

Existing Tools for the Identification of Frailty and Multimorbidity

The Importance of an Integrated Response

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SUNFRAIL Transnational Workshop

Understanding and caring for frailty and multimorbidity

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Special Article

Frailty Consensus: A Call to Action

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“...A medical syndrome with multiple causes and contributors that is characterized by diminished strength, endurance, and reduced physiologic function that increases an individual’s vulnerability for developing increased dependency and/or death...”

Severe disease of the central nervous system may follow infection with several E.C.H.O. viruses, causing ataxia, vertigo, and nystagmus. Undifferentiated febrile illness with or without a rash is commonly seen with types 4, 6, 9, 14, and 16, and sometimes 2, 11, and 18. E.C.H.O. viruses, usually type 18 and occasionally 8, 11, 14, and 20, have also been isolated from cases of infantile gastroenteritis, but the causal relationship is by no means so clear as in the cases of aseptic meningitis. World-wide in distribution, E.C.H.O. virus infections, whether sporadic or epidemic, are commoner in the spring and summer than at other seasons. These viruses can be recovered from the nasopharyngeal secretions and faeces, and it is probable that these are the main source of transmitted infection.

In this week's issue of the *B.M.J.* Squadron-Leader L. J. German and his colleagues describe at page 742 an outbreak of E.C.H.O. type 5 infection in a maternity unit in Singapore. Sixty-four cases were observed between July and October 1965, of which 56 were among infants. All had a pyrexia of 99–103° F. (37.2–39.4° C.), the onset usually being between the fourth and eighth day of life. A faint pink maculopapular rash was seen in 20 infants, being more pronounced on the limbs and buttocks but present also on the trunk and face. Thirteen infants had loose, offensive stools and four others passed blood and mucus. The eight adults, seven of whom were mothers of the infants, complained of malaise, fever, severe headache, and vomiting. They also developed a rash, which was more persistent than in the infants. E.C.H.O. type 5 virus was detected in 31 cases. All patients recovered, and the outbreak lasted 16 weeks. A similar outbreak was reported by E. W. Hart and his colleagues⁴ from a London maternity unit in 1962. The symptoms then were fever, diarrhoea, lymphadenopathy, and an enlarged spleen, but no rashes were observed.

Virological investigations are particularly valuable in such circumstances, for the prognosis of E.C.H.O. virus infections generally is good, and during an outbreak in a maternity home this is comforting news to have. On the other hand, E.C.H.O. viruses can cause serious disease, particularly in the very young,⁵ but they do not appear to cause such severe disease in this age group as do Coxsackie B viruses.⁶

Old and Frail

One of the miracles of our time is the increase in the average length of life. In England and Wales, for instance, the expectation of life at birth has risen by 20 years since 1900, from about 50 to about 70 years.¹ Eileen M. Brooke² puts it another way when she says that in 1963 in England and Wales one in every eight persons was aged 65 or more, and if the trend is continued by 1982 the ratio will be one in six. Not only will the ratio of retired to working people be adversely affected, but the number of old people in absolute terms will have reached the formidable total of 7.4 millions in 1982. There will be proportionately fewer persons capable of looking after their aged kin, and for a variety of socio-economic reasons there will probably be fewer still able to do so even if they wished.

Two recent papers, one complementing the other, highlight the present inadequacies for the care of the aged and under-

line the danger in a failure to plan for the future. F. Allen Binks³ drew attention to the misuse of geriatric units, and criticized general hospitals for their failure to share the burden of the care of the aged. He implied that too many people who work in these hospitals fail to accept the responsibility they should for confused, restless, incontinent old patients, whom they shrug off after a period in their care as a "chronic patient" and "no longer a responsibility of this hospital." He also made a telling comparison between the understaffed geriatric unit working at 97% bed occupancy and the 70% occupancy of "acute" hospitals where there is no staff shortage. How, he argues, in the circumstances can there be complaints that the "acute" beds are being blocked by geriatric patients? Yet in an area of which he was writing "an excess of 750 acute beds and a deficiency of 270 geriatric beds is being changed to one with an excess of 1,025 acute beds and a deficiency of 245 geriatric beds."

In the second paper R. W. Parnell⁴ reports on two years' experience in a psychogeriatric unit which takes three-quarters of the patients over the age of 65 admitted to a mental hospital. He makes the most important point that, "Even today regional board psychiatric and geriatric advisory committees may act in isolation from each other, forgetting that the common focus of their attention is the provision of hospital care for old people, not for bodiless minds on the one hand or mindless bodies on the other." He goes on to turn the knife and points out that because of the grim shortage of beds for sick old people "they tend to flow into any vacant bed, irrespective of administrative edict, and are usually labelled selectively from their multiple pathology, with the diagnosis best calculated to gain admission by a particular hospital." It is indeed a curious perversion of the legend of Procrustes: instead of the patient being shaped to the bed, the bed is shaped to the patient. The pressure on mental hospital beds from general hospitals, geriatric units, and elsewhere was not foreseen a few years ago.^{5,6} As Parnell observes, this is in itself sufficient to upset the forecast that by the mid-1970s we might need only half as many beds for mental illness. Many mental hospital psychiatrists would agree with Parnell's observation.

Binks and Parnell paint on a small canvas framed by the limits of their own experience. Miss Eileen M. Brooke,² however, is able to project her statistical data on to a national screen. And some of her data are particularly pertinent. For example, a census of patients in psychiatric hospitals at the end of 1963 showed that there were 51,616 persons aged 65 and over. One in every 109 persons in the population as a whole was resident in a mental hospital or unit. Of all mental hospital patients 39% were aged 65 and over, and of these nearly half were 75 or more. Between 1954 and 1963 the numbers aged 65 and over in psychiatric hospitals in England and Wales increased by 6,300, representing an increase from 30 to 39% of the total hospital population. And the shift towards more older patients in these hospitals is most unlikely to be reversed.

What is perhaps the most alarming statistic is that 11% of the men and 6% of the women die within a month of

¹ *The Registrar General's Statistical Review of England and Wales for the Year 1965*, Part 2, Tables, Population. 1967. H.M.S.O.

² Brooke, E. M., in *Psychiatric Disorders in the Aged*, p. 214. Symposium held at Royal College of Physicians, 1965. Geigy (U.K.) Limited, on behalf of the World Psychiatric Association. 1967. Manchester

³ Binks, F. A., *Brit. med. J.*, 1968, 1, 269.

⁴ Parnell, R. W., *Geront. Clin.*, 1968, 10, 30.

⁵ Norton, A., *Brit. med. J.*, 1961, 1, 528.

⁶ Tooth, G. C., and Brooke, E. M., *Lancet*, 1961, 1, 710.

Multimorbidity (presence of multiple chronic conditions at the same time)

The impact of multimorbidity on functioning, quality of life and risk mortality may be significantly greater than the sum of the individual effects that might be expected from these conditions.

Although multimorbidity refers to the presence of two or more chronic conditions, there is no standard definition or consensus on which conditions should be considered.



WORLD
REPORT
ON
**AGEING
AND
HEALTH**

SPECIAL ARTICLES

The End of the Disease Era

Mary E. Tinetti, MD, Terri Fried, MD

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.

"...The time has come to abandon disease as the primary focus of medical care. When disease became the focus of Western medicine in the 19th and early 20th century, the average life expectancy was 47 years and most clinical encounters were for acute illness. Today, the average life expectancy in developed countries is 74 years and increasing, and most clinical encounters are for chronic illnesses or non-disease-specific complaints..."

The Frailty Phenotype

Table 1. Operationalizing a Phenotype of Frailty

<i>A. Characteristics of Frailty</i>	<i>B. Cardiovascular Health Study Measure*</i>
Shrinking: Weight loss (unintentional) Sarcopenia (loss of muscle mass)	Baseline: >10 lbs lost unintentionally in prior year
Weakness	Grip strength: lowest 20% (by gender, body mass index)
Poor endurance; Exhaustion Slowness	"Exhaustion" (self-report) Walking time/15 feet: slowest 20% (by gender, height)
Low activity	Kcals/week: lowest 20% males: <383 Kcals/week females: <270 Kcals/week
	<i>C. Presence of Frailty</i>
	Positive for frailty phenotype: ≥ 3 criteria present
	Intermediate or prefrail: 1 or 2 criteria present

*See Appendix.

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

Table 2

The Simple “FRAIL” Questionnaire Screening Tool

3 or greater = frailty; 1 or 2 = prefrail

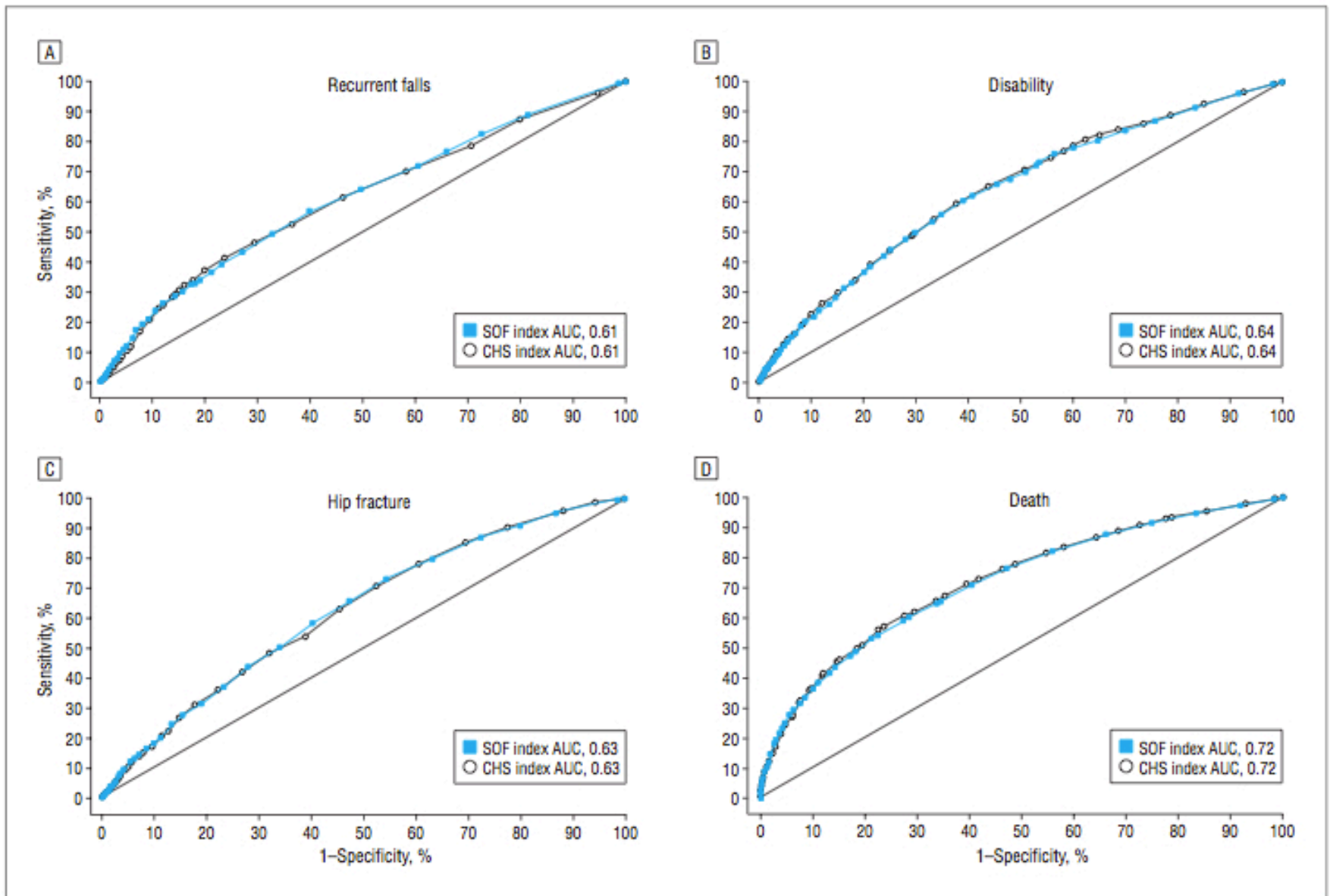
Fatigue: Are you fatigued?

Resistance: Cannot walk up 1 flight of stairs?

Aerobic: Cannot walk 1 block?

Illnesses: Do you have more than 5 illnesses?

Loss of weight: Have you lost more than 5% of your weight in the past 6 months?



1. Weight loss
2. Inability to rise from a chair
3. Reduced energy level

Table 1
The Gérontopôle Frailty Screening Tool (GFST)



Patients aged 65 years and older without both functional disability (Activities of Daily Living score $\geq 5/6$) and current acute disease.

	YES	NO	Do not know
Does your patient live alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your patient involuntarily lost weight in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your patient been more fatigued in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your patient experienced increased mobility difficulties in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your patient complained of memory problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your patient present slow gait speed (i.e., >4 seconds to walk 4 meters)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If you have answered YES to one or more of these questions:</i>			
Do you think your patient is frail?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
If YES, is your patient willing to be assessed for his/her frailty status at the Frailty Clinic?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	

Table 2. Screening instrument (PRISMA-7) for selecting clients eligible for the ISD system

CLIENT QUESTION	YES	NO
Are you older than 85 years?	<input type="checkbox"/>	<input type="checkbox"/>
Are you male?	<input type="checkbox"/>	<input type="checkbox"/>
In general, do you have any health problems that require you to limit your activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do you need someone to help you regularly?	<input type="checkbox"/>	<input type="checkbox"/>
In general, do you have any health problems that require you to stay at home?	<input type="checkbox"/>	<input type="checkbox"/>
If you need help, can you count on someone close to you?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly use a cane, a walker, or a wheelchair to move about?	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL CHECKED		

Groningen Frailty Indicator

Physical components

Are you able to carry out these tasks single-handedly and without any help?
(The use of help resources, such as a walking stick, walking frame, or wheelchair, is considered to be independent.)

- 1. Shopping
- 2. Walking around outside (around the house or to the neighbors)
- 3. Dressing and undressing
- 4. Going to the toilet
- 5. What mark do you give yourself for physical fitness? (scale 0 to 10)
- 6. Do you experience problems in daily life because of poor vision?
- 7. Do you experience problems in daily life because of being hard of hearing?
- 8. During the past 6 months have you lost a lot of weight unwillingly? (3 kg in 1 month or 6 kg in 2 months)
- 9. Do you take 4 or more different types of medicine?

Cognitive component

- 10. Do you have any complaints about your memory?

Social component

- 11. If you are at work, with your family, or at church do you believe that you are part of the social network?*
- 12. Do other people pay attention to you?*
- 13. Will other people help you if you are in need?*

Psychological component

- 14. In the past 4 weeks did you feel downhearted or sad?*
- 15. In the past 4 weeks did you feel calm and relaxed?*

Scoring:

Questions 1–4:	Yes = 0; No = 1
Question 5:	0–6 = 1; 7–10 = 0
Questions 6–9:	No = 0; Yes = 1
Question 10:	No = 0; Sometimes = 0; Yes = 1
Questions 11–13:	Never = 1; Sometimes = 1; Often = 0; All the time = 0 [†]
Question 14:	Never = 0; Seldom = 0; Sometimes = 1; Often = 1; Very often = 1; All the time = 1 [†]
Question 15:	Never = 1; Seldom = 1; Sometimes = 1; Often = 1; Very often = 0; All the time = 0 [†]

Cut-off: ≥4/15

*Psychosocial items were slightly rephrased compared with the previous published self-report version.²²

[†]Likert scales were adapted compared with the previous published self-report version.

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.

Table 2. Floor Effect and Discriminative Ability of Scales

Survey of Health, Ageing, and Retirement in Europe Frailty scale	Floor Effect (People with 0 score)		Other Scales Predicting Mortality ^a		AUC (95% Confidence Interval)	
	Proportion (%)	2 Years	5 Years	2 Years	5 Years	
Groningen Frailty Indicator	12.2	None	FI, FI-CGA, Edmonton	0.72 (0.70–0.75)	0.70 (0.69–0.72)	
Tilburg Frailty Indicator	8.2	None	FI, FI-CGA, Edmonton	0.74 (0.72–0.76)	0.73 (0.71–0.74)	
Frailty Index	0.1	N/A	N/A	0.77 (0.75–0.79)	0.75 (0.74–0.77)	
FI-CGA	2.1	None	None	0.75 (0.73–0.77)	0.74 (0.72–0.75)	
Clinical Frailty Scale	6.5	None	None	0.73 (0.70–0.75)	0.70 (0.68–0.71)	
Frailty phenotype	48.4	FI, FI-CGA, Edmonton, Tilburg, CFS	FI, FI-CGA, Edmonton, Tilburg, CFS	0.73 (0.70–0.75)	0.70 (0.68–0.71)	
Edmonton Frail Scale	11.5	FI	None	0.76 (0.74–0.79)	0.75 (0.74–0.77)	
FRAIL scale	57.2	All scales	All scales	0.70 (0.67–0.72)	0.67 (0.65–0.68)	

FI = Frailty Index; FI-CGA = Frailty Index based on a Comprehensive Geriatric Assessment; CFS = Clinical Frailty Scale

^a Other scales that had a significant area under the receiver operating characteristic curve (AUC) in participants who scored 0 in the scale of interest.

Correction made after online publication August 26, 2013: the formatting for Table 2 has been changed.

Table 3. Agreement of Survey of Health, Ageing and Retirement in Europe Frailty Scales (Cohen Kappa Statistic)

	Groningen Frailty Indicator	Tilburg Frailty Indicator	Frailty Index	FI-CGA	Clinical Frailty Scale	Frailty phenotype	Edmonton Frail Scale
Tilburg Frailty Indicator	0.50						
Frailty Index	0.46	0.52					
FI-CGA	0.46	0.52	0.82				
Clinical Frailty Scale	0.30	0.38	0.61	0.57			
Frailty phenotype	0.25	0.37	0.51	0.51	0.45		
Edmonton Frail Scale	0.18	0.27	0.45	0.46	0.52	0.55	
FRAIL scale	0.13	0.27	0.28	0.29	0.27	0.46	0.45

FI-CGA = Frailty Index based on a Comprehensive Geriatric Assessment.



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Review

Modifications to the frailty phenotype criteria: Systematic review of the current literature and investigation of 262 frailty phenotypes in the Survey of Health, Ageing, and Retirement in Europe



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ABSTRACT

We conducted a systematic review to determine variability in how the criteria of the frailty phenotype (grip strength, weight loss, exhaustion, walking speed, physical activity) were assessed. We then evaluated the impact on estimating prevalence and mortality of modifying the criteria, using the Survey of Health, Ageing, & Retirement in Europe (SHARE). Five databases were searched for original research articles published after 2000, which evaluated frailty using the phenotypic criteria. Among the 264 included studies, 24 studies provided enough information to demonstrate that all criteria were assessed as proposed in the original frailty phenotype study by Fried et al. (2001). Physical inactivity and weight loss were the criteria most often modified. We then created 262 phenotypes from SHARE based on common modifications found in the review. Among these phenotypes, frailty prevalence ranged from 12.7% to 28.2%. Agreement with the primary frailty phenotype ranged from 0.662 to 0.967 and internal consistency ranged from 0.430 to 0.649. Women had 2.1–16.3% higher frailty prevalence than men. Areas under receiver operating characteristic curves for discriminating five-year mortality ranged from 0.607 (95% CI: 0.583–0.630) to 0.668 (0.645–0.691). The frailty phenotype often has been modified, and these modifications have important impact on its classification and predictive ability.

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Different tools, different aims

Frailty phenotype	Frailty Index
Signs/symptoms	Diseases, activities of daily living, results of a clinical evaluation
Possible before clinical assessment	Doable only after a comprehensive clinical assessment
Categorical variable	Continuous variable
Pre-defined set of criteria	Unspecified set of criteria
Pre-disability syndrome	Accumulation of deficits
Meaningful results potentially restricted to non-disabled older persons	Meaningful results in every individual, independently of functional status or age

Special Article

Frailty: An Emerging Public Health Priority

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Key points for the detection and management of frailty

Raise awareness about age-related conditions among policymakers, public health authorities, practitioners, and general population

Promote healthy lifestyle and behaviours in the population starting since younger age and adulthood

Healthcare authorities should maximize efforts in the detection/care of frailty, **balancing priorities, needs, and resources**

Enhance access to care through a simple process possibly based on a single-point entry into the system and the “case manager” model

The choice of the specific frailty instrument should rely on the purpose of the evaluation, the outcome of interest, the validity of the tool, the studied population, and the setting

The detection of frailty should lead to a multidomain and person-centred evaluation (i.e., **CGA**) for supporting the design of an individualized plan of intervention



Fit for Frailty

Consensus best practice guidance for the care
of older people living with frailty in community
and outpatient settings

A report by the
British Geriatrics Society
*in association with the Royal College of
General Practitioners and Age UK*

June 2014

3. Recognising and identifying frailty in individuals

Recommendations

- ▶ Older people should be assessed for the possible presence of frailty during all encounters with health and social care professionals. Slow gait speed, the PRISMA questionnaire, the timed-up-and-go test are recommended as reasonable assessments. The Edmonton Frail Scale is recommended in elective surgical settings.
- ▶ Provide training in frailty recognition to all health and social care staff who are likely to encounter older people.
- ▶ Do not offer routine population screening for frailty.



Fit for Frailty

Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings

CGA

Recognition of Frailty in an individual

- Either by encounter screening or
- by frailty presentation (or by systematic screening - not yet recommended)

Holistic Medical Review including

- Identification and Optimisation of medical illnesses plus onward referral to other specialists
- Individualised goal setting
- Drug review
- Anticipatory care planning (which may include escalation plans, emergency plans, end of life care (EOLC) plans)

Geriatrician

Therapist or other
community team
member

Specialist nurse

OPMHT

Individualised Care and Support Plan –

With details of personal goals, optimisation plans, escalation and emergency plans as well as advance care plans where these are indicated.



Fit for Frailty

Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings

Thank you!

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