

Swiss Learning
Health System

Summary of the Stakeholder Dialogue on:

“Effect of frailty on healthcare utilization: a
Stakeholder Dialogue on the
recommendations to the Swiss health
system”

Cecilia Luini, Stefano Calciolari

Keywords

Aging; Frailty; Healthcare utilization; Healthcare access; Integrated care; Psychological frailty; Social frailty.

Authors

Cecilia Luini, PhD candidate – Institute of Economics and Institute of Public Health, Università della Svizzera Italiana, Switzerland.

Stefano Calciolari, Adjunct Professor – Institute of Public Health, Università della Svizzera Italiana, Switzerland; **Associate Professor** – Department of Economics, Management and Statistics, Università degli Studi di Milano-Bicocca.

Address for correspondence

Cecilia Luini
Departement of Economics and Institute of Public Health
University of Lugano
Via Buffi, 6
6900 Lugano
Switzerland
E-Mail: cecilia.luini@usi.ch

Suggested citation

The text of this policy brief may be freely quoted and printed, provided proper acknowledgment is given.

Luini C. & Calciolari S. (2023). *Effect of frailty on healthcare utilization: policy analysis and recommendations to the Swiss health system*. Swiss Learning Health System.

Table of Contents

Policy Briefs and Stakeholder Dialogues of the Swiss Learning Health System.....	4
Summary of the Stakeholder Dialogue	5
The Challenge.....	6
Recommendations for policy and practice.....	7
Summary of group discussions.....	8
R1: Reach a consensus on the definition of frailty and define a comprehensive measurement instrument”	8
R2: “Design frailty-specific, integrated care strategies to appropriately deal with the frailty needs”	8
R3: “Implement care integration to shift the burden from hospital to primary and home-care care settings, thus reducing the clinical and the economic burden of aging diseases”9	
R4: “Adopt a harmonized information system, which calls for the promotion of electronic health records”	9
Ranking of the recommendations	10
Identification of missing recommendations	10
Identification of missing stakeholders	10
Summary of key points	11

Policy Briefs and Stakeholder Dialogues of the Swiss Learning Health System

The Swiss Learning Health System (SLHS) was established as a nationwide project in 2017, involving academic partners across Switzerland. One of its overarching objectives is to bridge research, policy, and practice by providing an infrastructure that supports learning cycles.

Learning cycles enable the continuous integration of evidence into policy and practice by:

- continuously identifying issues relevant to the health system,
- systemizing relevant evidence,
- presenting potential courses of action, and
- if necessary, revising and reshaping responses.

Key features of learning cycles in the SLHS include the development of **Policy Briefs** that serve as a basis for **Stakeholder Dialogues**.

A **Policy Brief** describes the issue at stake by explaining the relevant contextual factors. It formulates a number of recommendations to address the issue (evidence-informed recommendations, when available), and for each possible recommendation, it explains relevant aspects and potential barriers and facilitators to their implementation.

Policy Briefs serve as standalone products to inform interested audiences on potential courses of actions to address the issue, as well as input for Stakeholder Dialogues.

A **Stakeholder Dialogue** is a structured interaction where a variety of key stakeholders are brought together for the purpose of defining a common ground and to identify areas of agreement and disagreement on how to solve issues in the Swiss health system. Based on a Policy Brief, stakeholders discuss the issue, recommendations, and barriers and facilitators, and work collaboratively towards a common understanding of the issue and the best course of action. The dialogue takes the form of a deliberation to ensure that stakeholders work together to develop an understanding and solutions that are acceptable to all parties.

Summary of the Stakeholder Dialogue

On May 3rd and 4th, a stakeholder dialogue was held at the Executive Center of the *University of Lugano*, to discuss the policy brief with the title “Effect of frailty on healthcare utilization: policy analysis and recommendations to the Swiss health system”. The dialogue lasted one hour on May 3rd, and 45 minutes on May 4th.

To facilitate the discussion and serve the objectives of the *Stakeholder Dialogue*, the authors first presented the results and recommendations emerged from the accompanying *SLHS Policy Brief*, whose Executive Summary and full text were offered to all participants beforehand, along with an agenda of the dialogue. During the dialogue, the discussion was supported by a Power Point presentation summarizing the evidence and the selected recommendations.

A total of 13 participants, representing public and private healthcare providers (clinics, hospitals, nursing homes, community care centers, rehabilitation clinics), pharmaceutical companies, and health insurances from various organizations in Ticino, took part in the dialogue:

- One Director of a multi-specialty clinic
- One Project Manager of a network of family-doctors
- One Executive Assistant/Project Manager of a rehabilitation center
- One staff member of the Central Accounting and Billing Service at a hospital
- One Manager of a residential center
- One Managing Director of a nursing home
- One Director of a community health center
- One Internal Medicine specialist of a medical practice
- One Medical Director of a pre-hospital emergency service
- Three staff members of pharmaceutical and medical-devices companies (one Medical Sales Representative, one Quality Assurance Specialist, one Product Designer)
- One Key Account Manager of a health insurance company

The stakeholders were either directly or indirectly involved in the coordinated and integrated management of elderly care.

On the first day, the participants were asked to discuss, for each recommendation: elements in favor and against; barriers and facilitators; suggestions for possible practical actions/implementations; appropriateness of the language.

On the second day, the participants were asked to: rank the recommendations in order of priority; suggest any potential missing recommendation; identify subjects/representatives not present during the discussion and potentially having an interest in the issue under discussion.

The Challenge

Frailty is being increasingly seen as a problematic consequence of population ageing. It represents an emerging challenge for health systems, because of its major implications for clinical practice, public health, and financial sustainability. It is a clinical geriatric condition characterized by increased vulnerability resulting from a diminished physiological reserve and function of multiple organs, compromising the ability to cope with every-day or acute stressors.

The most widespread measurement instruments adopt a definition of frailty limited to the physical domain. Despite the focus, there is still considerable inconsistency and a lack of consensus on the tools for measuring frailty, even within the same care setting. As a result, depending on the adopted metrics, there may be significant differences in the way the “same” elderly is classified, in the interventions put in place, and in the estimated prevalence of frailty.

In addition, more recently, it has been argued that the concept should be widened to adopt a multidimensional approach, including psychological and social aspects. This perspective change is not secondary, because disregarding a holistic approach may lead to care fragmentation and consequent negative health outcomes. In fact, the risks associated with omitting important psycho-social characteristics of the condition have been often highlighted in terms of lack of sensitivity in detecting health outcomes and poor choice of treatment interventions. Nevertheless, there is paucity of evidence regarding the effect of psychosocial frailty on healthcare utilization.

Despite Switzerland falling among countries with the lowest prevalence rates, physical frailty has increased over time, while psychological and social frailty have been fluctuating in the last decade. Moreover, physically frail individuals are more likely to be hospitalized and to have a higher number of doctor visits than physically non-frail ones. In addition, physical frailty is found to be more burdensome than multimorbidity in terms of healthcare utilization. Concerning the other two dimensions of frailty, individuals who are psychologically frail exhibit a higher likelihood of hospitalization and doctor visits, whereas socially frail individuals are less inclined to avail themselves of these resources. The elderly who are socially isolated may forgo health care due to their inability to reach health care facilities or because of the lack of availability of a caregiver. Interestingly, the influence of frailty on the likelihood of hospitalization is systematically larger than the one on doctor visits.

Evidence suggests that social and psychological frailty are important aspects to be considered in health policies as a strategy aimed to both contain expenditures and avoid potential health care inequalities.

Recommendations for policy and practice

R1: Reach a consensus on the definition of frailty and define a comprehensive measurement instrument. Acknowledging the multidimensionality of frailty represents a key factor of effective health-related risk stratification. Measuring the condition with a harmonized, comprehensive, instrument should be the first step towards its prioritization in health policy agendas. A convergence towards a standardized definition of the condition is a “work in progress” still lagging at the international level. In this respect, using appropriate tools to consistently measure frailty, would help identifying the frail population and use frailty as a valid risk stratification tool, correctly estimate the clinical and economic burden associated with the condition, designing targeted intervention strategies, and allowing useful comparisons across different studies and care settings.

R2: Design frailty-specific, integrated care strategies to appropriately deal with the frailty needs. The complexity and multidimensionality of frailty suggests the importance of designing and implementing integrated and comprehensive care strategies, carried forward by all the providers and professionals from different sectors: health care, social care, housing, community support. Such a strategy would improve the quality of life and functional ability of older adults. This should encourage policy makers, health care professionals, researchers in geriatrics and stakeholders in general alike, to shift from disease- to *healthy aging*-focused care.

R3: Implement care integration to shift the burden from hospital to primary and home-care care settings, thus reducing the clinical and the economic burden of aging diseases. The larger influence of frailty on acute than other care settings leads to hypothesize that improving the assessment and treatment of frailty might help shifting the burden from the acute to other care settings, with consequential savings at the system level, provided appropriate care integration across care settings. The systematic coordination between levels of care and sectors is precondition or facilitator of care integration and might not only improve the quality of life and functional ability of older adults, but also reduce health services utilization and, consequently, healthcare costs.

R4: Adopt a harmonized information system, which calls for the promotion of electronic health records. In Switzerland, the promotion of digitalization and the utilization of health data is stated as one of the main challenges for the future of the healthcare sector. Such an objective is included in the Health2030 program, where there is a reference to “coordinated digitalization” as a means to boost efficiency gains. An electronic Frailty Index, constructed using routinely collected electronic data, could represent an inexpensive, transferable, and valid tool, allowing reliable group stratification and individual prioritization for comprehensive frailty assessment. However, despite the Swiss Frailty Network and Repository is currently working on the establishment of a nationwide harmonized electronic Frailty Index, it would only be applicable in acute care settings, thus not allowing integration across different health care settings and between health and social care.

Summary of group discussions

R1: Reach a consensus on the definition of frailty and define a comprehensive measurement instrument”

The dialogue with the participants revolved around the importance of finding a consensus on an unambiguous measurement of frailty and of detecting the target population.

In this respect, the internal medicine specialist pointed out how, in clinical practice, frailty is measured using a variety of methods. He suggested that the Swiss Society for Geriatrics and representatives of Family Doctors (e.g., the new Institute of Family Medicine of the Biomed Faculty in Lugano) reach an agreement on an appropriate metric to correctly estimate the population at risk.

The medical specialist and the director of a multi-specialty clinic highlighted that the measurement burden shall not only fall on the Family Doctor, especially when it comes to measuring socio-psychological frailty. To this regard, they stressed the need for the detection of such domains to be passed on to other actors, such as social workers or (professional) caregivers. The medical specialist also emphasized that the lower the complexity of the tool, the higher the likelihood a doctor will perform the measurement and the larger the resulting target population. Therefore, the selection of the measurement tool influences the target population size one is willing to detect.

The health insurance representative, in addition, highlighted the need to understand the time-sequence of defining the concept and the measurement tool. He proposed to deal with the two aspects separately and clarify whether the challenge in defining frailty may lead to issues in the measurement, or conversely, if measurement problems contribute to the difficulty in defining frailty.

In conclusion, the participants agreed on the benefits of reaching a consensus on the definition and measurement of frailty. They also overall agreed that the language of the recommendation was appropriate; except for the health insurance representative which pointed out the potential need to split the recommendation in two to emphasize the sequencing of the of frailty definition and measurement.

R2: “Design frailty-specific, integrated care strategies to appropriately deal with the frailty needs”

The dialogue focused on the importance of improving the governance and the coordination at the system level. Despite the discussants agreed on the benefits of a targeted integrated strategy for the elderly frail, they also highlighted that the current financing system represents an important barrier to implementation of coordinated care. In fact, it reimburses providers individually, thus not creating incentives for managing the patient as a network and/or according to a defined care pathway.

The director of the multi-specialty clinic pointed out how, presently, coordination is not formalized and simply based on informal relations among provides of different care levels and settings. The situation calls for identifying an “orchestra director” to take on a coordinating

role. To this regard, it was also highlighted that such a solution would be realistic only if such a role was recognized by the financing system.

The medical specialist confirmed that family doctors could play a gatekeeping/case-manager role (and thus have a greater control on the patient care pathway) only if the system provided appropriate incentives. To this end, he hypothesized that the TARDOC (which will likely replace the TARMED in 2024 for the financing of outpatient medical services) could, albeit partially, represent a facilitator.

Overall, the respondents agreed that the recommendation was pertinent and that its language did not need any revision.

R3: “Implement care integration to shift the burden from hospital to primary and home-care care settings, thus reducing the clinical and the economic burden of aging diseases”

The dialogue with the participants revolved around the importance of strengthening community services, an aspect specifically stressed by the medical specialist and by the multi-specialty clinic director. In particular, the former highlighted the importance of an efficient use of home-care services and networks in facilitating the shift of care provision from the acute to other care settings. The latter instead mentioned that such a result might also be achieved by improving patients’ information, because they are frequently unaware of the variety of services offered at the community care level.

The health insurance representative, backed up by the representative of the multi-specialty clinic, stressed that the current financing system likely represents a barrier, because it does not provide the right incentives to promote such a change in the treatment approach.

Overall, the respondents agreed that the recommendation was pertinent and that its language did not need revision. However, the health insurance representative pointed that using mentioning the concept of “economic burden” may drive the attention on costs rather than patients’ outcomes.

R4: “Adopt a harmonized information system, which calls for the promotion of electronic health records”

The dialogue focused on the main barriers and facilitators to the implementation of a harmonized electronic information system. Overall, the participants agreed that the recommendation is hardly implemented in practice. In particular, the director of the multi-specialty clinic pointed that the main barriers are:

the scarcity of clinical resources and the inability of GPs to bear the burden of consistently feeding the information system with appropriate data;

the Federal Law on Data Protection (LDP), which introduce attrition in data management by strictly enforcing data protection.

The medical specialist agreed on the fact that an electronic information system should be shared, but he emphasized that it should be easy and fast to use.

From the discussion, it emerged the Federal Law on Electronic Medical Records (which aims at making data taken from the patient's health record and recorded in a decentralized way or data recorded by the patient himself accessible) may represent a facilitator.

Ranking of the recommendations

The participants concluded that recommendations 1, 2 and 3 were ranked properly. Instead, they noted that recommendation 4 may better be seen as supportive and transversal to the other three (in particular the second), though it does not represent a pre-condition for their achievement. In fact, given that its achievement is rather unlikely for the time being, its prioritization should be left aside and the achievement of the other three recommendations should not be made dependent on it. Specifically, they stated that recommendations 1-3 could be achieved independently from a harmonized electronic medical records system.

From the discussion, it emerged that public and private acute care providers currently use different electronic systems, all equally efficient but not easily harmonized and shared externally due to privacy issues. The problem is even worse when considering also outpatient and other community care providers, because they use additional (different) systems.

Identification of missing recommendations

The dialogue suggested that, for each recommendation, the subject entitled to enforce it should be specified or better defined. The enforcement is likely to depend on both an appropriate governance and effective processes.

With regards to the first point, it was noted that too many actors are entitled to take decisions and most of the coordination happens informally, with each provider choosing its peer-partners in full autonomy. The first step in coordinating care, thus, should consist of creating consensus on the care pathway that any frail patient should follow and to institutionalize an appropriate strategic and operating vision on that. Once a strategy is defined, providers would decide whether to adhere to it and to the consequential "rules of the game".

Regarding the matter of appropriate processes, it was stressed out that the system misses the figure of a *case-manager*, in charge of assuring the continuity of care across the care pathway. Depending on the contingency, this figure can be either the GP or (very often also) the specialist. Each of these two figures create her/his own informal network to manage their patients. Despite an electronic records system could help solve such a problem, it was again pointed out how this possibility is still lagging behind.

Identification of missing stakeholders

- Social workers and educators, nowadays very helpful in bridging hospital, outpatient and community settings.
- Home care attendand / formal caregivers (nurses) – including nurses specialized in the community care setting.
- Policy makers.

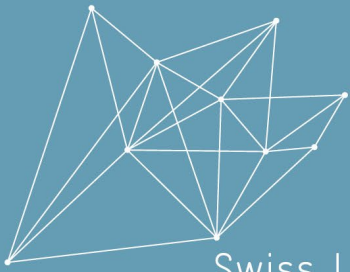
Summary of key points

Table 1: Relevance and ranking of the recommendations.

Recommendation	Confirmed relevance	Proposed ranking change
1	Yes	-
2	Yes	-
3	Yes	-
4	No	<i>The recommendation is a support and transversal to the other three</i>

Table 2: Proposed changes to the recommendations.

Recommendation	Proposed content changes
1	<i>Divide the recommendation in two points: one relative to the definition and one to the measurement of frailty.</i>
2	<i>The role of the financing system in achieving care integration should be further highlighted.</i>
3	<i>The recommendation should not emphasize the “economic burden” to avoid the discussion only revolving around costs rather than patients’ outcomes.</i>
4	-



Swiss Learning
Health System