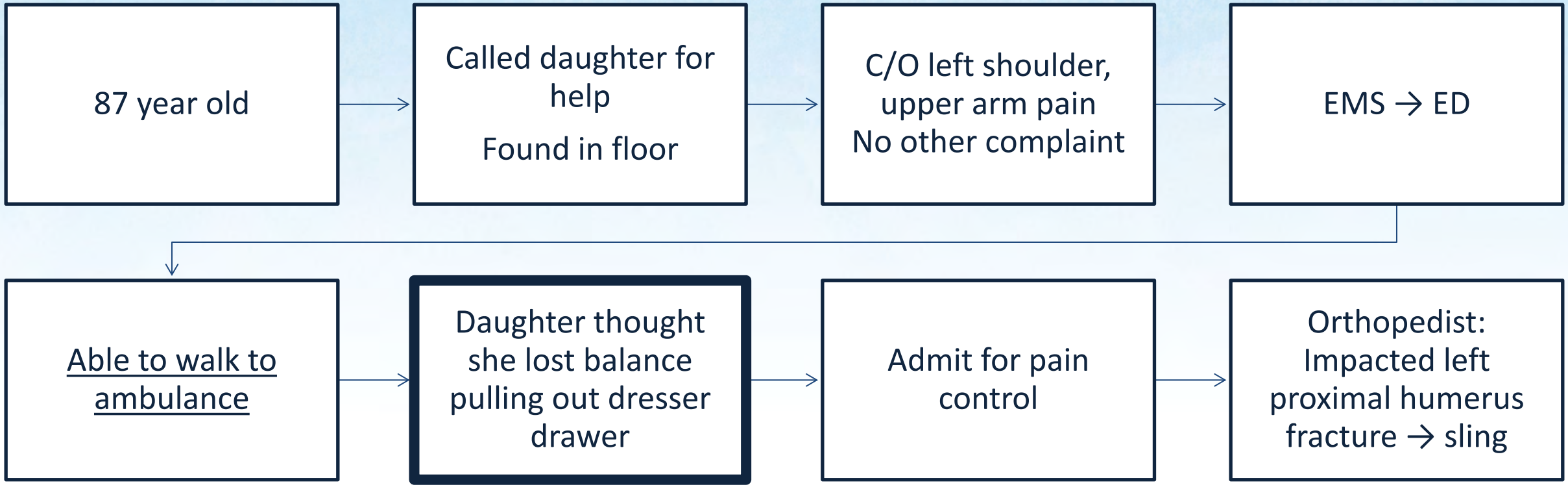
Frailty

A Unifying Concept for Care of the Older Adult

- KHA Quality Webinar
- November 7, 2024

Target Zero
Every Person. Every Time.

Helen



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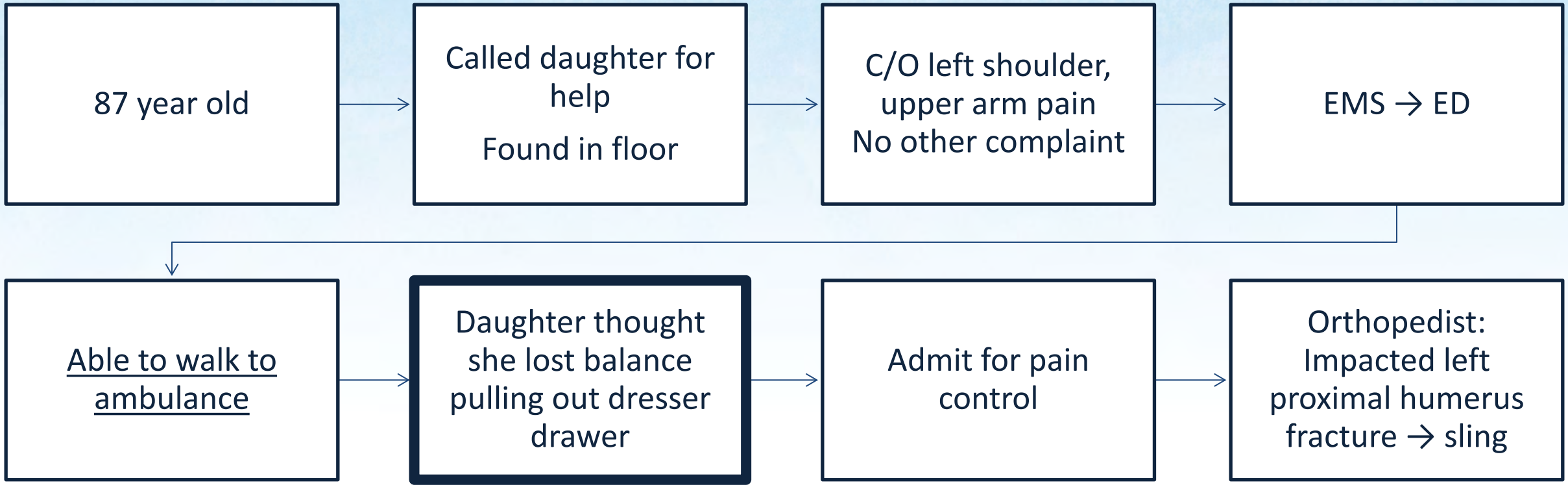

What problem(s) should we focus on?

Is Helen frail? Does it matter?

Target Zero
Every Person. Every Time.

Was Helen's outcome avoidable with <u>insight</u> into her frailty?

Target Zero
Every Person. Every Time.

CMS Age Friendly Structural Measure

Assesses hospital commitment to improving care for **patients ≥65**

Older Adult

≥65 years old → 100+ years old

Increasing rapidly

Federal Register: 8.28.2024

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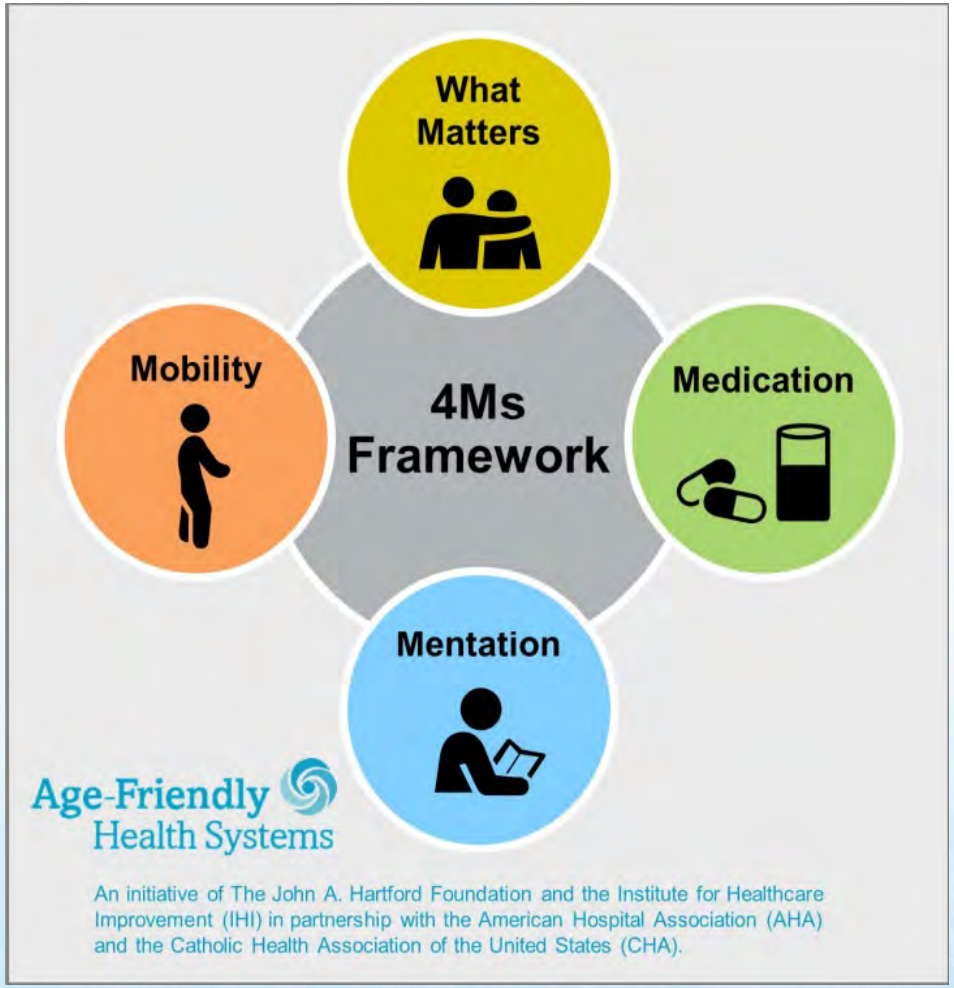

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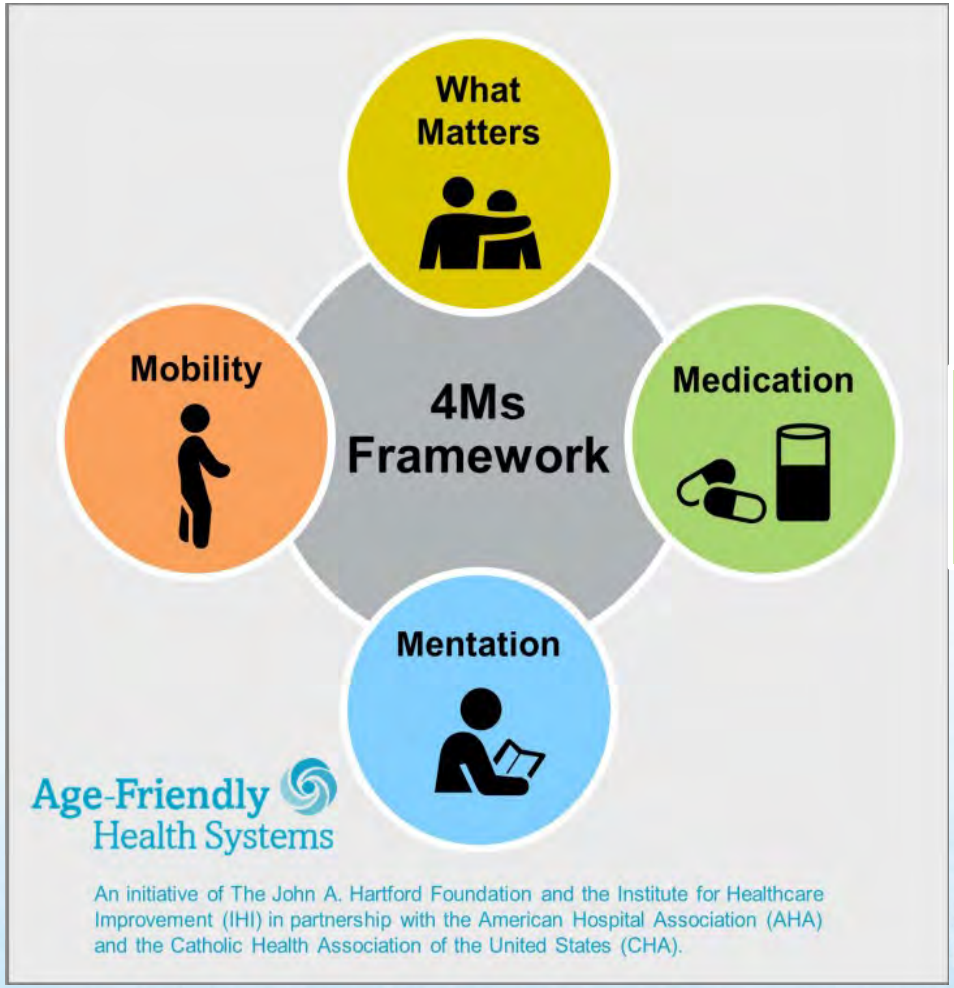
Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults (Fall 2022). Institute for Healthcare Improvement (IHI)

Domain 5
Age Friendly Care Leadership
(Commitment)

Domain 4
Social
Vulnerability

Domain 1
Eliciting Patient
Healthcare Goals



Domain 3
Frailty Screening
& Intervention

Domain 2
Responsible Medication
Management

Federal Register: 8.28.2024

Target Zero
Every Person. Every Time.

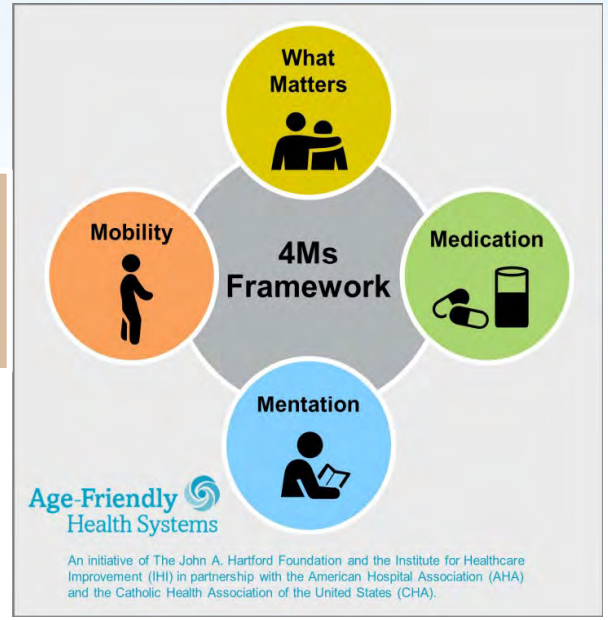
Domain 3: Frailty Screening & Intervention

Screen patients for geriatric issues related to **frailty** for the purpose of early detection and intervention, including…

- ❑ malnutrition
- ❑ physical function / mobility
- ❑ cognitive impairment / delirium

Malnutrition
Mobility
Mentation

Domain 3
Frailty Screening & Intervention



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Frailty = vulnerability

An increased risk of poor outcomes due to physiologic **vulnerability** to stress

Hospital management of older adults. Author Melissa Mattison, MD, **SFHM.** Literature review current through: Jan 2016. | This topic last updated: Jun 15, 2015. UpToDate. Accessed February 7, 2016
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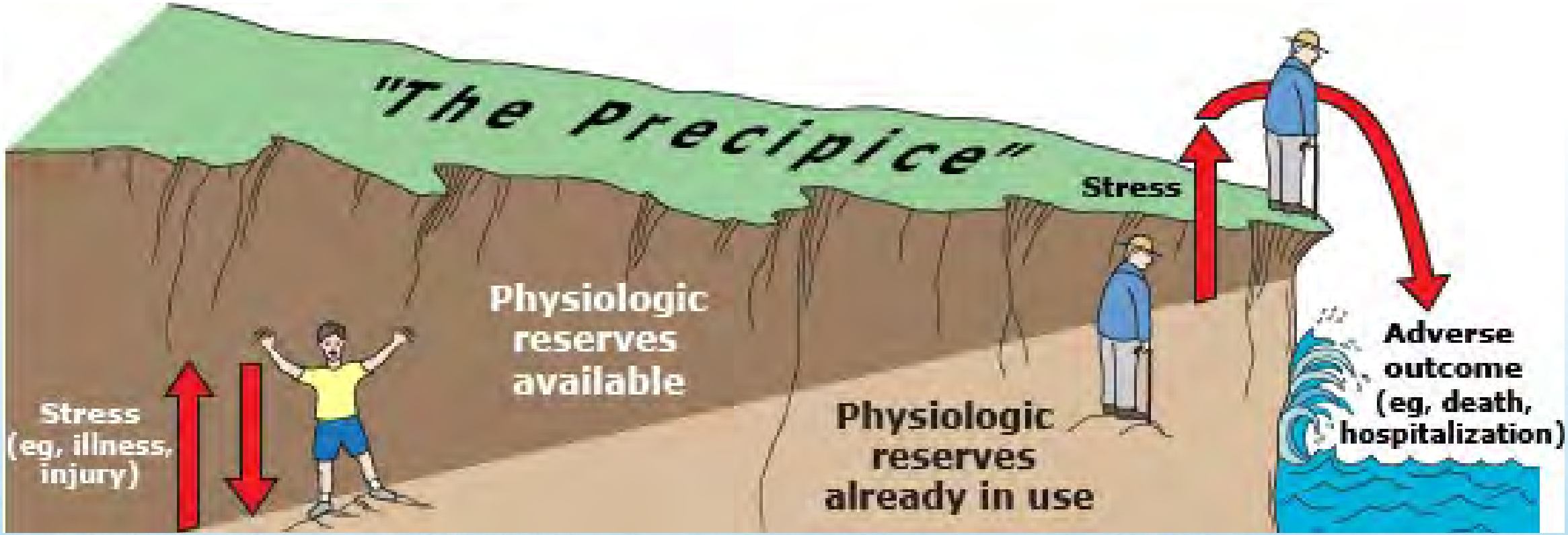

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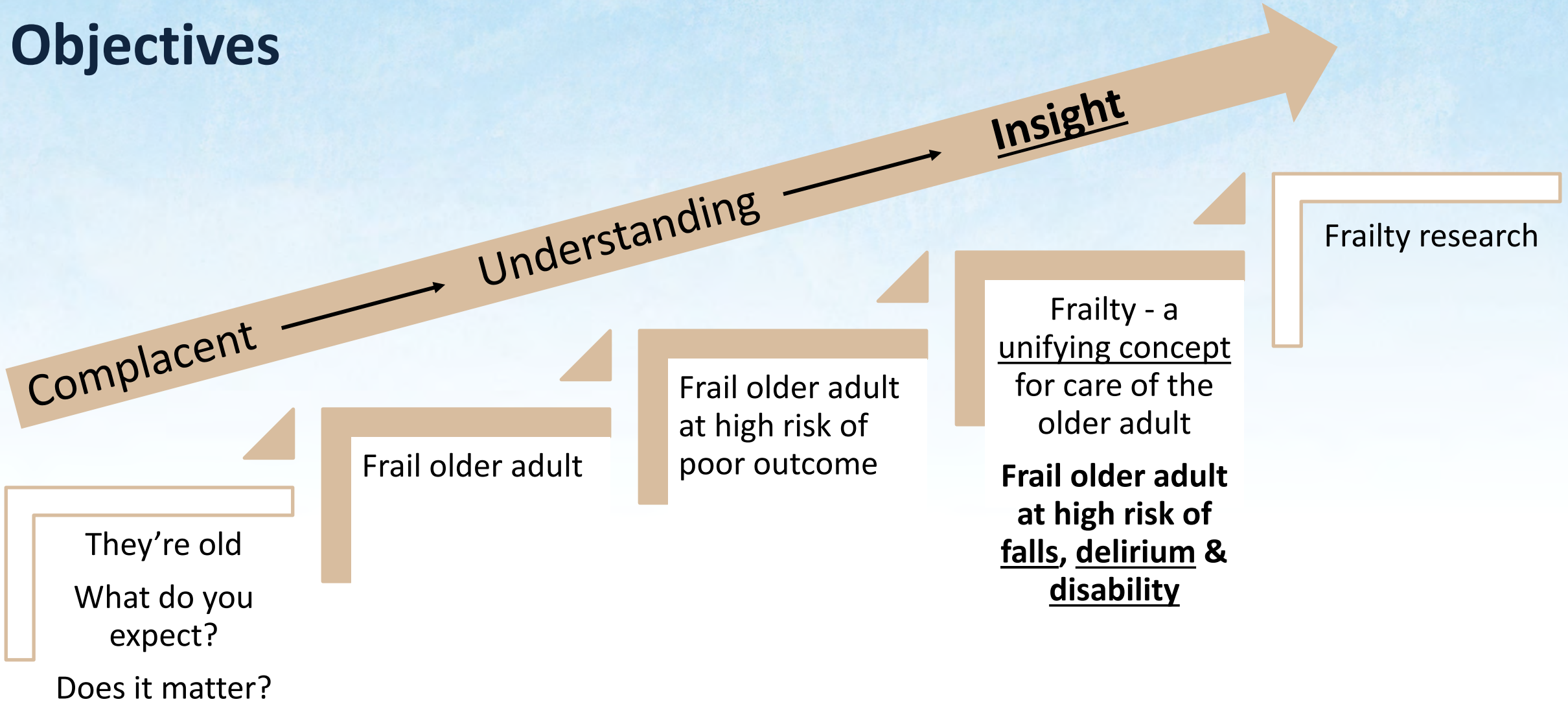
Objectives



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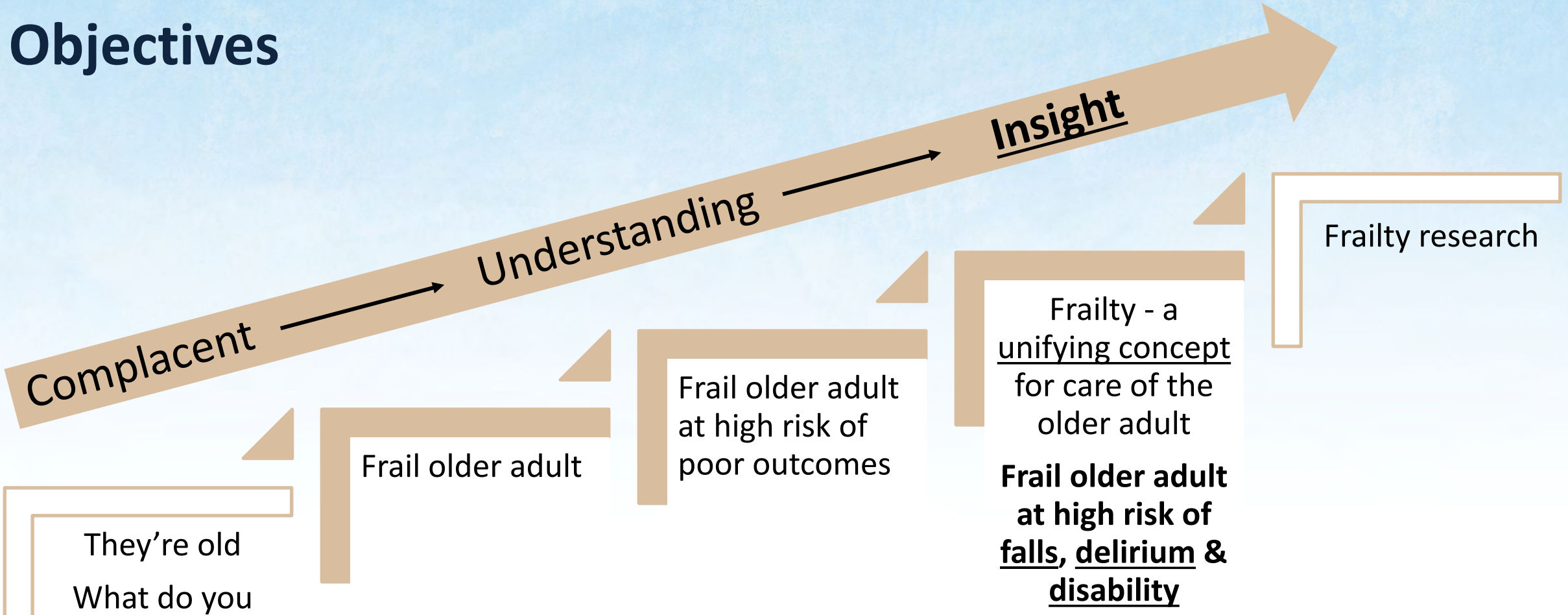

Frailty represents one of the most critical issues facing health care due to its inherent relationship with poor health care outcomes

Robinson et. al.

Target Zero
Every Person. Every Time.

Two Frailty Models

1. **Phenotypic Frailty Model** - Physical Frailty

- Fried Screening Tool
  1. Unintentional weight loss
  2. Grip strength weakness
  3. Slow walking speed
  4. Self-reported exhaustion
  5. Low activity levels

3-5 = Frail

1-2 = Pre-frail

0 = Not frail (robust)

Gait speed is a highly reliable single measurement tool

- 5 meter walk
- Timed Up & Go Score

Phenotype= physical or behavioral traits

Robinson et. al.

Two Frailty Models

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2. Cumulative Deficit Model

- Number of medical, social, & functional deficits → **Frailty Index**

Phenotype= physical or behavioral traits

Robinson et. al.

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly 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 very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – 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 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People 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 Severely Frail – 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 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.

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

physical frailty

physical frailty

cognitive frailty

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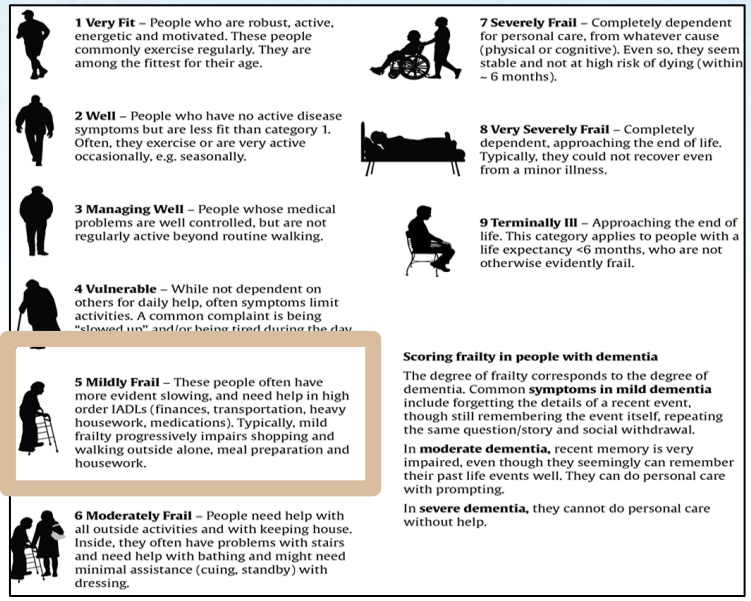
Adapted from: Athanase Benetos. Circulation Research. Hypertension Management in Older and Frail Older Patients, Volume: 124, Issue: 7, Pages: 1045-1060, DOI: (10.1161/CIRCRESAHA.118.313236)

Case Management & Physical Therapy: per Daughter

DME:

- Rolling Walker (RW) at times
  - Uses RW when it's nearby and if she remembers it;
  - Usually ambulates without assistive device
  - Shower seat and grab bar
- No fall in the past month

physical frailty



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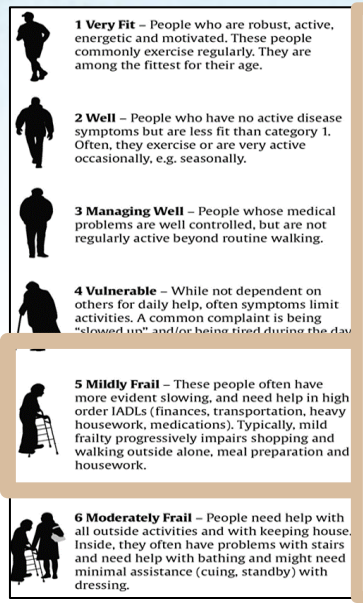

- **Living with mild frailty**
  - More **slowing**
  - Needs help with high order iADLs
    - finances, transportation, heavy housework, etc.
  - Frailty progressively impairs shopping and walking outside alone, meal preparation, and medications, and begins to restrict light housework

Case Management & Physical Therapy: per Daughter
Unable to recall event - states she did not fall
Named month correctly - Unable to recall year
Oriented to self & place

Knew she had a fall but unable to identify she broke shoulder
Follows commands 100% with increased time and repetition

<u>Important</u>
she's in the hospital
What is her baseline?

Case Management & Physical Therapy: per Daughter
Unable to recall event - states she did not fall
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Important
she's in the hospital
What is her baseline?

Able to identify time at home as she writes her own checks (iADL)
Daughter orders Ensure for her (a higher order iADL)
Chronic short term memory problems
Daughter states this is normal for her

***This is her baseline!**

Case Management & Physical Therapy: per Daughter
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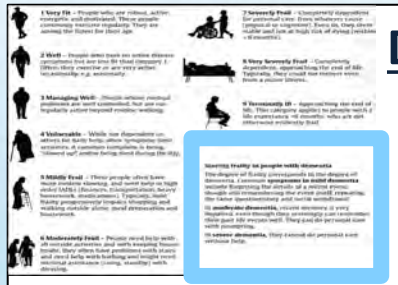
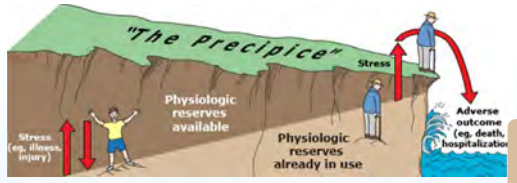


<u>Degree of frailty generally corresponds to the degree of cognitive impairment</u>

- **Mild Cognitive Impairment (MCI)**
- Mild dementia
- Moderate dementia
- Severe dementia

cognitive frailty



physical frailty

Physical frailty is associated with increased risk of delirium and reduced survival

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nnot personal care

Mind – Body Connection!!

cognitive frailty

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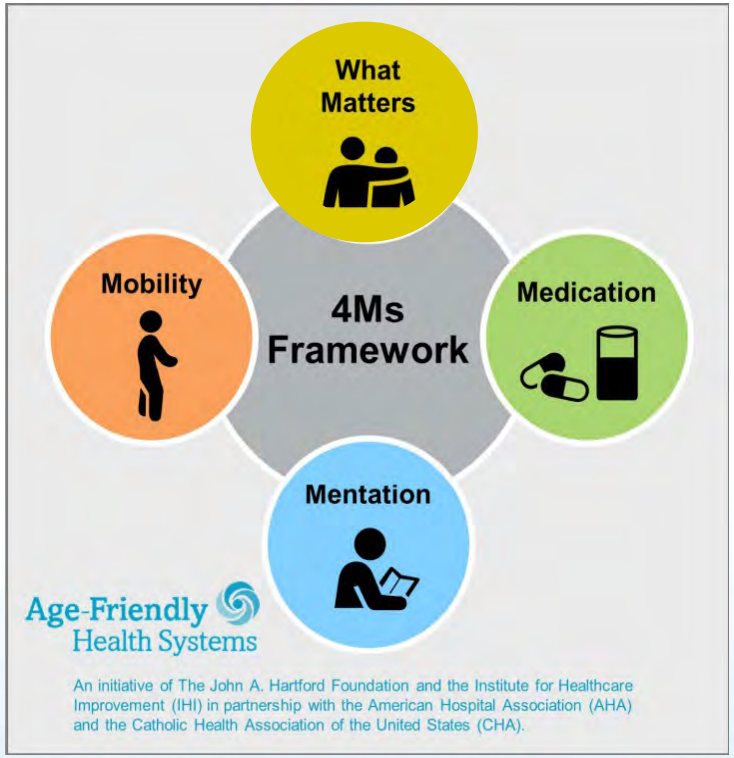
Dimensions of Frailty

- Social *Vulnerability*
- Nutritional *Vulnerability*
- Physical *Vulnerability*
- Cognitive *Vulnerability*

Domain 4 Social Vulnerability

Domain 3 Frailty Screening & Intervention

- Malnutrition
- Mobility
- Mentation



The combination of frailty and delirium identified elderly at especially high risk of poor outcomes

Federal Register: 8.28.2024
Clegg et al.

Lives independently except driving

Transportation per daughters

Daughters take turns staying overnight in her home

Daughter(s)…

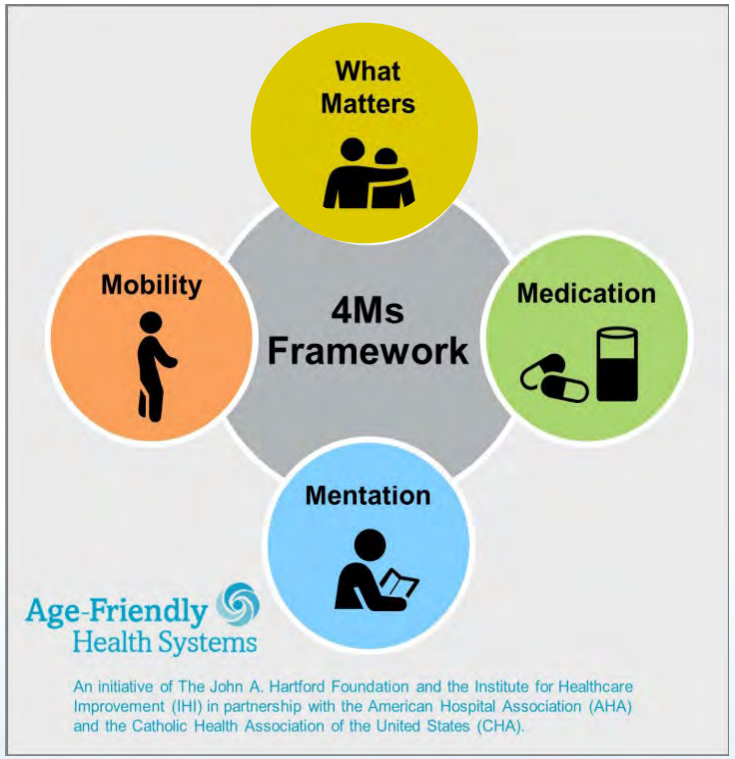
…at bedside …attentive at bedside

…participating in bedside report …morning rounds

Domain 4

Social

Vulnerability



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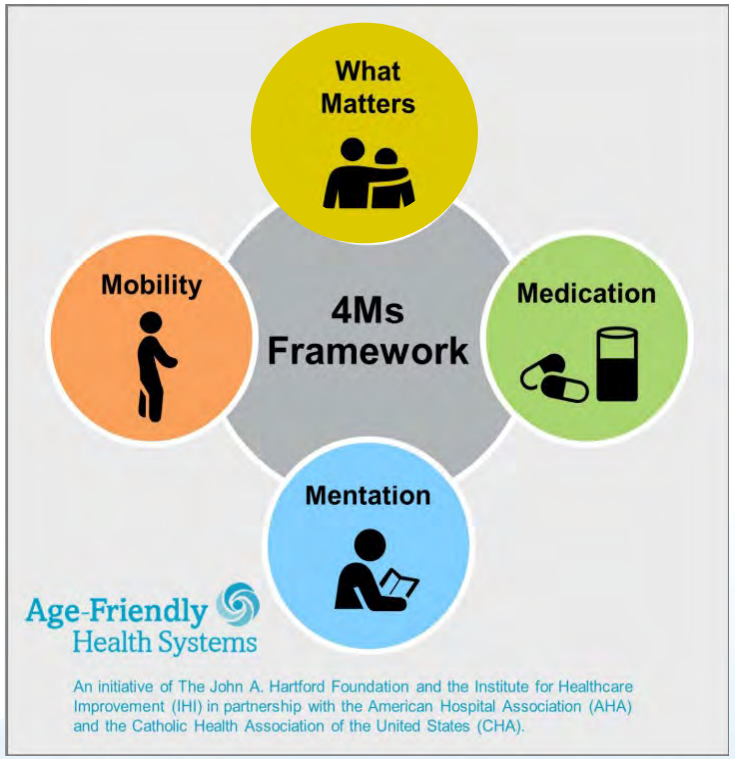


Nutritional *Vulnerability*

Malnutrition

Domain 3
Frailty Screening & Intervention

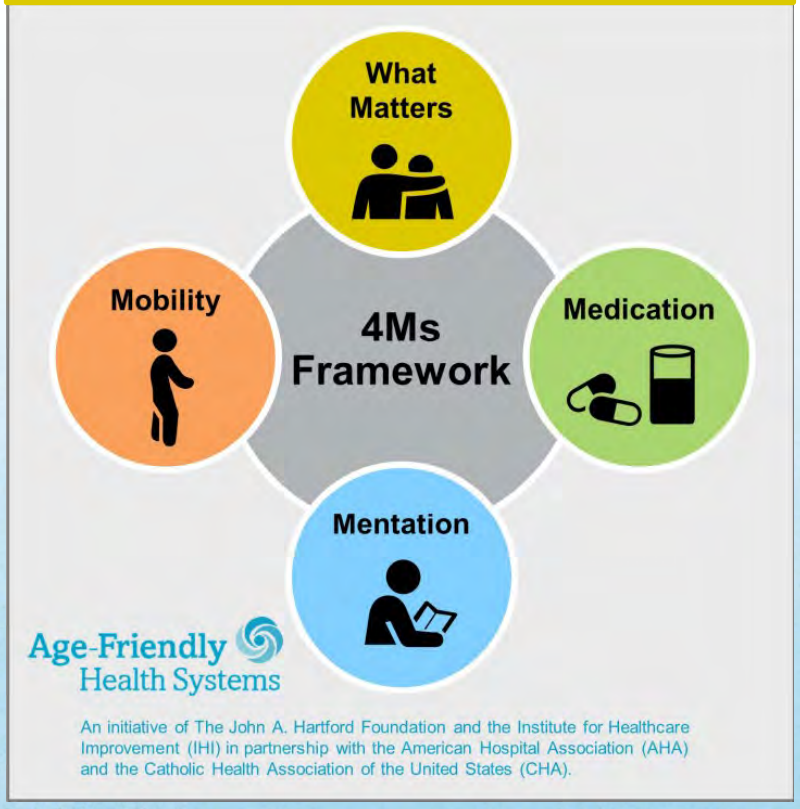
Her nutritional status at admission

- 130 lb. Body mass index: 21.63 kg/m²
- Protein 7.3
- Albumin 4.1
- Hemoglobin 11.3 Low

Domain 1: Eliciting Patient Healthcare Goals

Return home alone

Know and align care with each older adult's health outcome goals and care preferences…



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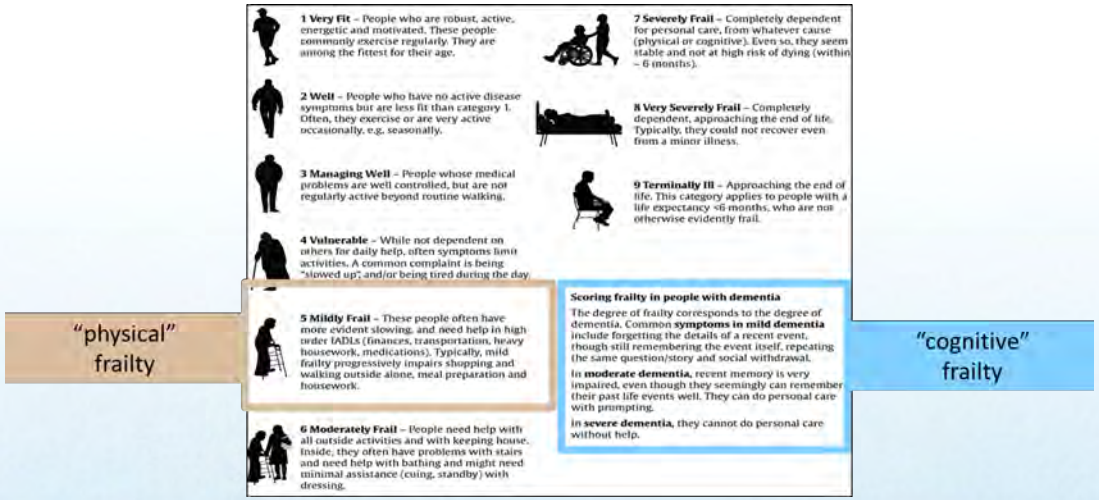

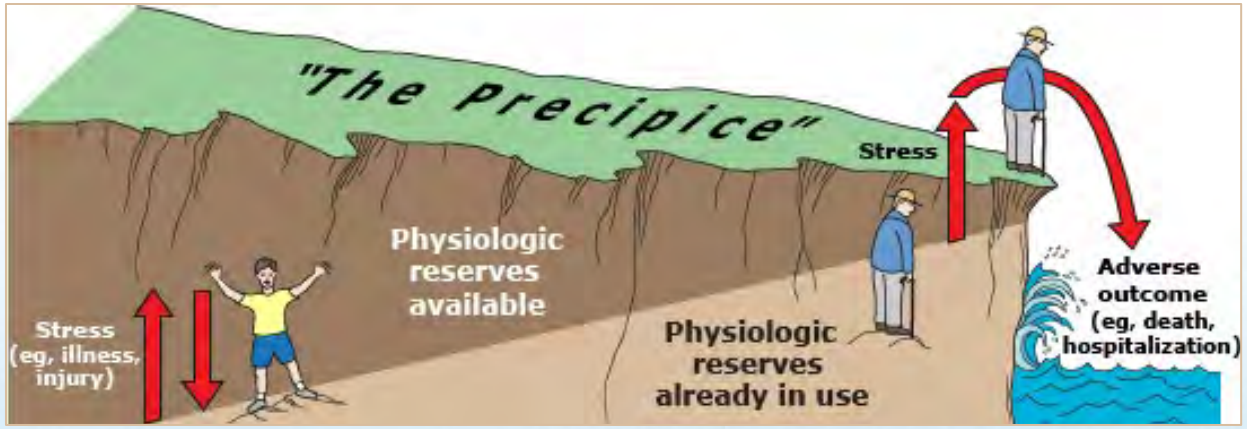

Domain 3: Frailty Screening & Intervention

Frailty is a dynamic process

Clegg et al.

Complexity

Care becomes more complex

Hospitals are not prepared for this complexity

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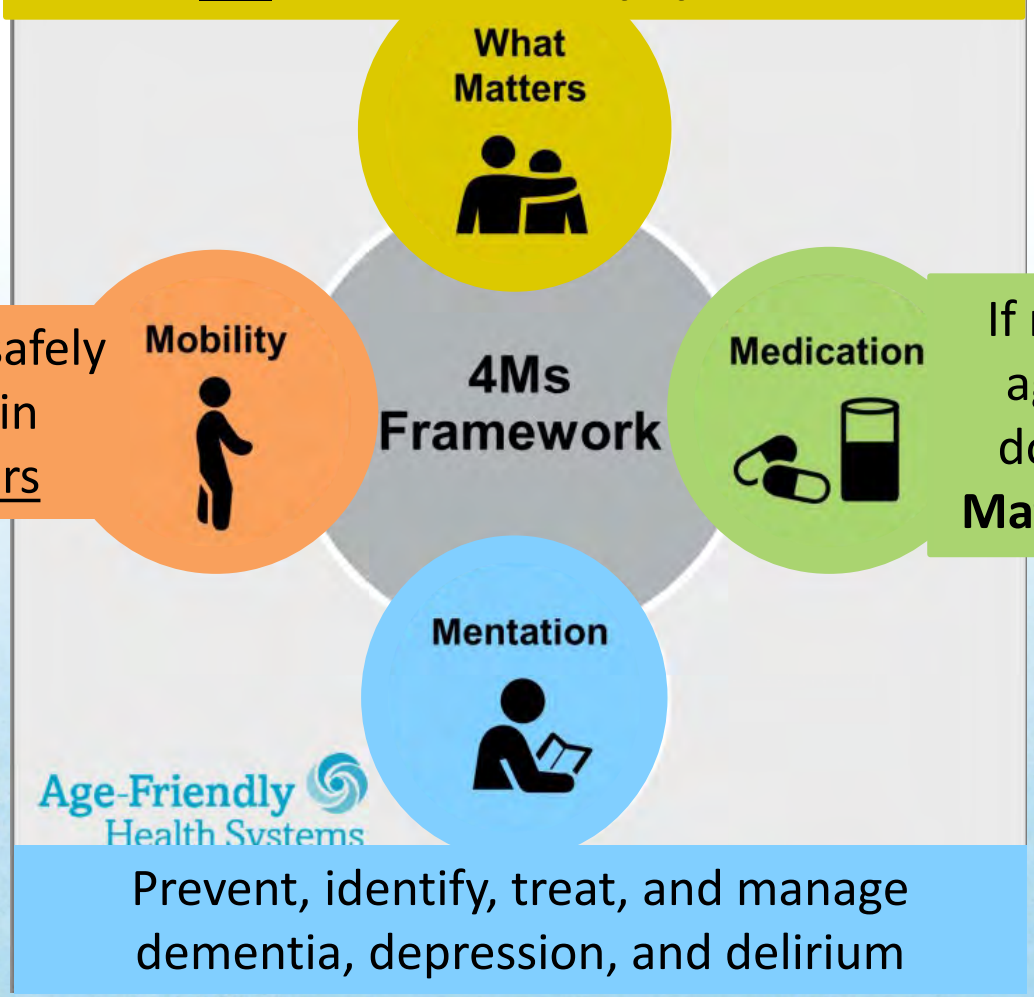
Return home alone

Know and align care with each older adult's health outcome goals and care preferences… *not limited to end-of-life care*

Ensure that older adults move safely every day in order to maintain function and do What Matters



If medication is necessary, use age-friendly medication that does not interfere with **What Matters**, **Mobility**, or **Mentation**

Prevent, identify, treat, and manage dementia, depression, and delirium

4Ms

A holistic care bundle

Return home alone

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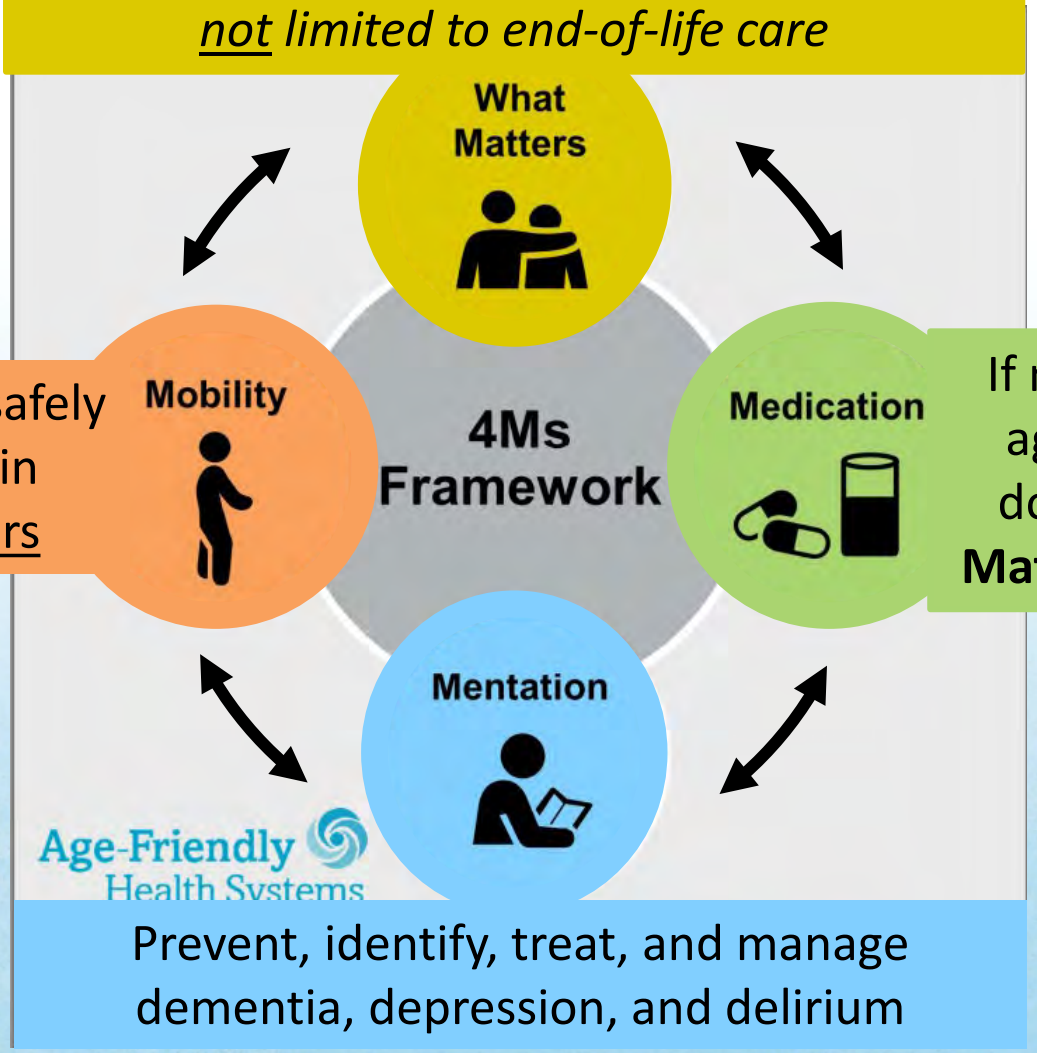

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If medication is necessary, use age-friendly medication that does not interfere with **What Matters**, **Mobility**, or **Mentation**

Prevent, identify, treat, and manage dementia, depression, and delirium

History & Physical

- History
  - No CP, SOB, syncope, lightheadedness, head trauma
  - Coronary Artery Disease with stent – Myocardial Infarction 2018
  - Paroxysmal Atrial Fib - anti-coagulated
- Examination
  - Appears stated age; thin weight, no acute distress
- Admission Lab (selective)
  - BUN 30 (H)
  - Creatinine 1.4 (H)
  - Hemoglobin 11.3 (L)

History & Physical

- Awake, alert, oriented x3
- Demonstrates insight into illness
- CKD 3b: eGFR 36 mL/min
- Slightly elevated BUN - maybe slight acute worsening renal function
- Keep on fluids – trend creatinine
- Delirium prophylaxis ⟷ Mentation
  - Geriatric so discourage day time naps, lights on during, tv on and opposite at night to ensure sleep hygiene; limit sedatives as able

Plan

- NPO at midnight
- Strict bed rest with head of bed flat
- O2
- Telemetry
- IV fluids maintenance 24hrs then re-assess
- IV Protonix → PO for 14 days
- Prophylactic constipation management
- **Resume home meds** except anticoagulants

Plan

Care becomes more complex

- NPO at midnight
- Strict bed rest with head of bed flat
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Restrictive Diet

Restricted Activity

Tethers

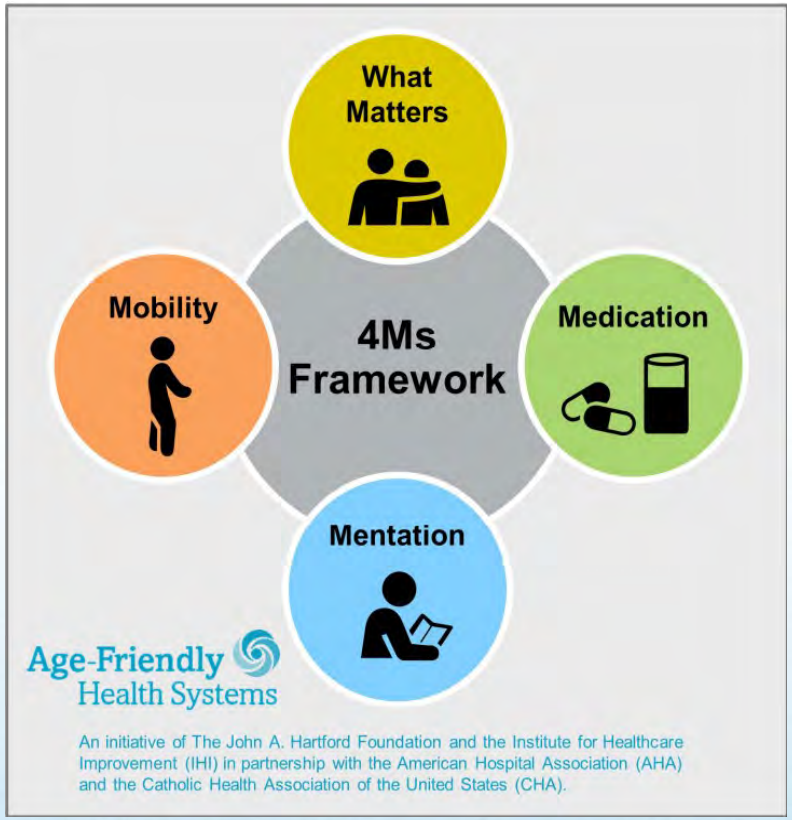
Medication

Hospitals are not prepared for this complexity

Day 1+ “What Matters”: Plan of care → Getting better (X3) → Get to SNF (X2)

Nurse

Mobility/Activity Orders
(blank entire hospitalization)



Mobility Day 1 - Her Baseline (consider hospitalized with shoulder fracture)

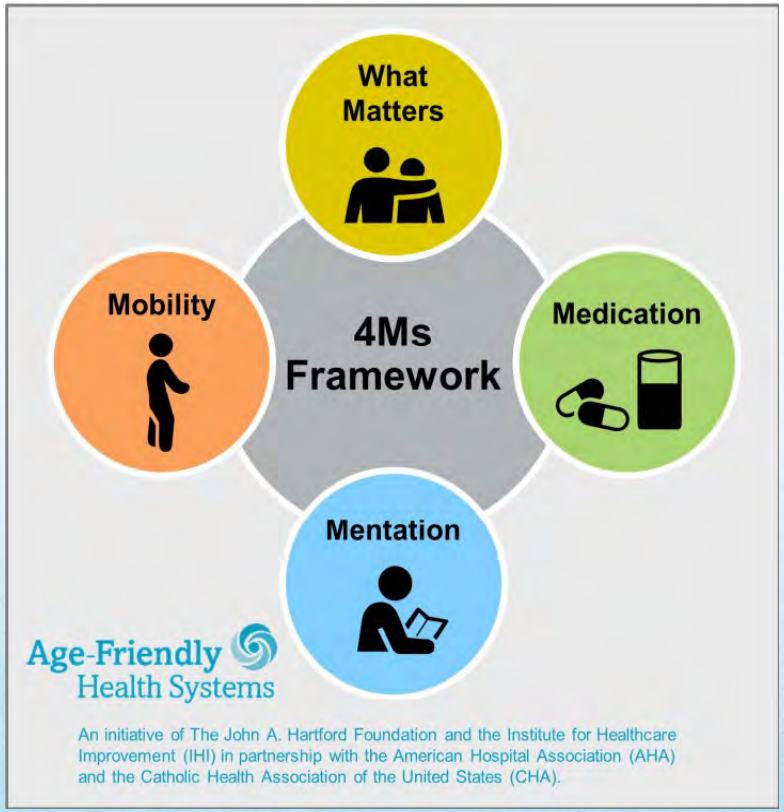
Physical Therapy

Ambulation

- Assist partial (Min - Moderate) x 1+1 for safety, for lines
- Distance: 20 ft - 10 ft - HHA x1, gait belt
- Decreased gait speed in room & to bathroom.
- Posterior & left lateral lean that improved with ambulation: Mod Assist

Balance:

- Sitting & Standing: Fair
- Can maintain static/dynamic standing balance w/mod assist transitioning to min assist & HHA x1
- No signs of loss of balance
- Max x2: sup>sit transfer due to increased shoulder pain
- As distance increased, patient required min assist and was able to ambulate with HHA x1



Mentation

Day 2

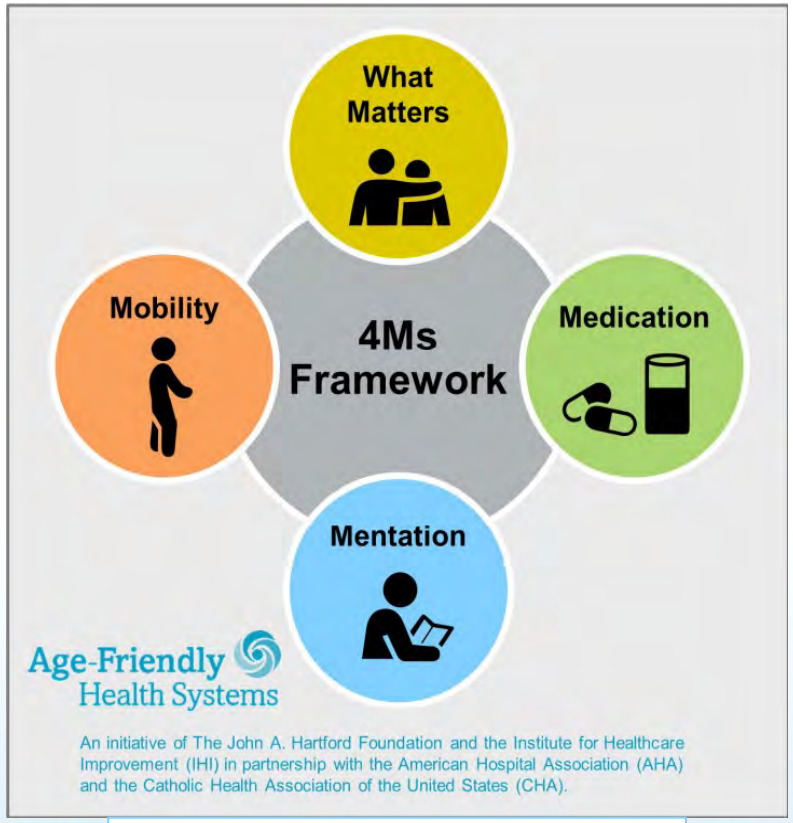
OT & PT

AM

- RN asked to hold PT/OT this AM because sleeping & did not sleep last night & very confused

PM

- **Increased confusion possible delirium**
- Asleep in recliner & unwilling to participate



Nurse

Patient confused

Confused at baseline

Delirium positive

Up in chair most of night

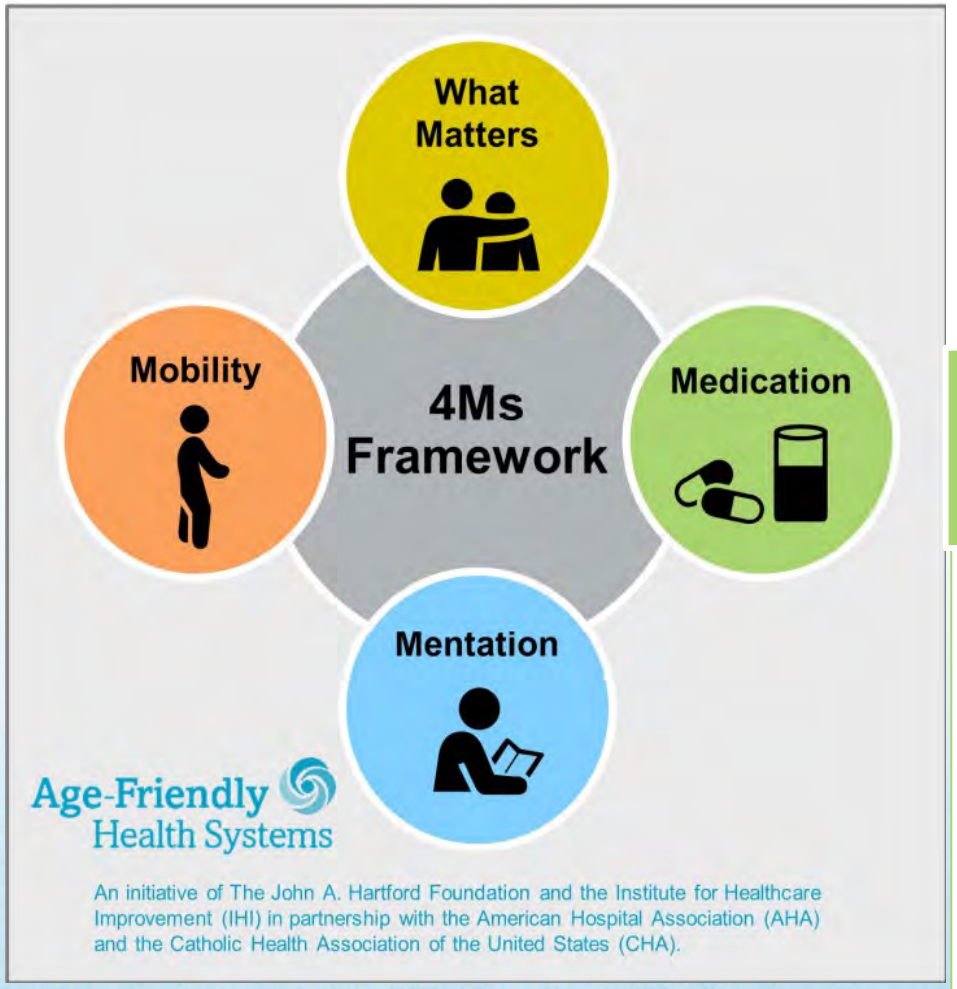
APRN/Physician

Mildly confused, awake

Delirium prophylaxis:

- Geriatric so discourage daytime naps, lights on, tv on, opposite at night to ensure sleep hygiene
- Limit sedatives as able

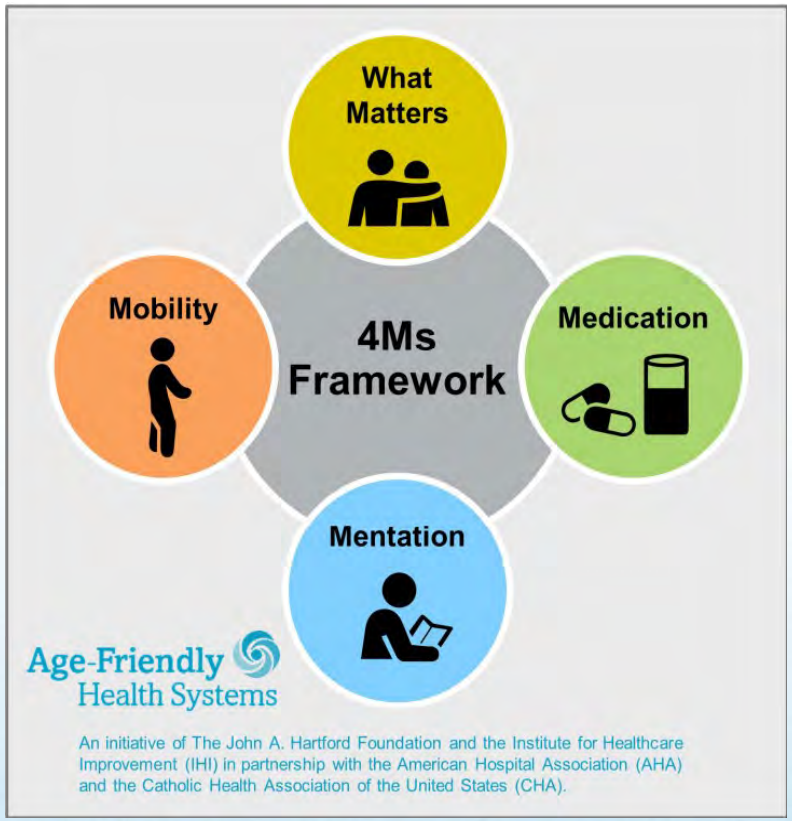
Home Medications



Domain 2
Responsible Medication Management

Nitroglycerin 0.4 mg SL PRN
apixaban (ELIQUIS) 2.5 mg 2 times daily
furosemide (LASIX) 40 mg daily
spironolactone (ALDACTONE) 25 mg daily
K-DUR 20 mEq daily.
carvedilol (COREG) 3.125 2 times daily
atorvastatin (LIPITOR) 40 mg daily
sertraline (ZOLOFT) 25 mg daily.
ferrous sulfate 325 mg daily
B-12 1000 mcg daily

Day 1-2



Day 1
Heart Rate: [**58-78**] 58
BP: (**105**-147) / (**43**-99) **105/46**

Day 2
Heart Rate: [62-67] 66
BP: (**91** - 145) / (**31**-50) **117 / 40**

Creatinine: 1.4 → 1.1

Low BP

- received 1L fluids
- BP slowly increased
- BP meds held this AM (Day 1)

FRIDs (Fall Risk Increasing Drugs) (from her home med list)

- **Polypharmacy**
- **Furosemide (Lasix)**
- **Sertraline (Zoloft)**

- Unclear
  - Carvedilol (Coreg)
  - Spironolactone
  - Atorvastatin

Medications are one of the most modifiable risk factors for falls

Huang et. al.

Huang et al.

Target Zero
Every Person. Every Time.

Medication: If medication is necessary, use age-friendly medication that does not interfere with **What Matters**, **Mobility**, or **Mentation**

Resume home meds except spironolactone

apixaban (ELIQUIS) 2.5 mg 2 times daily
furosemide (LASIX) 40 mg daily
spironolactone (ALDACTONE) 25 mg daily
K-DUR 20 mEq daily
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PRN Nitroglycerin 0.4 mg SL PRN

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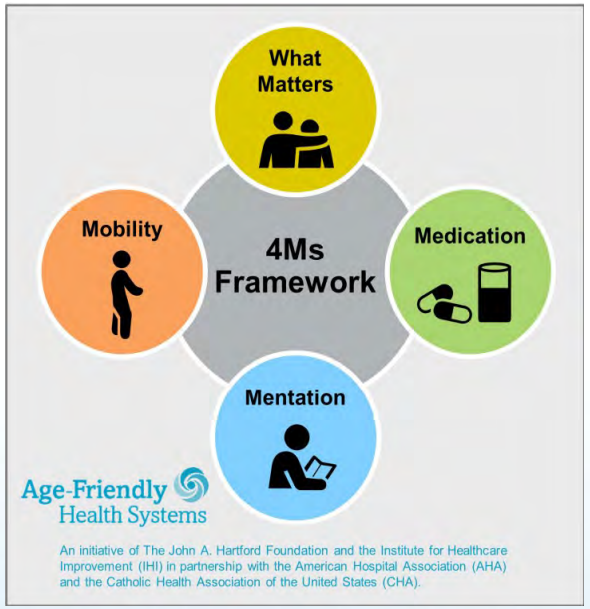
Day 3-4-5

PT

- Ambulated hallway HHA
- very slow cadence
- Unsteady
- No LOB
- Fatigue
- Forgetful - Requires frequent repetition of instruction

Incontinent → Purewick

Tether



APRN/Physician

Day 3

HR: [65-81] 65

BP: (114-162)/(42-62) 125/56

Awake

Mildly confused

Day 5

BP 116/45 (Lying)

Pulse 66

NAD, sitting in chair, eating breakfast

Medically stable for discharge

Alert, oriented x3

Nurses

Confused → **pleasantly confused** (X2) → Intermittent confusion (X3)

Delirium present → yes → yes → no → →→→→→

Delirium prophylaxis:

- Geriatric so discourage daytime naps, lights on, tv on, opposite at night to ensure sleep hygiene
- Limit sedatives as able

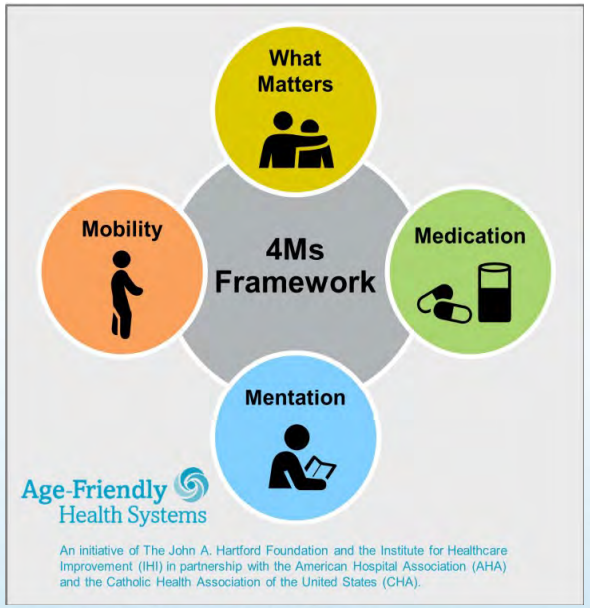
Day 5

PT

- worked on stop/go, backward, side steps left/right, increase/decrease speed, picked up object from floor, turning 180° left/right, up on toes x 5 all with touch asst
- No fatigue

Balance:

- Able to sit unsupported - slightly unsteady at beginning
- Slightly unsteady with standing balance challenges.
- No overt loss of balance
- Some dizziness with turning 180°



BP **114/55** (Lying)
Pulse 73
No distress
Sitting up in bed

Normal affect, alert, oriented x3

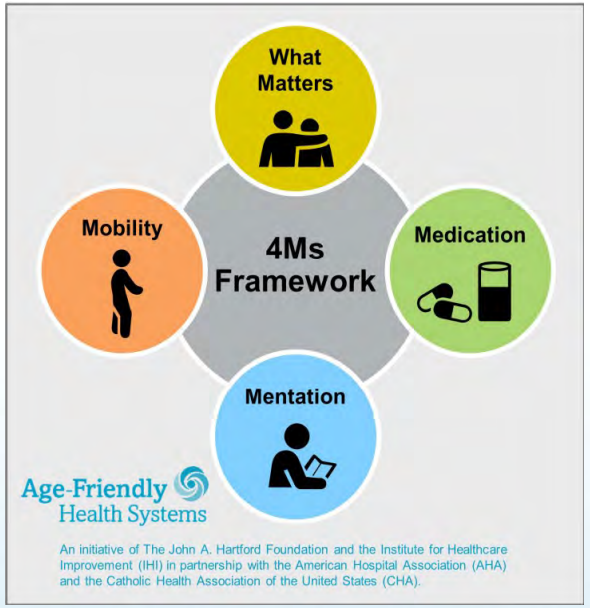
Day 6-7

Report called – transport called - Found on floor

Right Hip Fracture

Orthopedist

- **Nondisplaced periprosthetic fracture of intertrochanteric region**
- Previous right hip arthroplasty
- Pivot transfer only due to shoulder fracture with toe touch weight bearing



APRN/Physician

BP 107/50 Lying

Pulse 77

No distress, sitting up in bed

Forehead hematoma

Hold home Lasix & spironolactone for now given borderline BP with creatinine slightly up at 1.3

Some confusion this AM

Normal affect

Alert, oriented to person only

Day 6-11

Hip x-ray: Obscured by <u>bowel gas & feces</u>

Encouraged to eat

Dietician

- Inadequate intake: <50% - very little lunch
- **<u>Very thin and frail</u>**. **<u>No edema</u>**

Day 7

- Encouraged to drink
- Assisted with supper – ate only a few bites

Day 8

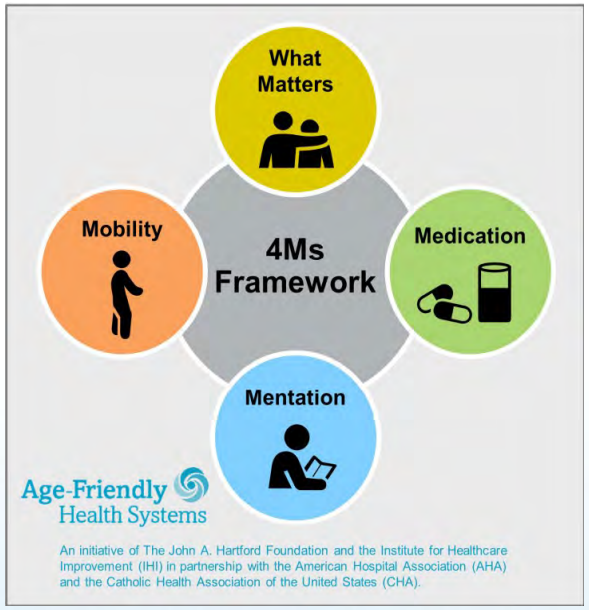
- Bedrest - using bed pan

Day 10 AM

- 1 BM

Day 11

- Needing to use toilet most of shift
- On bedpan & bedside commode x2
- Contacted doctor for KUB & bowels



APRN/Physician

BP 119/55 | Pulse 77

Holding spironolactone - borderline BP with creatinine 1.3

Restart Lasix

Confused, awake

What Matters: rest → rehab → Plan of Care → get better → **awaiting placement**

Day 7

Pleasantly confused

Can make needs known most of time

Delirium - No

Day 8

Intermittent confusion at baseline

Alert, oriented x2-3

Delirium No

Day 9 PM

Confused

up in chair

blinds open facing outside

Delirium No

Day 10 AM

Very confused tonight

Trying to get out of bed frequently.

Delirium No

Day 10 PM

Keeps going on and she's been trying to climb out of bed

Moved rooms

Day 11 AM

Remains confused

Asks the same question again and again

Very forgetful

Target Zero
Every Person. Every Time.

Day 10

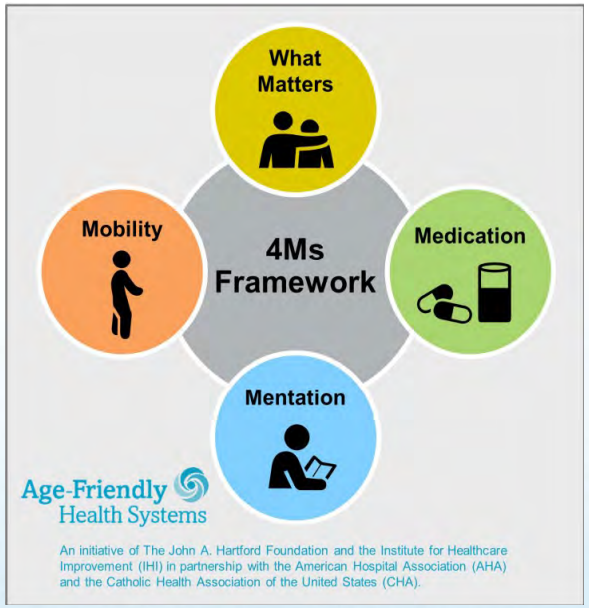
OT

Declines:

- Fluids
- Breakfast tray
- Oral care
- Personal Hygiene

Substantial / Max Assist (x2) for:

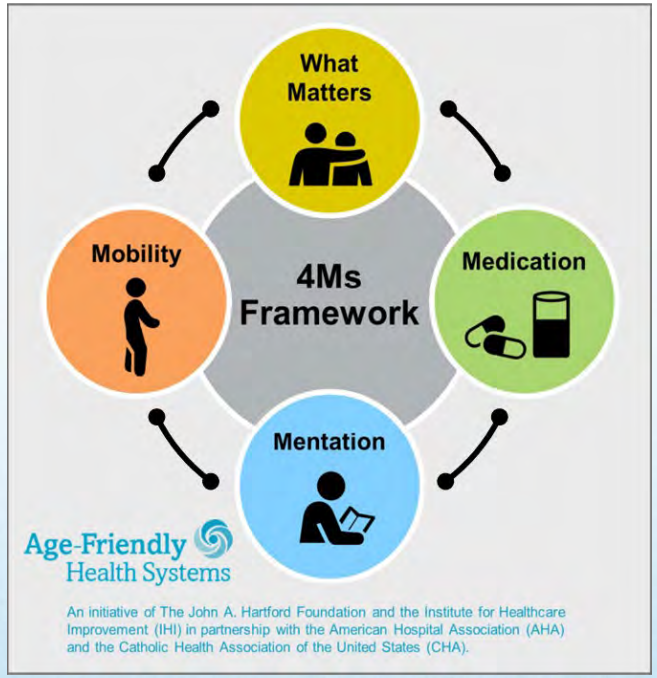
- UB Dressing
- Footwear
- LB Dressing
- Toilet Transfer
- Toileting



- ROSS:
  - General: - No weight loss or gain. No fever, chills, night sweats
  - Cardiovascular: No chest pain, palpitations
  - Respiratory: No cough, hemoptysis
  - Gastroenterology: No nausea, vomiting, diarrhea, constipation.
- BP **123/49** (Lying) |Pulse 71
- Elderly, no distress, awake, alert, appears stated age, in chair
- **CHRONIC/RESOLVED/STABLE**
  - A-fib - carvedilol, apixaban
  - CKD-3 - Monitor BMP, on furosemide; home spironolactone on hold
  - Iron deficiency anemia – ferrous sulfate
  - Hyperlipidemia – atorvastatin
  - Depression – sertraline
  - FEN/ppx:
    - F: none
    - E: monitor and replace as above
    - N: regular
    - DVT Prophylaxis: apixaban

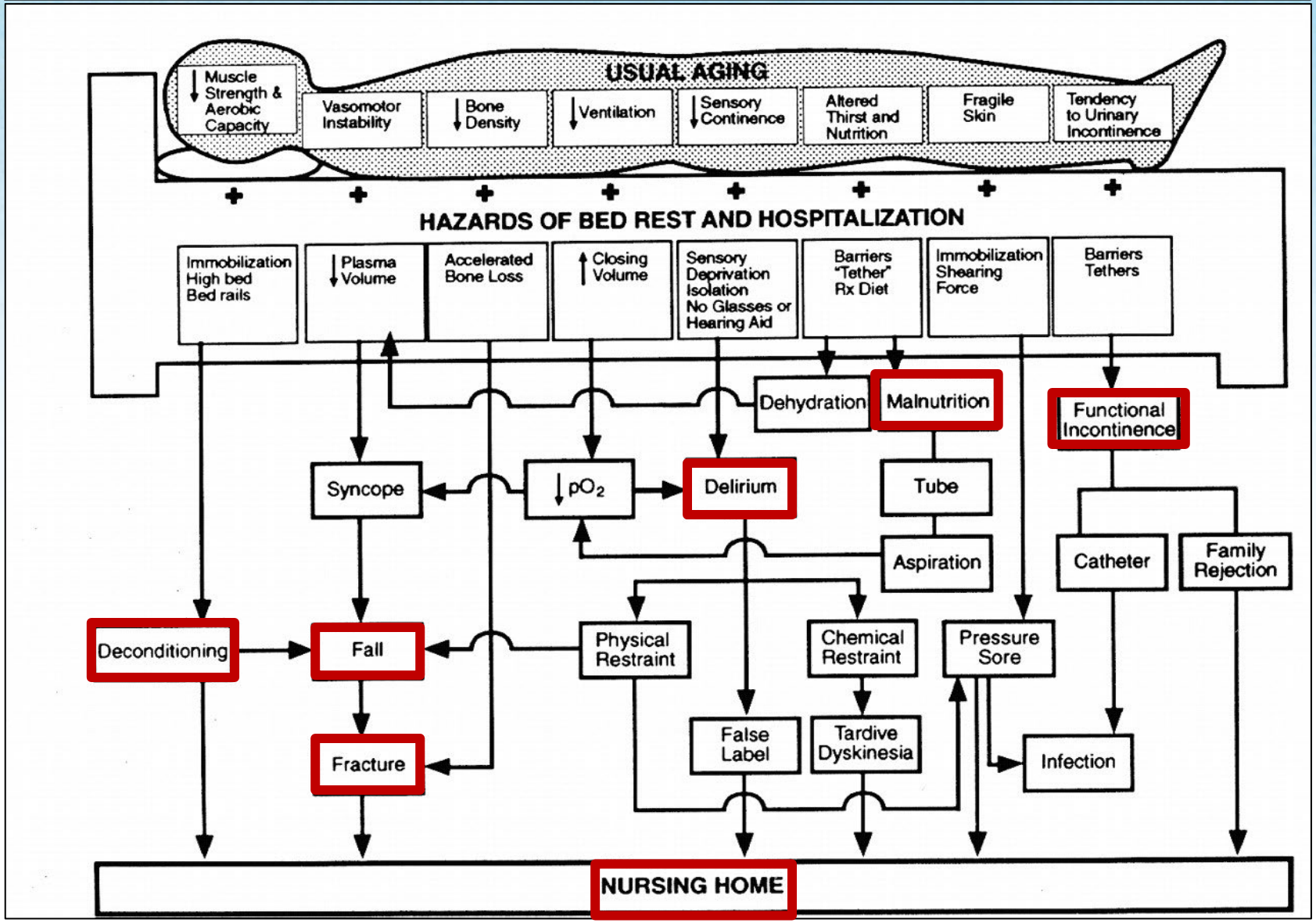
Return home alone → Awaiting Placement

Return home alone → Awaiting Placement



If our care team ever truly appreciated what her mental and physical baseline was, then it was lost in the midst of many shift changes and handoffs. The fact that she lived semi-independently at home with some short-term memory loss, yet able to pay her bills with checks, was quickly forgotten by everyone. Lacking insight into the significance of her frailty, we just saw a pleasantly confused older adult in the hospital bed who was at her baseline, instead of recognizing her delirium. She's simply old, frail, confused and now constipated. This is the way it is with older patients.

Hospitals are not prepared for this complexity



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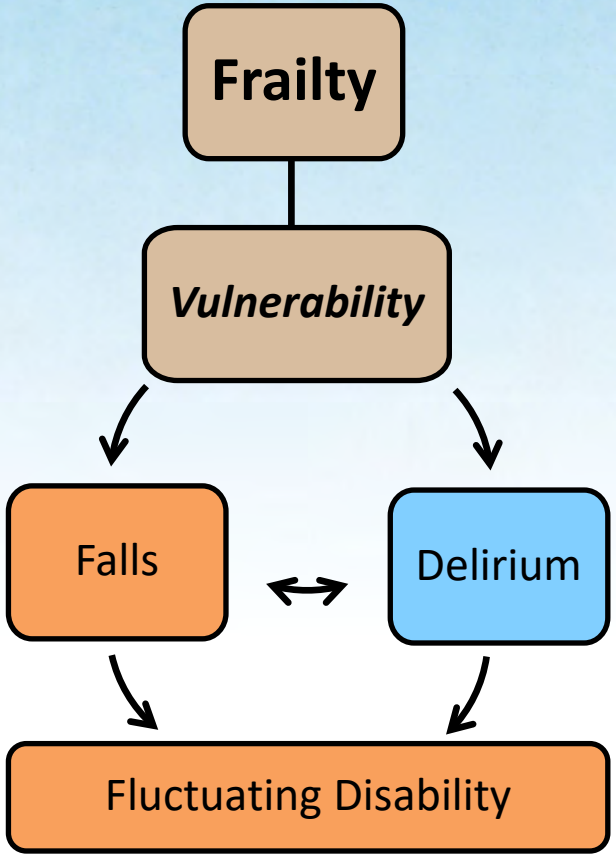

Frailty in elderly people. Andrew Clegg et. al. Lancet 2013; 381: 752-762

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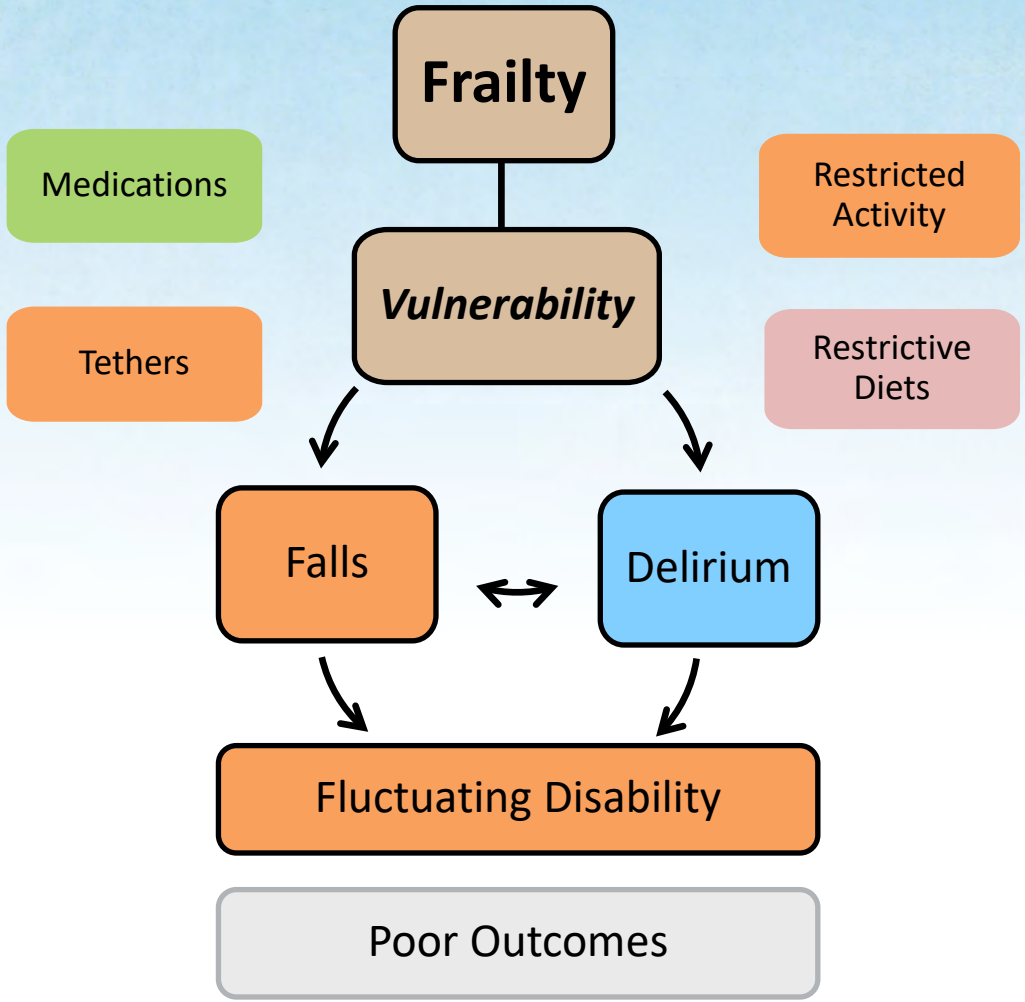

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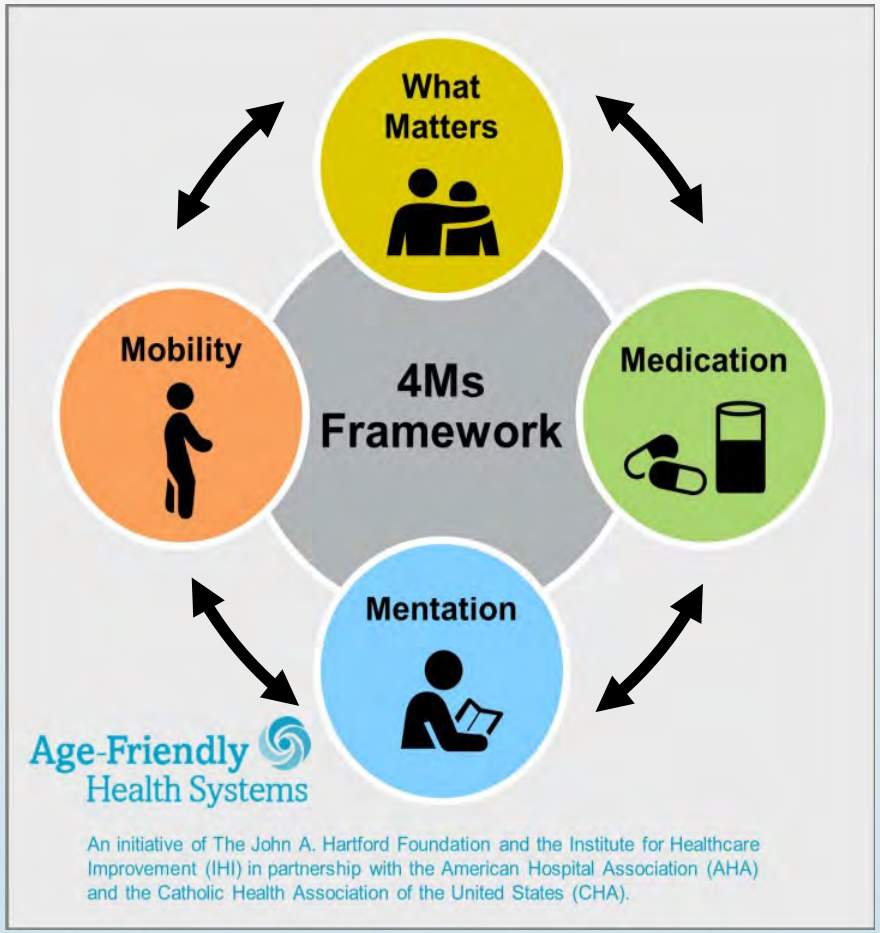
Insight

Vulnerability

Frailty

- Social *Vulnerability*
- Physical *Vulnerability*
- Nutritional *Vulnerability*
- Cognitive *Vulnerability*

Holistic Care Bundle



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Thank you!

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Target Zero
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