Indicators and Information Standards for Frailty Management

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The role of patient summaries for geriatric patients: focus on frailty

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Facts

1. Frailty is a **multidimensional dynamic condition**.
2. Frail people experience **frequent and complex care transitions** among
   – multiple health and care professionals
   – different specialties in different settings.

3. **Care coordination** would help ensure
   – *respect patient's needs and preferences* for care services
   – *information sharing* across people, functions, and sites
   are in the best interest of patients, carers and health and social care systems.
Our objective for the meeting

Reflect on **barriers to care transitions** and **failures in care transitions**.

Identify path forward for **interoperability, technology and standards related to management of frailty**.

Share thoughts on a brief survey: https://tinyurl.com/EIPAHAA3F

Present in brief the

• framework of indicators for managing and assessing the performance of organizations delivering care to frail old people developed and validated within the FOCUS Project (Grant Agreement 664367).

• Trillium Bridge II project on scaling up use of patient summaries (Grant Agreement 727745)
Scaling-up the use of patient summaries

• Consider the patient summary as
  • active window to a person's health data across locations and jurisdictions,
  • entry point with key information related to the current situation for navigation to more detailed data

Select and elaborate
• resources to accelerate implementation and sharing of experience
• new use cases using patient summaries from unplanned emergency care
We need you to help us figure out

What are the barriers to coordinated-integrated, holistic services for frail older citizens?

Your opinion on the statement:

➢ Current tools and approaches to standards support the flow of quality information for frail person on their health-illness trajectory.

What priority actions can help create an information infrastructure for frail people to navigate their complex life?

Summary health & social data about a (pre)frail person must be collected from different sources and presented in an organized Dashboard with what?

What data should the patient summary provide to optimize care in emergency, planned and every day settings?

Your opinion on the statement:

➢ An extended patient summary should be linked to indicators to coordinate, orient, monitor and evaluate health and care in the daily life of frail people.

Let us know what you think at: https://tinyurl.com/EIPAHAA3F
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THANK YOU!

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