



FONDAZIONE "ELISABETTA GERMANI"- Cingia de' Botti (CR)  
Centro sanitario assistenziale - ONLUS

**XXIX^ GIORNATA  
MONDIALE DELL'ALZHEIMER**  
**FRAGILITÀ...E SE PARLASSIMO DI  
RI-ABILITAZIONE?**  
I nuovi orizzonti interprofessionali  
**LUNEDÌ 3 OTTOBRE 2022**  
Ore 9.00 - 13.00  
Castello San Lorenzo de' Picenardi

# La fragilità e l'anziano: nuovi propositi per la presa in carico

Giuseppe Bellelli

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UOC Geriatria, ASST Monza, S Gerardo Monza*



Ospedale  
San Gerardo

Sistema Socio Sanitario



Regione  
Lombardia

ASST Monza



# Il faut lancer une politique d'adaptation des logements au vieillissement

**Luc Broussy**, auteur du rapport interministériel « Nous vieillirons ensemble », estime que les moyens manquent pour accompagner le désir des Français de vieillir chez eux

LA FRANCE DOIT  
SE PRÉPARER  
AU DÉFI  
DU GRAND ÂGE

ÉDITORIAL **M**

L'horloge démographique de la France est et restera implacable : le vieillissement sans précédent de la population va contraindre le pays à une mise à niveau sanitaire également historique. Qu'on en juge : les 85 ans et plus vont croître de près de 90 % entre 2030 et 2050. La France doit donc se préparer à vivre avec des baby-boomeurs vieillissants. Elle a dix ans pour y parvenir, alors que le premier mandat d'Emmanuel Macron s'est conclu par un renoncement dommageable, celui de répondre au défi justement posé par le grand âge.

Ce défi, qui va concerner très intimement des millions de Français ainsi que leurs proches, est compliqué par la concomitance de la crise qui frappe la gériatrie et de la remise

en cause de l'efficacité et de la compétence du secteur privé à la suite du scandale Orpea. La première est connue de longue date : la gériatrie est le parent pauvre d'un système hospitalier déjà à bout de souffle. Elle est donc victime d'une sorte de double peine, un manque de popularité qui s'ajoute aux carences en personnel criantes partout.

Face au dénuement des unités de soin de longue durée, une partie de la communauté des gériatres, notamment au sein de l'Assistance publique-Hôpitaux de Paris, préconise de réserver aux patients âgés qui requièrent un réel suivi médical l'accès à ces services spécialisés dans les maladies liées à l'avancement en âge. Ils plaident que beaucoup de patients actuellement hospitalisés devraient être orientés prioritairement vers des maisons de retraite. Mais cette solution implique de doter les établissements d'hébergement pour personnes âgées dépendantes (Ehpad) de davantage de moyens médicaux pour prendre en charge une population croissante dont les troubles physiques et cognitifs vont devenir de plus en plus lourds.

Cet impératif a été mis en évidence par le rapport rédigé par deux gériatres, Claude Jeandel et Olivier Guérin, remis il y a un an au ministère de la santé. Ils y soulignaient l'urgence d'un renfort de médecins et d'infirmières dans les Ehpad. Un tiers seulement des établissements disposent actuellement d'un médecin affecté au suivi médi-

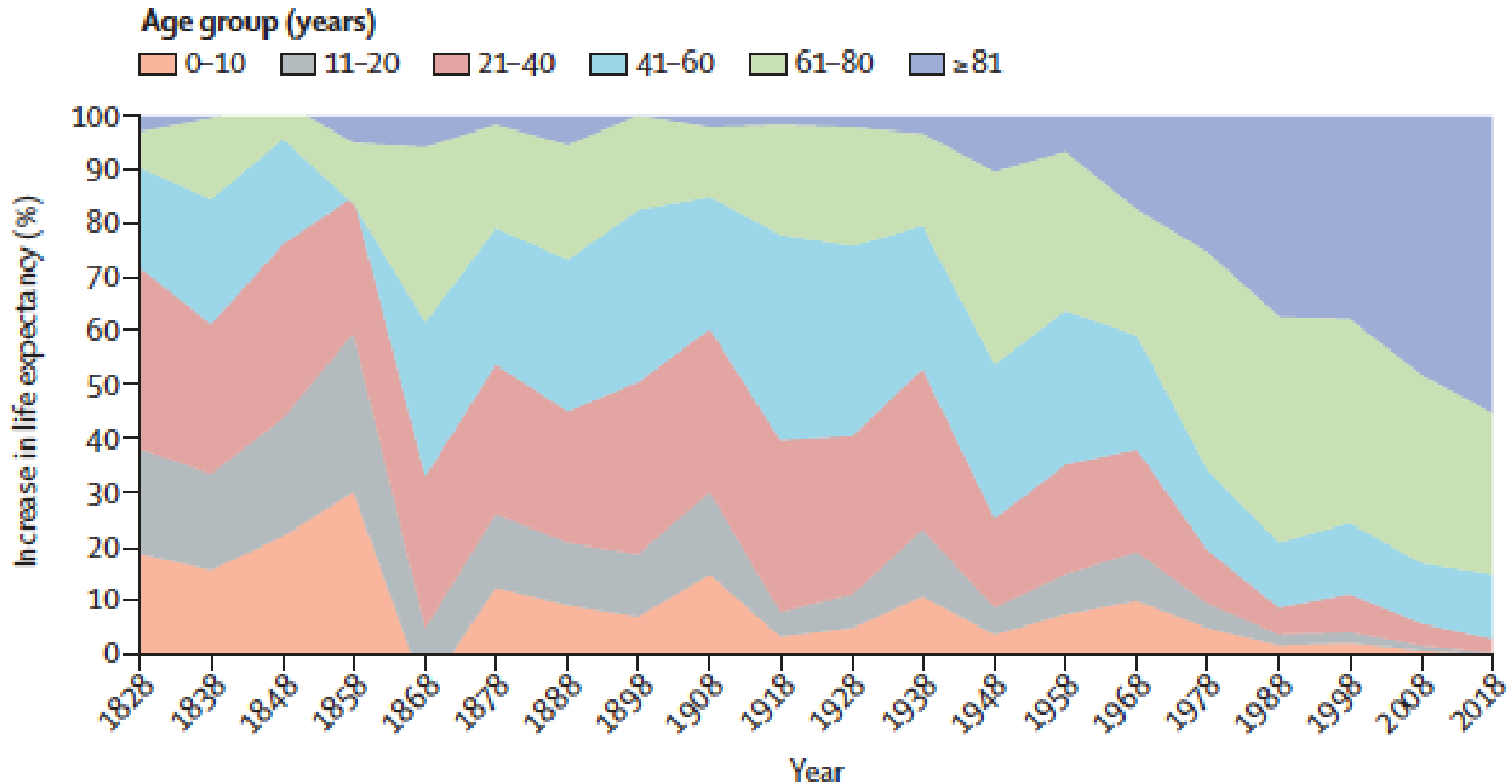
cal de leurs résidents alors que les besoins vont être croissants. Ils proposaient également une série de mesures pour attirer les médecins dans un secteur qui reste, en l'état, peu attractif. Sans moyens financiers à la clé, cet appel à une présence médicale renforcée dans les Ehpad restera lettre morte, d'autant que les territoires ruraux, ceux où la proportion d'habitants âgés dans la population est plus importante qu'ailleurs, sont aussi des déserts médicaux.

Depuis des années, les gouvernements successifs vantent le « virage domiciliaire », le maintien le plus longtemps possible des personnes âgées chez elles, pour vieillir mieux dans un environnement familial, susceptible en outre de préserver les liens affectifs. Pourtant, ils hésitent à prendre vraiment ce virage. Son financement est pourtant présenté par beaucoup de responsables politiques comme moins onéreux pour les comptes publics que des autorisations de création de lits d'Ehpad.

Ce maintien à domicile des Français vieillissants implique cependant une autre révolution, celle d'une politique nationale de prévention de la perte d'autonomie. La Cour des comptes y a consacré un rapport en novembre 2021, pour que les Français qui vivent plus longtemps coulent leurs vieux jours en moins mauvaise santé. L'ampleur de ces défis est évidemment redoutable, c'est précisément pour cette raison qu'il est impératif de s'y préparer dès à présent. ■

**Le Monde**  
SAMEDI 13 AOÛT 2022

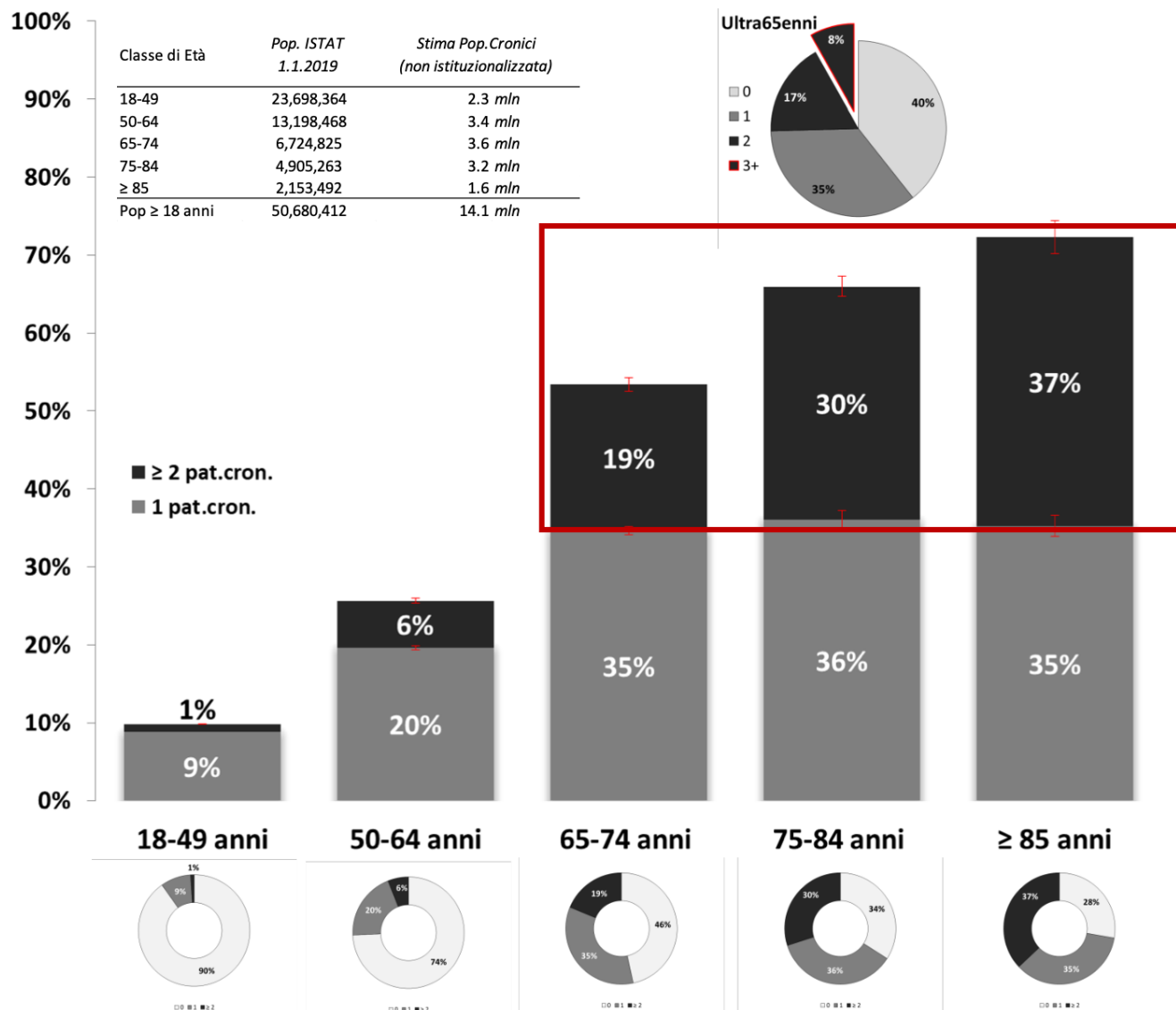
# The >81 segment shows the most rapid increase in life-expectancy



# Patologie Croniche *riferite* nella popolazione residente in **ITALIA**

**PASSI 2015-2018 (18-69enni) e PASSI d'Argento 2016-2018 (ultra65enni)**

**Prevalenze e relativi IC95%**



# Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie

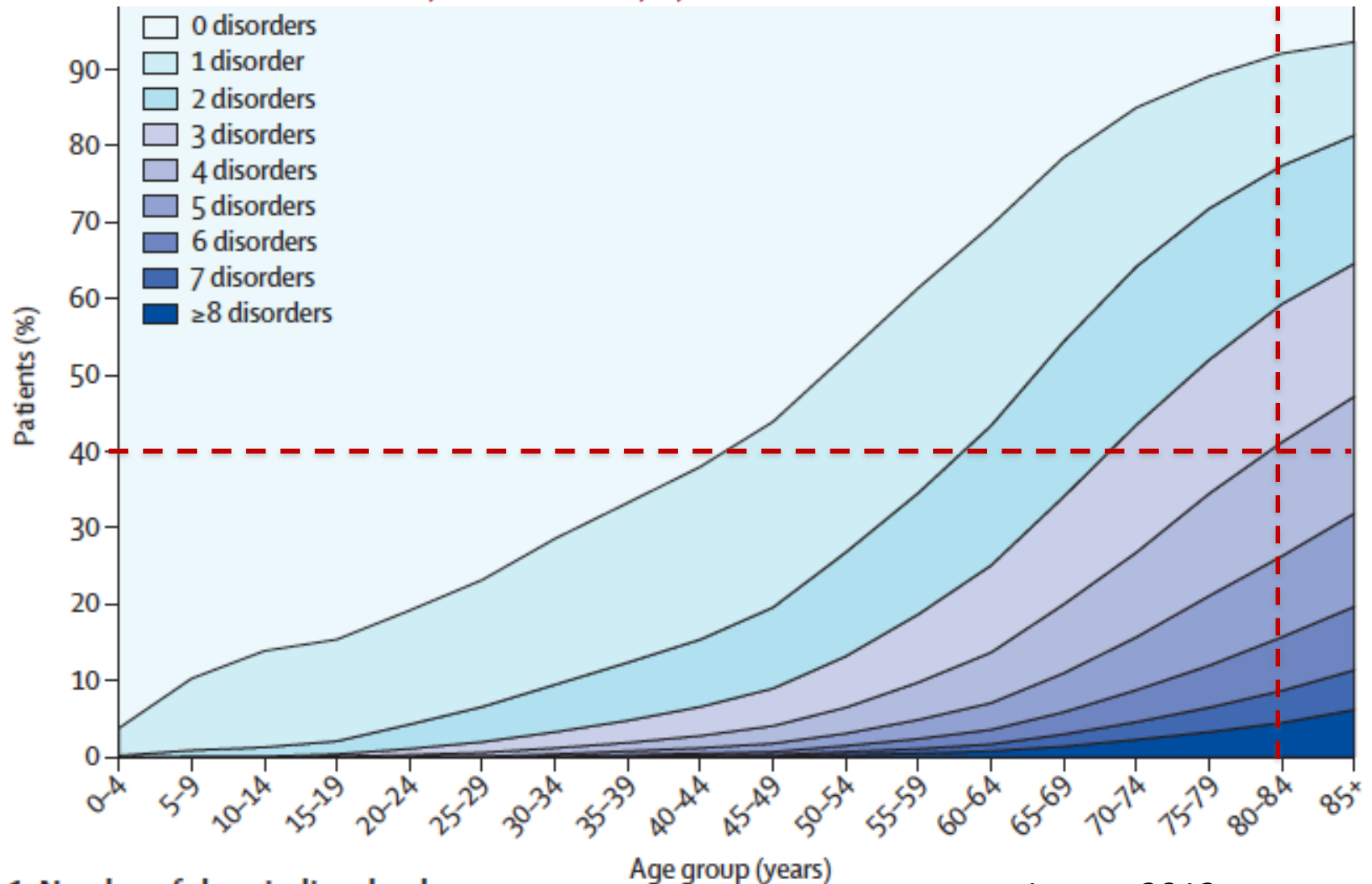


Figure 1: Number of chronic disorders by age-group

Lancet 2012

# Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

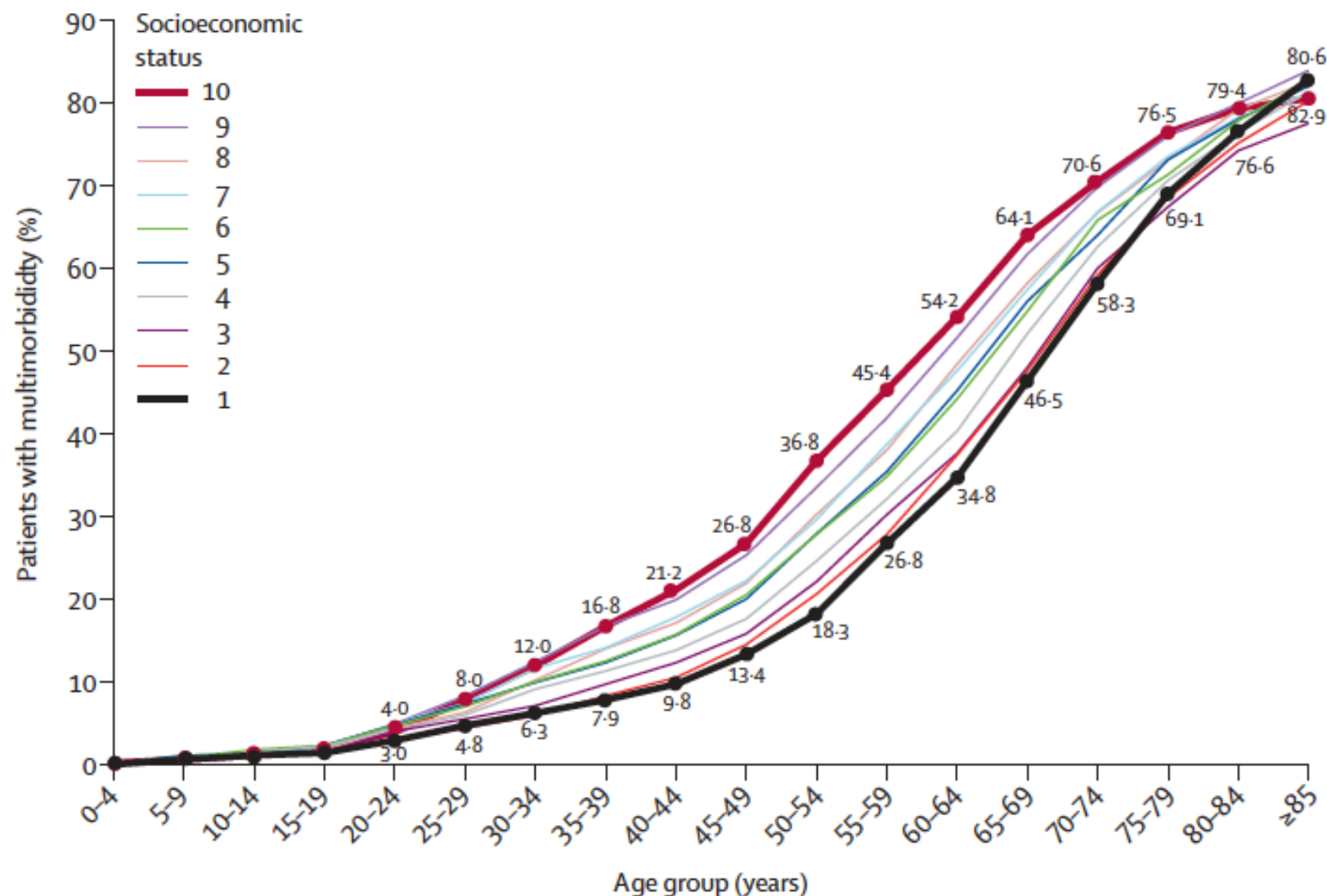


Figure 2: Prevalence of multimorbidity by age and socioeconomic status

*Lancet 2012*



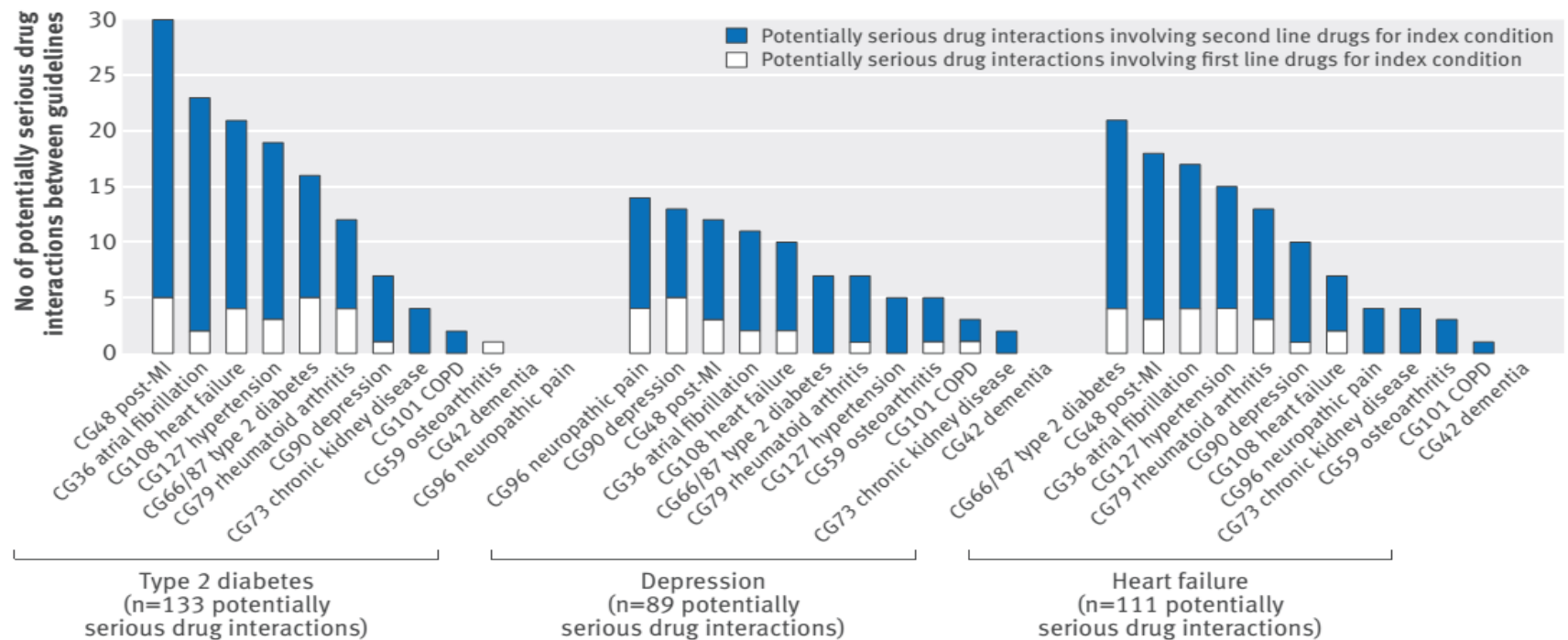
# Clinical features of 4133 patients enrolled in the Delirium Day (yrs 2015-2016)

	Total (n=4133)	Delirium 969 (23.4)	No delirium 3164 (76.6)	p
Age, yrs, mean (SD)	81.6 (7.6)	84.4 (7.0)	80.8 (7.6)	<.001
Female, n (%)	2284 (55.2)	540 (55.7)	1774 (55.1)	.73
Medical wards, n (%)	3770 (91.8)	906 (93.5)	2864 (90.5)	.004
Surgical wards, n (%)	363 (8.8)	63 (6.5%)	300 (9.5)	
Charlson Index, mean (SD)	6.4 (2.4)	6.7 (2.4)	6.3 (2.5)	<.001
Dementia, n (%)	977 (23.6)	566 (58.4)	505 (16.0)	.03
Number of drugs, median (SD)	5.3 (2.2)	5.5 (2.2)	5.3 (2.2)	.001
Benzodiazepines	1014 (24.5)	242 (25.0)	772 (24.4)	.071
Typical antipsychotics	335 (8.1)	177 (18.3)	158 (5.0)	<.001
Atypical antipsychotics	310 (7.5)	177 (18.3)	133 (4.2)	<.001

# Drug-disease and drug-drug interactions: systematic examination of recommendations in 12 UK national clinical guidelines

Siobhan Dumbreck,<sup>1</sup> Angela Flynn,<sup>1</sup> Moray Nairn,<sup>2</sup> Martin Wilson,<sup>3</sup> Shaun Treweek,<sup>4</sup> Stewart W Mercer,<sup>5</sup> Phil Alderson,<sup>6</sup> Alex Thompson,<sup>7</sup> Katherine Payne,<sup>7</sup> Bruce Guthrie<sup>1</sup>

thebmj | *BMJ* 2015;350:h949 | doi: 10.1136/bmj.h949



**Fig 2 | Potentially serious drug-drug interactions between drugs recommended by clinical guidelines for three index conditions and drugs recommended by each of other 11 other guidelines**



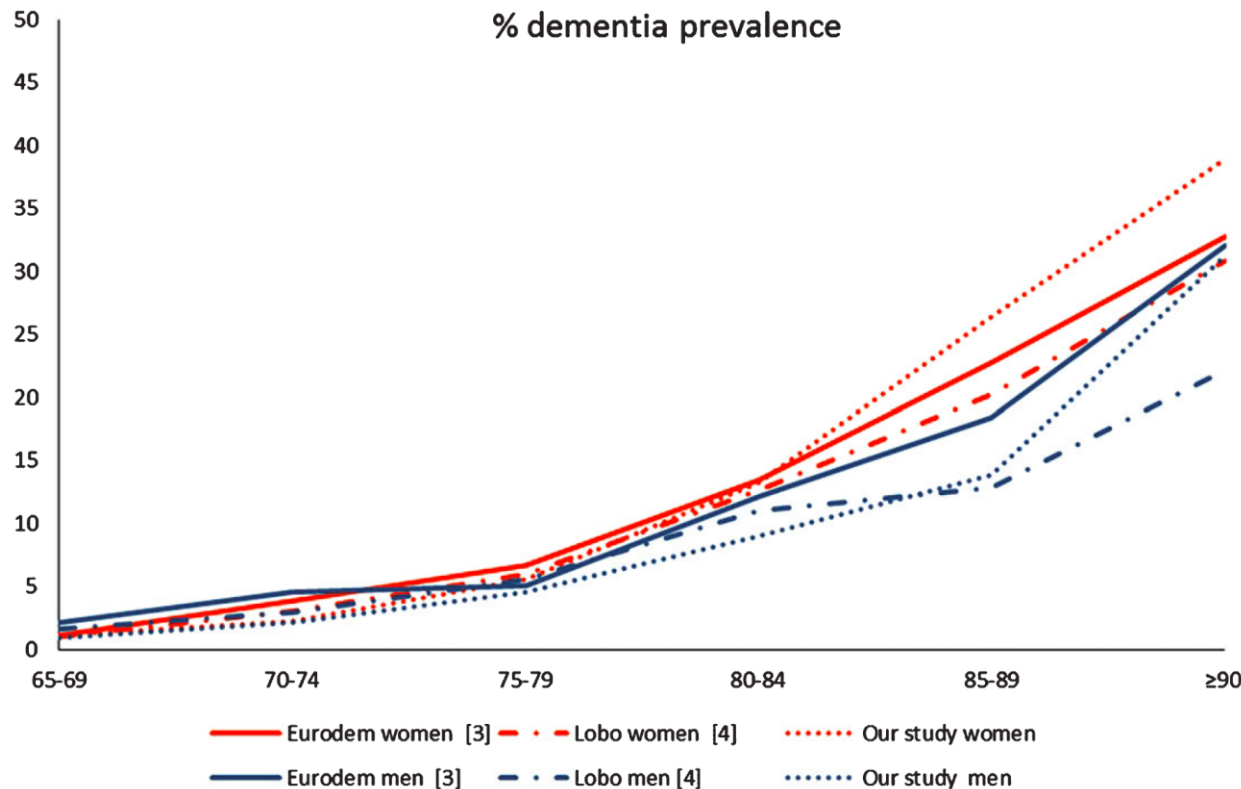
# A Systematic Review and Meta-Analysis on the Prevalence of Dementia in Europe: Estimates from the Highest-Quality Studies Adopting the DSM IV Diagnostic Criteria

Ilaria Bacigalupo<sup>a,\*</sup>, Flavia Mayer<sup>a</sup>, Eleonora Lacorte<sup>a</sup>, Alessandra Di Pucchio<sup>a</sup>,  
Fabrizio Marzolini<sup>a</sup>, Marco Canevelli<sup>b</sup>, Teresa Di Fiandra<sup>c</sup> and Nicola Vanacore<sup>a</sup>

<sup>a</sup>National Center for Disease Prevention and Health Promotion, National Institute of Health, Rome, Italy

<sup>b</sup>Department of Human Neuroscience "Sapienza" University of Rome, Rome, Italy

<sup>c</sup>General Directorate for Health Prevention, Ministry of Health, Rome, Italy



9 studies carried out in Europe between 1993 and 2018 including a total of 18,263 participants, of which 2,137 were diagnosed with dementia

# Proportion of dementia unrecognised in hospital cohorts

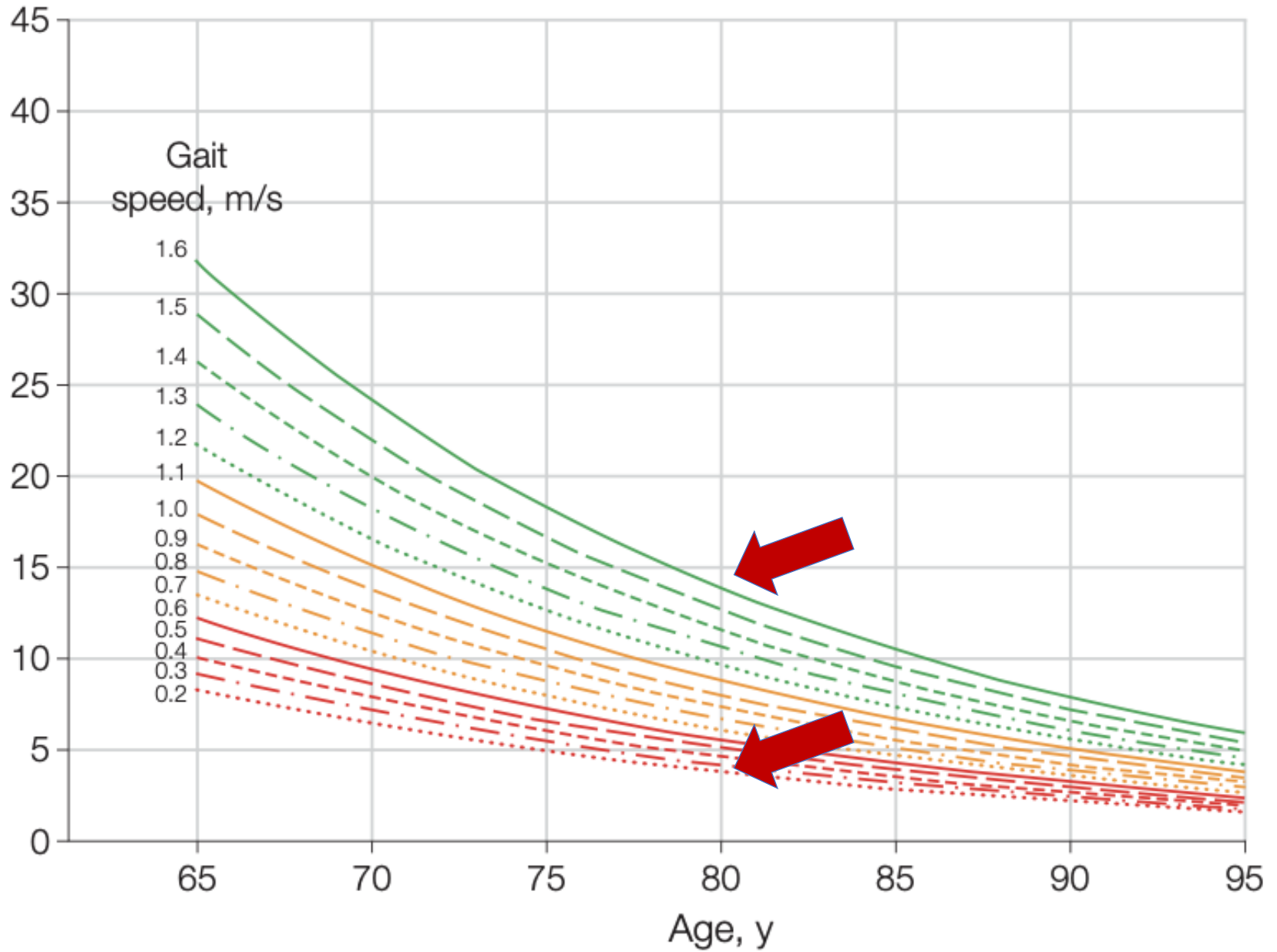
Study	Dementia ascertainment	Previously diagnosed	% unrecognised
Briggs 2016, Timmons 2015 General hospital, Ireland	DSM-IV	53/149	64%
Travers 2013 General hospital, Australia	Expert Dx	43/102	58%
Sampson 2009 Medical admissions, UK	Expert Dx	130/262	49%
Laurila 2004 Geriatric Medicine, Finland	Expert Dx	31/77	60%
Pooled data from above studies		257/590	56% (95% CI $\pm 4.01$ )
<b>Delirium</b>			
Jackson 2016 Pts with delirium, UK	DSM-IV	30/47	36%
Ryan 2013 Pts with delirium, Ireland	IQCODE + expert Dx	5/28	82%

# Men

Fig

Median Survival, y

Median Survival, y



# Presentazione «atipica» di malattia

Comment

## What proportion of older adults in hospital are frail?

Despite the increasing level of knowledge about individual illnesses, modern health-care systems seem lost when seeing patients whose diseases come not one at a time, but all at once—especially when they come with equally complex social needs. Although some geriatricians proclaimed the end of the disease era<sup>1</sup> to focus on the complexity of frailty in geriatric assessment,<sup>2</sup> the argument is falling flat. Disease-focused specialists who push on with the only course they know sometimes deny their frail patients as being unresolvable or requiring social support or failing to cope or thrive.<sup>3</sup> Many hospitals—and practitioners—still somehow expect patients to present with primary complaints that give rise to well-defined problems, which they can manage successfully using pathways that can be audited, such as time to thrombolytic event in an acute stroke or myocardial infarction.

How does health care get on track? Language should be the starting point. Elderly people whose multiple, interacting medical and social problems put them at greater risk of adverse outcomes have come to be called frail. Hospitals must be encouraged to expect and thereby plan for frail patients as a part of what is required of them. To make this requirement clear, they need the right tools.

In The Lancet, Thomas Gilbreath and colleagues<sup>4</sup> used International Statistical Classification of Diseases and Related Health Problems, Tenth Revision codes in electronic records to develop a hospital risk stratification tool. The tool was validated in a large English inpatient database ( $n=1013590$ ), and its generalisability tested using various hospitals. Frail or non-frail information was dichotomised and frailty further graded into low, intermediate, and high risk. In a cluster analysis, these frail groups accounted for a fifth of patients and almost a half of all hospitalisation days. The tool classified individual mortality risk no more than moderately well, but, as the investigators point out, individual risk stratification was not their objective. Instead, their goal was to identify “a group of patients who are at greater risk of adverse outcomes and for whom a frailty-tuned approach might be useful.”

A metric that identifies for hospitals the extent to which they are serving patients with frailty should signal the need to change from a most responsible diagnosis

model to practices that can reduce the hazards of hospital stays for patients who are frail, and perhaps even focus on the goals of patients and their families.<sup>5</sup> Stratification of risk groups might also offer a similarly useful role for the electronic frailty index, based on general practice records.<sup>6</sup> These hypotheses need to be tested.

To show what must change, consider a student on her first clinical rotation who encounters a patient with pneumonia. Most of what she has learned about pneumonia must now be set aside. Uncomplicated cases are rarely referred to specialty services; those patients get antibiotics and go home. Her patient cannot give a history. He is not coughing. He cannot even sit up so that she can auscultate his lungs properly, something she knows she must do. Her patient does not have a fever or an increased white cell count. Vague markings on the chest film alone support the diagnosis. No matter; the real issue, apparently, is that her patient cannot go home. She might now turn to her teachers and ask: “What have you been teaching me about pneumonia if none of it works in the patients I’m supposed to see?” More likely, insidious acclimatisation will lead her to conclude that this patient really does not belong in her hospital.

By contrast, those skilled in the care of older people will recognise the delirium and immobility that are typical presentations in a frail patient with pneumonia. They will ascertain whether the cognitive impairment and being bedfast are new. From this information, they will formulate a differential diagnosis and focused

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[http://dx.doi.org/10.1016/S0140-6736\(18\)30907-9](http://dx.doi.org/10.1016/S0140-6736(18)30907-9)  
See Article page 1715



"...Consider a student on her first clinical rotation who encounters a patient with pneumonia. **Most of what she has learned about pneumonia must now be set aside. Uncomplicated cases are rarely referred to specialty services; those patients get antibiotics and go home. Her patient cannot give a history. He is not coughing. He cannot even sit up so that she can auscultate his lungs properly, something she knows she must do. Her patient does not have a fever or an increased white cell count. Vague markings on the chest film alone support the diagnosis.** No matter; the real issue, apparently, is that her patient cannot go home..."

# Transient Cognitive Disorders (Delirium, Acute Confusional States) in the Elderly

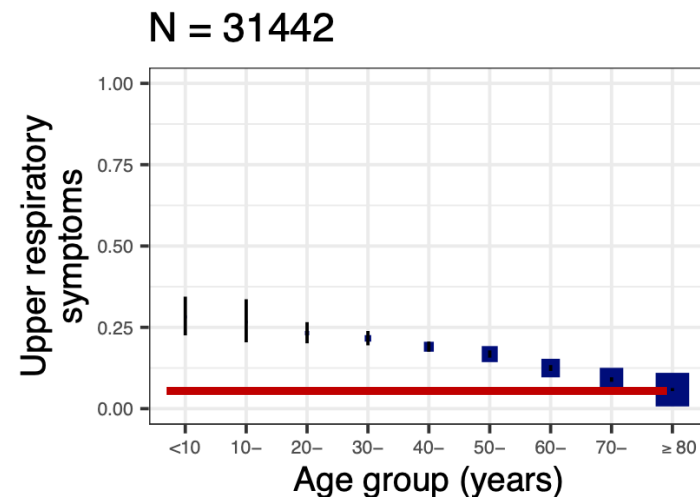
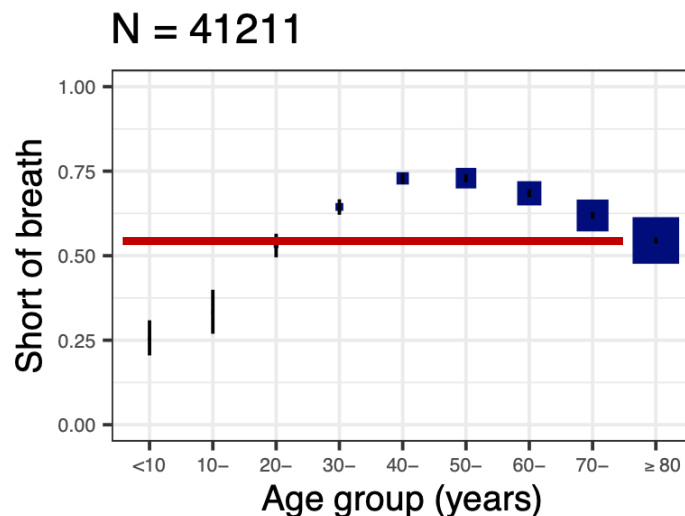
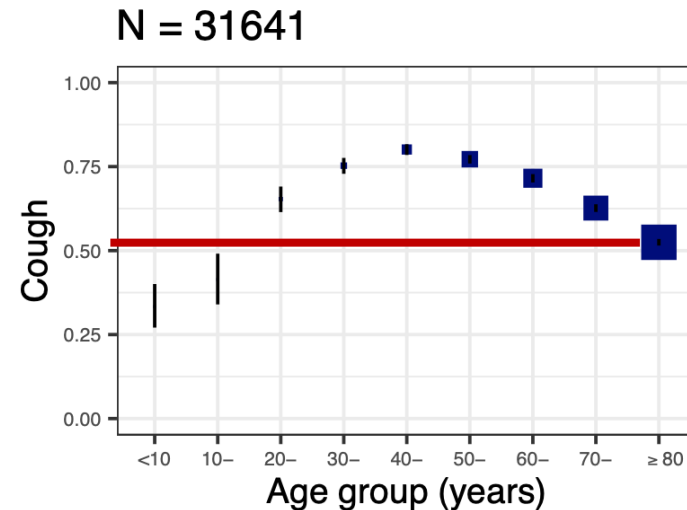
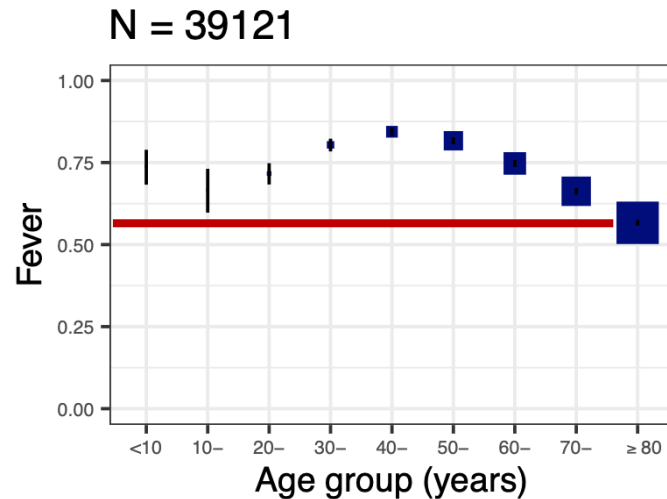
- “Acute confusion is a far more common herald of the onset of physical illness in an old person than are, for example, fever, pain or tachycardia”
- “Failure to diagnose delirium and to identify and treat its underlying causes may have lethal consequences for the patient, since it may constitute the most prominent presenting feature of myocardial infarction, pneumonia, or some other life-threatening physical illness”.

*Lipowski ZJ, Am J Psychiatry 1983*

*Lipowski ZJ, NEJM 1989*

# Symptoms recorded at hospital presentation stratified by age group

*ISARIC (International Severe Acute Respiratory and Emerging Infections Consortium) June 8, 2020*

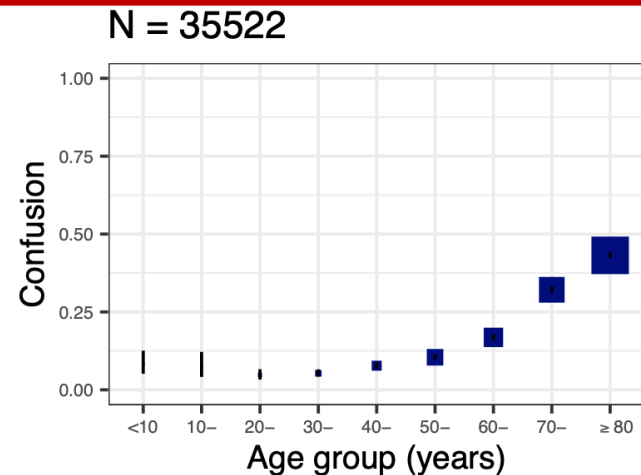
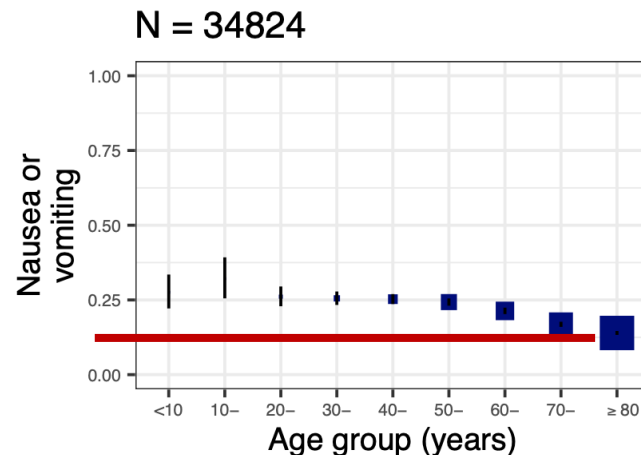
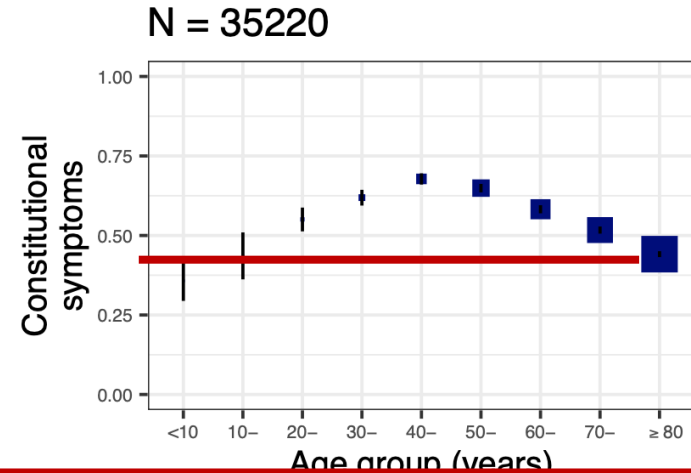
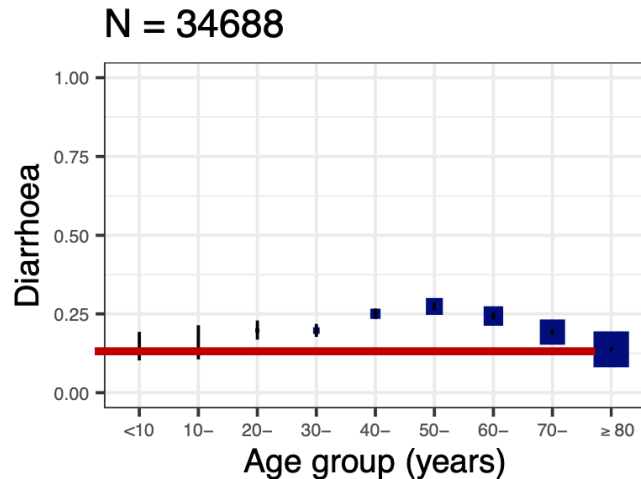


Boxes show the proportion of individuals with each symptom, with error bars showing 95% confidence intervals. The size of each box is proportional to the number of individuals represented



# Symptoms recorded at hospital presentation stratified by age group

ISARIC (International Severe Acute Respiratory and Emerging Infections Consortium) June 8, 2020



Boxes show the proportion of individuals with each symptom, with error bars showing 95% confidence intervals. The size of each box is proportional to the number of individuals represented

# The «Delirium Day» project



2015

231 centres  
1867 pts (acute  
hospitals)

22.9%

2016

276 centres  
2037 pts (acute  
hospitals)

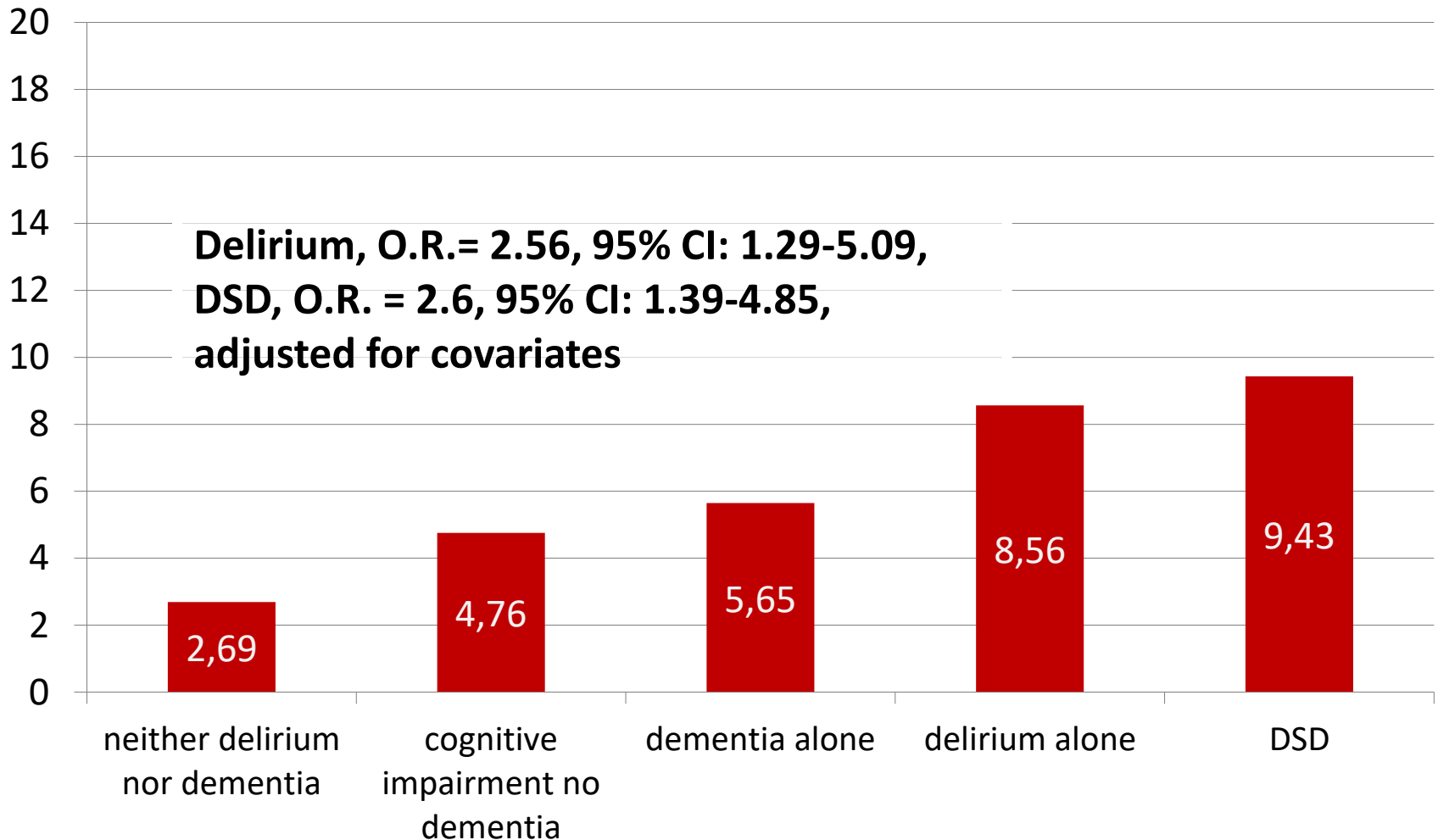
21.2%

2017

301 centres  
3068 pts (acute  
hospitals)

22.7%

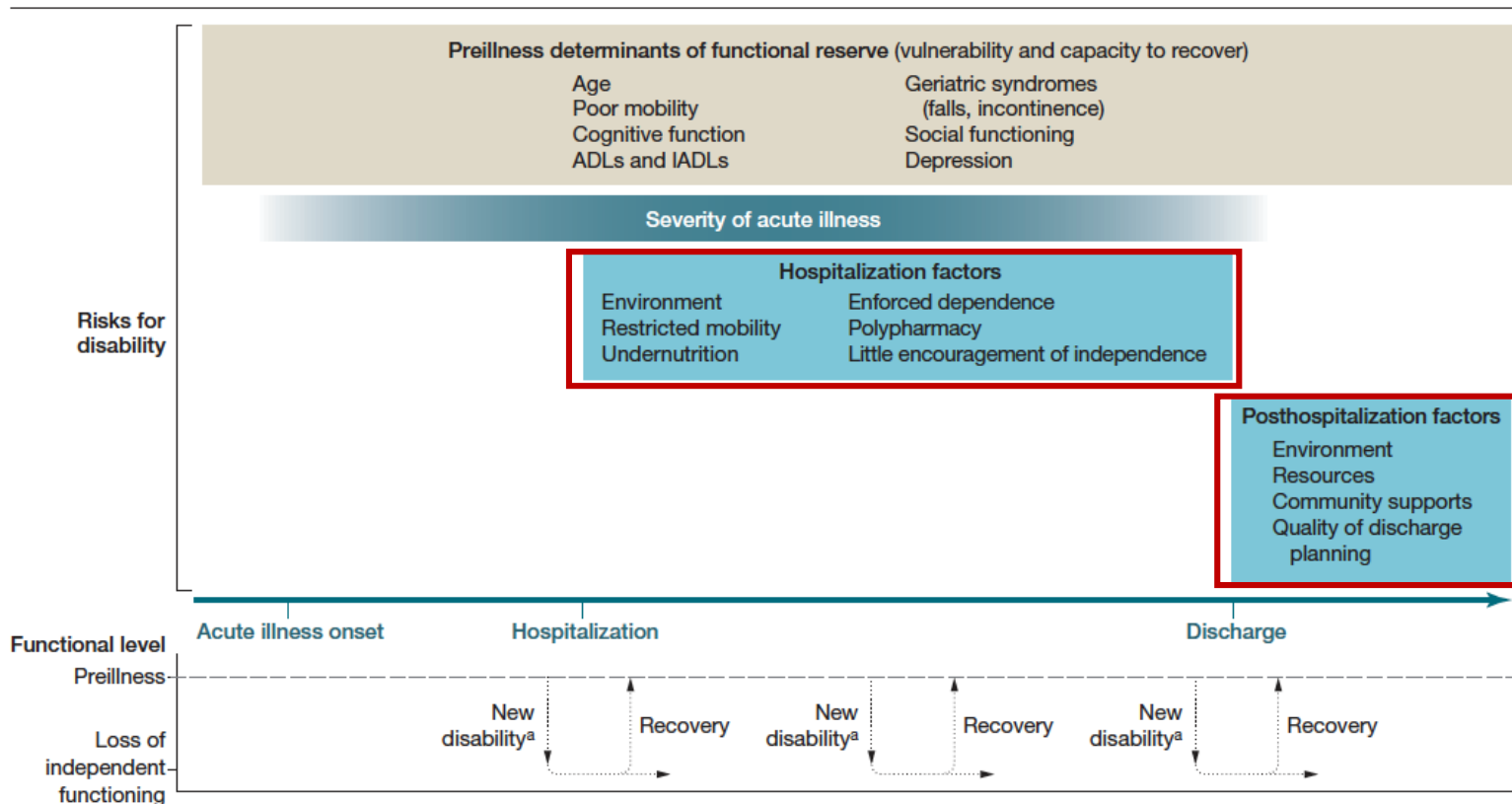
# In-hospital mortality rate (%) in 2037 patients with data on vital status at discharge according to the presence of delirium, dementia or neither



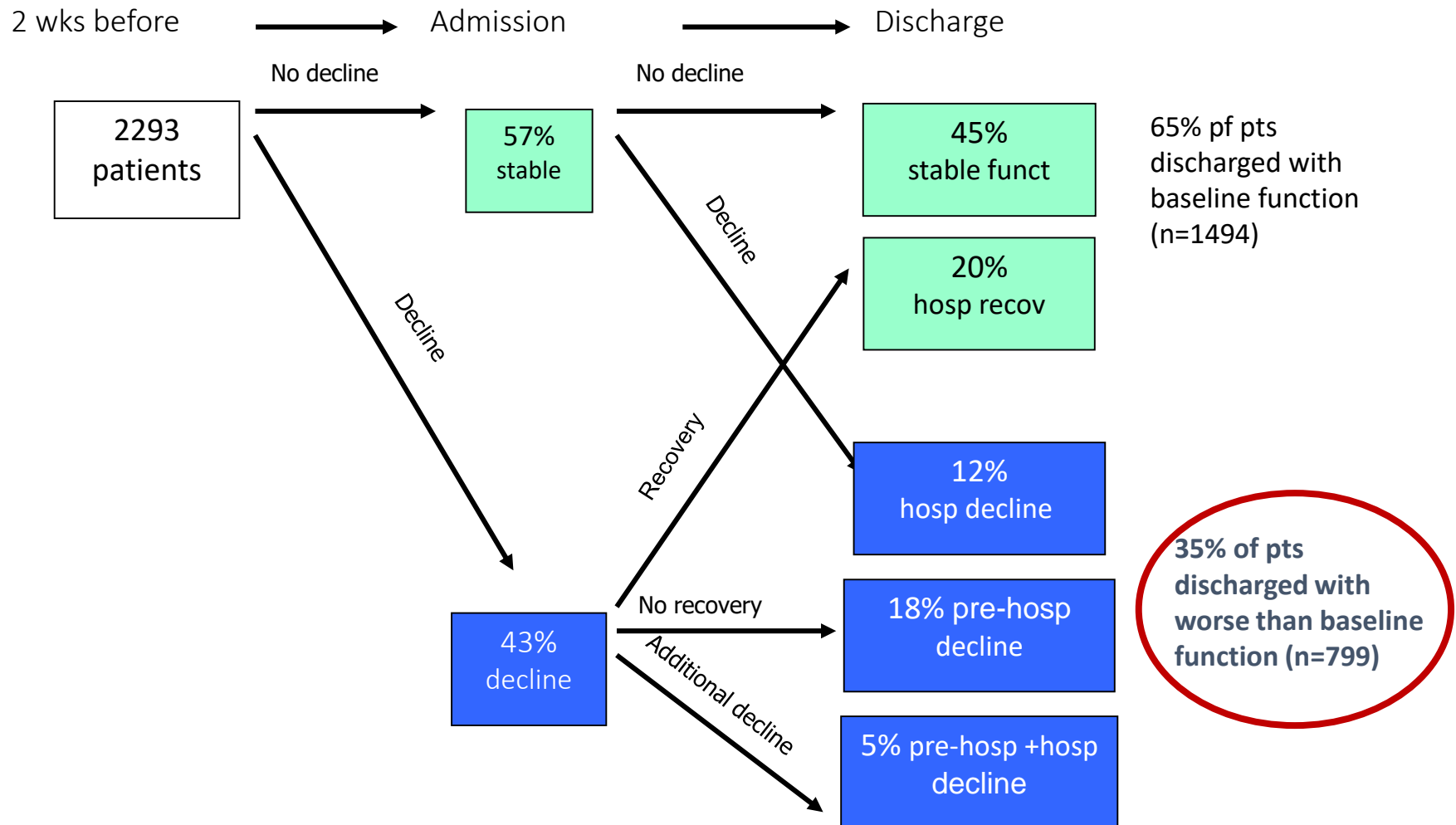
# Hospitalization-Associated Disability

“She Was Probably Able to Ambulate, but I’m Not Sure”

**Figure.** Factors Contributing to the Development of Hospitalization-Associated Disability

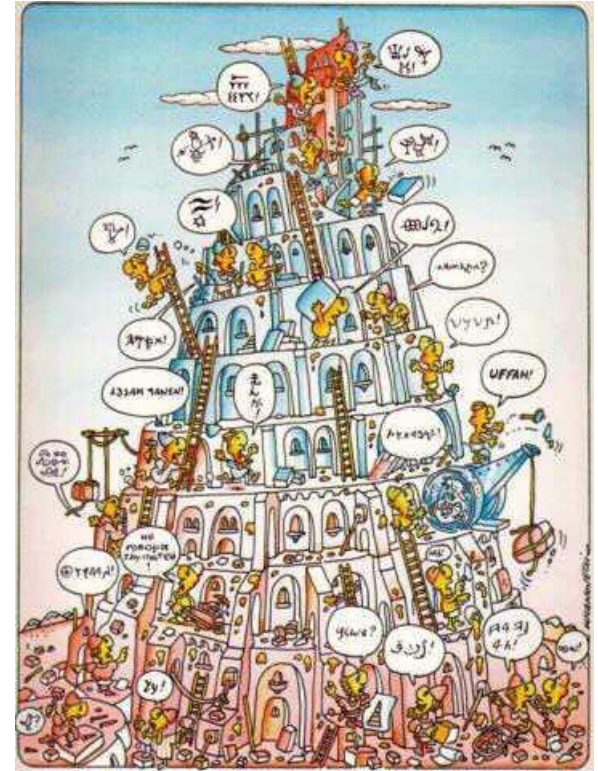


# Loss of independence in ADL in older adults hospitalized with medical illnesses



# Fragmentation of care

- It means the systemic misalignment of incentives, or lack of coordination, that spawns inefficient allocation of resources or harm to patients.



*Enthoven AC, 2009*

Accesso alle cure  
per acuti (P.S.)

Comunicazione tra  
specialisti

Pianificazione del  
percorso di  
dimissione

Accesso a strutture  
di riabilitazione/  
long term care

Servizi assistenziali  
extraospedalieri

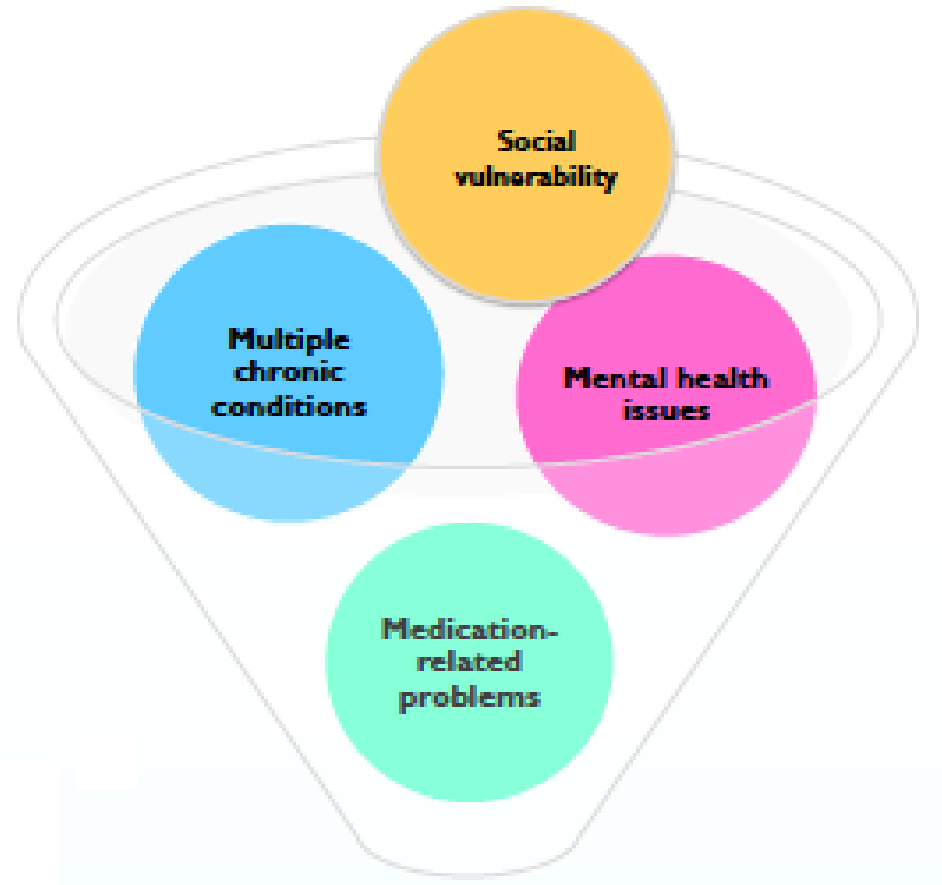
Assistenza al  
domicilio





# Complexity and the need of a comprehensive geriatric assessment

- “Complex patients”: usually defined as patients with complex care needs, with a combination of multiple chronic conditions, mental health issues, medication-related problems, and social vulnerability.
- Complex care needs encompass characteristics related to the patient, the organization, the practitioner, and the patient-practitioner interaction.



## SPECIAL ARTICLES

# The End of the Disease Era

Mary E. Tinetti, MD, Terri Fried, MD

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The time has come to abandon disease as the focus of medical care. The changed spectrum of health, the complex interplay of biological and nonbiological factors, the aging population, and the interindividual variability in health priorities render medical care that is centered on the diagnosis and treatment of individual diseases at best out of date and at worst harmful. A primary focus on disease may inadvertently lead to undertreatment, overtreatment, or mistreatment. The numerous strategies that have evolved to address the limitations of the disease model, although laudable, are offered only to a select subset of persons and often further fragment care. Clinical decision making for all patients should be predicated on the attainment of

individual goals and the identification and treatment of all modifiable biological and nonbiological factors, rather than solely on the diagnosis, treatment, or prevention of individual diseases. Anticipated arguments against a more integrated and individualized approach range from concerns about medicalization of life problems to “this is nothing new” and “resources would be better spent determining the underlying biological mechanisms.” The perception that the disease model is “truth” rather than a previously useful model will be a barrier as well. Notwithstanding these barriers, medical care must evolve to meet the health care needs of patients in the 21st century. *Am J Med.* 2004;116:179–185. ©2004 by Excerpta Medica Inc.

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**«...The time has come to abandon disease as the primary focus of medical care»**

**The failure of the stand-alone disease model**

# I modelli di erogazione delle cure

Disease-oriented model	Integrated, individually tailored model
Focus su diagnosi, prevenzione e trattamento sulla singola malattia	Focus sulle priorità e preferenze del paziente/famiglia
Le malattie sono causate da meccanismi fisiopatologici ben separati; fattori psicologici, sociali, ambientali ed altri sono secondari	Le condizioni di salute sono il risultato di complesse interazioni tra fattori genetici, ambientali, psicologici, sociali e di altro tipo
Il trattamento è orientato al singolo meccanismo fisiopatogenetico	Il trattamento è orientato ai fattori di rischio modificabili che determinano le condizioni di salute
I sintomi e gli impairments sono affrontati diagnosticando e curando i determinanti della malattia	I sintomi e gli impairments sono il focus del trattamento anche se non possono essere ascritti ad una specifica malattia
Gli outcomes clinici sono determinati dalla malattia	Gli outcomes clinici sono determinati dalle preferenze del paziente
La sopravvivenza è l'obiettivo primario della prevenzione e del trattamento	La sopravvivenza è solo uno degli obiettivi possibili della cura

# Comprehensive Geriatric Assessment (CGA)

- Processo multidisciplinare diagnostico-terapeutico che identifica problemi clinici, psicologici, sociali e funzionali di un individuo anziano «fragile» con l'obiettivo di sviluppare un piano di intervento coordinato, atto a massimizzare lo stato di salute complessiva dell'individuo stesso

## Domini

- Stato sociale, ambientale, economico
- Stato funzionale
- Funzione cognitiva
- Tono dell'umore
- Comorbidità
- Stato nutrizionale

# The World report on ageing and health: a policy framework for healthy ageing



*Lancet* 2016; 387: 2145-54

This complexity of health states in older age means that disease-based conceptualisations are inadequate proxies for health in an older person. Rather than the presence or absence of disease, the most important consideration for an older person is likely to be their functioning. Comprehensive assessments of functioning in older age are also much better predictors of survival and other outcomes than the presence of diseases or even the extent of comorbidities.<sup>41</sup>

# The Association Between Geriatric Syndromes and Survival

Robert L. Kane, MD,<sup>\*†</sup> Tatyana Shamliyan, MD,<sup>\*†</sup> Kristine Talley, PhD, RN,<sup>‡</sup> and James Pacala, MD<sup>§</sup>

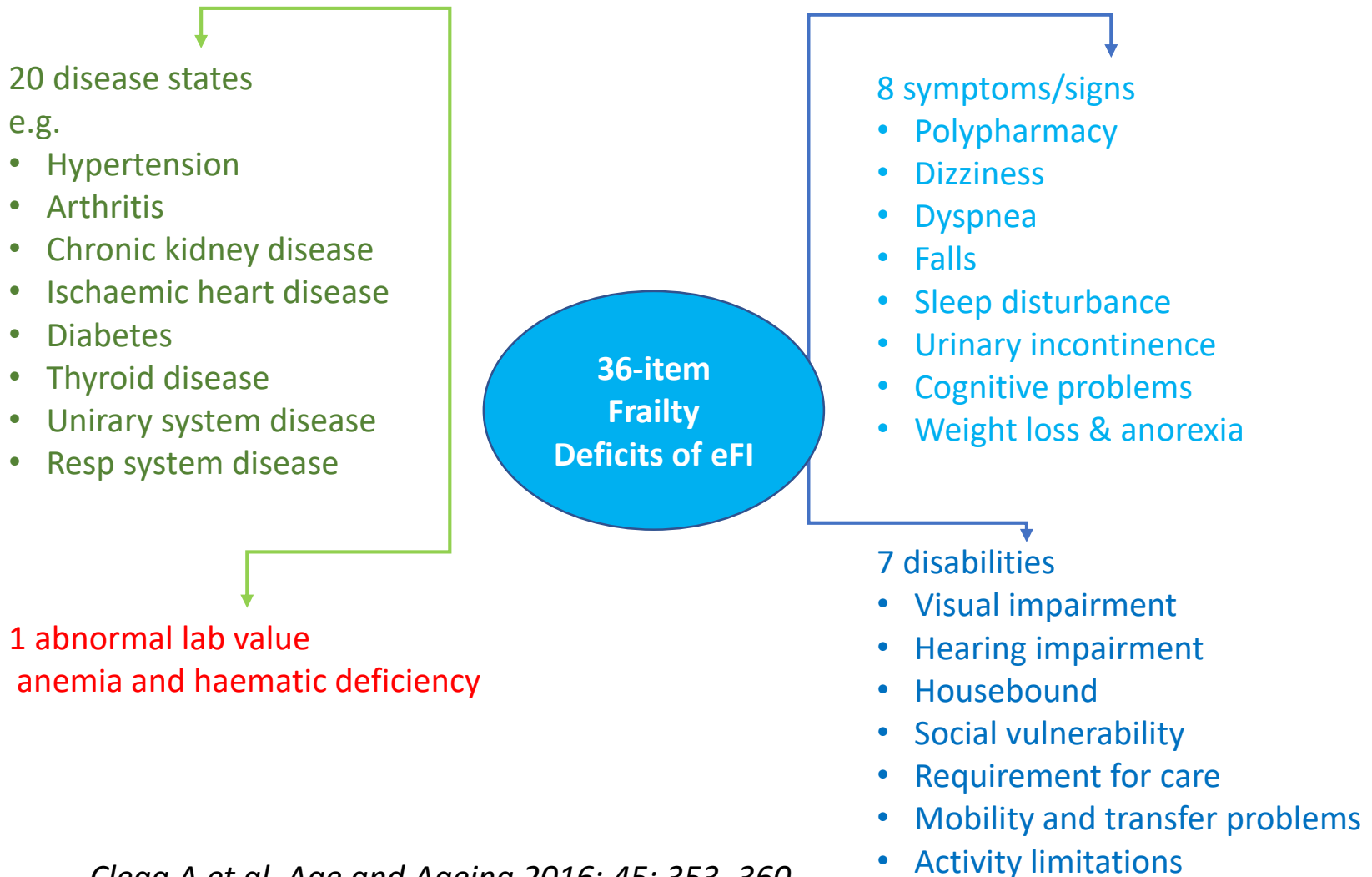
Table 3. Differences in Remaining Life Expectancy in Older Persons Between the General Population and Individuals with Selected Geriatric Syndromes

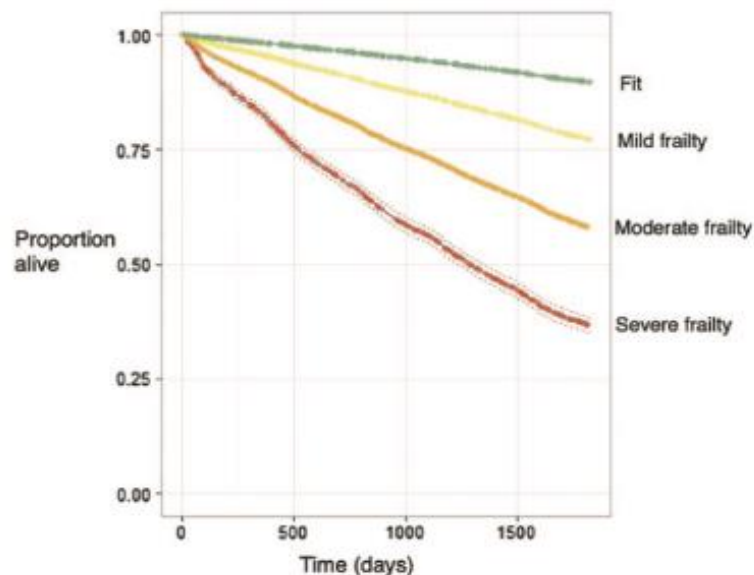
Age	Remaining Life Expectancy in the General Population	Geriatric Syndromes							Disability in Activities of Daily Living
		Multiple Morbidities (>3 Diseases)	Inflammation (High C-Reactive Protein)	Frailty (Phenotype)	Cognitive Impairment Mini-Mental State Examination Score <24	Frailty (Accumulation Deficit)	Low Body Mass Index	Allostatic Load	
65	18.4	-2.2	-2.8	-3.2	-2.5	-1.1	-5.4	-10.3	-3.9
70	14.9	-2.0	-2.5	-2.8	-2.2	-1.0	-4.8	-8.9	-3.4
75	11.7	-1.7	-2.1	-2.5	-1.9	-0.9	-4.1	-7.5	-3.0
80	8.9	-1.4	-1.8	-2.1	-1.6	-0.7	-3.4	-6.0	-2.5
85	6.5	-1.1	-1.4	-1.6	-1.3	-0.6	-2.7	-4.7	-2.0
90	4.6	-0.8	-1.1	-1.2	-1.0	-0.4	-2.0	-3.5	-1.5
95	2.8	-0.5	-0.6	-0.7	-0.6	-0.2	-1.2	-2.2	-0.9
100	0.4	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.4	-0.2



**Le risposte possibili per una  
presa in carico efficiente**

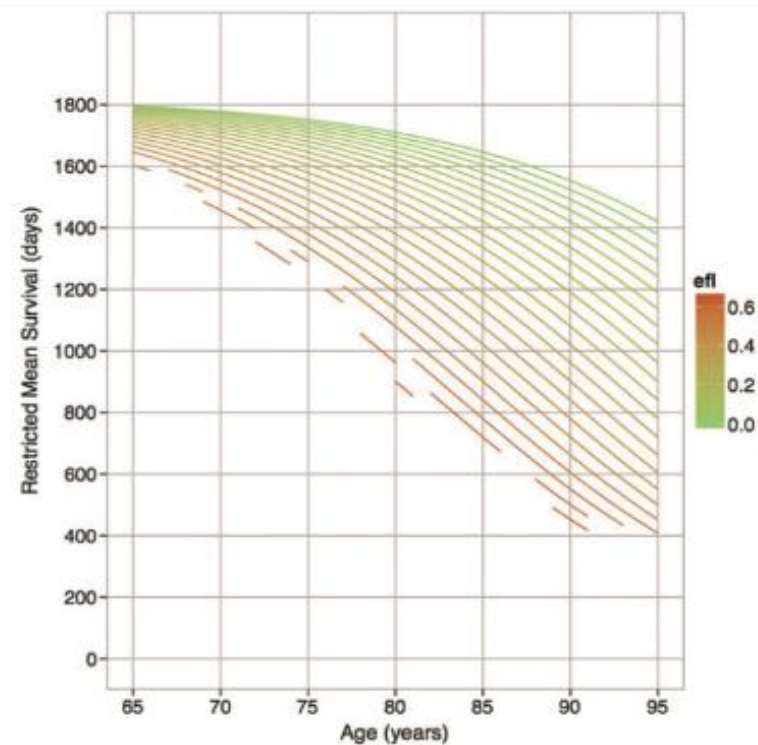
# Electronic Frailty Index





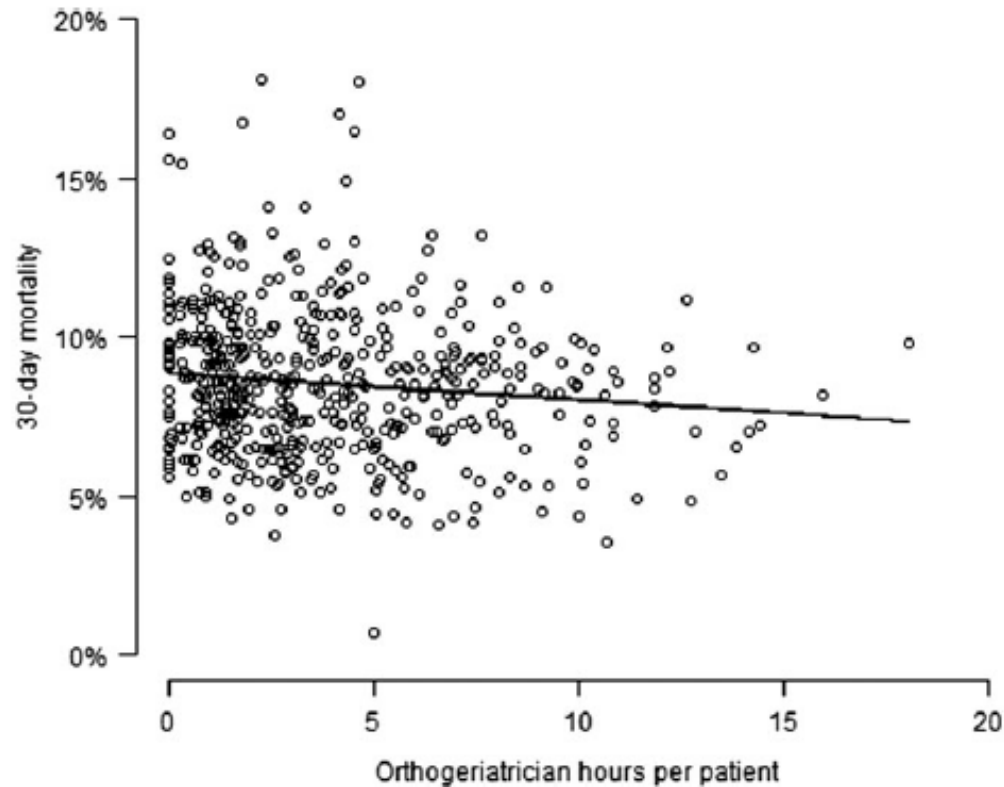
**Figure 1.** Five-year Kaplan–Meier survival curve for the outcome of mortality for categories of fit, mild frailty, moderate frailty and severe frailty (internal validation cohort).

*Age Ageing 2016;45:353-60*



**Figure 2.** Relationship between age, electronic frailty index score and mortality (internal validation cohort).

# Increased orthogeriatrician involvement in hip fracture care and its impact on mortality in England



**Figure 2.** Association between average per-patient hours worked by orthogeriatricians in orthopaedic departments and annual 30-day mortality.

## Indicatori di efficienza e criteri che regolano la best practice tariff in UK a partire dal 2018

KPI	Area of care
Key performance indicator 1	Prompt orthogeriatric assessment
Key performance indicator 2	Prompt surgery
Key performance indicator 3	NICE compliant surgical approach
Key performance indicator 4	Prompt mobilisation after surgery
Key performance indicator 5	Not delirious when tested after operation
Key performance indicator 6	Returned to original residence by 120 days

# Effect of Exercise Intervention on Functional Decline in Very Elderly Patients During Acute Hospitalization

## A Randomized Clinical Trial

Nicolás Martínez-Velilla, PhD, MD; Alvaro Casas-Herrero, PhD, MD; Fabricio Zambom-Ferraresi, PhD; Mikel L. Sáez de Asteasu, MSc; Alejandro Lucia, PhD, MD; Arkaitz Galbete, PhD; Agurne García-Baztán, MD; Javier Alonso-Renedo, MD; Belen González-Glaría, PhD, MD; María Gonzalo-Lázaro, MD; Itziar Apezteguía Iraizoz, PhD, MD; Marta Gutiérrez-Valencia, PharmD; Leocadio Rodríguez-Mañas, PhD, MD; Mikel Izquierdo, PhD



*Courtesy of Nicolas Martinez Velilla*

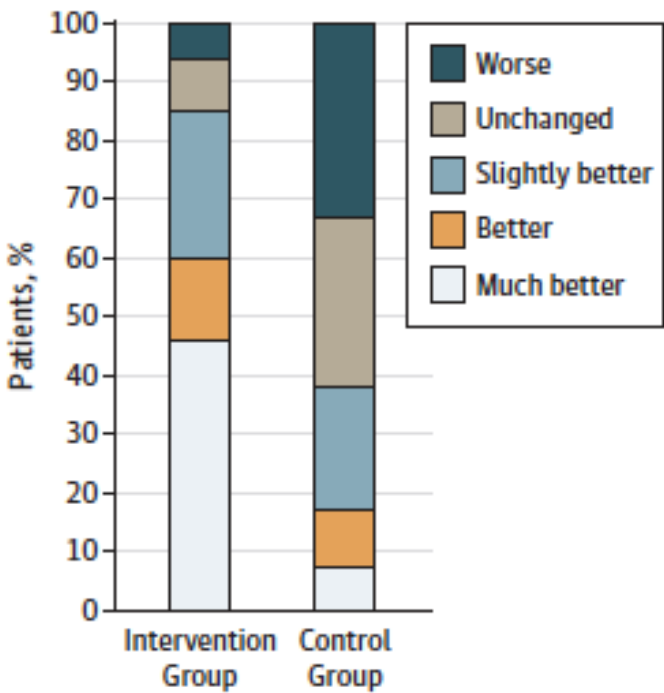


# Effect of Exercise Intervention on Functional Decline in Very Elderly Patients During Acute Hospitalization

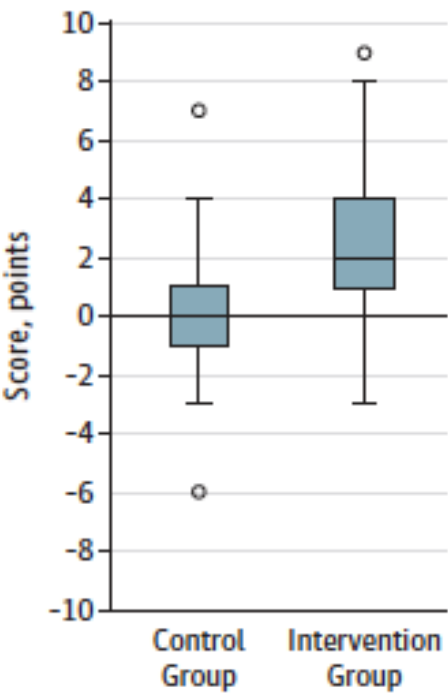
## A Randomized Clinical Trial

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**B** Change in SPPB from admission to discharge



**D** Change in SPPB



RESEARCH

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# Impact of a dementia-friendly program on detection and management of patients with cognitive impairment and delirium in acute-care hospital units: a controlled clinical trial design

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# Dissemination of the Hospital Elder Life Program: Implementation, Adaptation, and Successes

*Sharon K. Inouye, MD, MPH,\*<sup>†</sup> Dorothy I. Baker, PhD, RN-CS,<sup>‡</sup> Patricia Fugal, BS,<sup>‡</sup> and Elizabeth H. Bradley, PhD<sup>§</sup> for the HELP Dissemination Project*

**Table 2. Hospital Elder Life Program (HELP) Personnel Across Sites (N = 13)**

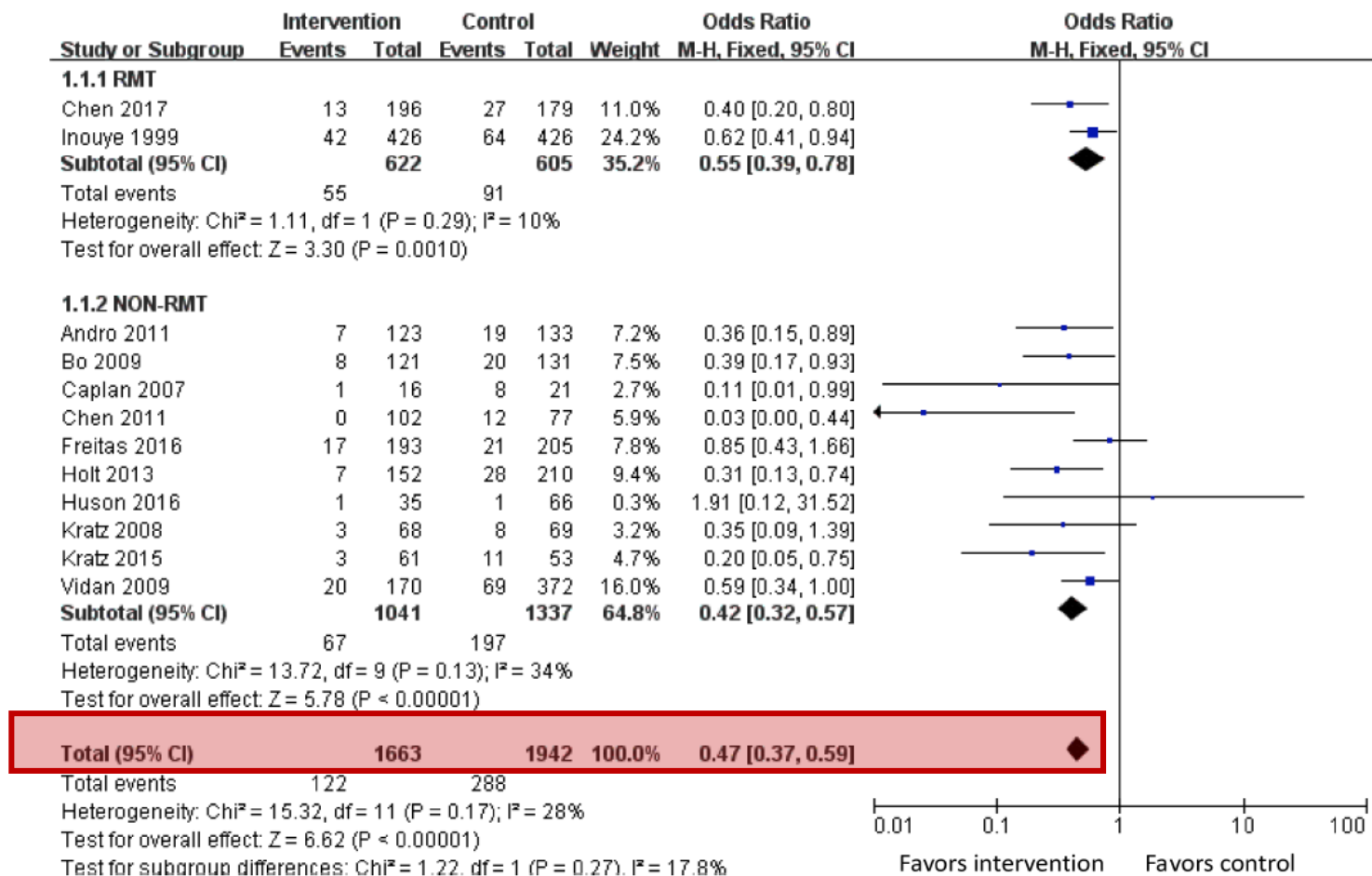
Personnel	n (%)
Presence of HELP team member(s)	
➡ Elder Life Specialist*	11 (84.6)
➡ Elder Life Nurse Specialist <sup>†</sup>	12 (92.3)
Geriatrician	12 (92.3)
Program director	13 (100)
➡ Interdisciplinary consultants <sup>‡</sup>	11 (84.6)
➡ Trained volunteers	13 (100)
Discipline of HELP program director	
Elder Life Nurse Specialist <sup>†</sup>	6 (46.2)
Elder Life Specialist*	3 (23.1)
Geriatrician	1 (7.7)
Other <sup>§</sup>	3 (23.1)

# HELP program interventions and staff: the bundle


Interventions	Staff	Description
<b>Core interventions</b>		
Orientation	ELS, volunteers	Daily orientation, orientation board with names of care team members and daily schedule
Therapeutic activities	ELS, volunteers	Cognitive stimulation activities three times daily
Sleep enhancement	ELNS, ELS, volunteers	At bedtime, warm milk or herbal tea, relaxation tapes or music, and back massage. Ward-wide noise reduction and schedule adjustments to allow uninterrupted sleep
Early mobilization	ELNS, ELS, volunteers	Ambulation or active range-of-motion exercises three times daily. Minimizing use of immobilizing equipment
Vision protocol & Vision protocol - Blindness	ELS, volunteers	Visual aids (e.g., glasses, magnifying lenses) and adaptive equipment (e.g., large illuminated telephone keypads, large print books, fluorescent tape on call bell), with daily reinforcement
Hearing protocol	ELNS, ELS, volunteers	Portable amplifying devices and special communication techniques, with daily reinforcement. Ear wax clearing by ELNS as needed
Fluid repletion/constipation	ELNS, ELS, volunteers	Encourage fluids. Encourage mobility and regular toileting. Added fiber to diet. Laxatives if needed
Feeding assistance	ELS, volunteers	Feeding assistance and encouragement during meals

# Hospital Elder Life Program: Systematic Review and Meta-analysis of Effectiveness

- Systematic review and Meta-Analysis: 44 final articles, 14 included in the meta-analysis for effectiveness, and 30 included for examining cost-savings, adherence and adaptations, role of volunteers, successes and barriers



# Identifying older adults with frailty approaching end-of-life: A systematic review

Alex Hall<sup>1</sup> , Elisabeth Boulton<sup>1</sup>, Patience Kunonga<sup>2</sup> ,  
Gemma Spiers<sup>2</sup>, Fiona Beyer<sup>2</sup>, Peter Bower<sup>1</sup>, Dawn Craig<sup>2</sup>,  
Chris Todd<sup>1</sup> and Barbara Hanratty<sup>2</sup>

# Conclusioni

- Persone sempre più anziane, socialmente isolate, con elevato carico di malattie e farmaci, che entrano in ospedale con una presentazione atipica di malattia acuta
- In ospedale sviluppano hospitalization-acquired disability e declino cognitivo e non trovano sul territorio risposte coordinate
- La necessità di cambiare il paradigma
  - Valutazione standardizzata e sistematica del profilo di rischio
  - Attenzione ai bisogni più che alle malattie
  - Interdisciplinarietà e innovazione