
- Exercise
- Palliative care
- Home services
- Community level care (Day care)
- Other social services

Subcategories of CCM-based changes

Chronic Care Model Elements and Sub-Categories					
Clinical Information System (CIS)	Decision Support (DS)	Delivery System Design (DSD)	Self-management Support (SMS)	Community Resources (CR)	Health Care Organization (HCO)
Patient registry	Guideline institutionalization and prompts	Care management roles	Patient education	For patients	Leadership support
Use of information for care management	Provider education	Team practice	Psychosocial support	For community	Provider participation
Feedback on performance data	Expert consultation support	Care delivery/ coordination	Self-management assessment		Coherent system improvement and spread
		Pro-active follow-up	SM resources and tools		
		Planned visit	Collaborative decision-making with patients		
		Visit system changes	Guidelines shared with patients		

(Described in: Pearson et al. Assessing the Implementation of the Chronic Care Model in Quality Improvement Collaboratives. *Health Services Research*. 2005; 40 (4): 978-996.)

Case Finding



Case finding

Widespread and systematic

versus

Opportunistic

Opportunistic

- Medical consultations for any reason
- Visits to the emergency department for any reason
- Prior to discharge from acute care hospitalization
- While accompanying their spouse, children, grandchildren or friends to a health care facility
- During immunization campaigns and health brigades
- In senior centers and places of gathering of old people
- When a person reports to a health care provider as a primary caregiver of another old person
- When applying or registering for any social support program
- When applying for retirement pension

Training

- Clinical information (frailty, nutrition and geriatric assessment)
- Decision support (training on frailty, nutrition and physical activity)
- Delivery system design (challenged by human resource constraints, group counseling, volunteers, expert patients, empowered peers)
- Self management support (nutrition and physical activity)
- Community resources (health promoters, matrons, using check lists and referral forms)

Core frailty training

- A basic core of skills and competences needs to be developed for each type of health care provider from community health care workers to highly specialized clinicians involved in frail elderly care.

Improving core frailty care and treatment services

- Coverage of people at risk
- Retention of patients
- Follow up of clinical outcomes for those being treated (gap analysis of coverage, retention and wellness)

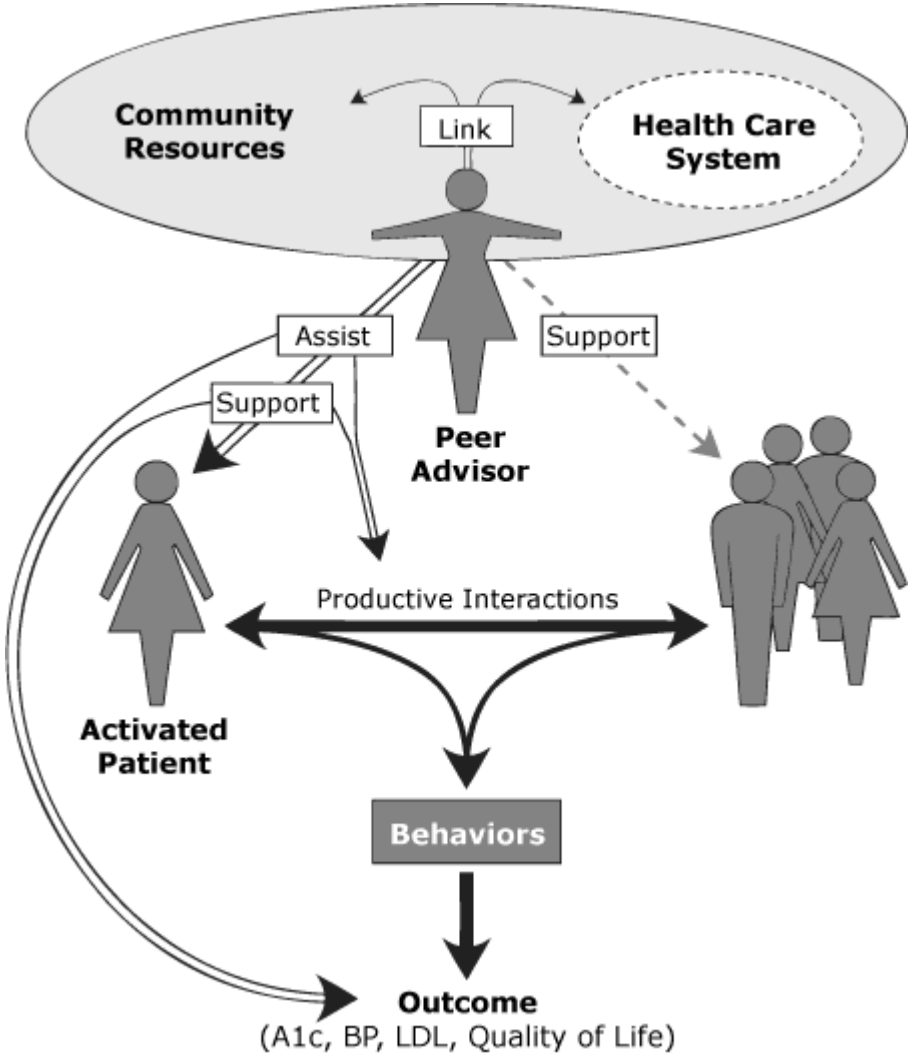
Components of the health delivery system

FRAILTY CARE MODEL	INPUT
Patient self management support	Intervention protocols
Delivery system design	Expert patients, empowered peers
Decision support	Check lists, guidelines
Community resources	Organizations / leaders
Clinical information system	Registers to be introduced, data base to be established
Health care organization	Patient tracking or other resources integrated as a component of home-based care system ***Referral system to the second level of care***

Community health care provider

- Many LAMIC have dealt with these carers in different modalities, and with varying degrees of training (lay health advisors, community health promoters, primary care technicians, community nurses).
- Usually well involved and committed to the community and in good position to detect, refer and follow frail older persons. Their role should be appraised and more efforts should be made to train them in age-related topics, including frailty.

Role of peer advisors in management of chronic conditions



Informal caregivers

- Informal support and care networks are already organized everywhere, and constitute an important potential source of labor force.
- Properly organized and trained, informal caregivers may be able to deliver frailty interventions safely and effectively not only to their own care recipients but also to others.

Future Stages

- Development, adaptation and application of the Frailty Care Model
- Integration (refers to that which occurs between: health care and levels of the health system; levels of patient care; social and health services; and core services and essential primary care services. All of these are important in meeting the long-term needs of people with frailty).
- Health workforce (interventions should also continuously monitor the impact of improvements on health worker job satisfaction and retention)

CHANGES TO BE IMPLEMENTED TO APPLY THE FRAILTY CARE MODEL

CHANGE OBJECTIVE	CHANGES/HOW TO
SELF MANAGEMENT SUPPORT	
CHANGE CONCEPT	IMPROVE PATIENT'S KNOWLEDGE, SKILLS AND CONFIDENCE
	DEVELOP SOCIAL SUPPORT SYSTEMS
DELIVERY SYSTEM DESIGN	
	PATIENT RETENTION
	CLINICAL EFFICIENCY
	MONITORING AND EVALUATION
	CONTINUITY OF CARE
	CARE ACCESS AND IMPROVED SERVICE DELIVERY
	FACILITATE SELF MANAGEMENT AND SUPPORT FOR PATIENTS
	PREVENTATIVE FRAILTY SCREENING
	PREVENTATIVE COMORBIDITY SCREENING
CLINICAL INFORMATION SYSTEMS	
	IMPROVED DATA MANAGEMENT
	IMPROVE DATA CAPTURE SYSTEMS
	CLINICAL MONITORING
DECISION SUPPORT	
	CAPACITY BUILDING AND TECHNICAL COMPETENCE
	DEVELOPING STANDARDS
	IMPLEMENTING STANDARDS

Levers and incentives

- Major drivers and incentives must be developed to bring frailty management to the fore front
- Working with local authorities and under the auspices of health ministries, should find incentives, reducing duplication, driving healthcare closer to home, and focusing on primary and secondary prevention.
- Aligning incentives and contracting requirements across a whole-system frailty pathway, including primary as well as acute, community and mental health providers, will help drive the required system changes.
- Primary care changes could include enhanced services for avoiding unplanned admissions that require case management of vulnerable patients; personalized care planning; and a named accountable GP and care coordinator.
- Primary care supervisors should ensure that the needs of frail older people are at the heart of their job. Older people with frailty are most in need of medical continuity and will have significant medical requirements. Primary care supervisors should show that they understand and resource these issues, including ensuring GPs provide adequate medical support.

Measuring outcomes

- Patient experience: where patients themselves have provided feedback on the quality or effectiveness of the service they have received.
- Harm reduction: where outcome measures indicate whether harm to frail older patients has occurred.
- Quality of life: whether or not frail older patients are able to maintain reasonable quality of life after contact with health services.
- Systems supporting older people: where measures relate to the systems that treat frail older patients, and whether these support improvements in care.
- Financial: where indicators show any savings released as a result of changes to the pathway

Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders Author: NHS England, South Publication date: February 2014

Measuring outcomes

Category	Measure
• Patient experience	• Support to self-manage long-term conditions (LTCs)
• Patient experience	• GP listening with care and concern
• Harm reduction	• Pressure ulcer incidence
• Harm reduction	• Harm from medication errors
• Quality of life	• Discharge rates to usual place of residence
• Quality of life	• Proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 120 days
• Systems supporting older people	• Emergency readmissions: 30 and 90 day
• Systems supporting older people	• Length of stay: key LTCs, without dementia
• SUS	• Cost of emergency readmissions in over 65s
• SUS	• Cost of excess bed days

Navigation through the health and social care systems

- Difficult, particularly for the frail elderly.
- It is of great importance that the processes be simplified.
- A single point of entry to the system would facilitate access.
- Coordinated, interdisciplinary care under the case-management frame would improve outcomes and make care provision more efficient.

- Physical activity and nutrition remain the cornerstones of frailty interventions. In the context of LAMIC, where a large part of the population lives in socioeconomic deprivation of some level, securing any kind of food and keeping oneself active enough to function on an everyday basis take priority over the kind of (adequate) nutrition and physical activity that are needed to maintain good health

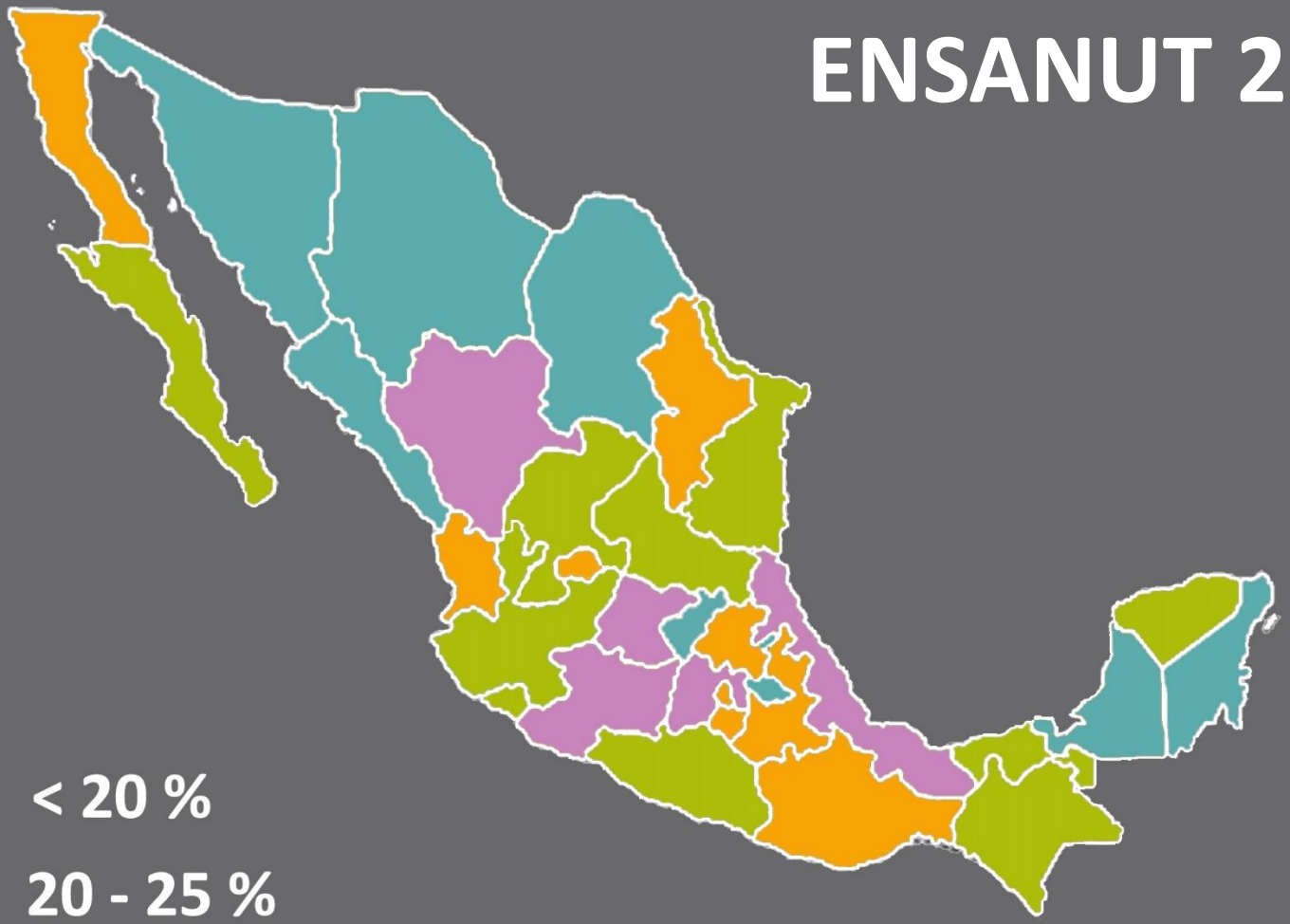
Beyond 'vulnerable groups': contexts and dynamics of vulnerability

DOI: 10.1177/1757975912470062 2013 20: 3Global Health Promotion Christina Zarowsky, Slim Haddad and Vinh-Kim Nguyen

Frailty and vulnerability

- Frailty intermingles with many other competing priorities. In order to be able to focus efforts in delivering frailty interventions, access to minimum living standards – including proper nutrition throughout the life course – must be first secured.
- Safe and age-friendly environments are also needed in order to promote physical activity and social participation.

Frailty prevalence (Rockwood)
ENSANUT 2012



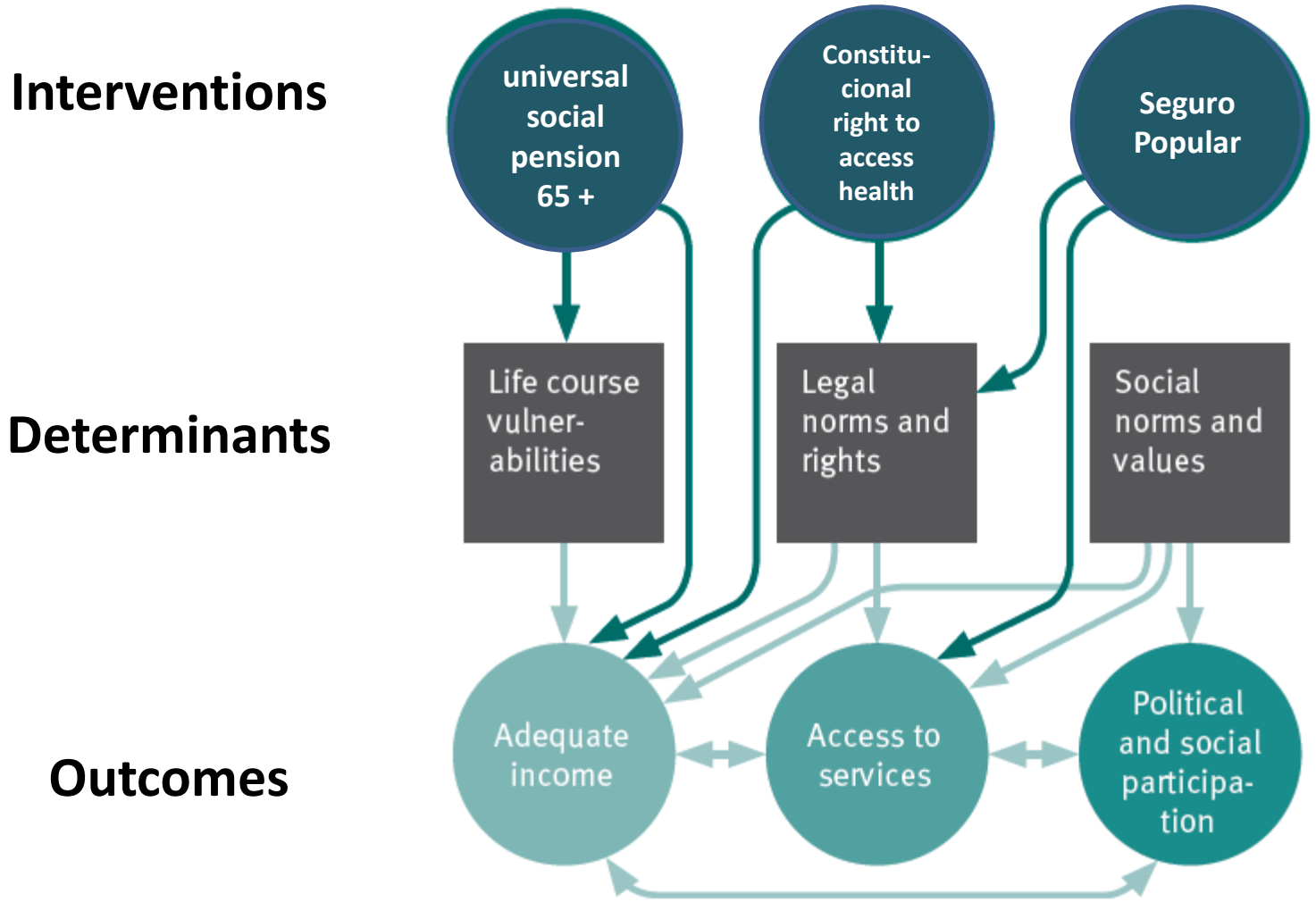
< 20 %

20 - 25 %

25 - 30 %

> 30 %

The impact of social protection on determinants of dependence and vulnerability in Mexico



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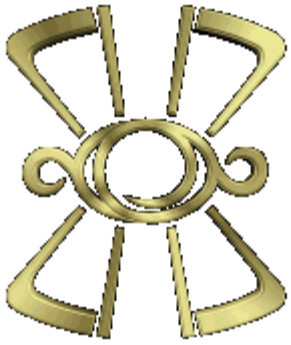

Thank you…..