SUNFRAIL TRANSNATIONAL WORKSHOP

Toward a Bio-Psychosocial Model of Frailty

Emilia Romagna Region

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Naples, October 27, 2016

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Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries

Co-funded by the Health Programme of the European Union

The SUNFRAIL Project has received funding from the European Union's Health Programme 2014-2020

SUNFRAIL Project

Promoted by a **network of Italian Reference Sites** of the **European Innovation Partnership on Active and Healthy Ageing (EIP-AHA)**

3rd EU Health Programme - WP 2014

- To share experiences, good practices and tools to identify and manage **frailty** and **multimorbidity**

- **EIP-AHA Initiative**

- **Italian Ministry of Health: Progetto Mattone Internazionale**

The Partnership

PARTNER	ORGANISATION	ACRONYM
RS LP1	Regione Emilia-Romagna - Agenzia Sanitaria E Sociale Regionale, Italy	(RER-ASSR)
	Aster - Societa Consortile Per Azioni, Italy	(ASTER)
RS PP2	Regione Piemonte, Italy	(RHAP)
RS PP3	Regione Liguria, Italy	(LIGURIA)
RS PP4	Azienda Ospedaliera Universitaria Federico II Campania, Italy	
RS PP5	Centre Hospitalier Universitaire De Toulouse, France	(GERONTOPOLE)
RS PP6	Centre Hospitalier Universitaire Montpellier, France	(CHRU)
RS PP7	Universytet Medyczny W Lodzi, Poland	(LODZ)
RS PP8	Universidad De La Iglesia De Deusto, Spain	(DEUSTO)
RS PP9	Regional Health & Social Care Board Of Northern Ireland, United Kingdom	(HSCB)
PP10	European Regional And Local Health Authorities Asbl, Belgium	(EUREGHA)

Collaborating:

- **Ministero – Programma Mattone Internazionale**
- **EIP-AHA Action Groups: A1, A3, B3**
- **International Scientific Research Networks on frailty and disability (IAGG-GARN)**

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General Objectives

To improve the **identification**, **prevention** and **management** of **frailty** and care of **multimorbidity** in **community dwelling persons** (**over 65**) of EU countries.

Specific Objectives

1. To design an **innovative, integrated model** for the **prevention and management of frailty and care of multimorbidity**

2. To **validate the model: assess** existing **systems and services** targeting frailty and multimorbidity – citizen's/**patient**'s needs.

3. To assess the **potential for the adoption/replication** and **sustainability of the model** (**good practices**) in different organizational contexts.

4. To **promote the dissemination** of the results (decision makers - regional, national, EU level).

Main Outcomes

- A **shared model-good practices** on frailty and multimorbidity
- **A tool kit** for the **prediction** of **frailty** and **multimorbidity**:

Primary care

-Instruments to assess the risks of frailty: **physical, cognitive, nutritional** and **psycosocial conditions** (**biomedical, individual, socio-economic dimensions**)

-to support the adoption of **care pathways** (early detection, management)

Integrated care

-methods and instruments to predict **multimorbidity**

Other tools:

-Instruments for **professional's capacity building**

-Analysis of **costs**

Operational Definition of Frailty and Pre-Frailty

Biomedical vs. Bio-Psychosocial Model

Biomedical

- **Biological**: Age, sex
- **Health-diseases**
- **Life Styles**: physical activity, nutrition...
- **Risk Factors**: smoke, alchool..
- **Family** network

Psyco-social

- **Well being** (physical, psychological)
- **Independent living**
- **Socialization**
- **Resources**: health care, social interaction, sport, leisures

Perceived/ Expressed Needs?

Loss = Pre-Frailty??

Criteria of Inclusion?

Frailty or Pre-Frailty??

An Operational Response to Frailty and Multimorbidity

Health and Social Care Services

II° Level: Specialist

I° Level:

Primary Health and Social Care

(GPs, Nurses, Social Workers, others)

•Community:

Alert, Promotion, Referral

(Pharmacy, Circles, Church, Gyms….)

•Possible Pathways:

•Diagnosis

•II° Prevention

•Therapy

•Referral

Social Response

Bio Medical Response

Possible Pathways:

•Identification - Referral

•I° Prevention-Promotion (Lifestyles)

•Social Activation (voluntary work, informatic literacy, sport, etc.)

•Individual, family, collective response

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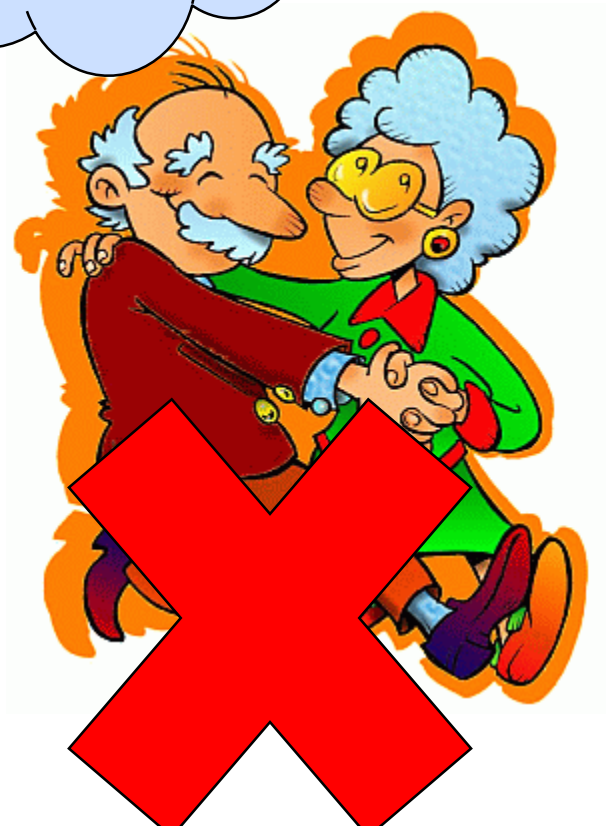
Preliminary Results
&
Suggestions for Improvement

Patient's/Beneficiaries & Professionals Perception of FRAILTY

INDEPENDENCE
dancing, driving, walking, playing with grandsons…..



Bridging the Gap?

State of late life decline and extreme vulnerability characterized by weakness and decreased physiologic reserve contributing to increased risk for falls, institutionalization, disability, and death…..

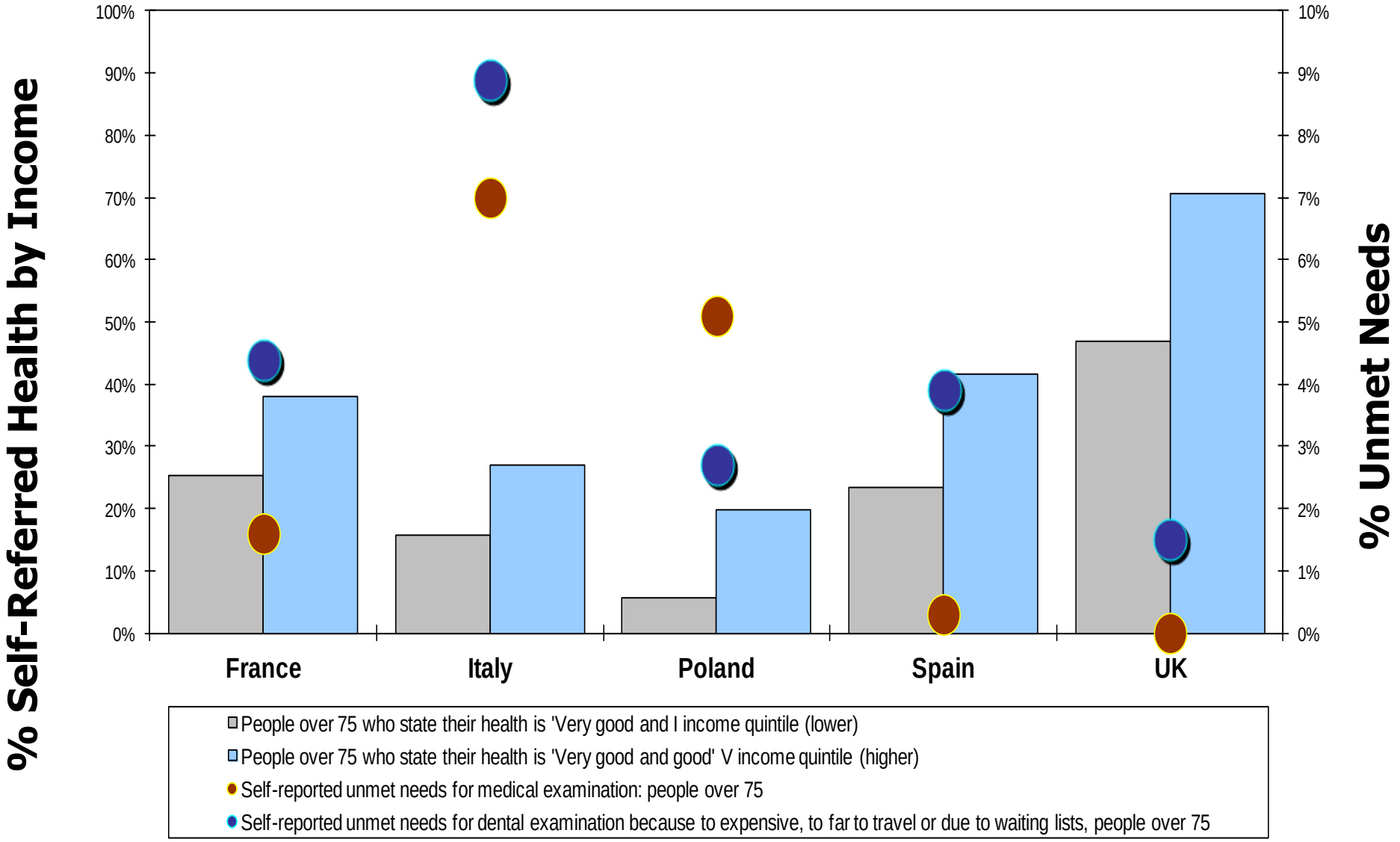
Take into Consideration Patient's/Citizens Perceptions and Needs - Bridging the Gap

- Build on **Patient's/Citizens** existing beliefs that 'living with frailty' is not an **inevitable** or **irreversible** part of **getting older.** It is possible to **maintain independence** by engaging with strategies and services.
- Raise **awareness** on the **risk factors** of frailty (eg: overweight).
- **Encourage older people** to talk to **professionals** and to enquire about services
- Encourage **professionals** to engage older people on the topic, using an **adequate language**, to assess needs in order to orient services.

Orienting Services Provision
Health, Social, Community

- Strengthen the **early identification of frailty - Risk Factors** (**bio-psycho social** domains: physical activity, nutrition, oral health, socio-economical.....);
- **Harmonize the tools** for the early identification of frailty at **Primary Care** and **Community: "first entry gate"** - patients/beneficiaries, formal and informal services;
- Support the delivery of **preventive activities** on frailty and multimorbidity (**prioritization - risk factors**).
- Identification of **barriers** (socio-cultural, economic, organizational etc) to the provision of services to older adults.
- **Engage patients/beneficiaries** on the development of **educational** and promotional messages
- **Train professionals and carers** on the need of a **multidisciplinary approach** to frailty
- Provide to **key decision makers** with **evidences on barriers to care** on frailty and multimorbidity (focusing on **sustainability** and **equity** of **early interventions**).

Self-Referred Health & Unmet Medical Needs



OECD 2015

SUNFRAIL Good Practices - Criteria

1. **Innovation**: novelty (product, process, tools, ICT), etc. √
2. **Duration-State of Art**: length of implementation; new √ practice or continuation/improvement of a previous action.
3. **Stakeholders Involved**: e.g. University-Research Institutes, Institutions responsible for planning and implementing services, patients/citizens groups. √
4. **Law/Regulation Scenario**: existing regional and/or national laws coherent with the local GPs. √
5. **Deliverables** (guidelines, models, ICT tools, report, questionnaire, database, tranining) √
6. **Transferability** (experience of replication-regions, districts) √

29 GPs Identified!!

Regione Emilia Romagna

A Regional Model to Predict Identify and Manage Multimorbidity and Frailty

A Sunfrail Good Practice

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Opportunities and Challenges

How to Identify Frailty and Multimorbidity within Primary Health-Social and Community Settings?

- **Scales - Items**
- **Professionals, Carers, Actors**

An "Easy to Use" Minimum Core of Items!

SUNFRAIL TOOL

In which way can a
Multidisciplinary - Multisectorial

Response to Frailty and

Multimorbidity be developed?

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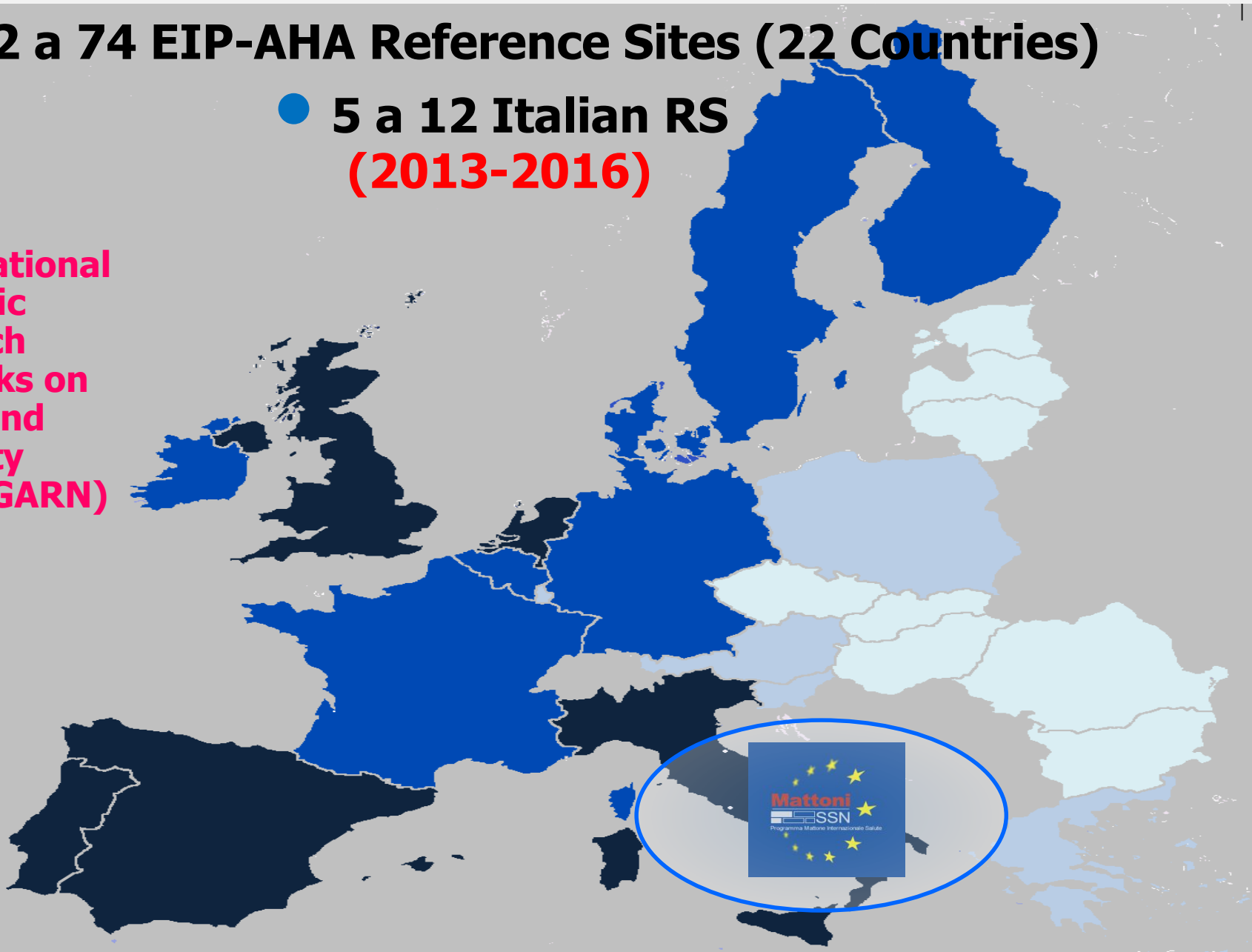
Opportunities & Challenges

- **Definition** of Frailty: **Bio-Psychosocial Model**
- **Instruments** to Identify Frailty and Multimorbidity: **Sunfrail - Other Tools - Models of Care**
- An **Operational Response** to Frailty and Multimorbidity in Primary Health and Social Care - Secondary Care
- **Instruments** and methods for **professional's** improvement pathways
- Criteria and methods: **Good Practices** on Frailty and Multimorbidity
- Equity and **Sustainability**
- **Synergies** Between EU Projects & Initiatives

The Potential For Synergies

- 32 a 74 EIP-AHA Reference Sites (22 Countries)
- 5 a 12 Italian RS (2013-2016)

•International Scientific Research Networks on frailty and disability (IAGG-GARN)



PARTICIPATION OF ITALIAN REFERENCE SITES TO THE JOINT ACTION ON FRAILTY

Main Objectives

•Engage in mutual learning on the **identification**, **prevention** and **management of pre-frailty and frailty** (physical, cognitive, nutritional, socioeconomic, behavioral domains) (synergy with **Sunfrail**/other projects)

•**Disseminate the outcomes** of the **JA** and **GPs emerging from Sunfrail project** and related EIP-AHA initiatives involving Regions and relevant stakeholders of the EIP-AHA and beyond

Participation of Italian Regions - Mattone Internazionale

•**WP2** (**Dissemination**) (**R. Marche-Leader**)

•Other **WPs**

Agenzia sanitaria e sociale regionale

RegioneEmilia-Romagna

Thank you for your attention!

www.sunfrail.eu

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