

# Northern Sydney Frailty Initiative

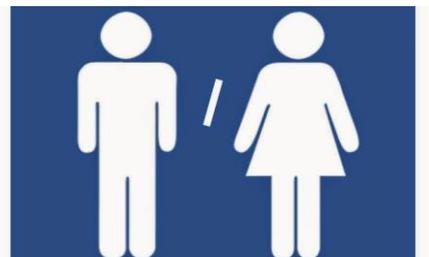
## The Impact of Frailty on Patients

**Nov 2018**

### Speakers

- Dr Christopher Bollen
- Jane Bollen RN
- Professor Susan Kurrle

# House Keeping



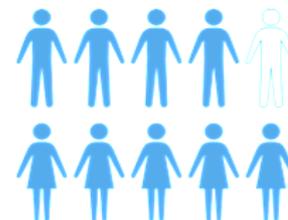
# Northern Sydney Frailty Initiative

## Frailty in the Northern Sydney Region – A growing need

- Northern Sydney has an ageing population
- Frailty can affect up to 25% people aged 70 and over—this equated to approximately 26,000
- About 50% of inpatients at NSLHD hospitals are aged 70 and over
- 30% of general practice encounters are with patients aged 65 years or more

**Total  
Population**

914,298



**Older People**

**15.6% (142,463)**  
of the total popn aged 65+ years

Between 2016-2036,  
there will be an increase  
of **55.1%↑** in the 65+  
years population



# Our approach: North Sydney Frailty Initiative

We will work together to enable :

**ONE PERSON**

(and their carers)

Supported by people working as

**ONE TEAM**

From organisations behaving as

**ONE SYSTEM**

## Speakers

Professor Susan Kurrle

Professor of Health Care of Older People, Director, NHMRC  
Partnerships Centre on Cognitive Decline, Geriatrician  
Hornsby Ku-ring-gai Hospital

Dr Christopher Bollen - MBBS MBA FRACGP FACHSM  
MAICD

Dr Bollen, practicing GP with a special interest in older  
people, and a RACGP representative on Centre for  
Research Excellence in Frailty (Adelaide)

Jane Bollen RN GAICD

Jane works at Allenby Gardens Family Practice in Adelaide  
running a nurse led (team based care) "Healthy Ageing  
Clinic."

# Overview

- Why this session?
- What is Frailty?
- Frailty screening tools
- Evidence for making a difference
- Case study
- Objective assessment tools to use in 75+ health assessments
- Referral pathways for frailty
- Summary and take home messages

# Learning objectives

- To recognise the concept of an older person living with frailty
- To learn to use evidence based screening tools to recognise older people with, or at risk of frailty
- To understand the treatment options/referral pathways for frailty which can assist with reducing further decline and supporting an older person to live at home independently
- To share ways of incorporating frailty assessment into everyday encounters in primary care

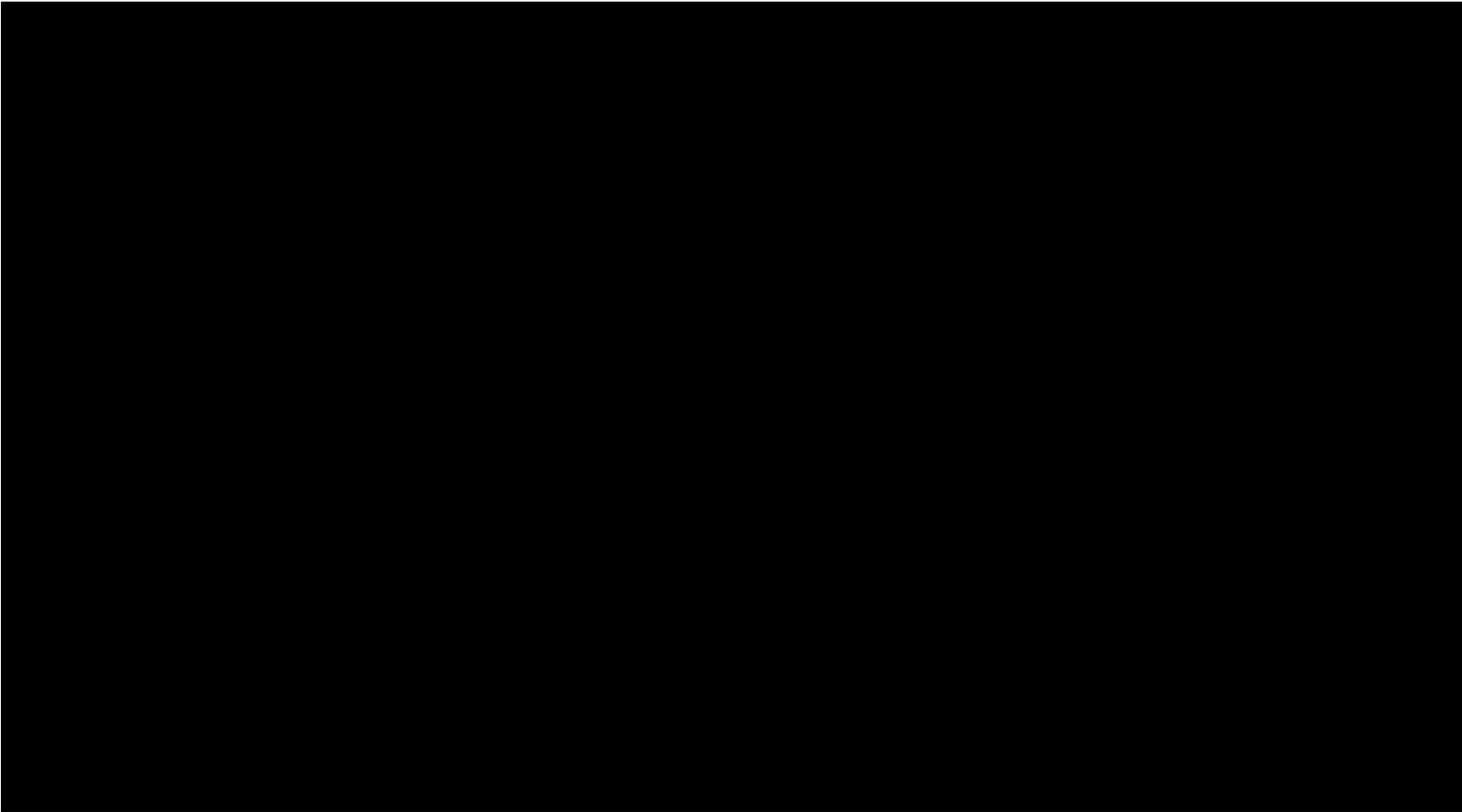
# Why do we need to be here?

Dr Chris Bollen

# Something to consider!

- [https://www.youtube.com/watch?v=T9-JPN\\_jY9I](https://www.youtube.com/watch?v=T9-JPN_jY9I)





# Atul Gawande reflections from “Being Mortal”

- “Our ultimate goal, after all, is not a good death, but a good life to very end”
- “We have been wrong about our job in medicine. We think our job is about health and survival, but it is larger than that. It is to enable wellbeing. And wellbeing is about the reasons one wishes to be alive. ”
- The importance of having the discussion about what is important to the older person
- It needs to be done in primary care, and not in the acute setting

“Care needs to be just as important as treatment. Older people should be properly valued and listened to, and treated with compassion, dignity and respect at all times. They need to be cared for by skilled staff who are engaged, understand the particular needs of older people and have time to care.”

‘Hard Truths, the Journey to Putting Patients First’,  
Government response to the Francis Report, November 2013

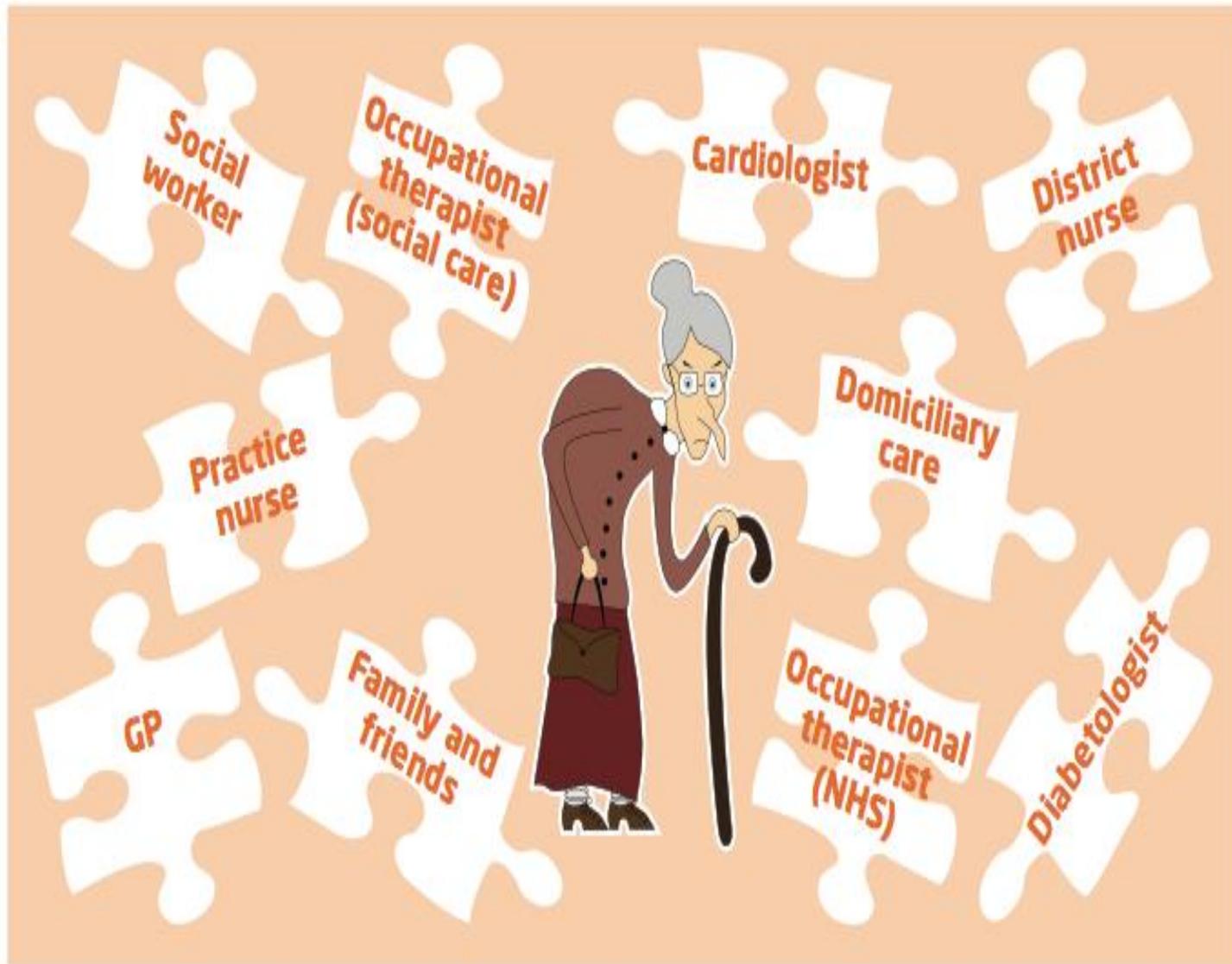
# Can it be done differently?



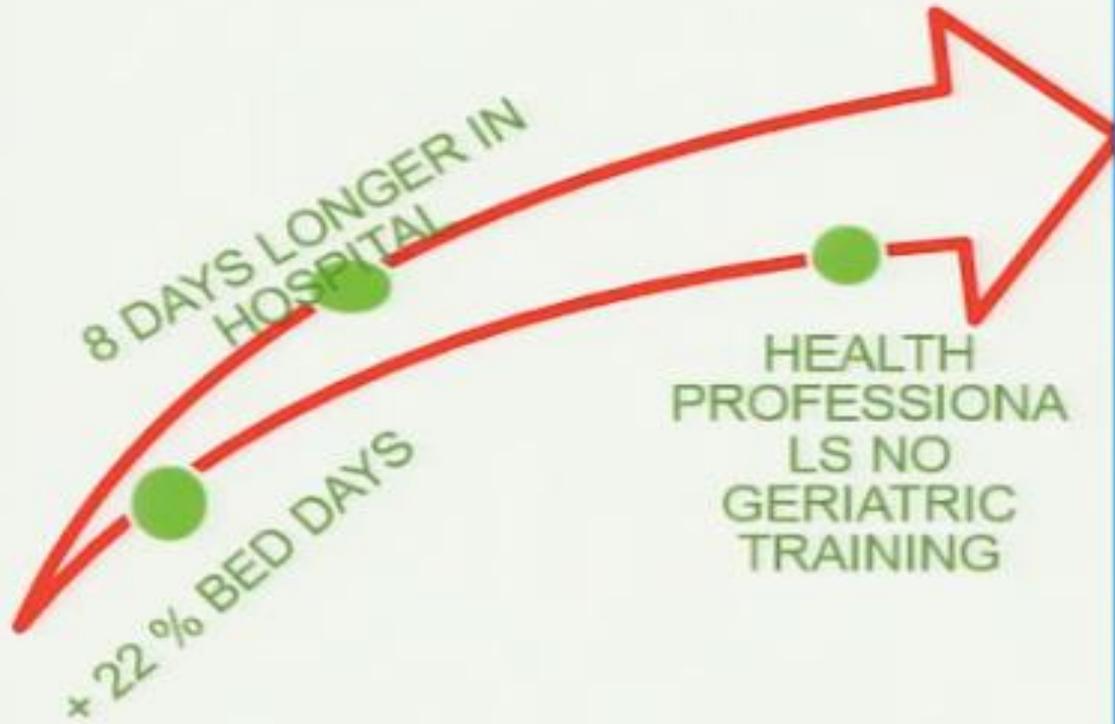
# 75+ 5Ms 3Ds 1F

- What **M**atters?
- **M**obility
- **M**edicines
- **M**entation
  - **D**epression
  - **D**ementia
  - **D**elirium
- **M**alnutrition
- **FRAIL**





PATIENTS OVER 80:  
OVER THE PAST 10 YEARS



# Issues which do not support older people achieving their “good health”

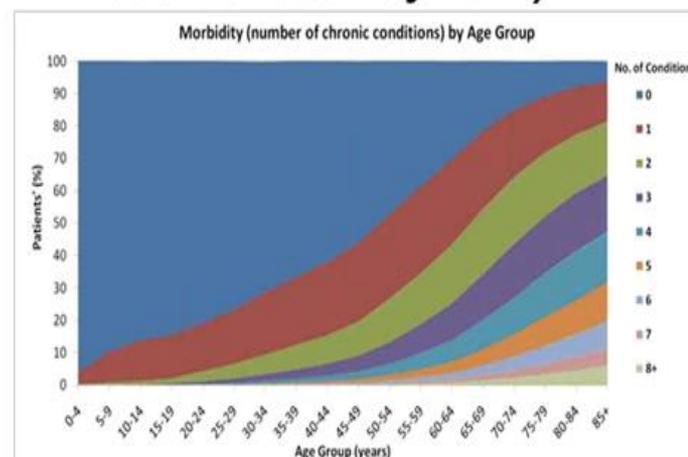
- Communication issues
  - Between providers
  - Between provider and client
- Education levels of older people
- Cultural issues of older people
- Social stigma of ageing
- Health professionals attitudes towards ageing “you are 85, what do you expect, you are getting old.....not much can be done....”
- Myagededcare website and lack of digital literacy of many people 75+
- Financial concerns
- Health systems structure and funding



# GP visits - BEACH and older people

- All ages avge visits/year 5-6
- 75-79 avge visits/year 12-13
- 80-84 avge visits/year 15-18
- 85+ avge visits/year 16-19

**Multimorbidity is the norm**  
*(Scottish School of Primary Care Barnett et al Lancet May 2012)*



The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions  
More people have 2 or more conditions than only have 1

# Polypharmacy and ageing

- 50% people aged 75+ on 8+ meds
- 1 in 3 people aged 75+ will have eGFR <60
- Multiple prescribers with single disease/organ focus
- Rarely is deprescribing occurring

# Older people and EDs

The attendance of an older person at an Emergency Department has been discussed as being a “sentinel event”, and a marker of functional decline.

*Nguyen et al Australian Health Review 2013*

One attendance may be a marker of future attendances.

*Grimmer et al, Australian Health Review 2013*



# What is Frailty

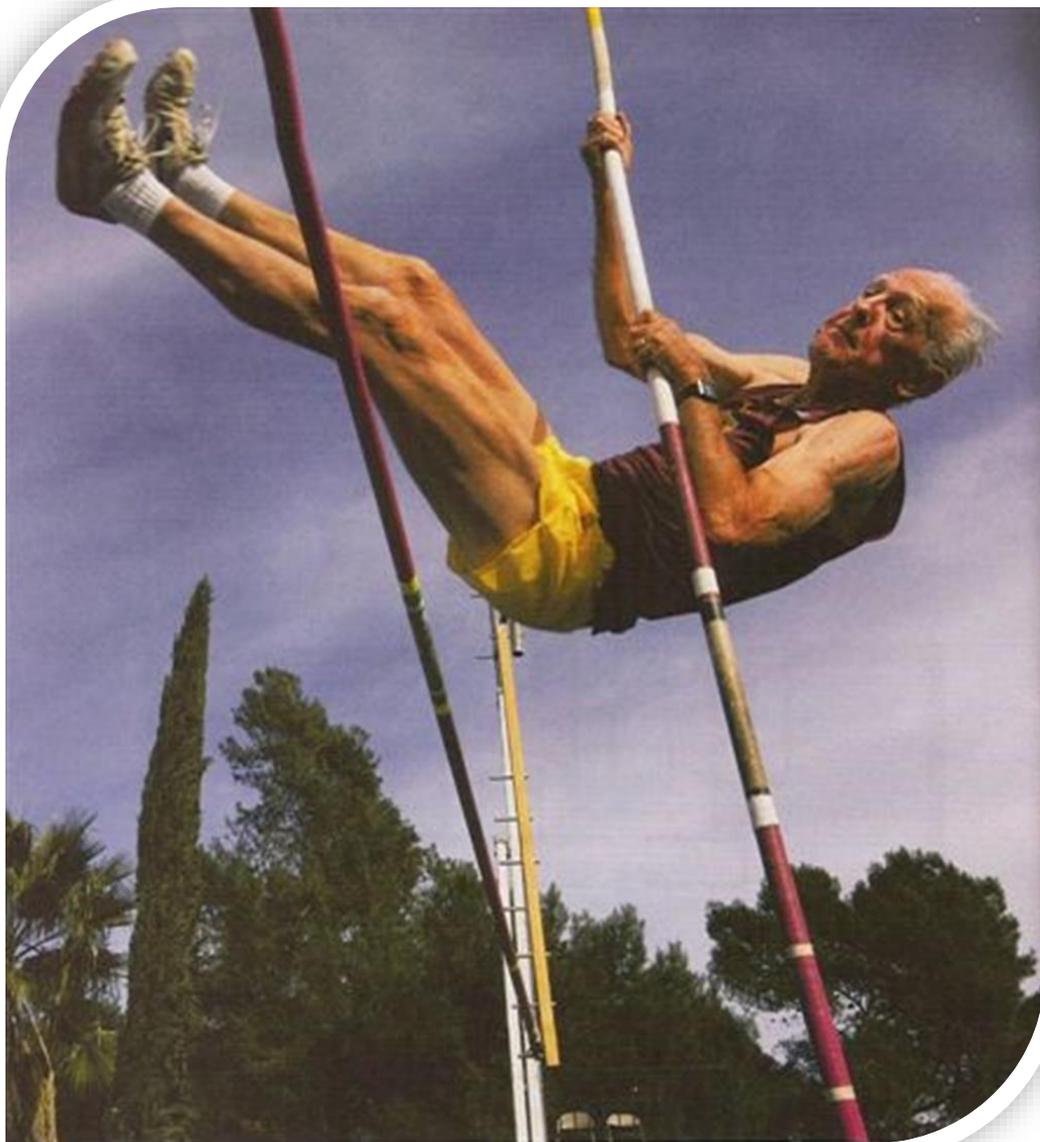
Presenter: Prof Sue Kurrle





# Appearances can be deceptive







# Definition of Frailty 1

## Frailty Phenotype

Operationally defined as:

“A clinical syndrome in which **three or more** of the following are present:

- unintentional weight loss (>4.5kgs in last year)
- self-reported exhaustion
- weakness (grip strength)
- slow walking speed
- low physical activity”

# Frail Scale

For Northern Sydney

## FRAIL SCALE RISK ASSESSMENT

	QUESTION	SCORING	RESULT
<b>F</b>	<b>FATIGUE</b> How much of the time during the past 4 weeks did you feel tired? A = All or most of the time B = Some, a little or none of the time	A = 1 B = 0	
<b>R</b>	<b>RESISTANCE</b> In the last 4 weeks by yourself and not using aids, do you have any difficulty walking up 10 steps without resting?	Yes = 1 No = 0	
<b>A</b>	<b>AMBULATION</b> In the last 4 weeks by yourself and not using aids, do you have any difficulty walking 300 metres OR one block?	Yes = 1 No = 0	
<b>I</b>	<b>ILLNESS</b> Did your Doctor ever tell you that you have? <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer (not a minor skin cancer) <input type="checkbox"/> Chronic lung disease <input type="checkbox"/> Heart attack <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Angina <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis <input type="checkbox"/> Kidney disease	0 - 4 answers ✓ = 0 5 - 11 answers ✓ = 1	
<b>L</b>	<b>LOSS OF WEIGHT</b> Have you lost more than 5kg or 5% of your body weight in the past year?	Yes = 1 No = 0	
<b>TOTAL SCORE</b>			
<b>SCORING: ROBUST = 0 PRE-FRAIL = 1-2 FRAIL = &gt;3</b>			

# Definition of Frailty 2

## Accumulated Deficits

- Biological process
- “Accumulated deficits”
- Gender specific
- Clearly related to mortality
- Expressed as an “index”

# Frailty Index

## Appendix 1: List of variables used by the Canadian Study of Health and Aging to construct the 70-item CSHA Frailty Index

- Changes in everyday activities
- Head and neck problems
- Poor muscle tone in neck
- Bradykinesia, facial
- Problems getting dressed
- Problems with bathing
- Problems carrying out personal grooming
- Urinary incontinence
- Toileting problems
- Bulk difficulties
- Rectal problems
- Gastrointestinal problems
- Problems cooking
- Sucking problems
- Problems going out alone
- Impaired mobility
- Musculoskeletal problems
- Bradykinesia of the limbs
- Poor muscle tone in limbs
- Poor limb coordination
- Poor coordination, trunk
- Poor standing posture
- Irregular gait pattern
- Falls
- Mood problems
- Feeling sad, blue, depressed
- History of depressed mood
- Tiredness all the time
- Depression (clinical impression)
- Sleep changes
- Restlessness
- Memory changes:
- Short-term memory impairment
- Long-term memory impairment
- Changes in general mental functioning
- Onset of cognitive symptoms
- Clouding or delirium
- Paranoid features
- History relevant to cognitive impairment or loss
- Family history relevant to cognitive impairment or loss
- Impaired vibration
- Tremor at rest
- Postural tremor
- Intention tremor
- History of Parkinson's disease
- Family history of degenerative disease
- Seizures, partial complex
- Seizures, generalized
- Syncope or blackouts
- Headache
- Cerebrovascular problems:
- History of stroke
- History of diabetes mellitus
- Arterial hypertension
- Peripheral pulses
- Cardiac problems:
- Myocardial infarction
- Arrhythmia
- Congestive heart failure
- Lung problems:
- Respiratory problems
- History of thyroid disease
- Thyroid problems
- Skin problems
- Malignant disease
- Breast problems
- Abdominal problems
- Presence of snout reflex
- Presence of the palmomental reflex
- Other medical history

# Clinical Frailty Scale

## 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.

\* 1. Canadian Study on Health & Aging, Revised 2008.

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

© 2007-2009. Version 1.2. All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada. Permission granted to copy for research and educational purposes only.



# Is Frailty Treatable?

...yes!

Frailty Phenotype : yes

- ◆ Improve physical function
- ◆ Improve nutrition
- ◆ Improve psychological status

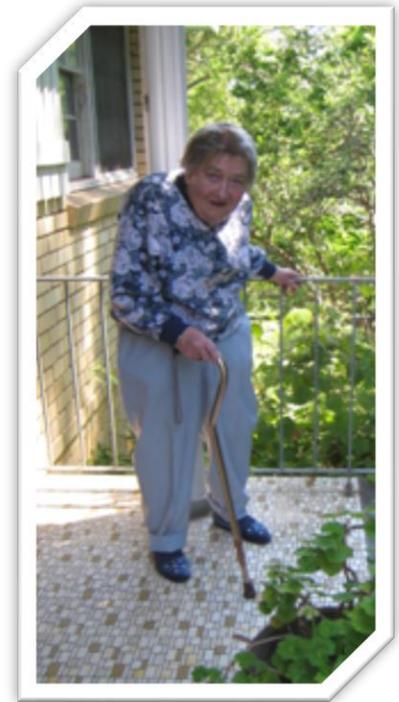
Accumulated Deficits : yes

- ◆ Amelioration of physical deficits
- ◆ Improvement of physiological reserve
- ◆ Treatment of medical conditions and polypharmacy



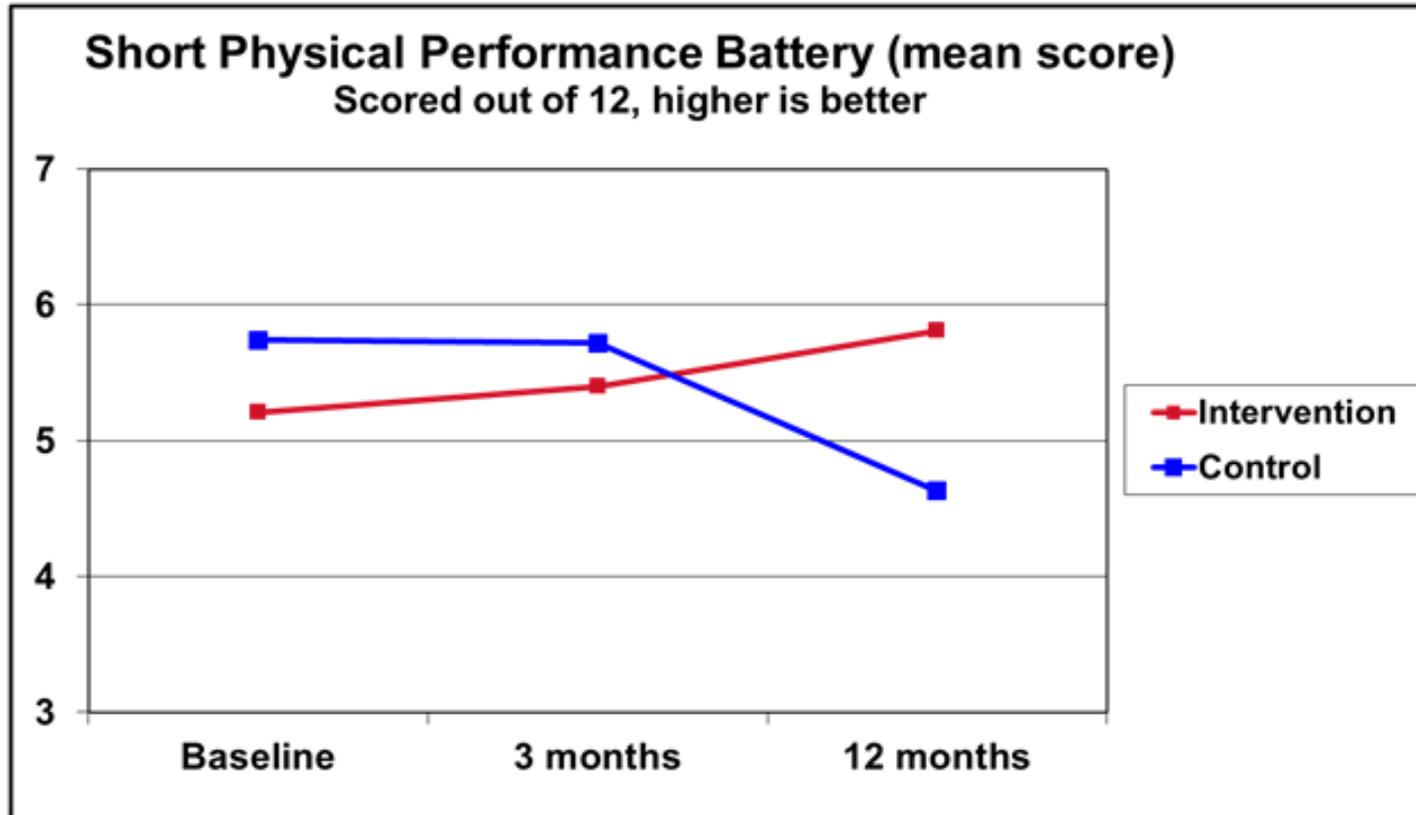
# Frailty Intervention Trial (FIT)

- ◆ RCT with intervention of individually designed program addressing physical limitations and nutrition
- ◆ 241 community dwelling people aged 70yrs and over, assessed as frail using Fried Frailty criteria (3 or more criteria)
- ◆ Randomised to intervention (mainly exercise and nutritional advice) or control (normal care)
- ◆ Blinded follow-up at 3 and 12 months
- ◆ Primary outcomes:
  - ◆ Frailty (Fried) index score
  - ◆ Short Physical Performance Battery (SPPB)



Cameron ID et al. A multifactorial interdisciplinary intervention reduces frailty in older people: randomised trial. BMC Medicine 2013, 11:65 doi:10.1186/1741-7015-11-65

# FIT Program Results





# Case Mrs T: start of intervention



Fried criteria “frail” – Walking speed, Exhaustion, Grip, Energy expenditure

# Case Mrs T: end of intervention



No longer “frail” – only grip strength

# Frailty Clinical Practice Guidelines

The Asia-Pacific Clinical Practice Guidelines for the Management of Frailty

## Recommendations:

- ◆ Strong:
  - Use a validated measurement tool to **identify frailty**
  - Prescribe **physical activity** with a resistance training component
  - Address **polypharmacy**
- ◆ Conditional
  - Screen for, and address, **fatigue**
  - Address weight loss with **protein/calorie** supplementation if appropriate
  - Prescribe **Vit D** if Vit D deficient

# Frailty Management Tool- Primary Care

Assessment Score	Intervention	Referral/Follow up
<b>FRAIL scale</b> 0 = robust	<ul style="list-style-type: none"> <li>Encourage ongoing activity levels</li> <li>Provide Staying Active and on your feet and Eating Well resource</li> </ul>	<ul style="list-style-type: none"> <li>Re-do FRAIL scale in 12 months</li> <li>Community exercise with balance/resistance component. Try NSLHD Stepping On and Healthy Lifestyle classes.</li> <li>Example of exercises in Staying Active and On Your Feet booklet and NSW exercise venues: <a href="http://www.activeandhealthy.nsw.gov.au">www.activeandhealthy.nsw.gov.au</a></li> </ul>
<b>FRAIL scale</b> 1-2 = Pre-frail <b>FRAIL scale</b> >3 = Frail	<b>If Frailty Score is positive, address underlying causes as suggested below</b>	
<b>F</b> Feeling fatigued most or all of the time	<ul style="list-style-type: none"> <li>Consider screening for reversible causes of fatigue (sleep apnoea, depression, anaemia, hypotension, hypothyroidism, B12 deficiency)</li> <li>Use EPWORTH scale, K10 or Geriatric Depression scale in Health Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Consider referral to Geriatrician /Specialist for complex care patients</li> <li>Consider referral to Occupational Therapy for functional and home review</li> <li>Consider referral Psychologist using Mental Health Care Plan</li> <li>Consider referral to Aged Care organisation for loneliness support (isolation can be a cause of fatigue!)</li> </ul>
<b>R</b> Resistance against gravity - Difficulty walking up 10 steps without resting	<ul style="list-style-type: none"> <li>Consider referring to an individualised progressive exercise program with resistance and strength component</li> </ul>	<ul style="list-style-type: none"> <li>Physiotherapy or Exercise Physiologist for exercise prescription</li> <li>If has diabetes-&gt; group session Medicare funded ex. physiologist</li> <li>Healthy Lifestyle for group exercise prescription and/or Stepping On</li> <li>Get Healthy for free telephone-based health coaching</li> <li>NSHNS Safe and Steady program</li> </ul>
<b>A</b> Ambulation-Difficulty walking 300 metres unaided	<ul style="list-style-type: none"> <li>Consider referring to an Individualised progressive exercise program with resistance and strength component</li> </ul>	<ul style="list-style-type: none"> <li>Physiotherapy or Exercise Physiologist for exercise prescription</li> <li>Healthy Lifestyle for group exercise prescription and/or Stepping On</li> <li>Get Healthy for free telephone-based health coaching</li> <li>Exercise options <a href="https://www.activeandhealthy.nsw.gov.au">https://www.activeandhealthy.nsw.gov.au</a></li> </ul>
<b>I</b> Having 5 or more illnesses	<ul style="list-style-type: none"> <li>Review indication, side effects and use of medication (evidence for use of some medicines changes after 75!)</li> <li>Consider discussing with pharmacist</li> <li>Consider reducing/de-prescribing superfluous medication</li> </ul>	<ul style="list-style-type: none"> <li>Pharmacist for comprehensive medication review, (HMR item 900)</li> <li>Occupational Therapy for functional and home safety review</li> <li>Self-management support from aged care org volunteer</li> </ul>
<b>L</b> Loss of > 5% weight in 12 months	<ul style="list-style-type: none"> <li>Consider screening for reversible causes of weight loss and consider</li> <li>Protein and caloric supplementation/food fortification (75mg protein per day required- range of products available at pharmacy)</li> <li>Advice and encourage healthy eating; provide "Eating Well" resource</li> </ul>	<ul style="list-style-type: none"> <li>Weigh and assess BMI - record in patient record</li> <li>Dietician for diet review and management</li> <li>Add Sustagen</li> <li>Meal Delivery Services</li> <li>Speech pathologist for swallowing review</li> <li>Dentist for dental review (pain/infection/ill fitting dentures)</li> <li>Occupational Therapy for functional and home cooking ability review</li> </ul>

# Frailty in Primary Care

**Dr Chris Bollen and  
Jane Bollen RN**

# Why worry?

## Frailty as a Clinical Syndrome

### Clinical Syndrome of Frailty

#### Symptoms

- Weakness
- Fatigue
- Anorexia
- Under nutrition
- Weight Loss

#### Signs

- Physiologic changes marking increased risk
- Decreased muscle mass
- Balance and gait abnormalities
- Severe deconditioning



### Adverse Outcomes of Frailty

- Falls
- Injuries
- Acute Illnesses
- Hospitalizations
- Disability
- Dependency
- Institutionalization
- Death

# Case study - Sam

- Sam is a retired mechanic, 86 years old.
- He consults the GP roughly every three months for monitoring of moderate hypertension and for hypercholesterolemia
- He usually appears well nourished and fairly robust
- He pays attention to his diet to avoid high fat and hyper caloric foods.
- PH: hypertension, hyperlipidemia, hypothyroidism, OA knees, benign prostatic hypertrophy, and mild Alzheimers disease (AD).
- Total cholesterol 5.9 and eGFR 49
- no history of alcohol use/abuse but has a 60+ year history of tobacco use.
- Sam says he stopped using tobacco about a year ago

# Who is in his “team”?

- GP-> sees him when needed for scripts, immunisations and when unwell
- Practice nurse-> sees him annually for “care plan” so he can access podiatry
- Another practice nurse-> sees him annually for 75+ health assessment
- Pharmacist-> sees him occasionally. Wife often picks up scripts
- Podiatrist-> sees him 5 x per year
- Neurologist-> sees him 1-2 x year for mild AD
- Urologist for bladder symptoms

# Current medications

- Oxazepam 15mg nocte for sleep
- Oxybutynin 5mg TDS for continence
- Tapentadol 100mg BD for arthritis pain
- Panadol Osteo 2 BD for arthritis
- Amlodipine 10mg for hypertension
- Frusemide 40mg for hypertension and mild CCF
- Slow K 1 daily
- Movicol 1 sachet daily for constipation
- Simvastatin 20mg daily
- Thyroxine 100mcg for hypothyroid
- Polaramine 3 x week for hayfever/allergy

# Alert to medicines issues?

## TABLE EXERCISE:

- What are your concerns?
- What can be offered?



# Case study

- Sam is due for his annual health assessment and receives his recall letter
- His wife calls the practice to book a time
- The Practice Nurse visits Sam a few days later. He opens the door and leads you slowly to the dining room where you greet his wife
- He says his health seems to be as usual.
- Sam seems to have gradually lost weight and his wife indicates he never leaves the house
- BP 150/85, pulse 64 regular, afebrile, O2 sats 96%

# Case study

- What is happening?
- How would you assess?

# More information

- His wife informs you that Sam has fallen several times over the past two months. In two weeks, he fell more than four times, with minor bruising and abrasions.
- All these "problems" seem to have occurred since his hospitalization 3 months ago, when he underwent surgery for benign prostatic enlargement.

# Can Sam be helped?

TABLE EXERCISE:

- **Why is this happening to Sam?**
- **What could be done to avoid Sam from becoming more dependent?**

# Who could be in Sam's "team"?

- Referral options?

# Thinking about frailty as a chronic condition

Dr Chris Bollen



# Frailty as a Long Term Condition

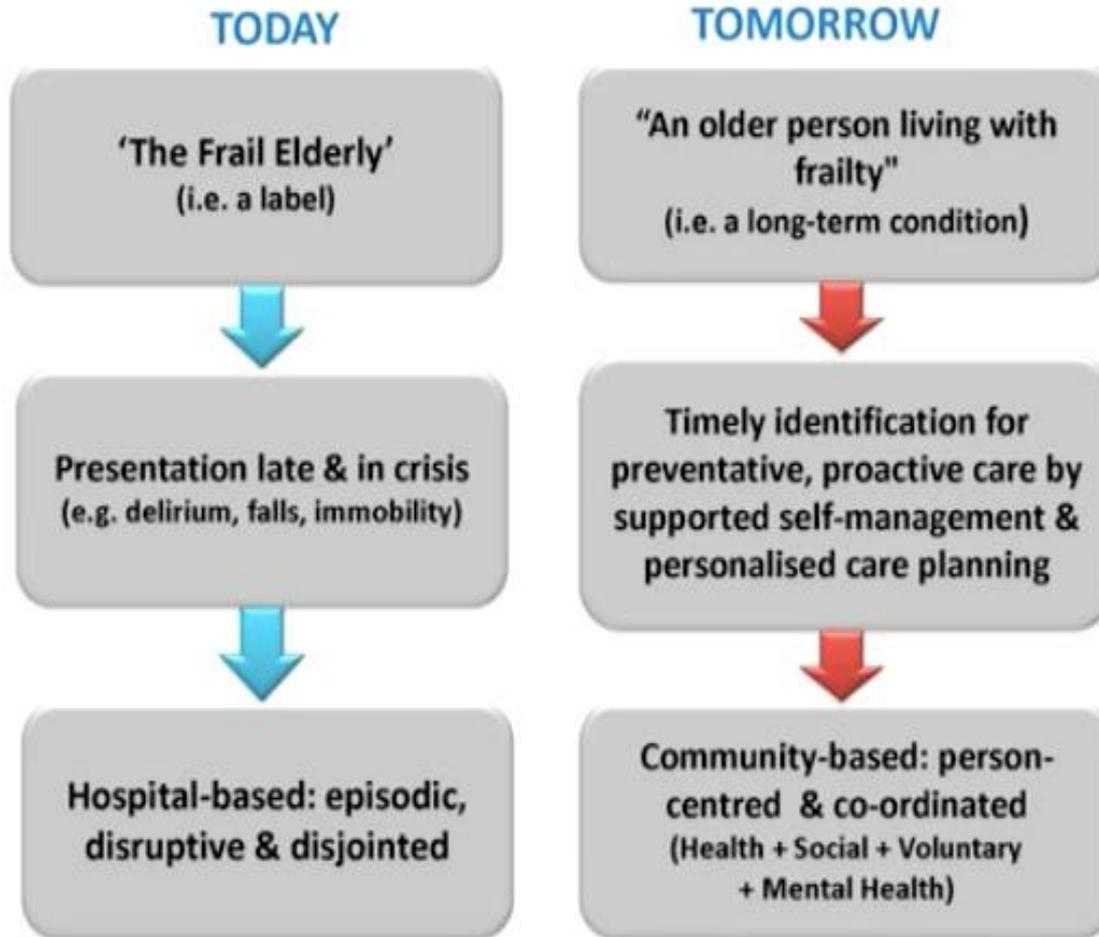
## A Long Term Condition is:

*“A condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies” (DH 2012)*

## Frailty is:

- Common (25-50% of people over 80 years)
- Progressive (5 to 15 years)
- Episodic deteriorations (delirium; falls; immobility)
- Preventable components
- Potential to impact on quality of life
- Expensive

# New Care Paradigm for Older People & Frailty



# Proactive interventions in frailty

"I'm not as steady on my feet as I was"

## Frailty as a Long-term Condition

"Dad is slowing down"



'He is a fall waiting to happen'

WV

# Barriers to recognising frailty! (GROUP)



25-year old healthy adult



75-year old healthy adult

# Making a difference in Primary Care

Dr Chris Bollen and  
Jane Bollen RN

# Why do 75+ Health Assessments?

- “The main purpose of health screening in this vulnerable age group is to facilitate timely and appropriate interventions to prevent further decline in function or complications associated with chronic conditions” (Gray and Newbury 2004)
- Low take up (<20% of older people)
- Evidence for impact?
- Are the templates fit for purpose?
- Barriers for older people?

# Who really needs the 75+HA?

- Diagnosis of dementia
- History of falls or change in mobility
- Confusion/Delirium
- Change in continence
- 75+ and >3 long term conditions
- 10+ medicines
- Complex neurological condition=stroke,MS,PD
- Aged 85+
- Current home care package
- Recent ED/hospitalisation

# What are the “geriatric syndromes”?

Unique features of common health conditions that do not fit into discrete disease categories

- Incontinence
- Falls
- Frailty
- Dementia
- Delirium
- Depression
- Malnutrition
- Polypharmacy

# Objective assessment tools for General Practice

- to use in 75+ health assessments or other clinical encounters with older people
- Incorporating a screening tool for frailty is essential
- Objective measures such as
  - gait speed,
  - TUG and
  - grip strength should also be incorporated
  
- Nutrition, cognition and depression scales essential

# Remember the FRAIL scale

- Fatigue-are you feeling fatigued? (yes 1 point)
- Resistance- Difficulty walking a flight of stairs? (yes 1 point)
- Ambulation- difficulty walking around the block? (yes 1 point)
- Illnesses- 5 or more chronic conditions? (yes 1 point)
- Loss of weight of 5% or more over past 6 months? (yes 1 point)

If the older person scores 1- 2, they are pre-frail, 3+ indicates they are frail and would benefit with:

- physical activity
- polypharmacy review
- address fatigue
- protein/calorie supplementation
- vitamin D



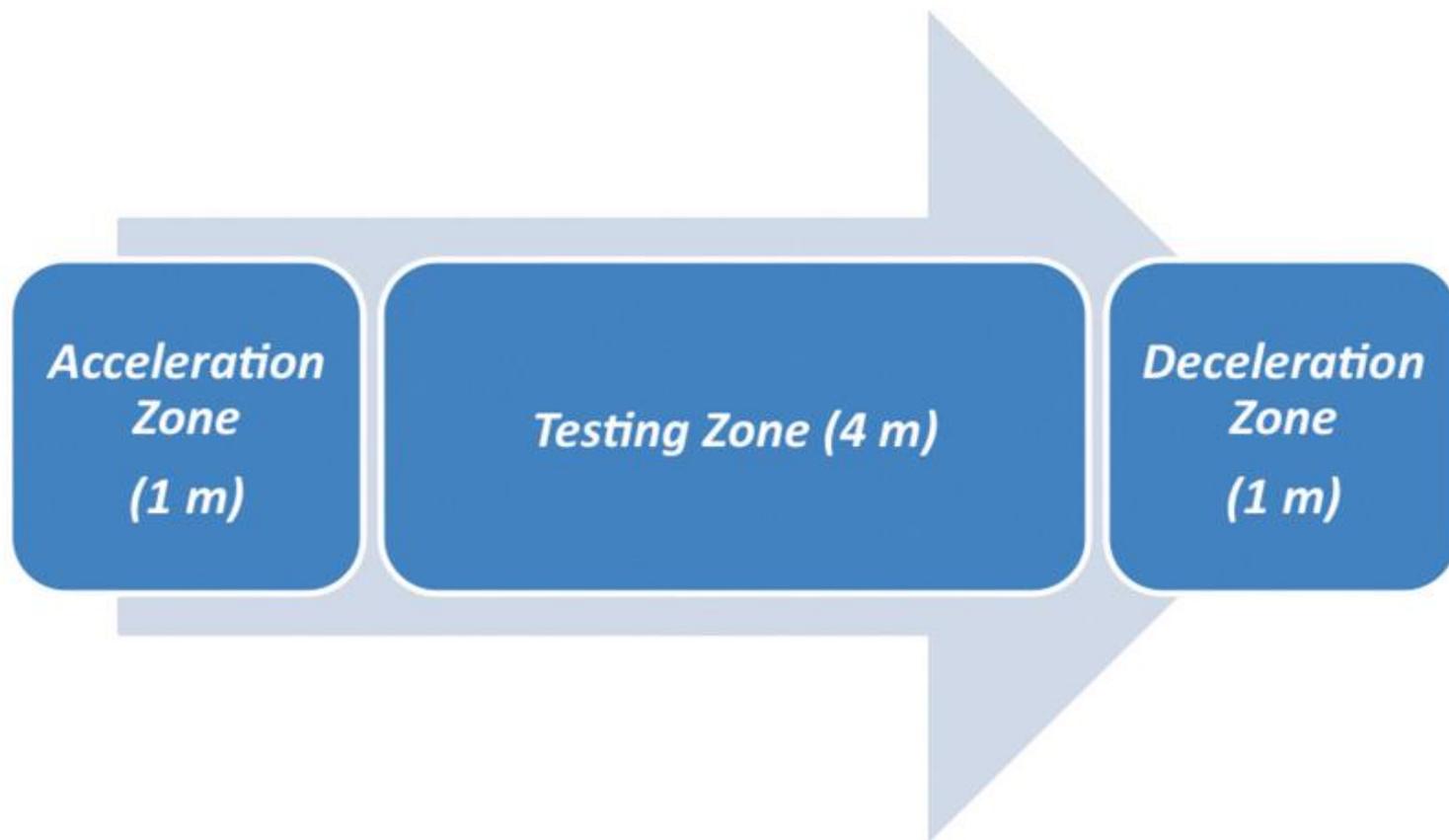


Taking more than 5 seconds to walk 4m predicts future:

- ✓ Disability
- ✓ Long-term care
- ✓ Falls
- ✓ Mortality

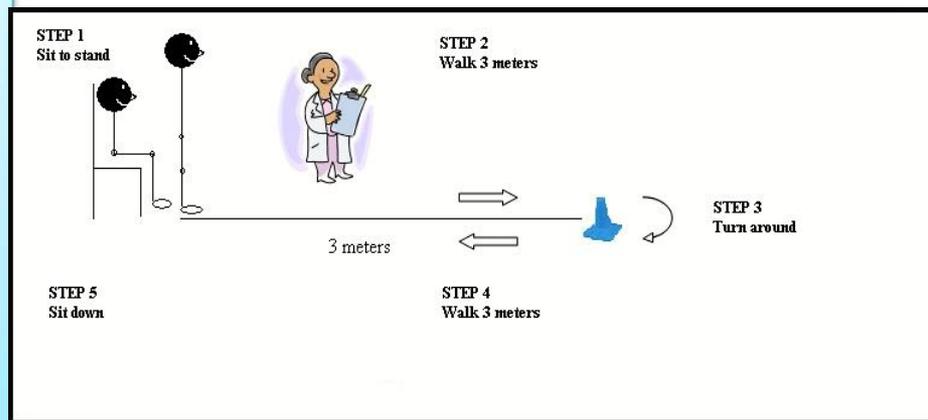
Van Kan et al JNHA 2009; 13:881  
Systematic Review of 21 cohorts

# 4m walk test



## TIMED GET UP AND GO TEST

- Begin timing; Ask patient to:
  - Rise unaided from standard armchair using usual footwear and assistive device
  - Walk in a straight line about 10 feet
  - Turn and return to chair
  - Sit down
- End timing



Completed in  $\leq 10$  Seconds

- Give and review educational materials:  
[How to Prevent Falls](#)  
[Check for Safety](#)

Completed in  $> 10$  Seconds

- Perform a [Comprehensive Assessment](#) to address risk areas such as:
  - Orthostatic hypotension
  - Vision or hearing impairments
  - Medication regimen
  - Chronic conditions
  - Home hazards

# GDS

Table 4

## Geriatric Depression Scale (Short Form)

Choose the best answer for how you felt over the past week.

- |   |                |
|---|----------------|
| 1. Are you basically satisfied with your life?                                | yes/ <b>NO</b> |
| 2. Have you dropped many of your activities and interests?                    | <b>YES</b> /no |
| 3. Do you feel that your life is empty?                                       | <b>YES</b> /no |
| 4. Do you often get bored?  | <b>YES</b> /no |
| 5. Are you in good spirits most of the time?                                  | yes/ <b>NO</b> |
| 6. Are you afraid that something bad is going to happen to you?               | <b>YES</b> /no |
| 7. Do you feel happy most of the time?  | yes/ <b>NO</b> |
| 8. Do you often feel helpless?  | <b>YES</b> /no |
| 9. Do you prefer to stay at home, rather than going out and doing new things? | <b>YES</b> /no |
| 10. Do you feel you have more problems with memory than most?                 | <b>YES</b> /no |
| 11. Do you think it is wonderful to be alive now?                             | yes/ <b>NO</b> |
| 12. Do you feel pretty worthless the way you are now?                         | <b>YES</b> /no |
| 13. Do you feel full of energy?   | yes/ <b>NO</b> |
| 14. Do you feel that your situation is hopeless?                              | <b>YES</b> /no |
| 15. Do you think that most people are better off than you are?                | <b>YES</b> /no |

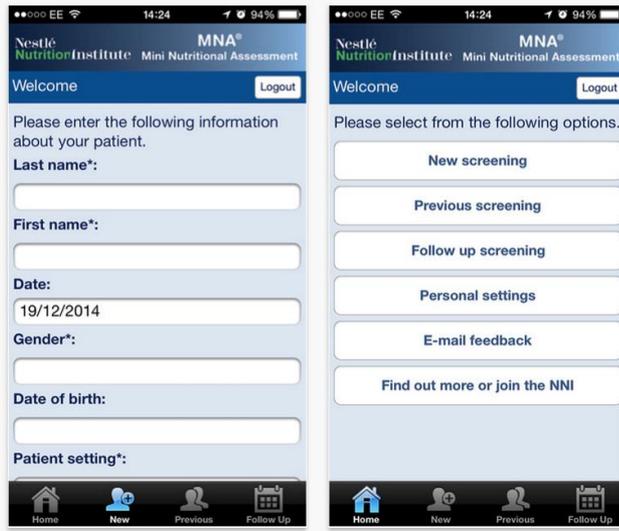
**Scoring:** Score boldfaced answers (1 point for each of these answers).  
0–5 = normal; > 5 suggests depression.

Adapted, with permission, from Yesavage.[45]

# Mini Nutritional Assessment (MNA)

Screening and Assessment tool for the identification of malnutrition in the elderly

The free MNA®-SF app for iPhone® and iPad® is now available in English and French.



## Screening

**A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?**  
 0 = severe decrease in food intake  
 1 = moderate decrease in food intake  
 2 = no decrease in food intake

**B Weight loss during the last 3 months**  
 0 = weight loss greater than 3kg (6.6lbs)  
 1 = does not know  
 2 = weight loss between 1 and 3kg (2.2 and 6.6 lbs)  
 3 = no weight loss

**C Mobility**  
 0 = bed or chair bound  
 1 = able to get out of bed / chair but does not go out  
 2 = goes out

**D Has suffered psychological stress or acute disease in the past 3 months?**  
 0 = yes                      2 = no

**E Neuropsychological problems**  
 0 = severe dementia or depression  
 1 = mild dementia  
 2 = no psychological problems

**F Body Mass Index (BMI) = weight in kg / (height in m)<sup>2</sup>**  
 0 = BMI less than 19  
 1 = BMI 19 to less than 21  
 2 = BMI 21 to less than 23  
 3 = BMI 23 or greater

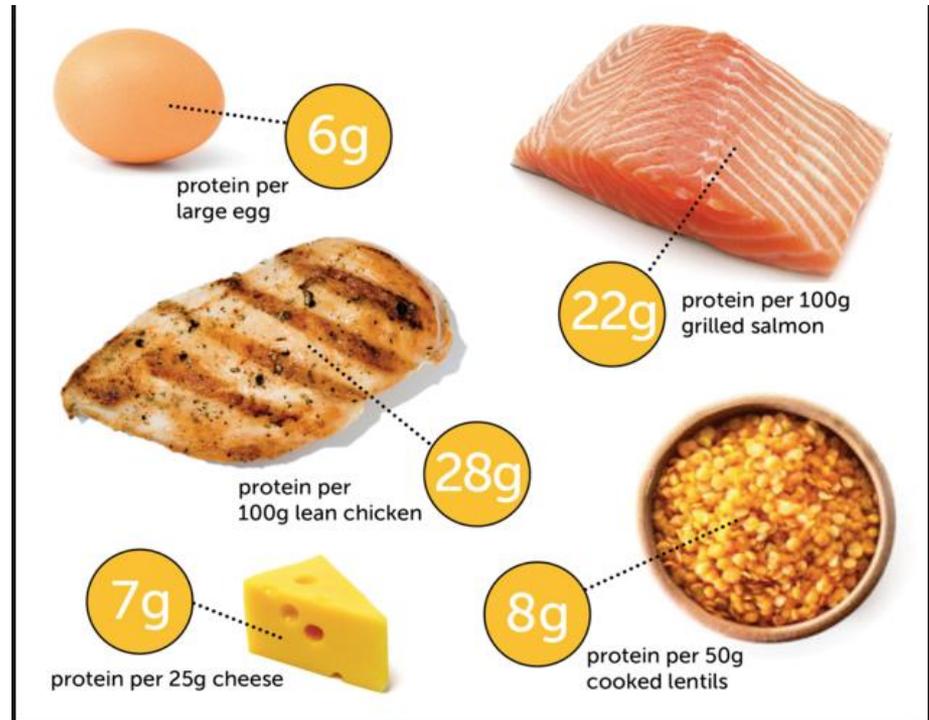
**Screening score (subtotal max. 14 points)**

12-14 points:            Normal nutritional status  
 8-11 points:            At risk of malnutrition  
 0-7 points:              Malnourished

For a more in-depth assessment, continue with questions G-R

# Barriers to protein intake

- Like/tastiness
- Convenience
- Preparation
- Shelf life/freshness
- Affordability
- Consumption
- “Healthiness”



# “Planning care” which make a difference for older people-> do you?

- Care plans for older people which need to be shared and are not just about single disease!
- Team care arrangements-> it is more than just the EPC providers!
- Care plan reviews for complex older people every 3-6 months are needed (“coordination”)
- AND, don't forget to give the older person a copy of the assessment and care plan in a folder with the practice details-> they can take it to all appointments

# BGS: Frailty approach/anticipatory

- **Comprehensive Geriatric Assessment**
  - Medical, cognitive, mental health, functional
  - Social supports, participation levels, Compensatory strategies/resources
- **Individualised Care Plan**
  - Optimisation plan
  - Escalation plan
  - Urgent Plan
- **Medication Review**
- **Advance Care Plan**

AVOID HOSPITAL

LIMIT IATROGENIC PROBLEMS

ANTICIPATE PROBLEMS

ATTEMPT TO HOLD COMMON RECORDS

# Care planning-a patient centred approach



What are the most important things you'd like to discuss today?

1. The pain in my feet
2. Difficulty sleeping
3. Getting out for a chat
4. I don't like all these tablets; do I really need them all?

# Care planning with impact

Instead of	The plan should read
<p>Need: Fall prevention</p> <p>Goal: Prevent A&amp;E attendances</p> <p>Action: Attend physiotherapy appointments once per month</p>	<p>Need: I need to build up my muscle strength to assist with balance</p> <p>Goal: To be able to use the stairs without needing any assistance</p> <p>Actions: Doctor to refer me to a physiotherapist; I will discuss strengthening exercises with my physio; I will join a weekly walking group</p>



# Referral pathways in Northern Sydney:

[www.sydneynorth.healthpathways.org.au](http://www.sydneynorth.healthpathways.org.au)

- Healthpathways
- Joint PHN and LHD funded services
- Myagedcare and Frailty programs run by aged care providers
- Local:
  - Geriatricians
  - Exercise physiologists
  - Physiotherapists
  - Dieticians
  - Pharmacists
  - Psychologists



# Frailty Information webpage

[www.sydneynorthhealthnetwork.org.au/programs/frailty/](http://www.sydneynorthhealthnetwork.org.au/programs/frailty/)



The screenshot shows the top section of a website. At the top left is a hamburger menu icon. In the center are the logos for 'phn NORTHERN SYDNEY An Australian Government Initiative' and 'SYDNEY NORTH Health Network'. To the right are icons for a telephone and an envelope. Below the logos is a banner image of five diverse elderly people smiling. Underneath the banner is a breadcrumb trail: 'Home > Programs > Healthy Ageing & Frailty'. The main heading 'Healthy Ageing & Frailty' is displayed in large blue text. Below the heading are three colored buttons: a blue button with a medical bag icon labeled 'Clinical Resources', an orange button with a person icon labeled 'Referrals', and a green button with a person icon labeled 'Patient Information'.

# What to include in inter-professional communication?

- Think about coordinating the care for best outcomes for an older person
- Include as much social, functional, medical and demographic information as possible
- Helps reduce error when “handing over” care as frequently the older person can not recall all the details

# Importance of social history

- Basis of primary health care
- Context of care
- Motivation issues
- Goals
- Transfer of information between health care providers

# Social history check list

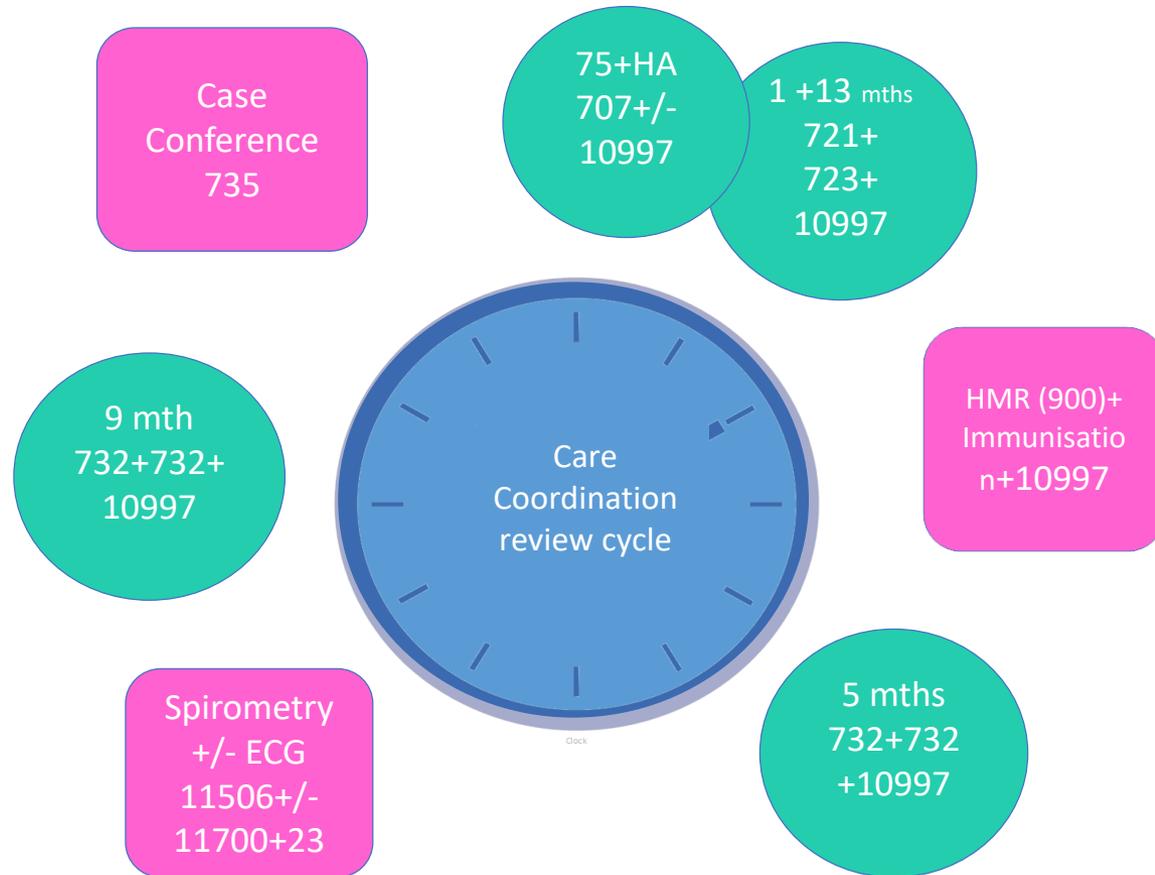
1. Name of person/people who live with older person
2. Name of carer/other family members
3. Name of person being cared for if a carer
4. Pets and their names!
5. Own house/unit/rented/supported hostel
6. Community package provider name, case manager, contact number
7. Pharmacist details/medication management used eg Webster
8. Involvement of other support organizations such as RDNS, Domiciliary Care, Meals on Wheels, Council, Community aged care etc
9. Mobility status/aids required such as stick, 4 wheel walker, wheelchair, scooter/gopher, has drivers license
10. Cognition status- Age related memory loss, Mild Cognitive impairment, dementia (Even a MMSE score and year could be helpful here)
11. Contenance status/aids-urinary incontinence and wears pads/has IDC
12. Language issues-eg stroke and has aphasia, speaks Spanish and requires interpreter
13. Advance Directive status- has EPOG/EPO/Medical Power of Attorney/Good Palliative Care Order

# Health assessments + care plan?

- Effective use of time for the older person and the practice
- Continuity
- Reduces duplication
- Use person centred pre-visit survey

# HHA/ GPMP/ TCA cycle

## 4 monthly reviews



Consultation	MBS Item No.	Billing	12 months
HHA	707		\$268.80
GPMP	721	\$144.25	\$144.25
TCA	723	\$114.30	\$114.30
GPMP/TCA Reviews	732 x 4	\$72.05	\$288.20
HMR	900	\$154.80	\$154.80
Case Conf	735	\$70.65	\$70.65
PN Monitoring	10997 x 5	\$12.00	\$60.00
ECG	11700	\$31.25	\$31.25
Spirometry	11506	\$17.50	\$17.50
ABI	11610	\$63.75	\$63.75
Bulk billing	10991 x 17	\$10.85	\$206.15
GP Consults			
<b>Total</b>			<b>\$1,397.95</b>

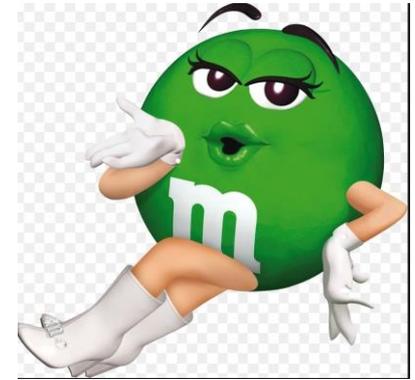
# Summary and take home messages

- Recognise frailty as a long term condition rather than responding “you are just getting old”
- Use a screening tool at every interaction with older people
- Referral for multi disciplinary team care can make a difference, **but only** if the older person sets goals
- Dignity in the care of older people is vital
- “You can’t turn back the clock but you can wind it up”

# 75+

## 5Ms 3Ds 1F

- What **M**atters?
- **M**obility
- **M**edicines
- **M**entation
  - **D**epression
  - **D**ementia
  - **D**elirium
- **M**alnutrition
- **FRAIL**



# Remember the FRAIL scale

- Fatigue-are you feeling fatigued? (yes 1 point)
- Resistance- Difficulty walking a flight of stairs? (yes 1 point)
- Ambulation- difficulty walking around the block? (yes 1 point)
- Illnesses- 5 or more chronic conditions? (yes 1 point)
- Loss of weight of 5% or more over past 6 months? (yes 1 point)

If the older person scores 1- 2, they are pre-frail, 3+ indicates they are frail and would benefit with:

- physical activity
- polypharmacy review
- address fatigue
- protein/calorie supplementation
- vitamin D

# Small group reflections

1. What are the 3 most important things you have learnt tonight?
2. What are 2 things you will be doing differently tomorrow when at work?
3. What system based issues will prevent you putting your new learning into place at your workplace?
4. Who needs to change this?

# Something else to think about

- Issues of Mrs Andrews

[https://www.youtube.com/watch?v=Fj\\_9HG\\_TWEM](https://www.youtube.com/watch?v=Fj_9HG_TWEM)

- (Acknowledge the Health Services Journal as the source of this- permission to use occurred from the HSJ editor Feb 9 2016)

# Questions?

## Contact details:

Dr Chris Bollen

0412952043

[chris.bollen@bmpconsulting.com](mailto:chris.bollen@bmpconsulting.com)

[www.bmpconsulting.com.au](http://www.bmpconsulting.com.au)

Jane Bollen RN

0412771482

[jbollen@bmpconsulting.com](mailto:jbollen@bmpconsulting.com)

*Thank You*



**SYDNEY NORTH**  
Health Network

**Phone:** (02) 9432 8250 | **Email:** [admin@snhn.org.au](mailto:admin@snhn.org.au)

**Address:** Level 5, Tower 2

475 Victoria Avenue, Chatswood NSW 2067

**Post:** PO Box 1083 Chatswood

[www.snhn.org.au](http://www.snhn.org.au)

**phn**  
NORTHERN SYDNEY

An Australian Government Initiative