

CONFERENCE ABSTRACT

Program of integrated geriatric and primary care for frail older adults in the community. An innovation case.

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Background: Frailty is a multidimensional geriatric syndrome, characterized by increased vulnerability to internal and external stressors, determining a risk of rapidly progressing disability (Fried LP et al., *J Gerontol MS* 2001).

Consistent evidence shows multi-component interventions interventions can revert frailty and prevent disability (TM Gill et al, *Arch Intern Med.* 2006; Pahor M, et al, *JAMA* 2014). Successful interventions pivot on tailored programs based on exercise, nutrition and comprehensive geriatric assessment, with an individualized plan (Fairhall N, et al, *BMC Geriatr.* 2008). Coordination and integration between Primary Care and Geriatrics has been piloted with promising results (Vellas B, et al, 2013).

We created a specialized geriatric outpatient unit in a primary care center, with the aim of improving the management of frail older adults at the community level, through integrated detection and individualized intervention between primary care and geriatrics. The general goal is to delay mobility disability, but we are also assessing other healthcare related, patient experience and costs outcomes. The unit also can also provide support to primary care for the management of patients with complex needs or difficult management.

In this paper we present baseline characteristics of older adults evaluated in the unit during the first 3 months of functioning. In parallel, we are conducting a 1 and 3 months triple aim evaluation looking at disability and other health related outcomes, patients experience and costs.

Methods: Population: frail older adults of the Primary Care area Bordeta, in Barcelona (total population of 30829 people, 26,5% over 65 years old, estimated prevalence of frailty around 10% from epidemiological studies).

Intervention: participants are detected by the primary care team (physicians, nurse, social worker) for the presence of signs and symptoms of frailty (slowness of walking, reduced strength or endurance, sedentary habits, unintentional weight loss, suspect of cognitive impairment, possibly associated with reduced social relations), and referred to the geriatric team (geriatrician and physical therapist), which operates in the Primary Care center 1 day/week.

The geriatric team revised the appropriateness of the screening through the Gerontopole Frailty Screening Tool (GFST) (including the objective measure of gait speed) and confirms frailty, scoring for severity, using Short Physical Performance Battery (SPPB) and Clinical Frailty Scale (CFS). Based on an eventual comprehensive geriatric assessment, the geriatrician identifies problems and priorities, and, together with the physical therapist, proposes an individualized treatment plan, including physical exercise as one pillar.

The primary care professionals (physician, nurse, social worker) can join the assessment visit and share the treatment plan if they wish.

The physical therapists offers a 8 weeks, weekly group exercise program focused on functional exercises, directed to engage, motivate and empower the participant.

One follow-up visit is scheduled to adjust the plan and monitor the progresses of the person, who is followed, after that visit, by the primary care team.

Outcomes: improvement of physical function (measured using SPPB) at the end of the program and 3 months, the evolution of global function (Barthel index), the reduction of the number of prescriptions, the use of healthcare resources, any potential adverse effect related to physical activity, and patients experience (specific interviews).

Results: According to preliminary descriptive data of the first 30 patients included (first 3 months of implementation), the selection was adequate (100% of patients screened positive to the GFST, 54% were vulnerable or mild frail at CFS, mean SPPB \pm SD was 6.4 \pm 2.37, and mean gait speed \pm SD was 0.65 \pm 1.27). The vast majority of patients received one or more interventions within the treatment plan (exercise groups 93%, health education / nutrition 93%, 67% change in drug treatment, referral to study cognitive impairment 17%).

Conclusions: We think that our experience is innovative, because it implements, in the real world, a new specialized and multidimensional model of care for frail older adults in the community, through an intervention individually modulated according to specific needs. We also think this is sustainable and scalable, since it counts on existing resources. The integration between geriatrics and primary care should add value for the intervention.

Keywords: frailty; disability; integrated care; geriatrics; exercise; drugs
