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### Literature search results

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### Search details

Screening tools, patient-centred care and integrated care for frailty.

### Resources searched

NICE Evidence; TRIP Database; Cochrane Library; AMED; CINAHL; EMBASE; MEDLINE; Google Scholar;

### Database search terms:

frail*, (screen* OR identif* OR tool* OR assess* OR score* OR index* OR instrument*), pathway*, (integrat* OR “patient centred” OR “person centred” OR “patient centered” OR “person centered” OR holistic OR “whole person”)

### Evidence / Google Scholar search string(s):

(frail OR frailty) (screening OR assessment OR identify OR identification) (frail OR frailty) “integrated care” (frail OR frailty) (“patient centred care” OR “person centred care” OR holistic OR “whole person”)

### Guidelines and Policy

**British Geriatrics Society**

Fit for Frailty: part 1, 2014
Fit for Frailty: part 2, 2015

**Health Improvement Scotland**

Think Frailty: improving the identification and management of frailty, 2014
Frailty Screening in the Community Using the FRAIL Scale.

Author(s): Woo, Jean, Yu, Ruby, Wong, Moses, Yeung, Fannie, Wong, Martin, Lum, Christopher

Citation: Journal of the American Medical Directors Association, May 2015, vol. 16, no. 5, p. 412-419 (May 1, 2015)

Publication Date: May 2015

Abstract: To explore the feasibility of using the FRAIL scale in community screening of older Chinese people aged 65 years and older, followed by clinical validation by comprehensive geriatric assessment of those classified as pre-frail or frail. Two-phase study: screening of people aged 65 years and older by trained volunteers, followed by comprehensive geriatric assessment by multidisciplinary staff for those classified as pre-frail or frail. Elderly Centers in the New Territories East Region of Hong Kong SAR China. A total of 816 members of elderly centers attending by themselves or accompanied by relatives. For phase 1, questionnaire (including demographic, lifestyle, chronic diseases) and screening tools were administered by trained volunteers. These consist of the FRAIL scale, SARC-F to screen for sarcopenia, and mild cognitive impairment using the abbreviated screening for mild cognitive impairment (Abbreviated Memory Inventory for the Chinese). Blood pressure, body mass index, and grip strength were recorded. For phase 2, comprehensive geriatric assessment include questionnaires assessing lifestyle domain (physical activity, nutritional status using the Mini-Nutritional Assessment-Short Form), the physical domain (number of diseases and number of drugs, activities of daily living and instrumental activities of daily living disabilities, geriatric syndromes, self-rated health, sleep quality), cognitive and psychological domain (Mini-Mental State Examination, Geriatric Depression Scale), and social domain (income, housing, living satisfaction, family support). The prevalence of pre-frailty and frailty were 52.4% and 12.5%, respectively. The prevalence for frailty increasing with age from 5.1% for those aged 65-69 years to 16.8% for those ≥75, being greater in women compared with men (13.9% vs 4.2%). Of those who were pre-frail or frail (n = 529), 42.5% had sarcopenia and 60.7% had mild cognitive impairment. Among those who were frail (n = 102), sarcopenia and mild cognitive impairment were also frequently present: 12.8% had sarcopenia, 14.7% had mild cognitive impairment, 63.7% had both sarcopenia and mild cognitive impairment, and only 8.8% had neither. In phase 2, participants who were classified as pre-frail or frail (n = 529) were invited for further interviews; 255 participants (48.2%) returned. Compared with the pre-frail group, those in the frail group were less physically active, had higher number of chronic diseases, were taking more medications (more were taking sleeping pills), reported more falls, rated their
health as poor, had higher prevalence of depressive symptoms and mild cognitive impairment, had higher prevalence of sarcopenia, and a high number of activities of daily living and instrumental activities of daily living disabilities. The FRAIL scale may be used as the first step in a step care approach to detecting frailty in the community, allowing targeted intervention to potentially retard decline and future disability. Copyright © 2015 AMDA – The Society for Post-Acute and Long-Term Care Medicine. Published by Elsevier Inc. All rights reserved.

Source: Medline

Optimal screening for increased risk for adverse outcomes in hospitalised older adults.

Author(s) Heim, Noor, van Fenema, Ester M, Weverling-Rijnsburger, Annelies W E, Tuijl, Jolien P, Jue, Peter, Oleksik, Anna M, Verschuur, Margot J, Haverkamp, Jasper S, Blauw, Gerard Jan, van der Mast, Roos C, Westendorp, Rudi G J

Citation: Age and ageing, Mar 2015, vol. 44, no. 2, p. 239-244 (March 2015)

Publication Date: March 2015

Abstract: Screening for frailty might help to prevent adverse outcomes in hospitalised older adults. To identify the most predictive and efficient screening tool for frailty. Two consecutive observational prospective cohorts in four hospitals in the Netherlands. Patients aged ≥70 years, electively or acutely hospitalised for ≥2 days. Screening instruments included in the Dutch Safety Management Programme [VeiligheidsManagementSysteem (VMS)] on four geriatric domains (ADL, falls, undernutrition and delirium) were used and the Identification of Seniors At Risk, the 6-item Cognitive Impairment Test and the Mini-Mental State Examination were assessed. Three months later, adverse outcomes including functional decline, high-healthcare demand or death were determined. Correlation and regression tree analyses were performed and predictive capacities were assessed. Follow-up data were available of 883 patients. All screening instruments were similarly predictive for adverse outcome (predictive power 0.58-0.66), but the percentage of positively screened patients (13-72%), sensitivity (24-89%) and specificity (35-91%) highly differed. The strongest predictive model for frailty was scoring positive on ≥3 VMS domains if aged 70-80 years; or being aged ≥80 years and scoring positive on ≥1 VMS domains. This tool classified 34% of the patients as frail with a sensitivity of 68% and a specificity of 74%. Comparable results were found in the validation cohort. The VMS-tool plus age (VMS+) offers an efficient instrument to identify frail hospitalised older adults at risk for adverse outcome. In clinical practice, it is important to weigh costs and benefits of screening given the rather low-predictive power of screening instruments. © The Author 2014. Published by Oxford University Press on behalf of the British Geriatrics Society.

Source: Medline

Available in fulltext from Age and Ageing at Free Access Content

Screening for frailty among older patients with cancer that qualify for abdominal surgery.

Author(s) Kenig, Jakub, Zychiewicz, Beata, Olszewska, Urszula, Richter, Piotr

Citation: Journal of geriatric oncology, Jan 2015, vol. 6, no. 1, p. 52-59 (January 2015)

Publication Date: January 2015

Abstract: The Geriatric Assessment (GA) is an established method for evaluating and optimizing diagnostic and treatment plans. However, it requires experience and is time-consuming. Therefore, a variety of screening methods have been developed. The aim of this study was to compare their accuracy for predicting frailty among older patients with cancer qualified for abdominal surgery based on comparison to the GA. One hundred and thirty five consecutive patients ≥65years of age were prospectively enrolled. The diagnostic performance of eight screening tests was evaluated: The Vulnerable Elderly Survey (VES-13), Triage Risk Screening Tool (TRST), Geriatric 8 (G8), Groningen Frailty Index (GFI),
abbreviated Comprehensive Geriatric Assessment (aCGA), Rockwood, Balducci and Fried score. The prevalence of frailty as diagnosed by the GA was 73%. Screening methods identified frail patients in 40-75.5% of cases. The sensitivity and specificity of these tests in predicting frailty were 52%-97% (Fried score-G8) and 44-100% (G8-Rockwood score), respectively. The positive and negative predictive values were 82-100% (Balducci-Rockwood) and 43-84% (TRST-G8), respectively. Age significantly influenced the predictive value of the screening tests whereas gender and type of cancer did not. At present, there is no universal screening test that adequately identifies frailty in at risk older patients. The results of this study showed that the aCGA and G8 were the best screens for older patients with cancer that qualified for elective abdominal surgery; the G8 had the highest sensitivity and negative predictive value and the aCGA was a good overall assessment tool. Copyright © 2014 Elsevier Inc. All rights reserved.

Source: Medline

Screening for frailty in older adults using a self-reported instrument.

**Author(s)** Nunes, Daniella Pires, Duarte, Yeda Aparecida de Oliveira, Santos, Jair Lício Ferreira, Lebrão, Maria Lúcia

**Citation:** Revista de saúde pública, Jan 2015, vol. 49, p. 2. (2015)

**Publication Date:** January 2015

**Abstract:** OBJECTIVE To validate a screening instrument using self-reported assessment of frailty syndrome in older adults. METHODS This cross-sectional study used data from the Saúde, Bem-estar e Envelhecimento study conducted in Sao Paulo, SP, Southeastern Brazil. The sample consisted of 433 older adult individuals (≥ 75 years) assessed in 2009. The self-reported instrument can be applied to older adults or their proxy respondents and consists of dichotomous questions directly related to each component of the frailty phenotype, which is considered the gold standard model: unintentional weight loss, fatigue, low physical activity, decreased physical strength, and decreased walking speed. The same classification proposed in the phenotype was utilized: not frail (no component identified); pre-frail (presence of one or two components), and frail (presence of three or more components). Because this is a screening instrument, "process of frailty" was included as a category (pre-frail and frail). Cronbach's α was used in psychometric analysis to evaluate the reliability and validity of the criterion, the sensitivity, the specificity, as well as positive and negative predictive values. Factor analysis was used to assess the suitability of the proposed number of components. RESULTS Decreased walking speed and decreased physical strength showed good internal consistency (α = 0.77 and 0.72, respectively); however, low physical activity was less satisfactory (α = 0.63). The sensitivity and specificity for identifying pre-frail individuals were 89.7% and 24.3%, respectively, while those for identifying frail individuals were 63.2% and 71.6%, respectively. In addition, 89.7% of the individuals from both the evaluations were identified in the "process of frailty" category. CONCLUSIONS The self-reported assessment of frailty can identify the syndrome among older adults and can be used as a screening tool. Its advantages include simplicity, rapidity, low cost, and ability to be used by different professionals.

**Source:** Medline

Diagnostic test accuracy of simple instruments for identifying frailty in community-dwelling older people: a systematic review.

**Author(s)** Clegg, Andrew, Rogers, Luke, Young, John

**Citation:** Age & Ageing, 01 January 2015, vol./is. 44/1(148-152), 00020729

**Publication Date:** 01 January 2015

**Abstract:** Background: frailty is a state of vulnerability to adverse outcomes. Routine identification of frailty is recommended in international guidance. This systematic review investigates the diagnostic test accuracy (DTA) of simple instruments for identifying frailty in community-dwelling older people. Methods: the
review methodology followed Cochrane procedures. Databases were searched from January 1990 to October 2013. Prospective studies assessing the DTA of simple instruments for identifying frailty in community-dwelling older people (aged ≥65 years) as index tests against a reference standard phenotype model, cumulative deficit frailty index or comprehensive geriatric assessment were eligible for inclusion. Sensitivity, specificity, positive predictive value, negative predictive value and likelihood ratios were calculated for index tests. Risk of bias was assessed using the QUADAS-2 checklist.

Results: three studies involving 3,261 participants were included. Median frailty prevalence was 10.5%. Seven index tests were assessed: gait speed, timed-up-and-go test, PRISMA 7 questionnaire, self-reported health, general practitioner clinical assessment, polypharmacy and Groningen Frailty Index. For a gait speed of <0.8 m/s, the sensitivity = 0.99 and specificity = 0.64. For the PRISMA 7, the sensitivity = 0.83 and specificity = 0.83. For the timed get-up-and-go test of 10 s, the sensitivity = 0.93 and specificity = 0.62. DTA was notably lower for all other index tests. All three studies were judged at unclear risk of bias.

Discussion: slow gait speed, PRISMA 7 and the timed get-up-and-go test have high sensitivity for identifying frailty. However, limited specificity implies many false-positive results which means that these instruments cannot be used as accurate single tests to identify frailty.

Source: CINAHL
Available in fulltext from Age and Ageing at Free Access Content

Frailty indexes, screening instruments and their application in Belgian primary care.

Author(s) Sieliwonczyk, E, Perkisas, S, Vandewoude, M

Citation: Acta clinica Belgica, Aug 2014, vol. 69, no. 4, p. 233-239, 1784-3286 (August 2014)

Publication Date: August 2014

Abstract: The complex and expensive medical care for a rising number of older patients presents a significant challenge to the health care system. Identifying cost-effective preventive interventions and systematically applying them in the elderly population could help address this challenge. Frailty assessments could prove to be valuable tools by identifying at-risk individuals to which these interventions would be offered. This review seeks to provide the reader with an overview of frailty and explain how frailty assessments could contribute to daily practice. PubMed was searched for articles concerning frailty assessment (July 2013). Articles discussing prominent frailty models and articles primarily focused on comparing frailty assessments in the home-dwelling population were used for this article. Domus Medica was searched for guidelines concerning the use of frailty in Belgian primary care. Several notable models of frailty are summarized and discussed to provide the reader with an overview of available frailty assessments. Frailty screening modalities in primary care are discussed, as well as the current recommendations for the use of frailty assessments in Belgian primary care. The advantages of a systematic frailty assessment in primary care and other settings are highlighted. This article recommends the assessment of frailty status as a screening tool for the evaluation of the older person in primary care. An overview of available frailty models is offered for this purpose. A consensus should be reached on which model is most appropriate. The screening for frailty promotes early intervention and timely involvement of specialists with the purpose of avoiding unfavourable outcomes, such as death or disability.

Source: Medline

Identifying Common Characteristics of Frailty Across Seven Scales.

Author(s) Theou, Olga, Brothers, Thomas D., Peña, Fernando G., Mitnitski, Arnold, Rockwood, Kenneth

Citation: Journal of the American Geriatrics Society, 01 May 2014, vol./is. 62/5(901-906), 00028614

Publication Date: 01 May 2014
Vulnerable Elderly Survey 13 as a screening method for frailty in Polish elderly surgical patient—prospective study.

Author(s): Kenig, Jakub, Richter, Piotr, Zychiewicz, Beata, Olszewska, Urszula

Citation: Polski przegląd chirurgiczny, Mar 2014, vol. 86, no. 3, p. 126-131, 0032-373X (March 2014)

Publication Date: March 2014

Abstract: The Vulnerable Elders Survey (VES-13) is a simple function based frailty screening tool that can be also administered by the nonclinical personnel within 5 minutes and has been validated in the out- and in patient clinic and acute medical care settings. The aim of the study was to validate the accuracy of the VES-13 screening method for predicting the frailty syndrome based on a CGA in polish surgical patients. We included prospectively 106 consecutive patients ≥65, that qualify for abdominal surgery (both due to oncological and benign reasons), at the tertiary referral hospital. We evaluated the diagnostic performance of VES-13 score comparing to the results from the CGA, accepted as the gold standard for identifying at risk frail elderly patients. The prevalence of frailty as diagnosed by CGA was 59.4%. There was significantly higher number of frail patients in the oncological group (78% vs. 31%; p<0.01). According to the frailty screening methods, the frailty prevalence was 45.3%. The VES-13 score had a 60% sensitivity and 78% specificity in detecting frailty syndrome. The positive and negative predictive value was 81% and 57%, respectively. The overall predictive capacity was intermediate (AUC=0.69)

CONCLUSIONS: At present, the VES-13 screening tool for older patients cannot replace the comprehensive geriatric assessment; this is due to the insufficient discriminative power to select patients for further assessment. It might be helpful in a busy clinical practice and in facilities that do not have trained personal for geriatric assessment.

Source: Medline

Validating SPICES as a Screening Tool for Frailty Risks among Hospitalized Older Adults.

Author(s): Aronow, Harriet Udin, Borenstein, Jeff, Haus, Flora, Braunstein, Glenn D, Bolton, Linda Burnes

Citation: Nursing research and practice, Jan 2014, vol. 2014, p. 846759., 2090-1429 (2014)

Publication Date: January 2014

Abstract: Older patients are vulnerable to adverse hospital events related to frailty. SPICES, a common screening protocol to identify risk factors in older patients, alerts nurses to initiate care plans to reduce the probability of patient harm. However, there is little published validating the association between SPICES and measures of frailty and adverse outcomes. This paper used data from a prospective cohort study on frailty among 174 older adult inpatients to validate SPICES. Almost all patients met one or more SPICES criteria. The sum of SPICES was significantly correlated with age and other well-validated assessments for vulnerability, comorbid conditions, and depression. Individuals meeting two or more SPICES criteria had a risk of adverse hospital events three times greater than individuals with either no or one criterion. Results suggest that as a screening tool used within 24 hours of admission, SPICES is both valid and predictive of adverse events.

Source: Medline

Available in fulltext from Nursing Research and Practice at Free Access Content

Available in fulltext from Nursing Research and Practice at National Library of Medicine
A self-reported screening tool for detecting community-dwelling older persons with frailty syndrome in the absence of mobility disability: the FiND questionnaire.

Author(s): Cesari, Matteo, Demougeot, Laurent, Boccalon, Henri, Guyonnet, Sophie, Abellan Van Kan, Gabor, Vellas, Bruno, Andrieu, Sandrine

Citation: PloS one, Jan 2014, vol. 9, no. 7, p. e101745. (2014)

Publication Date: January 2014

Abstract: The “frailty syndrome” (a geriatric multidimensional condition characterized by decreased reserve and diminished resistance to stressors) represents a promising target of preventive interventions against disability in elders. Available screening tools for the identification of frailty in the absence of disability present major limitations. In particular, they have to be administered by a trained assessor, require special equipment, and/or do not discriminate between frail and disabled individuals. Aim of this study is to verify the agreement of a novel self-reported questionnaire (the “Frail Non-Disabled” [FiND] instrument) designed for detecting non-mobility disabled frail older persons with results from reference tools. Data are from 45 community-dwelling individuals aged ≥60 years. Participants were asked to complete the FiND questionnaire separately exploring the frailty and disability domains. Then, a blinded assessor objectively measured the frailty status (using the phenotype proposed by Fried and colleagues) and mobility disability (using the 400-meter walk test). Cohen's kappa coefficients were calculated to determine the agreement between the FiND questionnaire with the reference instruments. Mean age of participants (women 62.2%) was 72.5 (standard deviation 8.2) years. Seven (15.6%) participants presented mobility disability as being unable to complete the 400-meter walk test. According to the frailty phenotype criteria, 25 (55.6%) participants were pre-frail or frail, and 13 (28.9%) were robust. Overall, a substantial agreement of the instrument with the reference tools (kappa = 0.748, quadratic weighted kappa = 0.836, both p values<0.001) was reported with only 7 (15.6%) participants incorrectly categorized. The agreement between results of the FiND disability domain and the 400-meter walk test was excellent (kappa = 0.920, p<0.001). The FiND questionnaire presents a very good capacity to correctly identify frail older persons without mobility disability living in the community. This screening tool may represent an opportunity for diffusing awareness about frailty and disability and supporting specific preventive campaigns.

Source: Medline

Available in fulltext from PLoS ONE at EBSCOhost
Available in fulltext from PLoS ONE at National Library of Medicine

The predictive properties of frailty-rating scales in the acute medical unit.

Author(s): Wou, Franklin, Gladman, John R F, Bradshaw, Lucy, Franklin, Matthew, Edmans, Judi, Conroy, Simon Paul

Citation: Age and ageing, Nov 2013, vol. 42, no. 6, p. 776-781 (November 2013)

Publication Date: November 2013

Abstract: older people are at an increased risk of adverse outcomes following attendance at acute hospitals. Screening tools may help identify those most at risk. The objective of this study was to compare the predictive properties of five frailty-rating scales. this was a secondary analysis of a cohort study involving participants aged 70 years and above attending two acute medical units in the East Midlands, UK. Participants were classified at baseline as frail or non-frail using five different frailty-rating scales. The ability of each scale to predict outcomes at 90 days (mortality, readmissions, institutionalisation, functional decline and a composite adverse outcome) was assessed using area under a receiver-operating characteristic curve (AUC). six hundred and sixty-seven participants were studied. Frail participants according to all scales were associated with a significant increased risk of mortality [relative risk (RR) range 1.6-3.1], readmission (RR range 1.1-1.6), functional decline (RR range 1.2-2.1) and the composite adverse outcome
(RR range 1.2-1.6). However, the predictive properties of the frailty-rating scales were poor, at best, for all outcomes assessed (AUC ranging from 0.44 to 0.69). Frailty-rating scales alone are of limited use in risk stratifying older people being discharged from acute medical units.

**Source:** Medline

Available in fulltext from Age and Ageing at Free Access Content
Available in fulltext from Age and Ageing at Highwire Press
Available in fulltext from Age & Ageing at EBSCOhost

The Vulnerable Elders Survey and its prognostic relationship to survival in an older community-based palliative population.

**Author(s)** Chapman, Michael David, Le, Brian H C, Gorelik, Alexandra

**Citation:** BMJ supportive & palliative care, Sep 2013, vol. 3, no. 3, p. 335-342 (September 2013)

**Publication Date:** September 2013

**Abstract:** Frailty denotes a vulnerability to poor outcomes and is a common risk factor for mortality in older persons. The Vulnerable Elders Survey (VES) is an easy to administer validated screening tool to detect a frail population. Assessment of frailty has the potential to aid in prognostication for the older community dwelling palliative population. This study seeks to evaluate the relationship of the VES to prognosis in this population. Prospective cohort study of patients over 65 years old admitted to a community palliative care service. The VES was performed in addition to the usual assessments of physical function. Comorbidity was assessed using the Charlson Comorbidity Index (CCI). Physical function and CCI were assessed to determine whether they improved the prognostic power of the VES. Patients were followed-up for 8 months with the primary endpoint of survival. 197 patients completed the study with a high proportion of malignant diagnoses (87.5%); 98% of patients died during the study with a median survival of 61 days; 93.4% of patients were vulnerable on the VES and high risk scores predicted death within 100 days. In this study the VES demonstrated high rates of vulnerability and has the potential to improve the accuracy of prognosis in older palliative community dwelling patients. Improving prognostication has potential clinical benefits, including aiding clinical communication and determining the best use of community services. The limitations of this study and the evolving understanding of frailty suggest that further work in this area is required.

**Source:** Medline

Looking for frailty in community-dwelling older persons: the Gérontopôle Frailty Screening Tool (GFST).

**Author(s)** Vellas, B, Balardy, L, Gillette-Guyonnet, S, Abellan Van Kan, G, Ghisolfi-Marque, A, Subra, J, Bismuth, S, Oustric, S, Cesari, M

**Citation:** The journal of nutrition, health & aging, Jul 2013, vol. 17, no. 7, p. 629-631 (July 2013)

**Publication Date:** July 2013

**Abstract:** The frailty syndrome is a pre-disability condition suitable to be targeted by preventive interventions against disability. In order to identify frail older persons at risk of negative outcomes, general practitioners must be provided with an easy and quick screening tool for detecting frailty without special effort. In the present paper, we present the screening tool for frailty that the Gérontopôle of Toulouse (France) has developed and implemented in primary care in the region with the collaboration of the Department of Family Medicine of the University of Toulouse. The Gérontopôle Frailty Screening Tool (GFST) is designed to be administered to persons aged ≥65 years with no physical disability and acute clinical disease. It is composed by an initial questionnaire aimed at attracting the general practitioner's attention to very general signs and/or symptoms suggesting the presence of an underlying frailty status. Then, in a second section, the general practitioner expresses his/her own view about the frailty status of the individual. The clinical
The identification of frail older adults in primary care: comparing the accuracy of five simple instruments.


Citation: Age & Ageing, 01 March 2013, vol./is. 42/2(262-265), 00020729
Publication Date: 01 March 2013
Source: CINAHL
Available in fulltext from Age and Ageing at Free Access Content
Available in fulltext from Age and Ageing at Highwire Press
Available in fulltext from Age & Ageing at EBSCOhost

Development of an instrument for the identification of frail older people as a target population for integrated care.

Author(s) van Kempen, Janneke A L, Schers, Henk J, Jacobs, Anne, Zuidema, Sytse U, Ruikes, Franca, Robben, Sarah H M, Melis, René J F, Olde Rikkert, Marcel G M

Citation: The British journal of general practice: the journal of the Royal College of General Practitioners, Mar 2013, vol. 63, no. 608, p. e225. (March 2013)
Publication Date: March 2013
Abstract: Primary care is increasingly interested in the identification of frailty, as it selects the target population for integrated care. However, instruments for the identification of frailty specifically validated for use in primary care are scarce. This study developed the Easycare Two-step Older persons Screening (Easycare-TOS), which provides a valid, efficient, and pragmatic screening procedure to identify frail older people. This paper aims to describe the development of the Easycare-TOS and the data from the pilot studies. Observational pilot study in seven academic GP practices in and around Nijmegen, The Netherlands. The Easycare-TOS was developed in a cyclic process with the input of stakeholders. In every cycle, the requirements were first defined, then translated into a prototype that was tested in a pilot study. The Easycare-TOS makes optimal use of prior knowledge of the GP, and the professionals’ appraisal is decisive in the frailty decision, instead of a cut-off score. Further, it considers aspects of frailty, as well as aspects of the care context of the patient. The pilot data have shown that after step 1, two-thirds of the patients do not need further assessment, because they are judged as not frail, based on prior knowledge of the GP. The overall prevalence of frailty in this pilot study is 24%. Most professionals who participated in the pilot studies considered the time investment acceptable and the method to be of added value. The Easycare-TOS instrument meets the predefined efficiency, flexibility, and acceptability requirements for use as an identification instrument for frailty in primary care.
Source: Medline

Evaluation of the Groningen Frailty Indicator and the G8 questionnaire as screening tools for frailty in older patients with cancer.

Author(s) Baitar, Abdelbari, Van Fraeyenhove, Frank, Vandebroek, An, De
In this study, we evaluated the Groningen Frailty Indicator (GFI) and the G8 questionnaire as screening tools for a Comprehensive Geriatric Assessment (CGA) in older patients with cancer. Eligible patients with various types and stages of cancer were evaluated for frailty before treatment. Patients were categorized as patients with a normal CGA and abnormal CGA (≥2 impaired tests). The diagnostic performance of the screening tools was evaluated against the CGA with Receiver Operating Characteristic analysis. In total, 170 patients (79 women) with median age 77 years old (range 66-97 years) were included. Sixty-four percent of patients had an abnormal CGA while according to the GFI (GFI≥4) and G8 questionnaire (G8≤14) 47% and 76% of patients had an abnormal screening test, respectively. Overall, there was no significant difference (p=0.97) in diagnostic performance between the two screening tools. The Area Under the Curve was 0.87 for both tools. For the GFI and G8 questionnaire the sensitivity was respectively 66% (95% CI: 56-75%), 92% (95% CI: 85-96%); the negative predictive value (NPV): 59% (95 CI%: 49-69%), 78% (95% CI: 63-88%); and the specificity: 87% (95% CI: 76-94%), 52% (95% CI: 39-65%). In this study, we showed that overall both the GFI and the G8 questionnaire were able to separate older patients with cancer with a normal and abnormal CGA. For the G8 questionnaire, an adequate sensitivity and NPV were demonstrated, however at the expense of the specificity. For the GFI, we suggest to lower the threshold with one point to GFI ≥3 to screen patients for a CGA. Copyright © 2012 Elsevier Inc. All rights reserved.
Emergency Department (ED) visit. Comprehensive geriatric assessment (CGA) has been proposed to screen for frailty in the ED, but it is difficult to carry out. We tested whether a CGA-based approach using the Identification of Seniors At Risk (ISAR) screening tool was associated with the brief deficit accumulation index (DAI) of frailty. Prospective observational study. Two urban EDs in Italy. A cohort of 200 elderly (≥65 years) ED patients. Identifiers, triage, clinical and social data along with the administration of ISAR. CGA was performed using: Charlson Index, Short Portable Mental Status Questionnaire and Katz’s ADL. Follow-up data at 30 and 180 days included: mortality, ED revisit, hospital admission, and functional decline. Frailty was defined according to a brief DAI. Logistic regression evaluated the consistency of the frailty definition; ROC curves evaluated ISAR ability in identifying frailty. Frailty was present in 117 (58.5%) subjects and predicted ED revisit and frequent ED return, hospitalization and 6-month mortality. ISAR had an AUC of 0.92 (95%CI 0.88-0.96, p<0.0001) in identifying frail elders in the ED and using a cut-off of 2 showed 94% sensitivity and 63% specificity. ISAR is a useful screening tool for frailty and identifies elderly patients at risk of adverse outcomes after an ED visit. ISAR can also be used to select high-risk patients more likely to benefit from a geriatric approach or intervention, independently of admission or discharge.

Source: Medline
Available in fulltext from Journal of Nutrition, Health and Aging, The at ProQuest

Use of the Mini Nutritional Assessment to detect frailty in hospitalised older people.

Author(s) Dent, E, Visvanathan, R, Piantadosi, C, Chapman, I
Citation: The journal of nutrition, health & aging, Jan 2012, vol. 16, no. 9, p. 764-767 (2012)
Publication Date: January 2012
Abstract: The aims of this study were to: (1) determine the prevalence of undernutrition and frailty in hospitalised elderly patients and (2) evaluate the efficacy of both the Mini-Nutritional Assessment (MNA) screening tool and the MNA short form (MNA-SF) in identifying frailty. A convenient sample of 100 consecutive patients (75.0 % female) admitted to the Geriatric Evaluation and Management Unit (GEMU) at The Queen Elizabeth Hospital in South Australia. Frailty status was determined using Fried's frailty criteria and nutritional status by the MNA and MNA-SF. Optimal cut-off scores to predict frailty were determined by Youden's Index, Receiver Operator Curves (ROC) and area under curve (AUC). Undernutrition was common. Using the MNA, 40.0% of patients were malnourished and 44.0% were at risk of malnutrition. By Fried's classification, 66.0 % were frail, 30.0 % were pre-frail and 4.0 % robust. The MNA had a specificity of 0.912 and a sensitivity of 0.516 in predicting frailty using the recommended cut-off for malnourishment (< 17). The optimal MNA cut-off for frailty screening was <17.5 with a specificity of 0.912 and sensitivity of 0.591. The MNA-SF predicted frailty with specificity and sensitivity values of 0.794 and 0.636 respectively, using the standard cut-off of < 8. The optimal MNA-SF cut-off score for frailty was < 9, with specificity and sensitivity values of 0.765 and 0.803 respectively and was better than the optimum MNA cut-off in predicting frailty (Youden Index 0.568 vs. 0.503). The quickly and easily administered MNA-SF appears to be a good tool for predicting both under-nutrition and frailty in elderly hospitalised people. Further studies would show whether the MNA-SF could also detect frailty in other populations of older people.

Source: Medline
Available in fulltext from Journal of Nutrition, Health and Aging, The at ProQuest

The Identification of Frailty: A Systematic Literature Review.

Author(s) Sternberg, Shelley A., Schwartz, Andrea Wershof, Karunanathan, Sathya, Bergman, Howard, Mark Clarfield, A.
Citation: Journal of the American Geriatrics Society, 01 November 2011, vol./is.
**Publication Date:** 01 November 2011

**Abstract:** An operational definition of frailty is important for clinical care, research, and policy planning. The literature on the clinical definitions, screening tools, and severity measures of frailty were systematically reviewed as part of the Canadian Initiative on Frailty and Aging. Searches of MEDLINE from 1997 to 2009 were conducted, and reference lists of retrieved articles were pearled, to identify articles published in English and French on the identification of frailty in community-dwelling people aged 65 and older. Two independent reviewers extracted descriptive information on study populations, frailty criteria, and outcomes from the selected papers, and quality rankings were assigned. Of 4,334 articles retrieved from the searches and 70 articles retrieved from the pearling, 22 met study inclusion criteria. In the 22 articles, physical function, gait speed, and cognition were the most commonly used identifying components of frailty, and death, disability, and institutionalization were common outcomes. The prevalence of frailty ranged from 5% to 58%. Despite significant work over the past decade, a clear consensus definition of frailty does not emerge from the literature. The definition and outcomes that best suit the unique needs of the researchers, clinicians, or policy-makers conducting the screening determine the choice of a screening tool for frailty. Important areas for further research include whether disability should be considered a component or an outcome of frailty. In addition, the role of cognitive and mood elements in the frailty construct requires further clarification.

**Source:** CINAHL

Available in fulltext from *Journal of the American Geriatrics Society* at EBSCOhost

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**Comparison of two frailty screening tools in older women with early breast cancer.**

**Author(s)** Molina-Garrido, M J, Guillen-Ponce, C

**Citation:** Critical reviews in oncology/hematology, Jul 2011, vol. 79, no. 1, p. 51-64 (July 2011)

**Publication Date:** July 2011

**Abstract:** We have tested two frailty screening tools (the Barber Questionnaire [BQ] and the Vulnerable Elderly Survey [VES-13]) to select patients who may benefit from Comprehensive Geriatric Assessment (CGA). We included women ≥ 65 years old, diagnosed with early breast cancer at the University General Hospital in Elche. We compared impairment in the BQ score (score <0 vs. > 0) and impairment in the VES-13 score (<3 vs. ≥ 3), with impaired CGA results (< 2 scales with deficits vs. ≥2). We evaluated the diagnostic performance of both questionnaires by Area Under Curve [AUC] and analyzed their concordance with CGA scales (intraclass correlation coefficient [ICC]). Forty-one women were included. The risk of frailty was 41.76%, 29.3%, and 55.7% when evaluated with BQ, VES-13 and CGA, respectively. The correlation between BQ and CGA was fair (ICC=0.672), but between VES-13 and CGA was very good (ICC=0.814). The predictive capacity of the BQ and the VES-13 for detecting frailty risk was intermediate (AUC=0.719) and high (AUC=0.876), respectively. We propose the use of the VES-13 in older women with early breast cancer and the implementation of CGA when VES-13<3. Copyright © 2010 Elsevier Ireland Ltd. All rights reserved.

**Source:** Medline

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**Identifying frailty in high functioning older adults with normal mobility.**

**Author(s)** Verghese J, Xue X

**Citation:** Age & Ageing, 01 May 2010, vol./is. 39/3(382-385), 00020729

**Publication Date:** 01 May 2010

**Source:** CINAHL

Available in fulltext from *Age and Ageing* at Free Access Content

Available in fulltext from *Age and Ageing* at Highwire Press

Available in fulltext from *Age & Ageing* at EBSCOhost
The assessment of frailty in older adults.

**Author(s)** Abellan van Kan, Gabor, Rolland, Yves, Houles, Mathieu, Gillette-Guyonnet, Sophie, Soto, Maria, Vellas, Bruno

**Citation:** Clinics in geriatric medicine, May 2010, vol. 26, no. 2, p. 275-286 (May 2010)

**Publication Date:** May 2010

**Abstract:** No clear consensual definition regarding frailty seems to emerge from the literature after 30 years of research in the topic, and a large array of models and criteria has been proposed to define the syndrome. Controversy continues to exist on the choice of the components to be included in the frailty definition. Two main definitions based on clusters of components are found in literature: a physical phenotype of frailty, operationalized in 2001 by providing a list of 5 measurable items of functional impairments, which coexists with a multidomain phenotype, based on a frailty index constructed on the accumulation of identified deficits based on comprehensive geriatric assessment. The physical phenotype considers disability and comorbidities such as dementia as distinct entities and therefore outcomes of the frailty syndrome, whereas comorbidity and disability can be components of the multidomain phenotype. Expanded models of physical frailty (models that included clusters other than the original 5 items such as dementia) increased considerably the predicting capacity of poor clinical outcomes when compared with the predictive capacity of the physical phenotype. The unresolved controversy of the components shapes the clusters of original frailty syndrome, and the components depend very much on how frailty is defined. This update also highlights the growing evidence on gait speed to be considered as a single-item frailty screening tool. The evaluation of gait speed over a short distance emerges from the literature as a tool with the capacity to identify frail older adults, and slow gait speed has been proven to be a strong predictor for frailty-adverse outcomes.

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**Source:** Medline

Tools to identify community-dwelling older adults in different stages of frailty.

**Author(s)** Theou O, Kloseck M

**Citation:** Physical & Occupational Therapy in Geriatrics, 01 January 2008, vol./is. 26/3(1-21), 02703181

**Publication Date:** 01 January 2008

**Abstract:** There is a paucity of evidence regarding the ability of health professionals to recognize and manage frailty in community settings before it contributes to significant functional dependency. The purpose of this study was to examine, through a systematic review of the literature, tools that can identify community-dwelling older adults in different stages of frailty. We searched multiple electronic databases (Medline, Embase, Psycinfo, Cinahl, Scopus, Ageline, Eric, Hapi). Our search yielded 27 articles that met established criteria. Most commonly used tools included Fried et al.’s Frailty Phenotype (2001), Rockwood et al.’s Frailty Classification (1999), and Speechley and Tinetti’s Classification of Frailty and Vigorousness (1991). With our rapidly aging population an increasing number of health services are being provided in the community and it is important that therapists have the necessary tools to enable timely and well-targeted intervention.

**Source:** CINAHL

Screening for frailty among seniors in clinical practice.

**Author(s)** Corapi, Kristin M, McGee, Hannah M, Barker, Maja

**Citation:** Nature clinical practice. Rheumatology, Sep 2006, vol. 2, no. 9, p. 476-480, 1745-8382 (September 2006)

**Publication Date:** September 2006

**Abstract:** The normal course of aging is associated with gradual declines in a number of functional abilities. Patients who are at high risk of functional decline are
described as frail or vulnerable. A screening tool to identify such patients is needed, as it has been shown that intervention can delay the onset and/or slow the progression of functional decline. This Review describes the methods currently available for nonspecialist evaluation of aging individuals, including behavioral, interview and questionnaire assessments. Such assessments can be undertaken during routine physician visits. In recognition of the time pressures on physicians, this article focuses on those measurements that are fairly comprehensive yet concise, easy to administer in an office setting, and available in English.

**Source:** Medline

**Use of a questionnaire to screen for frailty in the elderly: an exploratory study.**

**Author(s):** Matthews, Margaret, Lucas, Amy, Boland, Rebecca, Hirth, Victor, Odenheimer, Germaine, Wieland, Darryl, Williams, Harriet, Eleazer, G Paul

**Citation:** Aging clinical and experimental research, Feb 2004, vol. 16, no. 1, p. 34-40, 1594-0667 (February 2004)

**Publication Date:** February 2004

**Abstract:** In a pilot study of community-dwelling geriatric clinic patients (N=48, aged 63-90) we examined the use of a questionnaire to classify frailty status by comparing it with standardized markers of frailty. The questionnaire, developed by Strawbridge et al. in 1998, defines frailty as difficulty in more than one of four domains of functioning: physical, cognitive, sensory, and nutritive. Subjects were classified as frail or not frail by questionnaire and assignment was compared with testing of physical and cognitive measures in cross-sectional analysis. Demographic variables, functional inventories, physical activity levels, clinician impression of frailty, and 3-year health outcomes were also examined. Thirty-three percent of subjects were classified as frail. Frailty classification by the Strawbridge questionnaire was correlated to Timed Up and Go and repetitive Sit-to-Stand tests, bimanual dexterity and cognitive tests. A discrepancy was found between assignment of cognitive difficulty, by questionnaire and cognitive performance. When overall Strawbridge frailty scores were modified to account for those with poor cognitive performance who did not report cognitive difficulty, the prevalence of frailty increased to 42%. At 3-year follow-up, the modified Strawbridge frailty classification (p<0.05) and clinician impression of frailty (p<0.01) were both significant predictors of death and institutionalization combined. This study serves as an initial inquiry into the potential validity and utility of the Strawbridge frailty questionnaire as a simple screening tool to identify patients who may warrant detailed functional testing.

**Source:** Medline

**Person-centred care**

**Successful ageing: keeping the 'person' in person-centred care.**

**Author(s):** Nolan, M

**Citation:** British journal of nursing (Mark Allen Publishing), Apr 2001, vol. 10, no. 7, p. 450-454, 0966-0461 (2001 Apr 12-25)

**Publication Date:** April 2001

**Abstract:** This article, based on a paper given at the International Network for Studies Concerning Older Adults conference, Brazil, charts the emergence of notions of successful ageing, health-related quality of life and person-centred care which currently figure prominently in debates about health and social care. It argues that these developments reflect the importance given to autonomy and independence, values which potentially disadvantage the oldest and frailest members of society. It is suggested that there is a need for a more inclusive conceptualization of person-centred care, which recognizes the values of interdependence and reciprocity.

**Source:** Medline

Available in fulltext from **British Journal of Nursing at ProQuest**
Integrated care/pathways

The short-term effects of an integrated care model for the frail elderly on health, quality of life, health care use and satisfaction with care.

Author(s) Looman, Wilhelmina Mijntje, Fabbricotti, Isabelle Natalina, Huijsman, Robbert


Publication Date: October 2014

Abstract: This study explores the short-term value of integrated care for the frail elderly by evaluating the effects of the Walcheren Integrated Care Model on health, quality of life, health care use and satisfaction with care after three months. Frailty was preventively detected in elderly living at home with the Groningen Frailty Indicator. Geriatric nurse practitioners and secondary care geriatric nursing specialists were assigned as case managers and co-ordinated the care agreed upon in a multidisciplinary meeting. The general practitioner practice functions as a single entry point and supervises the co-ordination of care. The intervention encompasses task reassignment between nurses and doctors and consultations between primary, secondary and tertiary care providers. The entire process was supported by multidisciplinary protocols and web-based patient files. The design of this study was quasi-experimental. In this study, 205 frail elderly patients of three general practitioner practices that implemented the integrated care model were compared with 212 frail elderly patients of five general practitioner practices that provided usual care. The outcomes were assessed using questionnaires. Baseline measures were compared with a three-month follow-up by chi-square tests, t-tests and regression analysis. In the short term, the integrated care model had a significant effect on the attachment aspect of quality of life. The frail elderly patients were better able to obtain the love and friendship they desire. The use of care did not differ despite the preventive element and the need for assessments followed up with case management in the integrated care model. In the short term, there were no significant changes in health. As frailty is a progressive state, it is assumed that three months are too short to influence changes in health with integrated care models. A more longitudinal approach is required to study the value of integrated care on changes in health and the preservation of the positive effects on quality of life and health care use.

Source: Medline

Available in fulltext from International Journal of Integrated Care at Free Access Content
Available in fulltext from International Journal of Integrated Care at National Library of Medicine

Integrated Client Care for Frail Older Adults in the Community: Preliminary Report on a System-Wide Approach.

Author(s) Goldhar, Jodeme, Daub, Stacey, Dhalla, Irfan, Ellison, Philip, Purbhoo, Dipti, Sinha, Samir K.

Citation: Healthcare Quarterly, 01 July 2014, vol./is. 17/3(61-69), 17102774

Publication Date: 01 July 2014

Source: CINAHL

Impact on hospital admissions of an integrated primary care model for very frail elderly patients.

Author(s) de Stampa, Matthieu, Vedel, Isabelle, Buyck, Jean-François, Lapointe, Liette, Bergman, Howard, Beland, Francois, Ankri, Joel

Citation: Archives of Gerontology & Geriatrics, 01 May 2014, vol./is. 58/3(350-355), 01674943
Frail elderly care pathway results in a seamless service.

**Author(s)**

**Citation:** Nursing standard (Royal College of Nursing (Great Britain) : 1987), Jan 2014, vol. 28, no. 20, p. 24., 0029-6570 (2014 Jan 15-21)

**Abstract:** Northumberland CCG has developed a frail elderly pathway to join up care and avoid hospital admissions.

**Source:** Medline

Available in fulltext from Nursing Standard at EBSCOhost

Development of integrated care pathways: toward a care management system to meet the needs of frail and disabled community-dwelling older people.

**Author(s)** Dubuc, Nicole, Bonin, Lucie, Tourigny, André, Mathieu, Luc, Couturier, Yves, Tousignant, Michel, Corbin, Cinthia, Delli-Colli, Nathalie, Raîche, Michel

**Citation:** International journal of integrated care, Apr 2013, vol. 13, p. e017. (April 2013)

**Abstract:** The home care and services provided to older adults with the same needs are often inadequate and highly varied. Integrated care pathways (ICPs) can resolve these issues. The aim of this study was to develop the content of ICPs to follow-up frail and disabled community-dwelling older people. A RIGOROUS PROCESS WAS APPLIED ACCORDING TO A SERIES OF STEPS: identification of desirable characteristics and a theoretical framework; review of evidence-based practices and current practices; and determination of ICPs by an interdisciplinary task team. ICPs are intended to prevent specific problems, maximize independence, and promote successful aging. They are organized according to a dynamic process: (1) needs assessment and assessment of risk/protection factors; (2) data-collection summary and goals identification; (3) planning of interventions from a client-centered view; (4) coordination, delivery, and follow-up; and (5) identification of variances, as well as review and adjustment of plans. Once computerized, these ICPs will facilitate the exchange of information as well as the clinical decision-making process with a perspective to adequately matching the needs of an individual person with resources that delay or slow the progression of frailty and disability. Once aggregated, the data will also support managers in organizing teamwork and follow-up for clients.

**Source:** Medline

Available in fulltext from International Journal of Integrated Care at Free Access Content

Available in fulltext from International Journal of Integrated Care at National Library of Medicine

Integrated care for frail older people: a clinical overview.

**Author(s)** Morris, Jackie

**Citation:** Journal of Integrated Care, 01 August 2012, vol./is. 20/4(257-257), 14769018

**Publication Date:** 01 August 2012

**Abstract:** Purpose DS The purpose of this paper is to elaborate a clinician's perspective on the shared integrated care of older people with dementia and/or frailty. In addition, it aims to describe the significance and value of dignity, kindness and compassion in care. Design/methodology/approach DS This is a general review of current policy, research and good practice, amplified from a clinical perspective. Findings DS The key components of effective integrated care are shared knowledge, understanding, training and support. Equally important are shared objectives, leadership, and governance. Originality/value DS The clinical
Using HIT to deliver integrated care for the frail elderly in the UK: current barriers and future challenges.

Author(s): Soares, Marcelo M., Jacobs, Karen, Waterson, Patrick, Eason, Ken, Tutt, Dylan, Dent, Mike

Citation: Work, 02 February 2012, vol./is. 41/(4490-4493), 10519815

Publication Date: 02 February 2012

Abstract: In this paper we briefly describe the results of a 3 year project examining the use of Health Information Technologies (e.g., electronic patient record systems) to deliver integrated care. In particular, we focus on one group of patient (the frail elderly) and efforts to design an e-health supported healthcare pathway (the frail elderly pathway - FEP). The aim of FEP is to bring together clinicians and staff from health and social care and allow them to share patient information. Our findings show that progress in delivering a fully-supported and working FEP has been slow, not least because of the difficulties experienced by healthcare staff in using current IT systems. In addition, there are many strategic and technical issues which remain unresolved (e.g., systems interoperability).

Source: CINAHL

Available in fulltext from Work at EBSCOhost

Integrated models of care delivery for the frail elderly: international perspectives.

Author(s): Béland, François, Hollander, Marcus J

Citation: Gaceta sanitaria / S.E.S.P.A.S, Dec 2011, vol. 25 Suppl 2, p. 138-146 (December 2011)

Publication Date: December 2011

Abstract: Interest is growing in integrated systems of care for the frail elderly. Few such systems have been both documented and evaluated in a rigorous manner. The present article provides an international review of such systems. The literature on integrated care covered the period from 1997 to 2010, inclusive. Some 2,496 citations were identified from Age Line, PsycINFO, CINAHAL and MedLine and were reviewed. To be included in this paper, articles had to provide a good description of the care delivery system and good quality evaluations. Only nine articles were retained. Most of the articles reviewed described some form of coordinated care without evaluation. There were essentially two types of models of integrated care delivery for the frail elderly. One was a smaller, community-based model that relied on cooperation across care providers, focused on home and community care, and played an active role in health and social care coordination. The second type of model was a large-scale model that could be applied at a national/provincial/state, or large regional health authority, level, had a single administrative authority and a single budget, and included both home/community and residential services. Integrated care delivery can be achieved in various ways. Irrespective of which model is adopted, some of the key factors to be considered are how care can be coordinated effectively across different types of services, and how all the care provider organizations can be coordinated to ensure continuity of care for frail elderly persons. Copyright © 2011 SESPAS. Published by Elsevier Espana. All rights reserved.

Source: Medline

Integrated care for the frail elderly.
Abstract: Chronic disease management initiatives have thus far focused on single disease entities. The challenge of an aging population is the occurrence of multiple diseases, complicated by geriatric syndromes, in the same person. The term frailty is used to denote such persons, who are more vulnerable to poor health outcomes when challenged by a health stressor. In this paper, it is argued that frailty is a chronic condition and thus requires a chronic disease management approach. Hospital-based and community interventions for managing frail seniors are discussed, with a focus on enhancing primary care, and with appropriate and targeted support from geriatric specialists in the form of capacity building as well as direct clinical service. Finally, a model for integrating individual geriatric interventions into a broader system is proposed.

Source: CINAHL

Outcomes of coordinated and integrated interventions targeting frail elderly people: a systematic review of randomised controlled trials.

Author(s) Eklund K, Wilhelmson K

Citation: Health & Social Care in the Community, 01 September 2009, vol./is. 17/5(447-458), 09660410

Publication Date: 01 September 2009

Abstract: The aim of this study was to review randomised controlled trials on integrated and coordinated interventions targeting frail elderly people living in the community, their outcome measurements and their effects on the client, the caregiver and healthcare utilisation. A literature search of PubMed, AgeLine, Cinahl and AMED was carried out with the following inclusion criteria: original article; integrated intervention including case management or equivalent coordinated organisation; frail elderly people living in the community; randomised controlled trials; in the English language, and published in refereed journals between 1997 and July 2007. The final review included nine articles, each describing one original integrated intervention study. Of these, one was from Italy, three from the USA and five from Canada. Seven studies reported at least one outcome measurement significantly in favour of the intervention, one reported no difference and one was in favour of the control. Five of the studies reported at least one outcome on client level in favour of the intervention. Only two studies reported caregiver outcomes, both in favour of the intervention for caregiver satisfaction, but with no effect on caregiver burden. Outcomes focusing on healthcare utilisation were significantly in favour of the intervention in five of the studies. Five of the studies used outcome measurements with unclear psychometric properties and four used disease-specific measurements. This review provides some evidence that integrated and coordinated care is beneficial for the population of frail elderly people and reduces health care utilisation. There is a lack of knowledge about how integrated and coordinated care affects the caregiver. This review pinpoints the importance of using valid outcome measurements and describing both the content and implementation of the intervention.

Source: CINAHL

Available in fulltext from Health & Social Care in the Community at EBSCOhost

Whole-system approaches to health and social care partnerships for the frail elderly: an exploration of North American models and lessons.

Author(s) Kodner, Dennis L

Citation: Health & social care in the community, Sep 2006, vol. 14, no. 5, p. 384-390, 0966-0410 (September 2006)

Publication Date: September 2006

Abstract: Irrespective of cross-national differences in long-term care, countries confront broadly similar challenges, including fragmented services, disjointed care,
less-than-optimal quality, system inefficiencies and difficult-to-control costs. Integrated or whole-system strategies are becoming increasingly important to address these shortcomings through the seamless provision of health and social care. North America is an especially fertile proving ground for structurally oriented whole-system models. This article summarises the structure, features and outcomes of the Program of All-Inclusive Care for Elderly People (PACE) programme in the United States, and the Système de soins Intégrés pour Personnes Agées (SIPA) and the Programme of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) in Canada. The review finds a somewhat positive pattern of results in terms of service access, utilisation, costs, care provision, quality, health status and client/carer satisfaction. It concludes with the identification of common characteristics which are thought to be associated with the successful impact of these partnership initiatives, as well as a call for further research to understand the relationships, if any, between whole-system models, services and outcomes in integrated care for elderly people.

Source: Medline
Available in fulltext from Health & Social Care in the Community at EBSCOhost

Fully integrated care for frail elderly: two American models.

Author(s): Kodner, D L, Kyriacou, C K

Citation: International journal of integrated care, Jan 2000, vol. 1, p. e08. (2000)

Publication Date: January 2000

Abstract: Integrated care for the frail elderly and other populations with complex, chronic, disabling conditions has taken centre stage among policymakers, planners and providers in the United States and other countries. There is a growing belief that integrated care strategies offer the potential to improve service co-ordination, quality outcomes, and efficiency. Therefore, it is critical to have a conceptual understanding of the meaning of integrated care and its various organisational models, as well as practical examples of how such models work. This article examines so-called "fully integrated" models of care in detail, concentrating on two major, well-established American programs, the social health maintenance organisation and the program of all-inclusive care for the elderly. A major challenge to understanding the performance and outcomes of fully integrated care and other organisational models is the lack of a meaningful, analytical paradigm. This article builds upon the work of Walter Leutz, to develop a framework by which new and existing programs can be analysed. This framework is then applied to the two American models that are the focus of this article. Existing data about integrated care in general, and the two model programs in particular, were collected and analysed from reports published by governmental and non-governmental organisations, and journal articles retrieved from Medline, HealthStar and other sources. This analysis strongly suggests that fully integrated models of care, such as the social health maintenance organisation and program of all-inclusive care for the elderly, are not only feasible, but offer significant potential to improve the delivery of health and social care for frail elderly patients. In addition, the authors identify the factors that are the most critical to the success of fully integrated care, and offer lessons for their development and implementation. Finally, issues are raised concerning the transferability of this complex model to other countries, as well as the vital importance of evidence-based evaluation research in furthering the evolution of integrated care.

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