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**Integrated Care for Frailty**

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**Abstract**

Integrated care for frailty improves quality of life and may reduce adverse outcomes, though more high-quality research is required. This chapter explores key components of effective integrated care for frailty, drawing on learning from the European Frailty Prevention Approach, a collaborative joint action involving 23 countries. The integrated model spans the continuum of prevention and health promotion, acute treatment, rehabilitation, proactive chronic care, long-term care, palliative and end-of-life care. It requires a capable multidisciplinary workforce with knowledge, skills and competencies in relational practice and comprehensive assessment. Care should be collaborative, outcomes focused, based on what matters to the individual and their caregivers, and include behavioural health and restorative approaches that support self-management and optimise functional ability, particularly when transitioning between care settings. The challenge for all systems is to understand how to adapt this model to their local context and to create the conditions to scale-up and sustain integrated care.

**Introduction**

Fragmented, reactive and poorly coordinated care for older people with frailty results in poor outcomes for individuals, generating greater dependency, reducing quality of life and further escalating service demand and costs. There is growing recognition of the value of an integrated model of care for older people with chronic and complex care and support needs [1,2]. Most of the evidence is drawn from studies of individual components of care. In comparison, there have been fewer studies of how to organise and deliver these at scale and across the whole system [3].

The rationale for integrated care for older people is based on the association between ageing, multimorbidity and frailty. Frailty is now considered as a long-term condition [4] that may be anticipated and prevented and is best managed through an integrated approach that enables people to live healthy and active later lives, live at home for longer, participate in the activities that they value, and contribute to their communities. The integrated model is underpinned by an enablement ethos combined with proactive chronic care coordination, timely access to effective transitional and intermediate care, and high-quality long-term care including palliative and end-of-life care [5].

**Enablement**

As frailty is generally associated with functional impairment and higher risk of deconditioning, it requires a restorative approach after illness or injury to enable older people to resume activity, rebuild social networks and regain independence [6]. Moving from the traditional model of home care maintenance and support increases the likelihood of the individual remaining at home, increases patient and caregiver satisfaction and a range of health related outcomes [6-9]. An effective holistic approach involves education, enablement, assistive technologies, rehabilitation and support for the individual to manage their conditions and maintain functional ability, and support for the caregiver to remain well and continue in their caring role. Targeted approaches and support are needed to fully involve people with communication, cognitive, sensory or physical impairments.

**Continuity and care coordination**

Continuity enables care coordination by creating the conditions and relationships to support seamless interactions among multiple providers, within interdisciplinary teams and across care settings or sectors [10].

- **Continuity:** the degree to which a series of discrete health care events is experienced by people as coherent and interconnected over time, and consistent with their continually changing health needs and preferences

- **Care coordination:** a proactive approach in bringing care professionals and providers together around the needs of service users to ensure that people receive integrated and person-focused care across various settings

Evidence for a positive association between a continuing relationship with a primary care physician and better care coordination outcomes [11] and fewer admissions to hospital for ambulatory care-sensitive conditions [12,13] has informed the concept of the patient-centred medical home [14].

This model is often overlaid by case management - a targeted, proactive approach that involves case-finding, assessment, care planning and care coordination to integrate services to meet the needs of individuals with chronic conditions [15]. Many integrated care programmes aim to create a continuous relationship with a named practitioner who coordinates tailored interventions delivered by an interdisciplinary team [16]. The approach requires highly skilled health and care professionals who are attuned to the local context of health and care and have the right skills: good communication skills, ability to solve complex problems, cultural competence, effective practice in interdisciplinary teams and experience in geriatric and community nursing and coaching for self-management [17, 18]. The report of a telephone survey in 11 high-income countries for the study of international health

policy by The Commonwealth Fund showed that adults who had a care coordinator were less likely to find that their care was poorly organized and coordinated [19].

Proactive and coordinated care at home is more likely to anticipate and plan for deterioration and trigger earlier interdisciplinary interventions tailored to the individual's health conditions, stage of frailty, trajectory of needs, carer support, housing, social circumstances and personal goals. The interventions should include shared decision-making, advance care planning and structured medication reviews and other aspects of comprehensive geriatric assessment (CGA). The evidence for CGA in community settings [20] is less mature than the relatively strong evidence-base for CGA in acute care as described in Chapter xxx. Most community-based studies are small in scale and of relatively short duration and follow-up with varying levels of frailty in the study cohort. Few studies included access to urgent community assessment and advice, particularly after office hours or at weekends. Optimal benefits from chronic care will not be realised unless there is also access to effective urgent community response and alternatives to emergency hospital admission. This can be facilitated by remote monitoring and decision-support in the community and by trusting relationships between care professionals and across provider organizations, particularly for managing transitions of care and accessing urgent advice and support for managing acute illness.

**Intermediate Care**

Many older people with frailty prefer to receive short-term enhanced care at home for episodes of acute illness. This reduces risk of deconditioning, delirium and hospital-acquired infection and can improve hospital flow. Intermediate care is a range of time-limited services, at the interface between home and acute hospital, which ensure continuity and quality of care, promote recovery, and restore independence and confidence. [21]. The continuum of transitional and intermediate care services includes Rapid Response alternative pathways for falls; Hospital at Home; virtual wards (hospital-led alternatives to admission supplemented by technology and remote monitoring to co-ordinate care); discharge to assess and nurse led transitional care programmes; reablement and rehabilitation at home; and step up and step-down beds in community hospitals, care homes or skilled nursing facilities. Reviews note a range of positive outcomes but mixed evidence for cost-effectiveness [22, 23].

However, hospital-at-home appears to be a cost-effective alternative to hospital admission for selected older people, providing similar outcomes and reducing demand for readmission and long-term support [24, 25]. Close working between hospital same-day assessment units, primary care teams, ambulance providers, community rehabilitation, and intermediate care and reablement services is required to ensure an integrated network of intermediate care alternatives to inpatient hospital. The development of acute community frailty response teams combining many of these elements has shown potential but requires evaluation in high quality studies [26]. More evidence is also needed for virtual ward. While

there is a trend towards a reduction in mortality and institutionalisation, higher quality data and assessment of data protection issues are required [27].

**A care eco-system**

A success factor in seven international case studies of effective models of integrated care for older people with complex needs [28] was moving from a service-orientated care pathway to a population-orientated system model with comprehensive wrap-around care and support

The European Frailty Prevention Approach [29] described the key components of effective integrated care for frailty as follows:

- a single entry point in the community – generally in Primary Care
- use of simple frailty specific screening tools in all care settings
- comprehensive assessment and individualised care plans – including for caregivers
- tailored interventions by an interdisciplinary team – both in hospitals and community
- case management and coordination of support across the continuum of providers
- effective management of transitions between care teams and settings
- shared electronic information tools and technology enabled care solutions
- clear policies and procedures for service eligibility and care processes.

The model is enabled by using population health data to identify frailty in order to better target interventions. This may require a two-step process using a brief frailty-specific screening tool in primary care and community settings, followed by CGA delivered by suitably trained practitioners to identify the appropriate cohort and deliver tailored interventions.

Integrated care approaches must be applied across the continuum of care from prevention through to palliative and end-of-life care. Transitional palliative care models for older adults with frailty can reduce admissions, length of hospitalisations if admitted and improve quality of life for both patients and caregivers, though again few studies are available and higher quality studies are required [30].

The British Geriatrics Society described seven system 'touchpoints' that together build a comprehensive 'wrap around' system of care and support to enable older people to age well and live well at home for longer [31].

- **Enabling Independence, Promoting Wellbeing**
- **Population based proactive anticipatory care**
- **Urgent Community Response, Reablement, Rehabilitation and Intermediate Care**
- **Frailty-attuned acute hospital care**
- **Reimagined Outpatient and Ambulatory Care**
- **Enhanced healthcare support for Long Term Care**

- **Co-ordinated, Compassionate End of Life Care**

**Lessons from implementation experience**

Although the key components of the integrated model for frail older adults with complex care needs are clear, the real prize is understanding how to adapt it to local context and to scale up and sustain integrated care. Scale up may require a favourable political, funding and organisational context as illustrated by the PACE Programme in the USA [32] and the Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) in Quebec [33]. It takes time to realise economic benefits – these were only evident from year three for the PRISMA programme. Emerging evidence from Scotland [34], Norway [35] and Sweden [36, 37] demonstrates encouraging evidence of impacts but to date there is little evidence that integrated care for older people is cost saving. Yet the counterfactual scenario is stark as frailty and multimorbidity are strong predictors of both health and social care utilization and associated costs [38, 39].

New services require a lead time for staff to develop the right relationships, confidence and skills. This requires investment in education and training for all disciplines and adequate time to influence organisational and professional cultures so professionals can build trusting relationships. Effective relational practice can be enabled through interprofessional communication, education and collaboration [40].

As adherence to new practice tends to diminish over time, support for adoption and continuous quality improvement are critical for success.

A wide range of digital solutions can enable remote monitoring, self-management, professional to professional decision support, and facilitate electronic sharing of information underpinned by appropriate information governance protocols and clear guidance on data protection [27].

Models of care should be designed around the outcomes that matter for individuals and their caregivers and acknowledge the contribution that care makes to participation and societal value [41]. That means performance improvement should include a focus on user-defined goals, care experience, quality of life and participation outcomes in addition to measures of functional ability and more traditional health and social care system metrics.

Integrated care must also embrace the reality of health and social care for people who require long-term support and may be approaching end-of-life.

**Long-Term Care**

The World Health Organisation (WHO) defines long-term care as a broad range of personal, social and healthcare services and supports that ensure people with, or at risk of, a significant loss of intrinsic capacity can maintain a level of functional ability consistent with their basic human rights and dignity [42]. Their framework to support countries to achieve an integrated continuum of long-term care connects the healthcare and social care paradigms that too often appear ideologically distanced and unhelpfully compete for much

needed investment and skilled workforce. It tasks national, regional and local governments to create the conditions for these services to be integrated within a system that provides a continuum of promotion, prevention, treatment, assistive care and social support, rehabilitation and palliation.

The Framework doesn't have all the answers on how to achieve this but helps system leaders to ask the right questions. These include how best to organise governance, finance and accountability across boundaries at national, regional and local levels? What arrangements enable meaningful co-design of creative and sustainable solutions by citizens, communities and care providers together? How can we ensure strong horizontal integration between primary care, community providers, public health and local communities to improve and protect wellbeing, particularly for populations who face socioeconomic disadvantage and inequalities, exacerbated by Covid-19? How can specialists in care for older people work alongside expert generalists to best support all of the above, particularly in rural, remote and island communities facing more severe workforce challenges? And how can we build on the local collaborations achieved during the pandemic to strengthen collective local workforce planning?

**Conclusions**

Providing high-quality seamless integrated care for older people with, or at risk of, frailty should be the primary goal of health and care systems in response to global ageing. Care should be provided across the life course and across care settings rather than in silos, focusing on both prevention and management of frailty. Integrated care should be provided by interdisciplinary teams putting the individuals, caregivers, at the centre. For that's where the magic of integrated care is realised - at the level of the neighbourhood or local team. Whatever the organisational model, ultimately it's through people working together that we improve lives and address what matters most to older adults living with frailty.

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