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

Luis Miguel Gutiérrez Robledo
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 RESOURCES

ALLOCATIONS

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

# FRAILTY STAGES AND PUBLIC POLICY GOALS

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<th>HEALTHY POPULATION</th>
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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 equipped 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

COMMUNITY
- Resources and policies

HEALTH SYSTEM
- Organization of health care
- Self-management support
- Delivery system design
- Decision support
- Clinical information systems

Productive interactions
- Informed activated patient
- Prepared proactive practice team

Functional and clinical outcomes
The Frailty Care Model

COMMUNITY
- Resources and policies

HEALTH SYSTEM
- Organization of health care
  - Self-management support
  - Delivery system design
  - Decision support
  - Clinical information systems

Informed activated patient
Productive interactions
Prepared proactive practice team

Functional and clinical outcomes
WHO building blocks for health system strengthening

**System Building Blocks**

1. Service Delivery
2. Health Workforce
3. Information Systems
4. Medical Products and Technologies
5. Health Financing
6. Leadership/Governance

**Functions**

1. Improved Health (Level & Equity)
2. Responsiveness
4. Improved Efficiency

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

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<td>Patient registry</td>
<td>Guideline institutionalization and prompts</td>
<td>Care management roles</td>
<td>Patient education</td>
<td>For patients</td>
<td>Leadership support</td>
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<tr>
<td>Use of information for care management</td>
<td>Provider education</td>
<td>Team practice</td>
<td>Psychosocial support</td>
<td>For community</td>
<td>Provider participation</td>
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<tr>
<td>Feedback on performance data</td>
<td>Expert consultation support</td>
<td>Care delivery/coordination</td>
<td>Self-management assessment</td>
<td>Coherent system improvement and spread</td>
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<td>Pro-active follow-up</td>
<td>SM resources and tools</td>
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<td>Planned visit</td>
<td>Collaborative decision-making with patients</td>
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<td>Visit system changes</td>
<td>Guidelines shared with patients</td>
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Case Finding

- Identifying older people (case finding)
  - lower risk
    - Navigation service (menu of services)
  - higher risk
    - Community matrons (case management)

Specialist services (new and existing)
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

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<tr>
<th>FRAILTY CARE MODEL</th>
<th>INPUT</th>
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<tbody>
<tr>
<td>Patient self management support</td>
<td>Intervention protocols</td>
</tr>
<tr>
<td>Delivery system design</td>
<td>Expert patients, empowered peers</td>
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<tr>
<td>Decision support</td>
<td>Check lists, guidelines</td>
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<tr>
<td>Community resources</td>
<td>Organizations / leaders</td>
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<tr>
<td>Clinical information system</td>
<td>Registers to be introduced, database to be established</td>
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<tr>
<td>Health care organization</td>
<td>Patient tracking or other resources integrated as a component of home-based care system</td>
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*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

<table>
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<th>Change Objective</th>
<th>Changes/How To</th>
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<tr>
<td><strong>Self Management Support</strong></td>
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<tr>
<td><strong>Change Concept</strong></td>
<td><strong>Improve patient’s knowledge, skills and confidence</strong></td>
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<td><strong>Develop social support systems</strong></td>
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<td><strong>Delivery System Design</strong></td>
<td><strong>Patient Retention</strong></td>
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<td><strong>Clinical Efficiency</strong></td>
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<td><strong>Monitoring and Evaluation</strong></td>
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<td><strong>Continuity of Care</strong></td>
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<td><strong>CARE ACCESS AND IMPROVED SERVICE DELIVERY</strong></td>
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<td><strong>Facilitate Self Management and Support for Patients</strong></td>
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<td><strong>Preventative Frailty Screening</strong></td>
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<td><strong>Preventative Comorbidity Screening</strong></td>
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<td><strong>Clinical Information Systems</strong></td>
<td><strong>Improved Data Management</strong></td>
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<td><strong>Improve Data Capture Systems</strong></td>
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<td><strong>Clinical Monitoring</strong></td>
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<td><strong>Decision Support</strong></td>
<td><strong>Capacity Building and Technical Competence</strong></td>
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<td><strong>Developing Standards</strong></td>
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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
## Measuring outcomes

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<td>GP listening with care and concern</td>
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<td>Harm reduction</td>
<td>Pressure ulcer incidence</td>
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<td>Harm reduction</td>
<td>Harm from medication errors</td>
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<td>Quality of life</td>
<td>Discharge rates to usual place of residence</td>
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<tr>
<td>Quality of life</td>
<td>Proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 120 days</td>
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<td>Systems supporting older people</td>
<td>Emergency readmissions: 30 and 90 day</td>
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<td>Length of stay: key LTCs, without dementia</td>
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<td>SUS</td>
<td>Cost of emergency readmissions in over 65s</td>
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<td>SUS</td>
<td>Cost of excess bed days</td>
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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

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

Interventions
- Universal social pension 65 +
- Constitucional right to access health
- Seguro Popular

Determinants
- Life course vulnerabilities
- Legal norms and rights
- Social norms and values

Outcomes
- Adequate income
- Access to services
- Political and social participation
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