

Emergency care for frail older people – urgent AND important [1] – but what works?

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In well conducted systematic review, [Anon et al] have reminded us that there is a paucity of good quality evidence to guide the care for frail older people attending Emergency Departments. Their review focussed on trials of transitional care models to support frail older people being discharged from EDs in six different countries; notably, all of the trials were at least five years old. The review authors rightly raise questions about methodology – are we targeting the right people with the right interventions, and are we measuring the right outcomes? Certainly all for the studies looked at vulnerable older people and the interventions were based upon Comprehensive Geriatric Assessment (CGA), which remains the best evidenced care model for frail older people [2], at least for inpatient care. But what about the outcomes available for analysis? These almost exclusively focussed upon service related outcomes – short and long term admissions or readmissions. This focus is understandable, as there are few health care systems that do not place patient flow (bed-days) as an overarching priority. This focus is partly in response to operational pressures, but also motivated by concerns that congestion in the ED (which is driven by overall resource use i.e. bed-days) is associated with adverse patient outcomes [3]. Service developments struggle to gather individual patient related outcomes that can be meaningfully analysed, and formal research in urgent care is challenging to conduct. Nevertheless, resource use is not a patient related outcome: the danger is that in pursuit of metrics that will be relevant from the operational perspective, we risk forgetting that the primary purpose of the hospital is to save lives, and get people better. A different set of outcomes are required, focussing on areas such as quality of life, improvements in function and cognition.

There are a paucity of trials involving frail older people in the ED, and few of these truly address patient related outcomes [4, 5]. A huge challenge for clinicians and researchers is to develop patient related outcome measures and /or patient experiences measures that can be used to inform the design of truly patient centred services. It is just possible that a focus on addressing patient need rather than service pressures might move us into the realm of delivering interventions that can make a real difference.

An added challenge for services seeking to traverse the acute-community divide are the structures and processes in place to support service delivery. These range from Information Technology (IT) to facilitate information sharing, through to ensuring clinical teams have a shared understanding of each other's roles and develop trust in one another. It is likely that such conditions are necessary precursors for any clinical service to be effective.

Even in a perfect world where we have patient-outcome driven service development and all the IT support necessary to facilitate cross-boundary working, it will still be tricky to prevent hospital readmission. A wealth of clinical trials over the years have shown only relatively limited impact upon this tricky metric [6], but consistently point toward the need for multifactorial and interdisciplinary response. Coordinating these across the acute-community interface is tricky, as Anon et al have shown.

So what is to be done until Nirvana arrives? First we need to ensure that urgent care systems identify frailty at the earliest possible opportunity. Although is limited evidence

for the discriminant ability of frailty scales in the urgent care context [7-9], more pragmatic approaches can be employed. When defining a population for intervention in clinical practice, acceptability and ease of use are important considerations as well as discriminant ability [10]. Until more accurate tools become available, simple, clinically acceptable criteria should be used to identify a large proportion of frail older people (sensitivity). The risks are that some older people without frailty will be included (specificity – usually inversely related to sensitivity). A frailty service will usually be able to manage non-frail older people, or at least identify them and re-direct if appropriate (whilst the converse does not always apply). Studies are underway that will help develop automated frailty identification systems for acute care with higher discriminant properties.

An example of easy to use frailty criteria might include the following:

- Age 65+ AND presenting with one or more frailty syndromes (confusion, care home residents, Parkinson's disease, recurrent falls or fragility fractures OR people aged 85+

AND/OR

- Moderate or severe frailty (grade 6-9) using the Canadian Frailty Scale - moderate to severe frailty identifies a cohort of patients at increased risk of death or long stays in acute care [11].

The next step is to change the response for frail older people, developing interventions that seek to embed CGA principles into routine practice. There are three main models available that have been tested in urgent care settings – frailty units that focus CGA resources in discrete areas [12, 13], education and training of all staff in managing frailty or liaison type services [14, 15]. Whilst frailty units appear to be effective, they are limited by their geographical constraints, which limit access. Education and training is an obvious answer, but the concern is that a key component of delivering high quality care for frail older people are the appropriate behaviours alongside knowledge and skills; at present undergraduate and postgraduate curriculae in a range of disciplines are somewhat limited in their delivery of frailty competencies. Although education is improving [16], it will many years until frailty competence becomes normalised. Liaison services are attractive bridging model, especially where resources to deliver frailty units are limited, but the concern is that the evidence for efficacy is limited [15, 17].

So for now it appears that the best approach would be to have embedded frailty units that combine outreach/liaison and education and training, whilst developing educational curriculae and patient related outcome measures for urgent care. Strong leadership and role modelling to influence attitudes and behaviours of all staff are key.

Finally, we need a new paradigm for research into urgent care needs of frail older people; we cannot keep testing variations of models that have been shown to be ineffective.

That should keep us busy for a while yet then!

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