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Editorial

Post Acute Care for Frail Older Persons: Time for a Standardized Model of Care

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With the aging population, healthcare systems are called at evolving their facilities and services to address the new needs and priorities of frail older persons (1). It is well-established that hospitalizations are often responsible for functional decline and increasing dependency in older persons, partly due to the consequences of the acute condition, partly for the so-called iatrogenic disability (2, 3). In this context, the role played by Post-Acute Care (PAC) is growingly considered as pivotal.

PAC facilities are crucial for relieving the pressure on acute hospital beds. It has also been demonstrated that frail patients discharged from PAC have a higher level of independence and a lower risk of hospital readmission compared to those discharged from general hospital care (4). The positive effects (also over the long-term) of PAC can be explained by the person-tailored, multidisciplinary interventions focused on functions that are here implemented. At the same time, the PAC admission after the resolution of an acute condition may better prepare the transition of the frail individual from the hospital to the community.

In the present issue of The Journal of Frailty & Aging, Fompeyrine and colleagues (5) report the association between frailty status on admission to a PAC unit and 12-month mortality. Two critical findings are worth to be mentioned:

1. The clinical complexity of patients at PAC admission is very high, as demonstrated by the high prevalence of frailty (i.e., 54% according to the Fried and colleagues' phenotypic model) and the high mortality after 12 months (i.e., 22.9%);
2. The frailty condition, despite the risk of a ceiling effect, was still a significant predictor of the study outcome, differently from the participants' age.

In other words, PAC facilities confirm an essential position in bridging hospital care and community/primary care. The often-advocated continuity of care to be guaranteed to frail older persons, especially after a significant event as a hospitalization, may find in the PAC setting an ally (6).

Nevertheless, PAC professionals often find themselves between the hammer and the anvil. On one side, the chaotic hospital rigidly focused on the diagnosis and treatment of the disease(s). On the other hand, the primary care setting that, with limited resources, tries to counteract the consequences of aging by preserving function. In this scenario, PAC may represent an ideal place to comprehensively assess frail older persons before returning to the community. It could provide the opportunity for reducing the pace and finally starting to consider the real priorities of the individual after the acute manifestation of the disease is over.

Here the need for a standardized language (both in terms of contents and instruments) becomes vital for guaranteeing the proper communication and continuity of care. Unfortunately, there is a gap to fill by research in this area. There are great opportunities out there that are not adequately valorized or disseminated for different reasons. A perfect example is represented by the InterRAI model (7, 8), developed into several setting-specific instruments for the comprehensive geriatric assessment of the older person with frailty. The InterRAI suite also includes the InterRAI Post-Acute Care and Rehabilitation (PAC-Rehab) package, composed of diagnostic and screening tests, outcome measures, clinical assessment protocols, quality indicators, and case-mix tools. The multidimensional and exhaustive approach used in the InterRAI has allowed Kerminen and colleagues (9) to develop a Frailty Index (following the deficit accumulation model proposed by Rockwood and Mitnitski (10)) and explore its predictive capacity for adverse health outcomes in PAC. Unfortunately, as above-mentioned, the InterRAI model is well-established in many countries but not yet so widely worldwide as it could be. A barrier to its diffusion has been indicated in the copyright and costs related to its use, although many possibilities exist for obtaining royalty-free licenses.

Frail older persons require a longer time to recover from acute illness (11). Unfortunately, healthcare systems are too busy focusing on hospital-centered and hyperspecialized care, and seem reluctant at investing in alternative settings of care. It would be important to standardize the PAC setting in the patient's profiling, the facility organization, and its integration within the healthcare system. This would benefit not only the frail older person (often too early discharged from the hospital) but also the public health system (which will reduce the consequences of chronic conditions through PAC programs). The modernization of the system through proper integration of care will also allow to better value some traditionally neglected settings of geriatric care and the professionals here working in the management of clinically complex, frail older persons.

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