EDITORIAL

IMPROVING CARE FOR COMMUNITY DWELLING FRAIL ELDERSTHROUGH PATIENT AND PROVIDER ENGAGEMENT

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Effective health care for older adults must attend to not only proper prevention and management of acute and chronic disease, but also to the unique health-related problems of late life. Health and functional difficulties in late life are characterized by multiple interacting age-related alterations in cells and organ systems. Often described within the conceptual framework of “frailty”, these complex health problems demand a new approach from the health care system that involves recognition, evaluation and management by a multidisciplinary team. Such multidisciplinary approaches are often categorized within the rubric of geriatric evaluation and management teams or “GEMS”.

Over the last decades, an evidence base for the effectiveness of GEMS has emerged. Much of this evidence is based on screening of hospital inpatients for those at high risk, while a smaller evidence base exists for purely outpatient- based approaches. Recent meta- analyses and summaries suggest, at best, modest and time-limited effects on survival, functional status, health care use and other important outcomes (1-9). Several important challenges that may contribute to limited program effectiveness, especially for outpatient programs, include engagement of primary care providers, convenient and accurate screening approaches to yield efficient targeting of high risk individuals, and capacity to implement management recommendations (10-15). In addition, the actual content of assessments has varied widely, as have the balance of medical, social and functional issues addressed by the process.

The Geriatric Frailty Clinic at the Gerontopole, described in this issue of JNHA (16), confronts these key issues in innovative ways. Most impressive is the engagement of primary care providers and regional health authorities. Primary care providers appear to be able to identify and refer patients using a convenient, brief screening tool integrated with the provider’s clinical judgment. This approach to screening appears to result in a referred population who resemble the target population of persons with clear vulnerability to disability but low rates of established serious disability. The intervention appears to incorporate a range of medical, functional, social and behavioral issues. While adherence rates are not yet reported, the approach prioritizes efforts to keep primary providers and patients involved and thus to enhance ongoing interest in the recommendations. Thus Gerontopole has addressed several major challenges of feasibility: primary provider education and involvement, efficient and acceptable screening that yields a

target population for services, a reasonable mix of medical, social and functional interventions and strong attention to adherence through ongoing communication with patients and providers.

This work to establish feasibility and to operationalize procedures is essential prior to the next important step; to evaluate effectiveness. The design of evaluation trials should focus on generalizable models of patient-centered care and on comparative effectiveness rather than on pure efficacy, perhaps along the models of PCORI in the US (17). To achieve this generalizable result, such a future multisite study will need to develop reproducible outreach plans for providers, patients and families; guidelines for care processes; consensus on key predictor and outcome factors; and complex plans for data management and analysis.

The work accomplished here is an important step toward the universal goal of advocates for the aging; future enthusiastic support by providers and health authorities for a change in approach to the care of vulnerable frail older adults. It’s been decades, but perhaps we are now on the right track.

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