FRAILTY MATTERS

The Frailty and Elder Care Network | Nova Scotia Health, EHS

Karen Nicholls / Francine Butts

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CANADA
VECTOR MAP EPS 10
Alert
Ellesmere Island
Resolute
Bank Island
Victoria Island
Baffin Island
Inuvik
Great Bear Lake
Mackenzie River
Gjoa Haven
Dawson
Yukon
Whitehorse
Northwest Territories
Yellowknife
Nunavut
Iqaluit
Baker Lake
Great Slave Lake
Fort Nelson
British Columbia
Prince George
Fraser River
Vancouver
Victoria
Kamloops
Fort McMurray
Alberta
Edmonton
Calgary
Saskatchewan
Saskatoon
Regina
Churchill
Manitoba
L. Winnipeg
Winnipeg
Sandy Lake
Thunder Bay
Ontario
Kuujjuaq
La Grande Riviere
Quebec
Sept-iles
Montreal
Ottawa
Toronto
Nain
Newfoundland and Labrador
Churchill Falls
St John's
Prince Edward Island
Charlottetown
Fredericton
Quebec
New Brunswick
Nova Scotia
Halifax

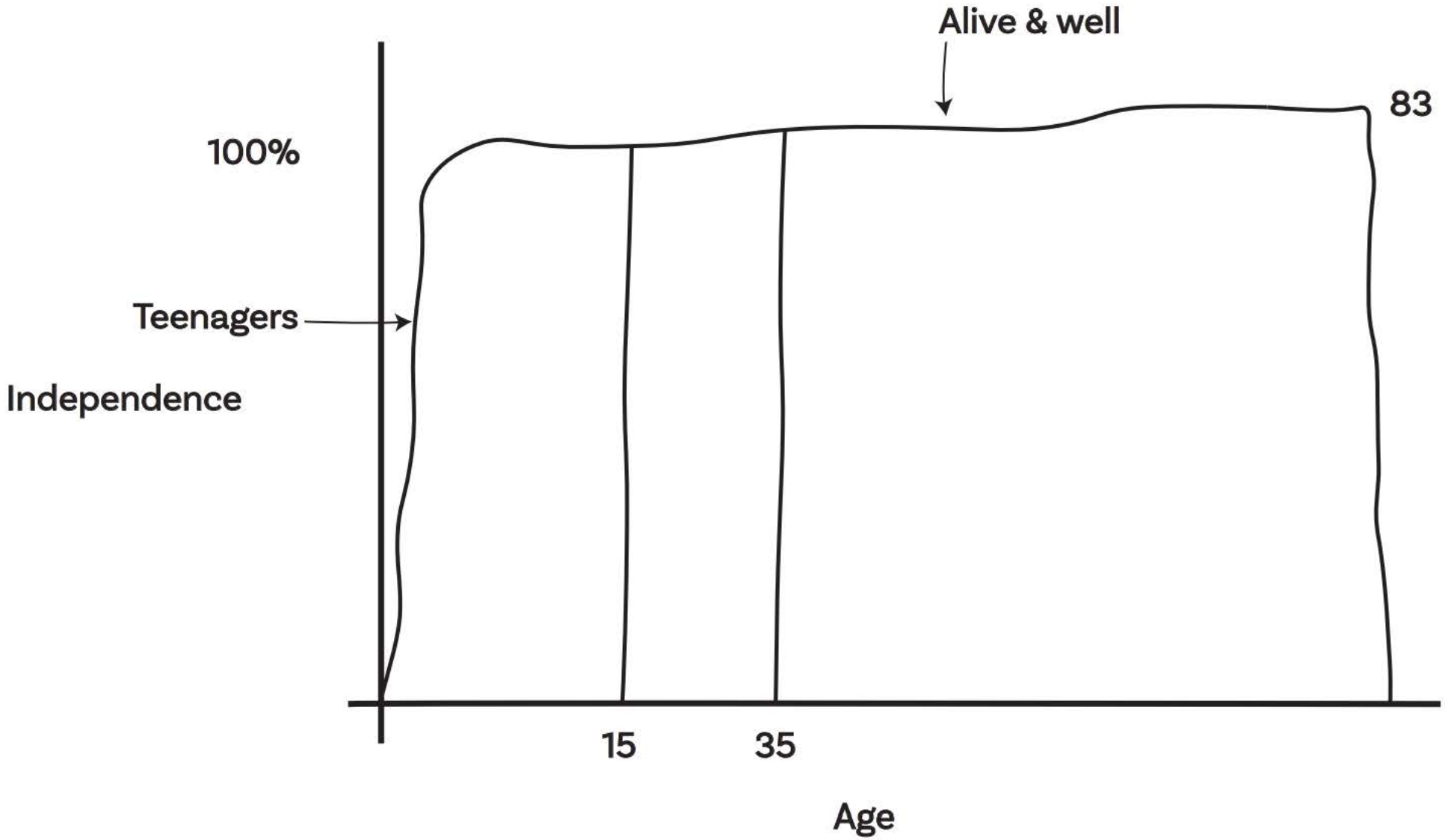
TO START | Words Matter

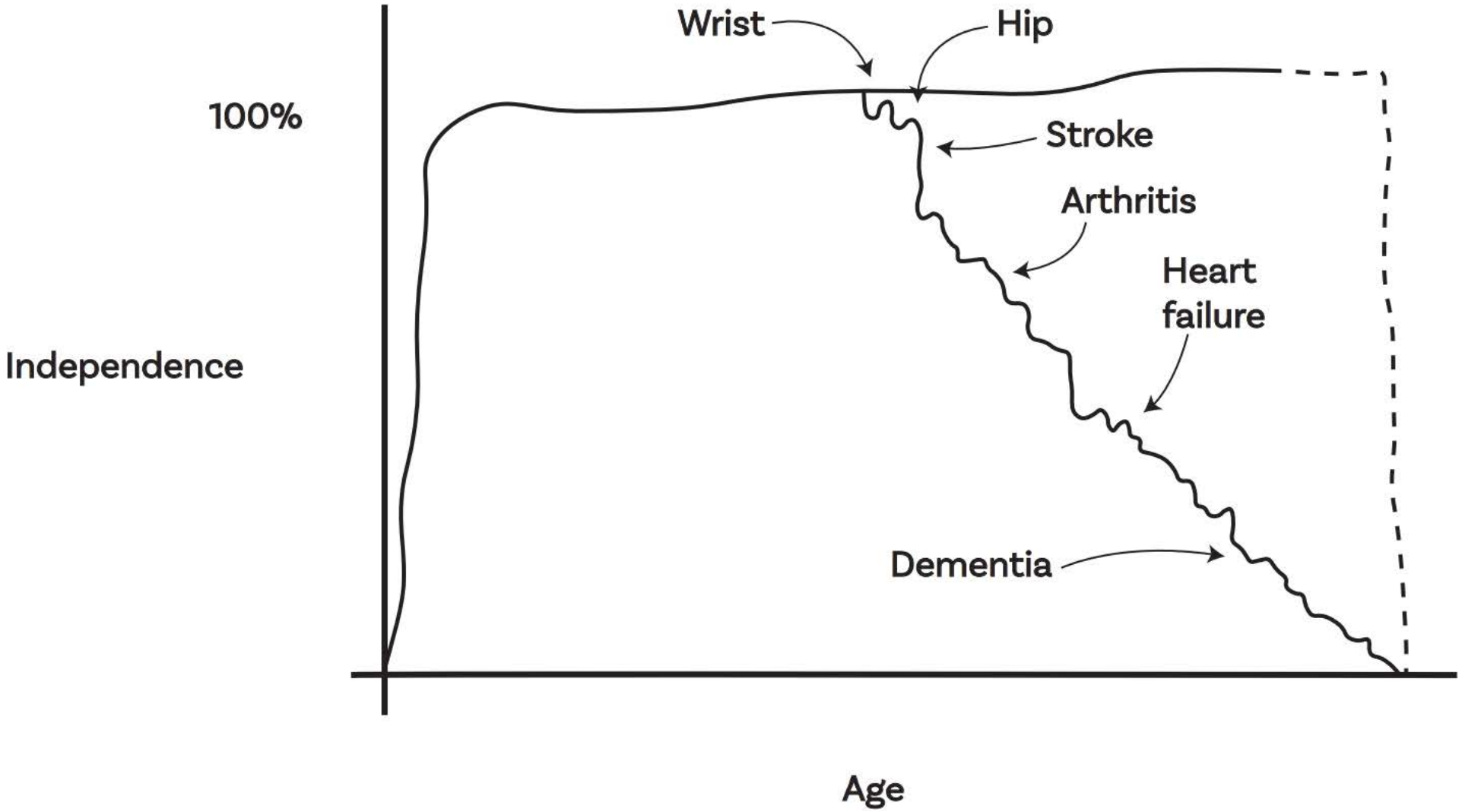
- People who live with frailty emphasize that it does not define them.
- They fear that it might be used to “give up” on them.

- Canada's population is aging exponentially | the Geri Boom.
- And, over the next 10 years, will add 93 billion to health care costs (over half of all health care spending is on those over the age of 65).
- In 2020, 25% of Canadian Seniors were living with frailty.

Better identification and understanding of frailty and how to support older people to live well with frailty is one of the key challenges for health care systems.

Patients can't change how they get sick. We must change how we care for them.


Alive & well
83
100%
Teenagers
Independence
15
35
Age


Wrist
Hip
100%
Stroke
Arthritis
Heart
failure
Independence
Dementia
Age

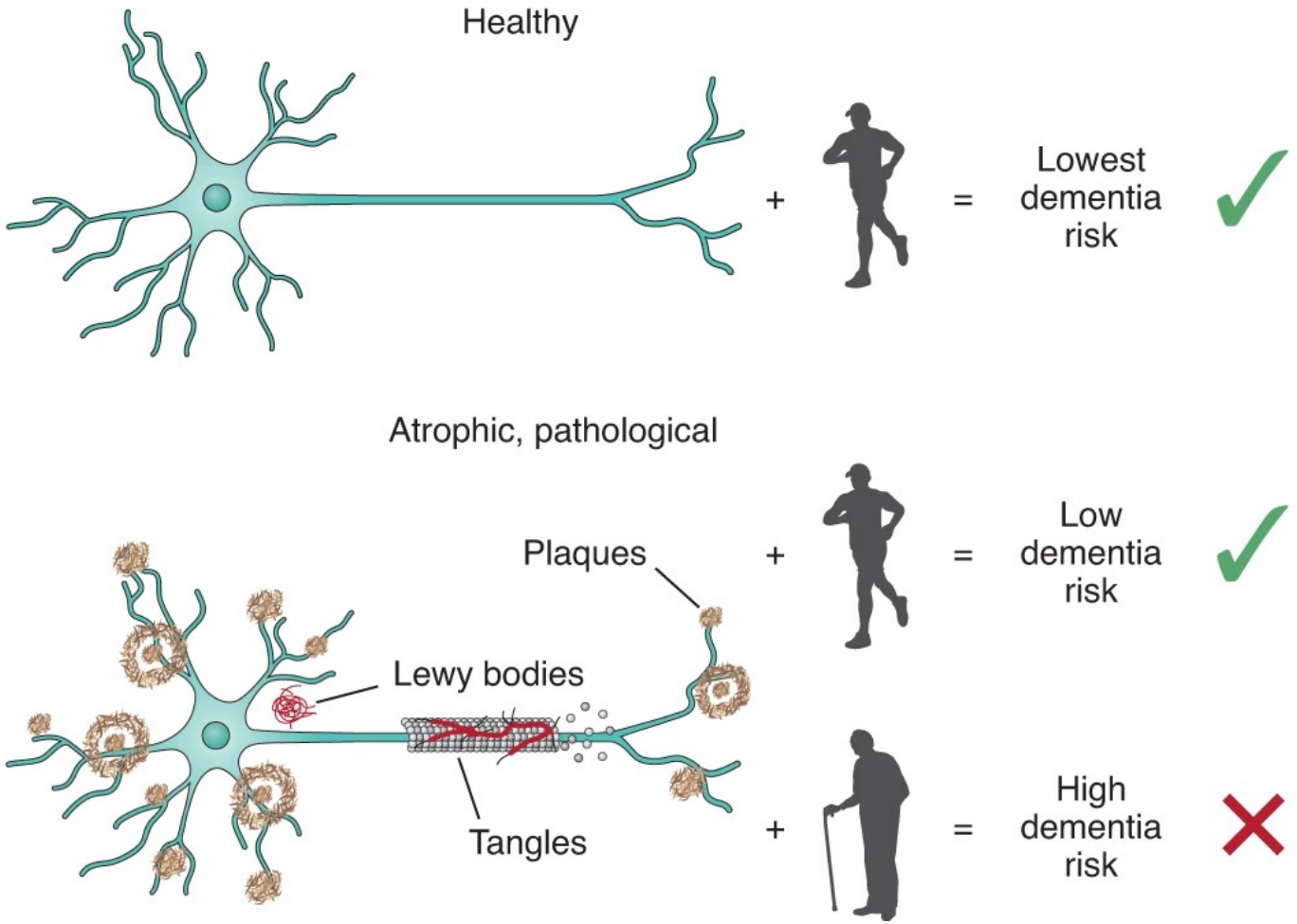
What does it mean to be Frail?

- Frailty is a predictor of poor outcomes that is more strongly based than simply looking at person's diagnosis.
- Inasmuch as most health risks increase with age, a handy way to think about frailty is that it is a risk compared with others of the same age – accelerated ageing.
- Like the risk of dying, on average frailty increases with age.
- Older people who live with frailty can be vulnerable even to relatively minor changes in their circumstances.

FRAILTY


Is dynamic and modifiable
Is all about the baseline state
Early intervention can allow patients to get back to baseline

Frailty is not a disease, but it profoundly influences disease expression.



Howlett et al., *Nature Aging* 2021;1:650-665

Song X et al. *Neurology* 2011;77:227-234. Rockwood K et al., *Nature Medicine* 2019;25:1331-1332. Wallace LMK et al., *Lancet Neurology* 2019;18:177-184.
Wallace LMK et al., *Neurology* 2020; 95:e3269-e3279. Wallace LMK et al., *Internat Psychogeriatric* 2021;33:1035-43. Ward DD et al., *Annals of Neurology* 2021; 89:1221-1225
Ward DD et al., *Journal of Neurology, Neurosurgery, Psychiatry* 2021;92:136-142. Ward DD et al., *Journal of Neurology, Neurosurgery, Psychiatry* 2022;93:343-350.

CLINICAL FRAILTY SCALE (CFS)

- The CFS is a quick reference to how frail older people ≥ 65 might be.
- It is a one page pocket-card tool that starts with a person upright and running (CFS score of 1 or very fit) to show that they are vital and energetic.
- Each succeeding picture shows someone who is a little less well and a little less functional.
- Ultimately, the person is lying flat in a bed and totally dependent in their activities of daily living (a CFS score of 8 or very severely frail).
- And, then sitting in a chair (a CFS score of (or terminally Ill for a person whose life expectancy is less that six months but show no sign of frailty).
- Each picture in the nine-point scale also has a few sentences describing what a person with the frailty score might be like or might be able to do at that level of frailty.

THE DEGREE OF FRAILTY HAS STEREOTYPICAL CLINICAL MANIFESTATIONS

The clinical frailty scale lets us grade the degree of frailty at baseline

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CLINICAL FRAILTY SCALE

1 VERY FIT — People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.

2 FIT — People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.

3 MANAGING WELL — People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.

4 LIVING WITH VERY MILD FRAILTY — Previously "vulnerable," this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up" and/or being tired during the day.

5 LIVING WITH MILD FRAILTY — People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

6 LIVING WITH MODERATE FRAILTY — People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 LIVING WITH SEVERE FRAILTY — **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).

8 LIVING WITH VERY SEVERE FRAILTY — Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.

9 TERMINALLY ILL — Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

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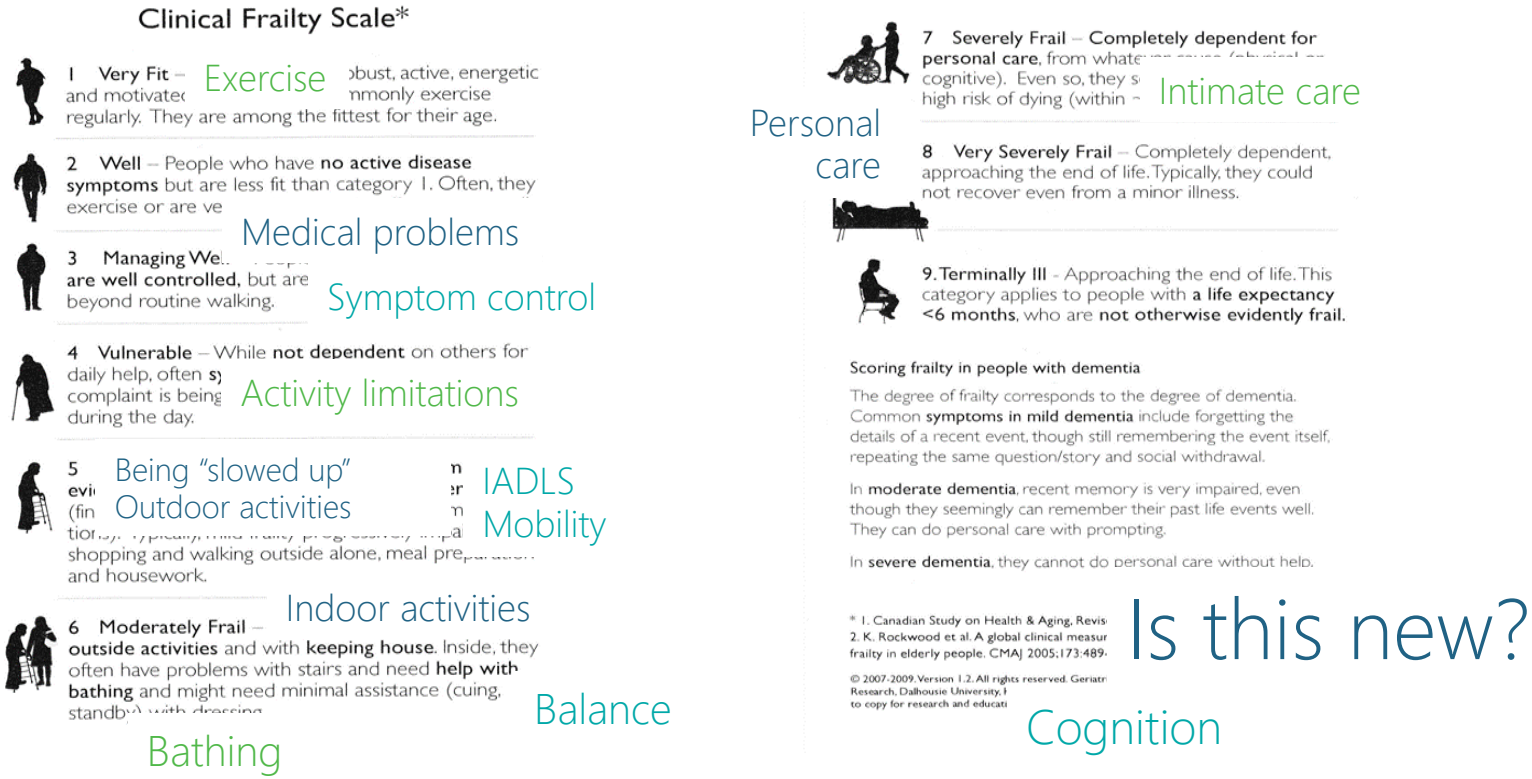
Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

The clinical frailty scale asks about **baseline** function



Clinical Frailty Scale*

1 Very Fit – ...bust, active, energetic and motivated ... monly exercise regularly. They are among the fittest for their age.

2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are ve...

3 Managing Wel... **are well controlled,** but are ... beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often s... complaint is being ... during the day.

5 ... evi... (fin... ...shopping and walking outside alone, meal pre... and housework.

6 **Moderately Frail** – **outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standb... with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whate... cognitive). Even so, they s... high risk of dying (within ...

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

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* 1. Canadian Study on Health & Aging, Revis...
2. K. Rockwood et al. A global clinical measur... frailty in elderly people. CMAJ 2005;173:489-...

Exercise

Medical problems

Symptom control

Activity limitations

Being "slowed up"

Outdoor activities

IADLS

Mobility

Indoor activities

Balance

Bathing

Personal care

Intimate care

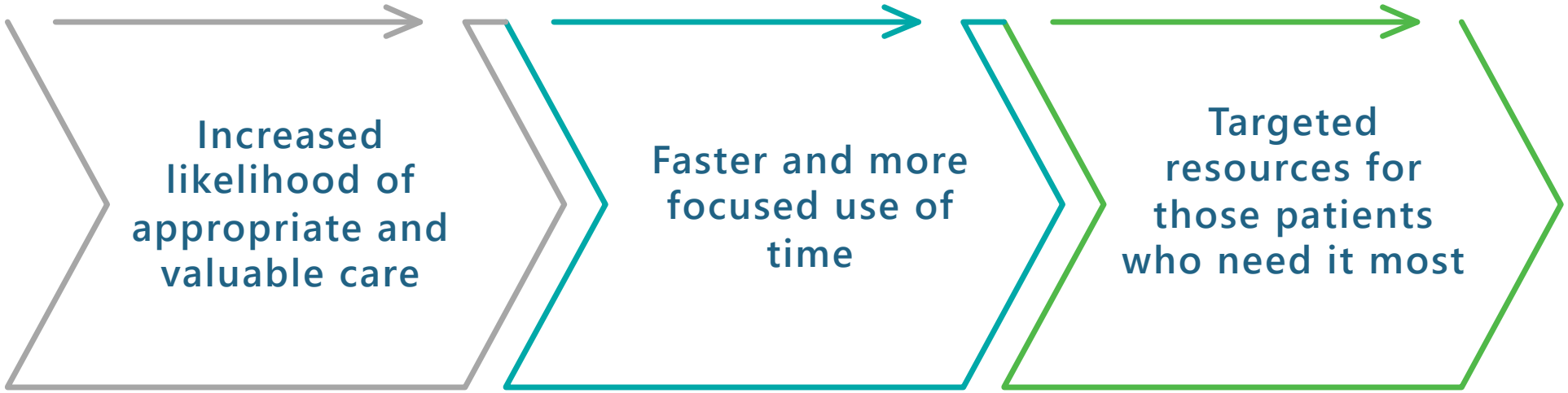
Cognition

Is this new?

Recovery capacity

Rockwood et al. A global clinical measure of fitness and frailty in elderly people. *CMAJ* 2005; 173:489-495.

FRAILTY IDENTIFICATION AND SCORING = IMPROVED PATIENT OUTCOMES



Best Practices in Proactive, Person-Centered, Frailty Care will:

Reduce

the burden on ED by reducing hospital admits, admissions from long term care, and discharges to it.

Motivate

identifying, monitoring, and managing frailty

Allow

More people admitted to hospital to be alive and in their own homes one year later

nova scotia health authority

Understand how the current state compares with the baseline state

Illness severity works differently in frail older adults: don't wait for the vital signs to become abnormal.

- ? Patient is confused: is this new?
- ? Patient can't walk: is this new?
- ? Patient can't care for themselves: is this new?
- ? Patient has no one to help them: is this new?

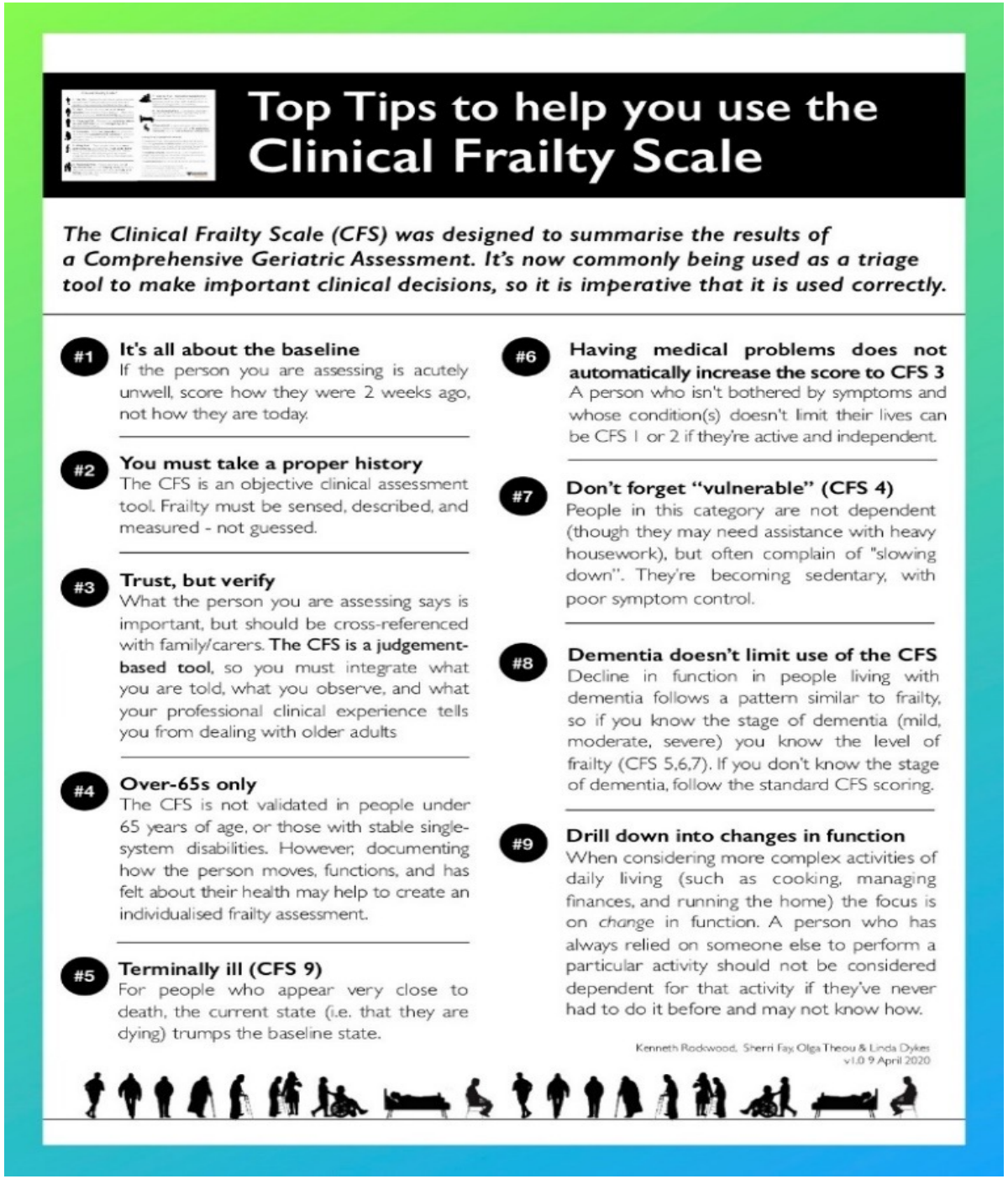
After the initial assessment: the first 48 hours are information packed.

Take advantage of the state variables:

- ? Is cognition improving?
- ? Is function improving?
- ? Is the patient moving better?

TOP TIP #1

Understand the baseline state



Top Tips to help you use the Clinical Frailty Scale

The Clinical Frailty Scale (CFS) was designed to summarise the results of a Comprehensive Geriatric Assessment. It's now commonly being used as a triage tool to make important clinical decisions, so it is imperative that it is used correctly.

#1 It's all about the baseline
If the person you are assessing is acutely unwell, score how they were 2 weeks ago, not how they are today.

#2 You must take a proper history
The CFS is an objective clinical assessment tool. Frailty must be sensed, described, and measured - not guessed.

#3 Trust, but verify
What the person you are assessing says is important, but should be cross-referenced with family/carers. **The CFS is a judgement-based tool**, so you must integrate what you are told, what you observe, and what your professional clinical experience tells you from dealing with older adults

#4 Over-65s only
The CFS is not validated in people under 65 years of age, or those with stable single-system disabilities. However, documenting how the person moves, functions, and has felt about their health may help to create an individualised frailty assessment.

#5 Terminally ill (CFS 9)
For people who appear very close to death, the current state (i.e. that they are dying) trumps the baseline state.

#6 Having medical problems does not automatically increase the score to CFS 3
A person who isn't bothered by symptoms and whose condition(s) doesn't limit their lives can be CFS 1 or 2 if they're active and independent.

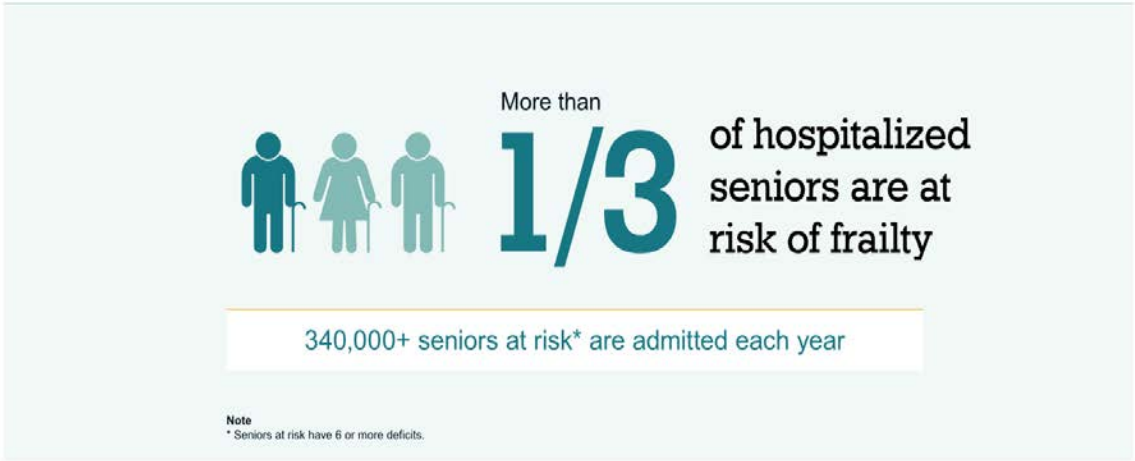
#7 Don't forget "vulnerable" (CFS 4)
People in this category are not dependent (though they may need assistance with heavy housework), but often complain of "slowing down". They're becoming sedentary, with poor symptom control.

#8 Dementia doesn't limit use of the CFS
Decline in function in people living with dementia follows a pattern similar to frailty, so if you know the stage of dementia (mild, moderate, severe) you know the level of frailty (CFS 5,6,7). If you don't know the stage of dementia, follow the standard CFS scoring.

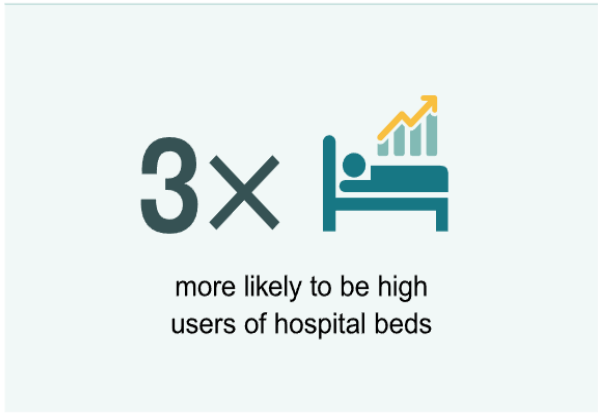
#9 Drill down into changes in function
When considering more complex activities of daily living (such as cooking, managing finances, and running the home) the focus is on *change* in function. A person who has always relied on someone else to perform a particular activity should not be considered dependent for that activity if they've never had to do it before and may not know how.

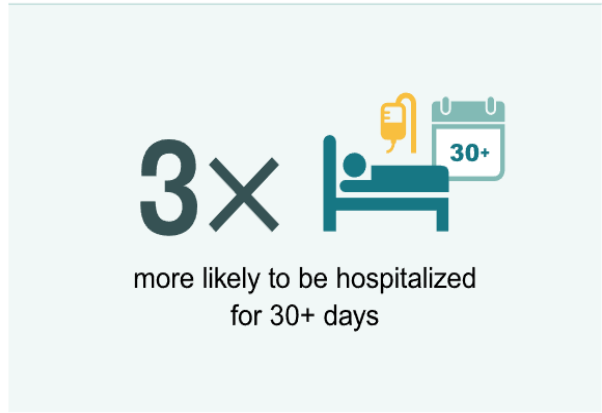
Kenneth Rockwood, Sherri Fay, Olga Theou & Linda Dykes
v1.0 9 April 2020

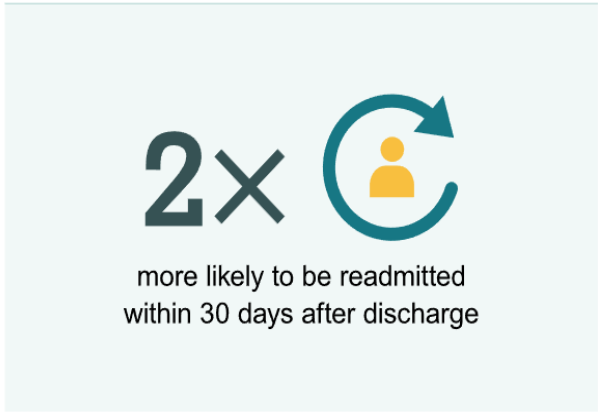
A profile of hospitalized seniors at risk of frailty in Canada

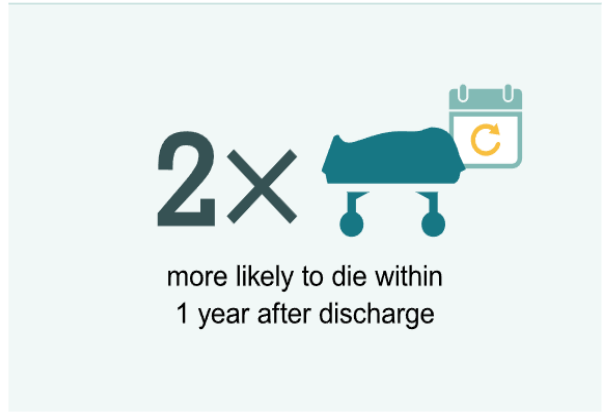


People who live with frailty are:









Data from Canadian Institute of Health Information, 2021.

Frailty matters because routine hospital care results in unnecessary disability and need for care.

- Unrecognized delirium Nutrition
- Mobility impairment
- Sleep deprivation
- IV's / catheters / lines in general
- Off load delays

Clinical Frailty Scale	Assessments	INTERVENTIONS AND INSTRUMENTS TO CONSIDER
1: VERY FIT 2. FIT 3. MANAGING WELL	CARE AS USUAL, SCREEN FOR AND ADDRESS REVERSIBLE ISSUES: Impaired nutrition Impaired sleep Impaired function: mobility, social withdrawal EARLY MOBILIZATION SLEEP HYGIENE ASSESS for DELIRIUM DOCUMENT BASELINE EXERCISE HABITS	MMSE as screen Free-Cog (or MoCA if copyright sorted). DELIRIUM in this setting likely marks severe illness, as does new decline in function, mobility or social engagement compared with baseline. DELIRIUM: SQiD, 4AT FUNCTION: PSMS\IADL. Important to document baseline function and how that has changed: the CGA for, lists the most important / least gendered but relevant information to gather.

4: LIVING WITH VERY MILD FRAILTY 5: LIVING WITH MILD FRAILTY **Frailty 3,4,5 and 6 are at the highest risk of losing their functional and cognitive autonomy when admitted to hospital.**	ACTIVELY SEEK OUT AND MANAGE GERIATRIC SYNDROMES – FALLS, COGNITIVE IMPAIRMENT, INCONTINENCE, POLYPHARMACY, FUNCTIONAL DECLINE, SOCIAL WITHDRAWAL REGULALR TOILETING IF MOBILITY IMPARIED ASSESS FOR DELIRIUM EARLY MOBILIZIATION SLEEP HYGIENE DIET AND NUTRITION EVALUATE NEED FOR FOOT CARE DISCUSS WITH PATIENT / FAMILY THE LEVEL OF FUNCTION REQUIRED FOR THE PATIENT TO RETURN HOME. DISCUSS WITH THE TEAM HOW LONG THEY THINK THAT WILL TAKE. SENIOR REVIEW FOR DISPUTES ABOUT DURATION OF REHAB, DISCHARGE DESTINATION, OR PROGNOSIS	CONSIDER CGA – ACCESS A GERIATRICAN OR HCOE PHYSICIAN WHERE AVAILABLE HABAM (Hierarchal Assessment of Balance and Mobility) DELIRIUM: SQiD (Single question in Delirium), 4AT (delirium screening tool)

Imagine a health condition that leads to the death of up to one-quarter of those hospitalized with it.

It's a condition that can convert an independent older person into one stuck in hospital awaiting a bed in a long-term care home. A condition that affects up to 25 per cent of older persons presenting to hospital, and is acquired by a further 25 per cent while in hospital. A condition that prolongs hospital stays, ties up beds and backs up emergency rooms.

The costs of this condition exceeded $160 billion in the United States alone in 2011. Finally, consider how this condition occurs in almost every hospital around the world, essentially making it a pandemic.

http://theconversation.com/preventing-delirium-protects-seniors-in-hospital-but-could-also-ease-overcrowding-and-emergency-room-backlogs-189220

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Recognizing delirium is likely our best hope for preventing dementia

The Bottom Line

- People cannot change how they get sick; we must change how we treat them.

- One way to reduce the burden on EDs and acute care, and prevent avoidable frailty is to develop alternative models for senior focused care in the Emergency Department.

- Frailty identification can help define the clinical threshold criteria for which patient qualifies for community paramedicine.

Role of Community Paramedicine

Community Paramedicine in partnership with multidisciplinary health care teams are an innovative way to improve patient outcomes and reduce system pressures through proactive, preventative and collaborative clinical care during admissions avoidance and supportive discharge

Improving Patient Outcomes

The Nova Scotia CP model of care focuses on:

- Taking a frailty informed approach to care to improve patient safety, and advocacy
- Improving timely access to community care post discharge
- Acting as a conduit between health care providers improving continuity of care and overall health outcomes
- Addressing the needs of each individual patient through collaboration, and partnerships within the overall health care system

Current Research

- A prospective study is in progress to identify core components/processes necessary for optimal implementation and integration with partner organizations
- Research is key to understanding outcomes and cost/benefit of such approaches
- Plan to conduct a larger trial of the supportive discharge services in future studies

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https://emspep.cdha.nshealth.ca/ParamedicEBPCourse.aspx

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