



# **SUNFRAIL TRANSNATIONAL WORKSHOP**

**Understanding and Caring  
Frailty and Multimorbidity**

**Emilia Romagna Region**

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**Bologna, March 23, 2016**



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



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the Health Programme  
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# SUNFRAIL Project

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

## 3<sup>rd</sup> EU Health Programme - WP 2014

- To share experiences, good practices and tools to identify and manage **frailty** and **multimorbidity**
- **EIP-AHA Initiative (A1, A3, B3)**
- **Italian Ministry of Health - Mattone Internazionale**

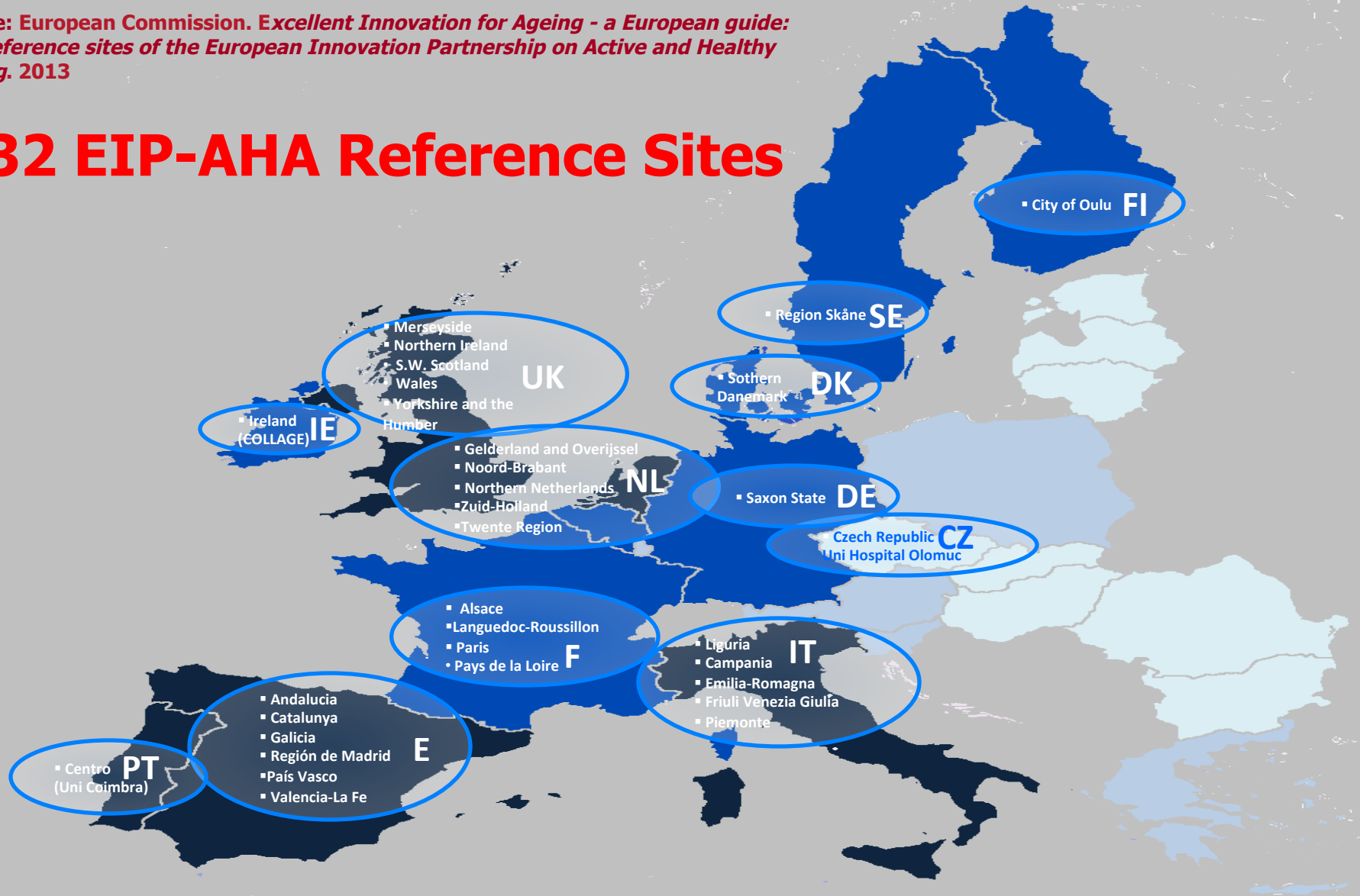
# The Partnership

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

# Synergies with the Ongoing EIP-AHA Initiatives

Source: European Commission. *Excellent Innovation for Ageing - a European guide: the Reference sites of the European Innovation Partnership on Active and Healthy Ageing*. 2013

## 32 EIP-AHA Reference Sites



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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** (**outcomes** of the **EIP-AHA**).
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).

# Reference Sites Systems Reflecting Frailty

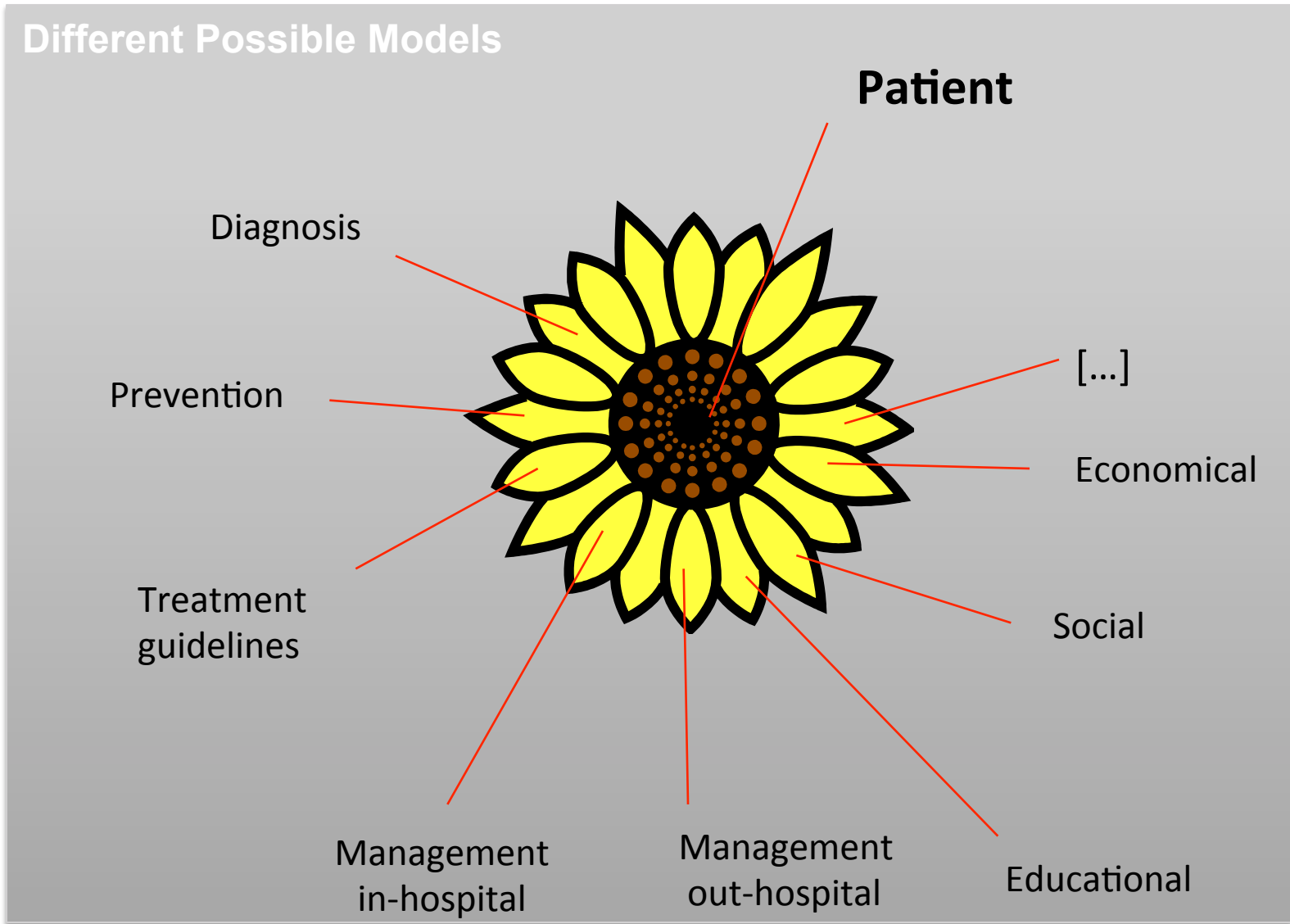
Region <i>Reference Site</i>	Frailty Dimensions					
	Chronic conditions	Multi morbidity	Adherence therapy	Falls Prevention	Social Economical	...
#1						
#2						
#3						
#4						
#..						

 Activities/Best practices

# Frailty: Areas Challenging Health Care Services

Primary prevention/Early Detection	a) Screening the population for frailty using both quantitative or qualitative approaches
Diagnosis	a) Identification and evaluation of frail and pre-frail patients
Secondary prevention/Care	a) Management of frailty progression
Emergency/Hospitalization	a) Management of hospitalized frail patients
Building Capacity/ professionals/social network	a) Improving "Patient Centered Care"

# Frailty Ecosystem for each Reference Site





# Main Outcomes

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

## Primary care

- to assess the risks of frailty: **physical, cognitive, nutritional and psychosocial conditions**
- 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** and **analysis** of **costs**

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**Opportunities & Challenges**

# 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, alcohol..

### Psychosocial

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

Perceived/  
Expressed  
Needs?

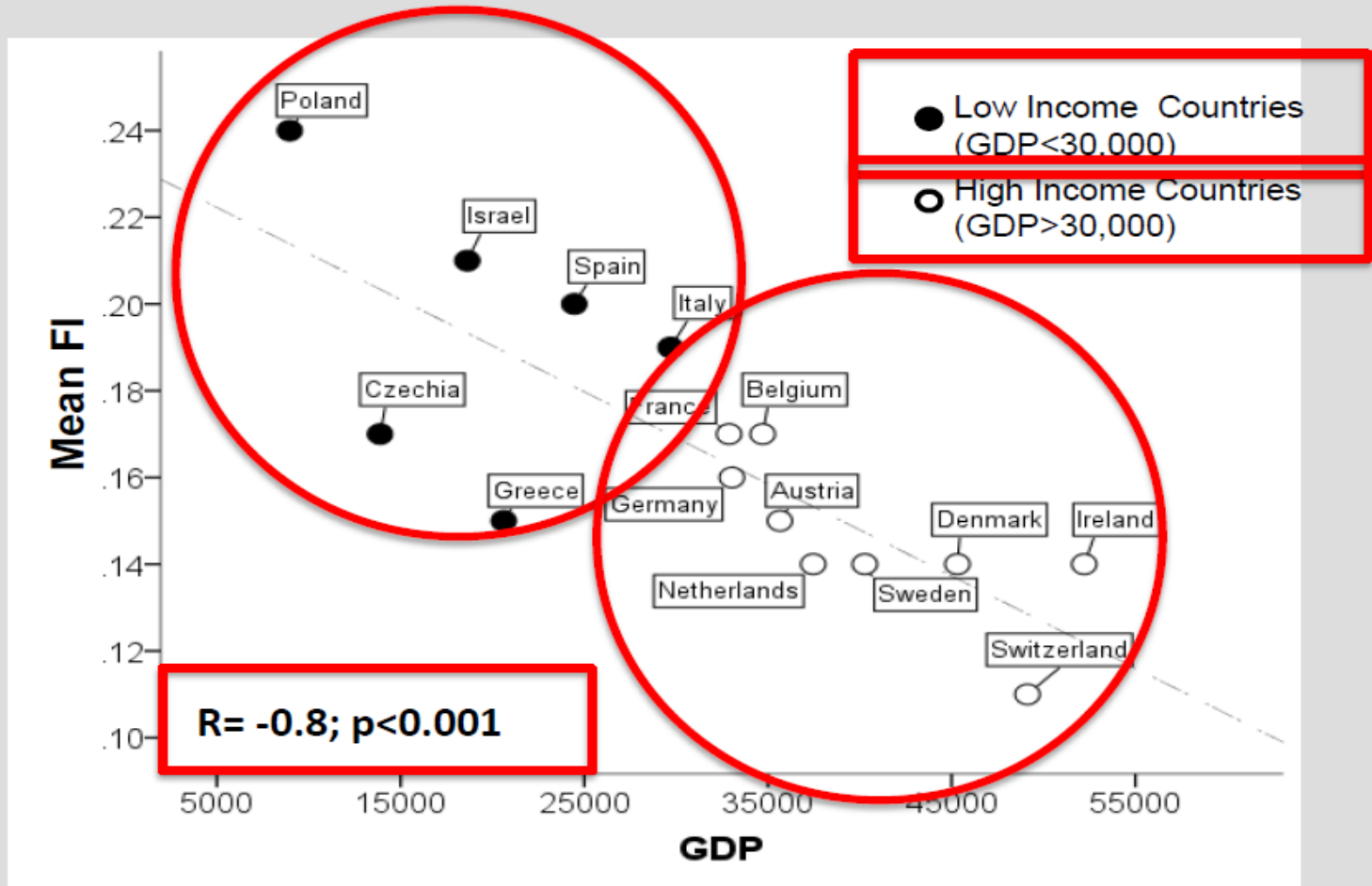
Criteria of  
Inclusion?

**Loss = Pre-Frailty??**

**Frailty or Pre-Frailty??**

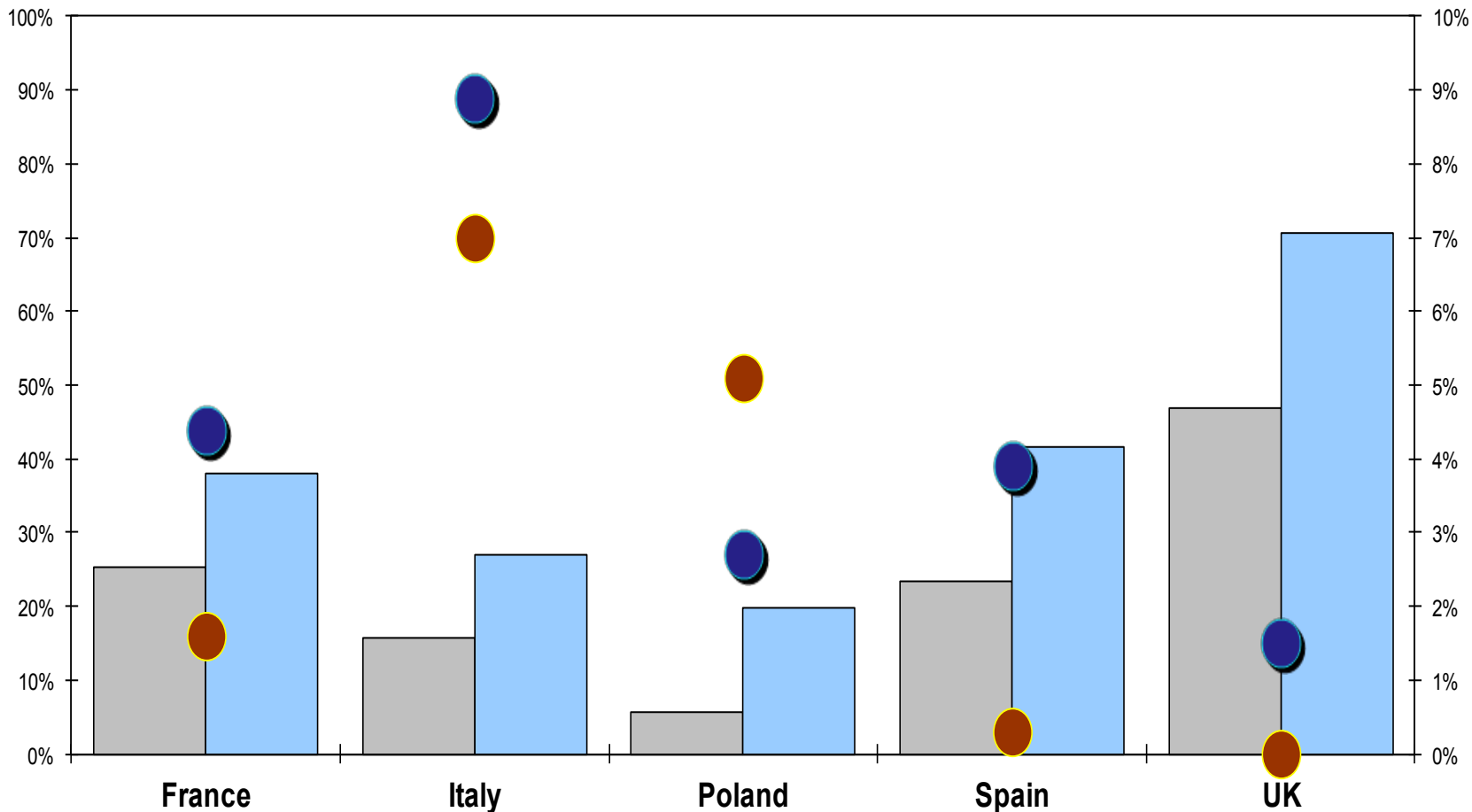
# Frailty (FI) & GDP across EU

Mean FI and Gross Domestic Product (GDP)



# Self-Referred Health & Unmet Medical Needs

**% Self-Referred Health by Income**



**% Unmet Needs**

- People over 75 who state their health is 'Very good and I income quintile (lower)
- People over 75 who state their health is 'Very good and good' V income quintile (higher)
- Self-reported unmet needs for medical examination: people over 75
- Self-reported unmet needs for dental examination because to expensive, to far to travel or due to waiting lists, people over 75

**In which way can a **Multidisciplinary**  
**Response to Frailty and**  
**Multimorbidity be developed?****

# An Operational Response to Frailty and Multimorbidity

## Health and Social Care Services

**II°Level:  
Specialist**

- Possible Pathways:**
- Diagnosis
  - II°Prevention
  - Therapy
  - Referral

**I°Level:**

**Primary Health and Social Care**  
(GPs, Nurses, Social Workers, others)

## •Living Environment:

**Alert, Promotion, Referral**  
(Pharmacy, Circles, Church, Gyms....)

**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

# **How to Identify Frailty and Multimorbidity in Primary Health and Social Care?**

- **Scales - Items**
- **Professionals**
- **Settings & Contacts**

**A Common Set of Items (language)?**



# **How to Identify Frailty and Multimorbidity in Primary Health and Social Care A Common Set of Items?**

- Physical activity**
  - Weight loss**
  - Dental status**
  - Mood disorders**
  - Memory problems**
  - History of falls**
  - Presence of 2 or more Chronic Conditions**
  - Recurrent Hospitalization**
  - Educational Level**
  - Social Isolation**
  - Economic Constraints**
- Socio-Economical Vulnerability**
- 

# **How to Identify Frailty and Multimorbidity in Primary Health and Social Care A Common Set of Items?**

- **To Provide a Differentiated – Integrated Response  
by Levels and Settings of Care**
- **With a focus on Primary and Social Care**
- **Common Core: Domains of Frailty**

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## Opportunities & Challenges

- **Definition** of Frailty and Pre-Frailty
- An **Operational Response** to Frailty and Multimorbidity in Primary Health and Social Care
- **Instruments** and **Items** to Identify Frailty and Multimorbidity
- How to identify **Good Practices** on Frailty and Multimorbidity
- **Synergies** Between EU Projects & Initiatives

***Thank you for your attention!***

[www.sunfrail.eu](http://www.sunfrail.eu)



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