

HEALTHCARE FOR ELDERLY PEOPLE- CURRENT TRENDS AND MODELS OF HEALTHCARE



Interview with:
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sity of the West of Scotland (UWS)
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Anne has a background that spans geriatric medical practice, policy, education and improvement science. She has extensive experience of teaching, mentoring and educational supervision of health and care professionals and makes regular contributions to interdisciplinary education and workforce development across Scotland and beyond.

These sessions generally focus on the quality of care for chronic disease, ageing, frailty, intermediate care and integrated care.

She supports the national Technology Enabled Care programme to illustrate the impact of technology in intermediate care and frailty, regularly contributes to leadership development work, and contributes to Masters programmes: Primary care; and Leading People-Centred Integrated Care.

As Senior Associate for the International Foundation for Integrated Care (IFIC), she regularly hosts study visits to Scotland by health and care professionals and policy makers from across the globe and supports coaching and mentoring in health systems.

Other international experience includes presenting, chairing or coordinating sessions at a wide range of scientific events, policy workshops and practice symposiums on older people or integrated care. She coordinates IFIC's Integrated Care Matters webinar series and IFIC's Special Interest Groups on Intermediate Care; Polypharmacy and Palliative Care.

Reporter: *Professor, it is a great pleasure and, at the same time, a great honor for me to approach an important and up to date topic for this interview with you, given that healthcare needs for elderly people are increasing in proportion as this population group is numerically in continuous growth.*

-In your opinion, why are current health care policies focused on healthcare for the elderly?

Anne Hendry: Older people are now living longer but that means more people are living with multiple physical and mental health conditions, often associated with functional and cognitive impairments. Europeans aged 65 years can expect to remain independent at home for less than half of their remaining years and the probability of needing long term care rises steeply from the age of 80 years. This growing demand for acute and longer term health and social care support has major implications for individuals and their families and for our public services. To deliver effective and sustainable healthcare we urgently need to review our policies and redesign models of care to better meet the complex and changing needs of older people.

R: *Professor, as you are involved in projects developed and implemented at national (Scotland) and international level, you have had the opportunity to be in touch with specialists and experts in this field all over the world.*

Your experience is valuable for our readers and in this context please refers to some experts groups, national and international initiatives that could be mentioned as references in this field.

-First of all, please try to define by providing special characteristics of the elderly people?

(please refer to health, social, economic, ethics, legal aspects related to this population group)

AH: Actions to promote active and healthy ageing must take place throughout life as we know that the cumulative impact of deprivation, disadvantage, and lack of opportunity at any life stage may have a negative effect on health and wellbeing in later life.

Active and healthy ageing is all about maintaining autonomy and independence in later life by maximising opportunities for physical, mental and social wellbeing, security, physical activity, and participation in social, economic, cultural, spiritual and civic affairs, or in employment.

What is the current trend in healthcare for elderly people?

AH: We are now more aware of the need to focus on frailty as a complex syndrome of increased vulnerability and reduced functional reserve that is associated with the ageing process, chronic conditions, and modulated by life course events, social and psychological factors. Across Europe, frailty is a common, growing public health challenge associated with an increased risk of functional (physical and/or cognitive) decline, falls, immobility, disability, institutionalization, reduced quality of life, increased use of health and social care resources, higher costs and higher mortality. We know that frailty is not an inevitable consequence of ageing. There is growing evidence that age friendly communities and early and effective interventions for at risk individuals can prevent, postpone, detect and manage frailty. Coordinated action on frailty is critical to improve health outcomes and quality of life in later life and to ensure the affordability and sustainability of health and care services.

What national and international policies, strategies and initiatives are concerned with resolving the problems of this population group?

AH: I have the privilege of working on these issues at both national and international levels.

In Scotland I have been supporting the Reshaping Care for Older People programme, supported by an innovation fund (around 1% of the healthcare and social care budget for older people) for the first four years 2011-2015. In each municipality, local partners from healthcare, social care, housing, independent and voluntary sectors collaborated to develop a Change Plan that guided testing and spreading a range of interdependent initiatives that would enhance the well-being and independence of older people and their carers; prevent, reduce or delay dependency; improve experience and personal outcomes; and increase the resilience of the system. I was the clinical lead for this national programme that has enabled more care to be delivered at home, or closer to home, and has seen older people spend almost 3 million more days at home than would have been expected based on the observed demographic change and patterns of previous utilization.

The European Innovation Partnership on Active and Healthy Ageing (EIPAH) is a response to the societal challenges from an ageing population, a reducing workforce, and the need to redesign and sustain services for people with multiple long term conditions. It aims to increase healthy life-years by an average of two years by 2020 and to deliver a Triple Win for Europe through:

- improving the health and quality of life of citizens, with a focus on older people;
- supporting long term sustainability and efficiency of health and social care systems;
- enhancing competitiveness by growth and expansion of new markets.

Colleagues from the Prevention of Frailty and Functional Decline Action Group of the EIP AHA developed a framework to describe an integrated policy, professional, public health and whole system response to the challenge of frailty. This Decalogue described ten actions or commitments that Member States can make to prevent, delay and manage the impact of frailty. Our evidence base is now being refreshed and enhanced through the European Joint Action ADVANTAGE: A comprehensive approach to promote a disability-free advanced age. ADVANTAGE is a project cofunded by the Health Program of the EU aiming to build a common understanding on frailty in Europe on which to base a common approach to diagnosis, care and education for managing older people who are frail or at risk of developing frailty.

I am also a Senior Associate with the International Foundation for Integrated Care (IFIC), a leading international 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 IFIC conferences, special interest groups and Integrated Care Matters webinars are supporting knowledge exchange on models of care for older people and to prevent and manage frailty.

As this population cohort suffer from chronic, disabling, sequelae and often become dependent, the system should give them all the support to improve their conditions and function.

Most older people make many vital contributions to their communities – financial, provision of social support, family caregiving, and volunteering. However loneliness and social isolation are common in later life, and are both risk factors for and the consequence of functional decline. Health and wellbeing, cognitive function, independence and resilience can all be enhanced by cross-sectoral interventions such as smart homes, transport and age friendly communities which offer accessible social, cultural and physical activities, peer support, befriending, intergenerational practice, and technological and social innovation that enables older people to stay connected and participate as active citizens.

From your experience, could you mention some barriers encountered in managing the most frequent problems in elderly people? What do you consider would be some effective solutions to overcome these barriers?

Frailty shares many features of a chronic condition: a dynamic syndrome that cannot be cured but may be prevented and better managed in primary care through an interdisciplinary chronic disease management approach that anticipates and proactively manages episodes of deteriorating function. People with chronic and complex conditions or frailty need support from many different care professionals and providers from health care, social care, housing, independent and community sectors.

They face many barriers in our current systems that frequently result in poor communication between providers, duplication of tasks, gaps in care, adverse effects from treating one condition without recognising others, and may result in poor outcomes for the person, caregiver *and* the system. A wide range of technological solutions can enable older people to remain independent at home, support caregivers, facilitate remote monitoring and self management, provide decision support, and improve Information sharing and coordination of services.

As you mentioned above, active ageing is one of the major challenges at international and European level, and also you mentioned approaching FRAILTY at European level as one of the current approach.

How important is the integration of services for the elderly? Are there good practice models that can be adopted and/or adapted?

AH: Integrated care is an effective way to improve outcomes for people with chronic and complex care and support needs through continuous relationships with a primary care or social care professional, supported by coordinated care from an interdisciplinary team. ADVANTAGE review of the evidence for integrated care for frailty suggest successful models of care blend chronic care management with education, enablement and rehabilitation to optimise function, particularly at times of a sudden deterioration in health, or when moving between home, hospital or care home. In all care settings, these approaches should be supported by comprehensive assessment and multidimensional interventions tailored to modifiable physical, psychological, cognitive and social factors and appropriate to the goals and circumstances of the individual, and the support needs of their caregiver. In summary, our emerging recommendations for models of care for frailty include:

- 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.

Would you like to add anything else, maybe an answer to a question unaddressed in this interview?

AH: Frail older people frequently experience emergency admissions to hospital where they are at high risk of experiencing adverse events and poor outcomes. There is strong evidence for the benefits of inpatient Comprehensive Geriatric Assessment (CGA) delivered by specialist teams in dedicated units. In an updated Cochrane review, inpatient CGA was associated with more patients living in their own homes at three to 12 months' follow-up after discharge. Intermediate care services offer time limited (usually for a period of days or weeks) safe and effective alternatives to acute hospital care at times of a deterioration in the health of the older person or their caregiver, and reduce or delay the need for long term institutional care. Examples include enhanced interdisciplinary assessment, treatment and rehabilitation at home, in day hospitals, or inpatient care in community hospitals.

We need more large-scale studies with longer intervention and follow up periods to evaluate system outcomes and costs for intermediate care and community integrated care approaches.

To be affordable and sustainable, models of care for frailty must be able to be adopted across the whole health and care workforce. This will require comprehensive workforce education and training strategies for frailty in all curricula, including assessment and case management skills, interdisciplinary practice, and collaboration between general practitioners, nurses, geriatricians, psychiatrists, pharmacists, allied health professionals, hospital specialists and partners from other sectors.

It is a very exciting time to be involved in healthcare for older people!

If you want to learn more please check for updates on the ADVANTAGE website www.advantageja.eu

*Thanks for your kindness to answer to our questions.
Interview conducted by: Marius Ciutan*