Healthy Ageing and Frailty Workshop

Practical Tips for Screening and Intervention

Tuesday 21 May 2024

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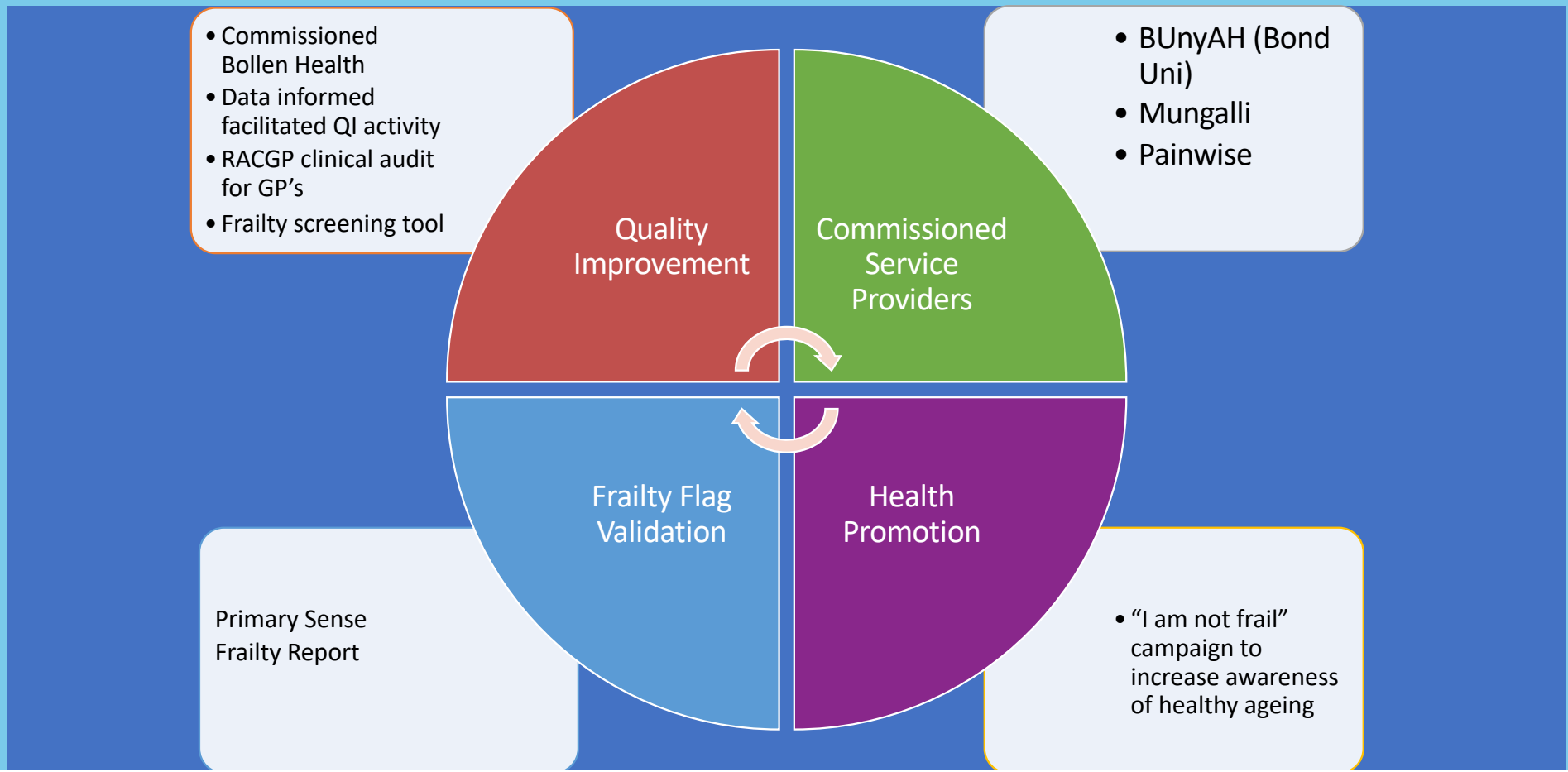
Acknowledgement to Country

Artist: NARELLE URQUHART, WIRADJURI WOMAN]

Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and the traditional practices of the families of the Yugambeh Language Region of South East Queensland and their Elders past, present and emerging.

Housekeeping

- In case of emergency please exit via the doors at the back of the room and proceed down the stairs to the front of the hotel.
- Toilets are located across the foyer
- WIFI password is: *mercureconf*
- Phones
- Recording


• Commissioned Bollen Health
• Data informed facilitated QI activity
• RACGP clinical audit for GP's
• Frailty screening tool
Quality Improvement
Commissioned Service Providers
• BUnyAH (Bond Uni)
• Mungalli
• Painwise
Frailty Flag Validation
Health Promotion
Primary Sense Frailty Report
• "I am not frail" campaign to increase awareness of healthy ageing

GP Reflection

"We have changed our adult health assessments so that we now do a Frailty screening test as well as other checks such as grip strength, walking speed etc. Upon making a diagnosis of frailty, or pre frailty, we now manage accordingly with aged care assessments, review my dietician and exercise physiologist."

"Ensure bone scans are done as this was poor previously."

"I have now incorporated the Frailty Screening Tool into my annual health assessments of patients. I am addressing this issue specifically with individuals, engaging patients where I can, and if they are not interested in a formal balance and strengthening program, I am advising on some simple home exercises, and I have witnessed improvements."

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Introducing

Dr. Chris Bollen
MBBS MBA FRACGP FACHSM MAICD

Jane Bollen RN Cert (Crit Care)
CertIVTAE dip. Acct GAICD

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Do you have a Mrs Andrews in your practice?

https://www.youtube.com/watch?v=Fj_9HG_TWEM&t=5s

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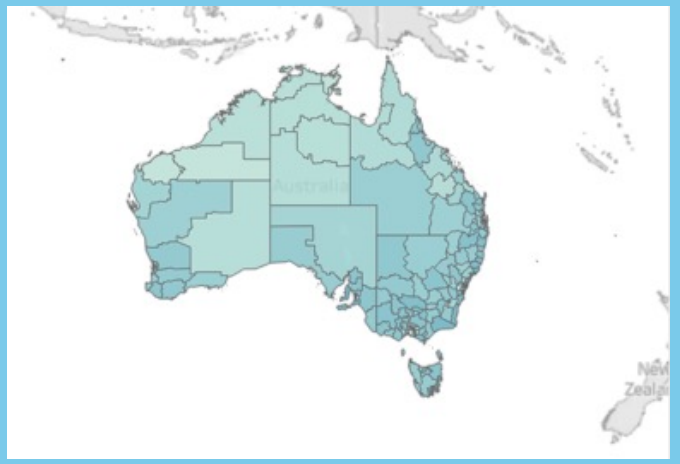
Why do we need to be here?

- Number of people in Australia aged over 65 (12% in 2016 and 16% 2021)
  - 1 in 6 Queenslanders are aged 65 and over (16.1%)
  - Gold Coast overall 17.7% 2021 (16.5% 2016)
  - Gold Coast North 23.7% 2021
  - Fastest rising group are men aged 70-74
- Multimorbidity
- What's the impact at a practice level?



https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/demographics-of-older-australians

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Why do we need to be here?

- Rates of Chronic Disease and Multimorbidity increasing
- 50% people aged 75+ on 8+ meds
- 40% people aged 75+ will have eGFR <60 (Chronic Kidney Disease)
- Multiple prescribers with single disease/organ focus
- Rarely is deprescribing occurring

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Why do we need to be here?

"Frailty is the most significant challenge to “ageing well' in Australia. More than 20% of people become frail as they age”

Professor Ruth Hubbard, Geriatrician

…….What does this all mean for your practice?

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"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

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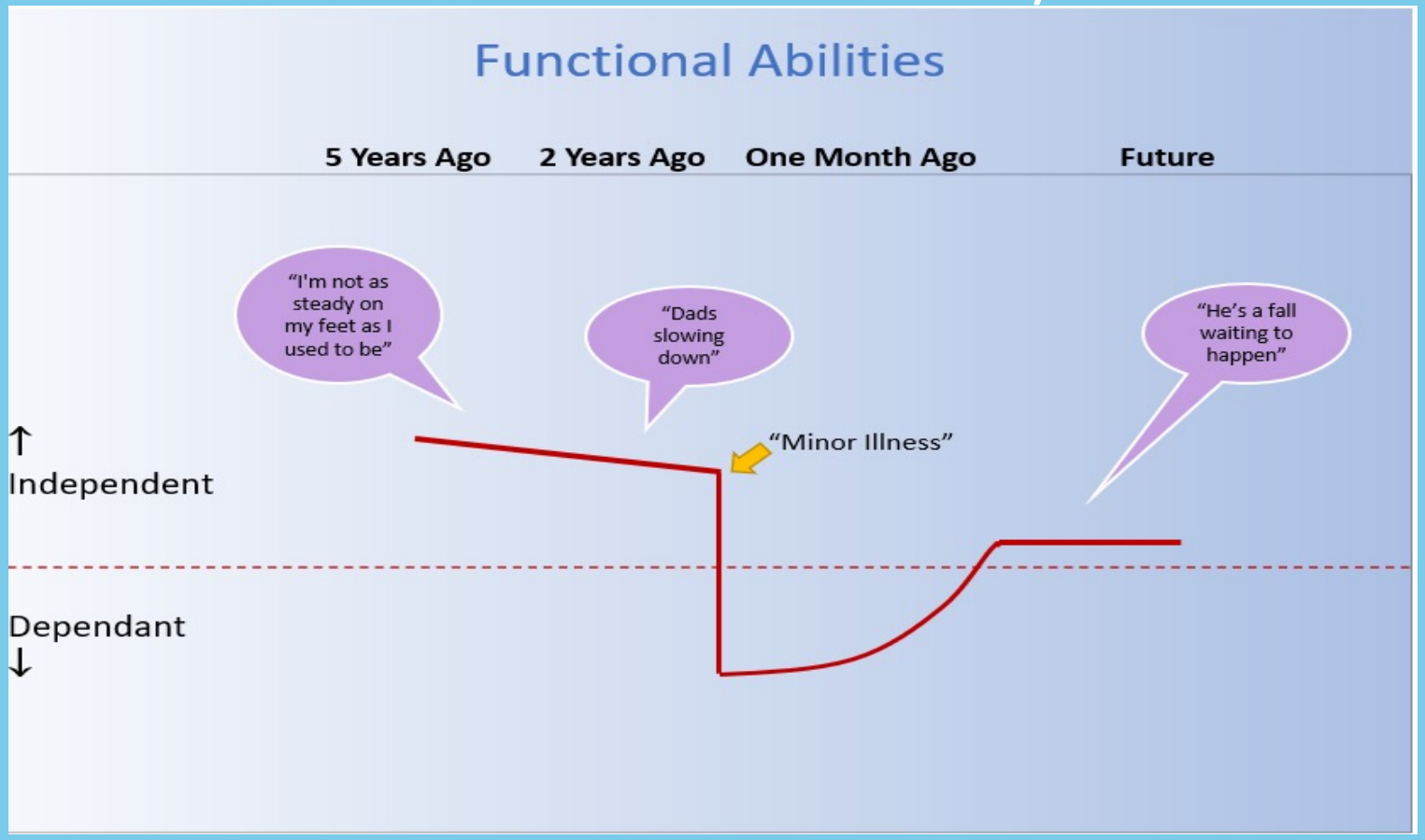
Can it be done differently?



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Can it be done differently?

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...."
- MyAgedCare website and low digital literacy of many people 75+
- Financial concerns
- Health systems structure and funding

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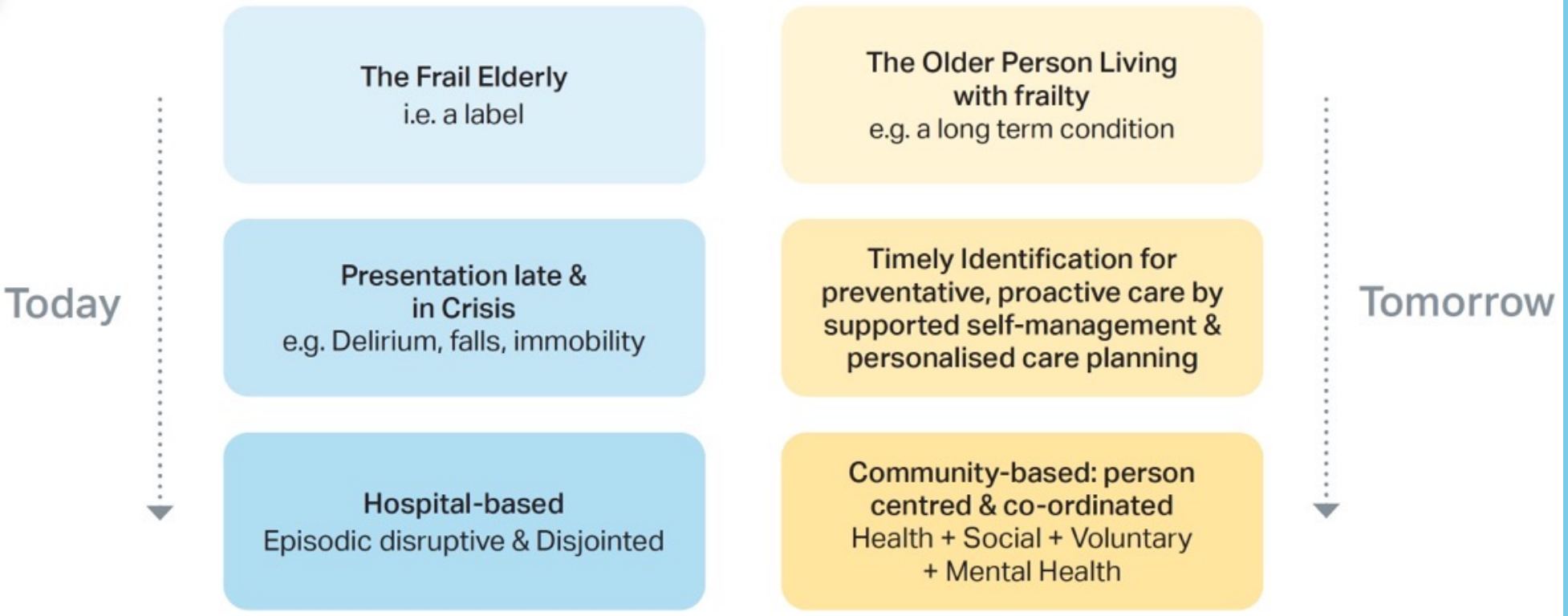
Care Paradigm for Older People & Frailty

Figure 1. Frailty is a long term Condition



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“Barriers to doing what matters-keeping older people well and at home…… …….Why frailty is not recognised in Australian General Practice”

AAG Conference Gold Coast 2023

Dr Chris Bollen MBBS MBA FRACGP FACHSM
Director Bollen Health

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phn CENTRAL AND EASTERN SYDNEY
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Barriers to recognising frailty in a General Practice (% responses n=475)
Not an issue I need to get involved with
1
Don't know what works
2
No barriers
3
Not in care plan template
4
Older people resistant
8
Not in 75+ HA template
13
Costs
13
Even if I assess for frailty, what do I do
14
Knowledge gap
16
Time
26
0
5
10
15
20
25
30

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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 12 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

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Learning objectives

Recognise	• … a person living with frailty
Learn	• … to use evidence-based screening tools to recognise people with, or at risk of frailty
Understand	• …the treatment options/referral pathways for frailty which can assist with reducing further decline
Engage	• … your patients by creating the concept of “Muscle Health Checks“ to support a proactive approach to Healthy Ageing

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Overview

- Why this session?
- What is Frailty?
- Why recognise frailty?
- How to recognise Frailty…… screening tools
- Sarcopenia assessment
- Case Study
- Now I have identified frailty...what do I do?
- Frailty Quality Improvement

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What is frailty?

Definition of Frailty:
Frailty Phenotype *(Dr Linda Fried 2001)*

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"

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Frailty v sarcopenia phenotype

Frailty is multisystem impairment associated with increased vulnerability to stressors operationalised as below

Fried et al J Gerontol A Biol Sci 2001

0/1 = Non-frail
2 = Pre-frail
3 + = Frail

Sarcopenia is the loss of muscle mass and strength or physical performance associated with increasing age

Cruz-Jentoft et al EWGSOP Consensus Guidelines Age Ageing 2010

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Rockwood's deficit model of frailty

- Memory & cognitive problems
- Cerebrovascular disease
- Dizziness
- Parkinsonism & tremor
- Mono/hemiparesis
- Weakness
- Sleep disturbance
- Visual impairment
- Hearing impairment
- Hypertension
- Ischaemic heart disease
- Atrial fibrillation
- Heart valve disease
- Hypotension/syncope
- Heart failure
- Peripheral vascular disease
- Dyspnoea
- Respirator disease
- Peptic ulcer
- Faecal incontinence
- Weight loss & anorexia
- Urinary incontinence
- Urinary system disease
- Chronic kidney disease
- Osteoporosis
- Fragility fracture
- Arthritis
- Diabetes
- Thyroid disease
- Skin ulcer
- Anaemia & haematinic deficiency
- Falls
- Foot problems
- Housebound
- Problems with bathing
- Problems carrying out personal grooming and toileting
- Mobility and transfer problems
- Unable to manage medications
- Activity limitation
- Social vulnerability
- Environment problems
- Requirement for care
- Polypharmacy

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What term have you decided to use instead of "frailty" when discussing frailty with your patients?

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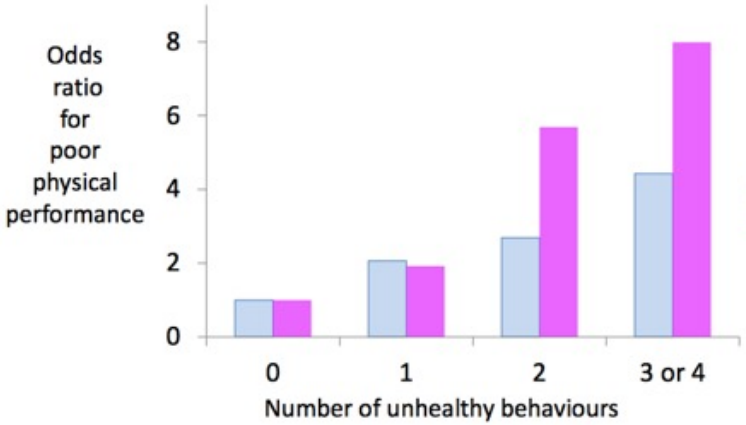
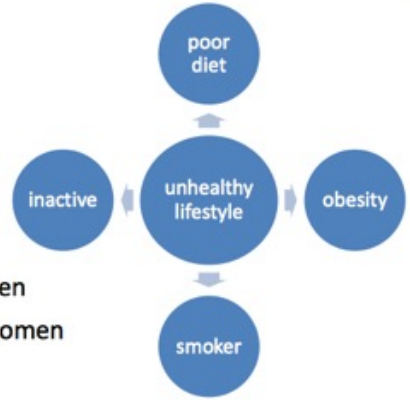
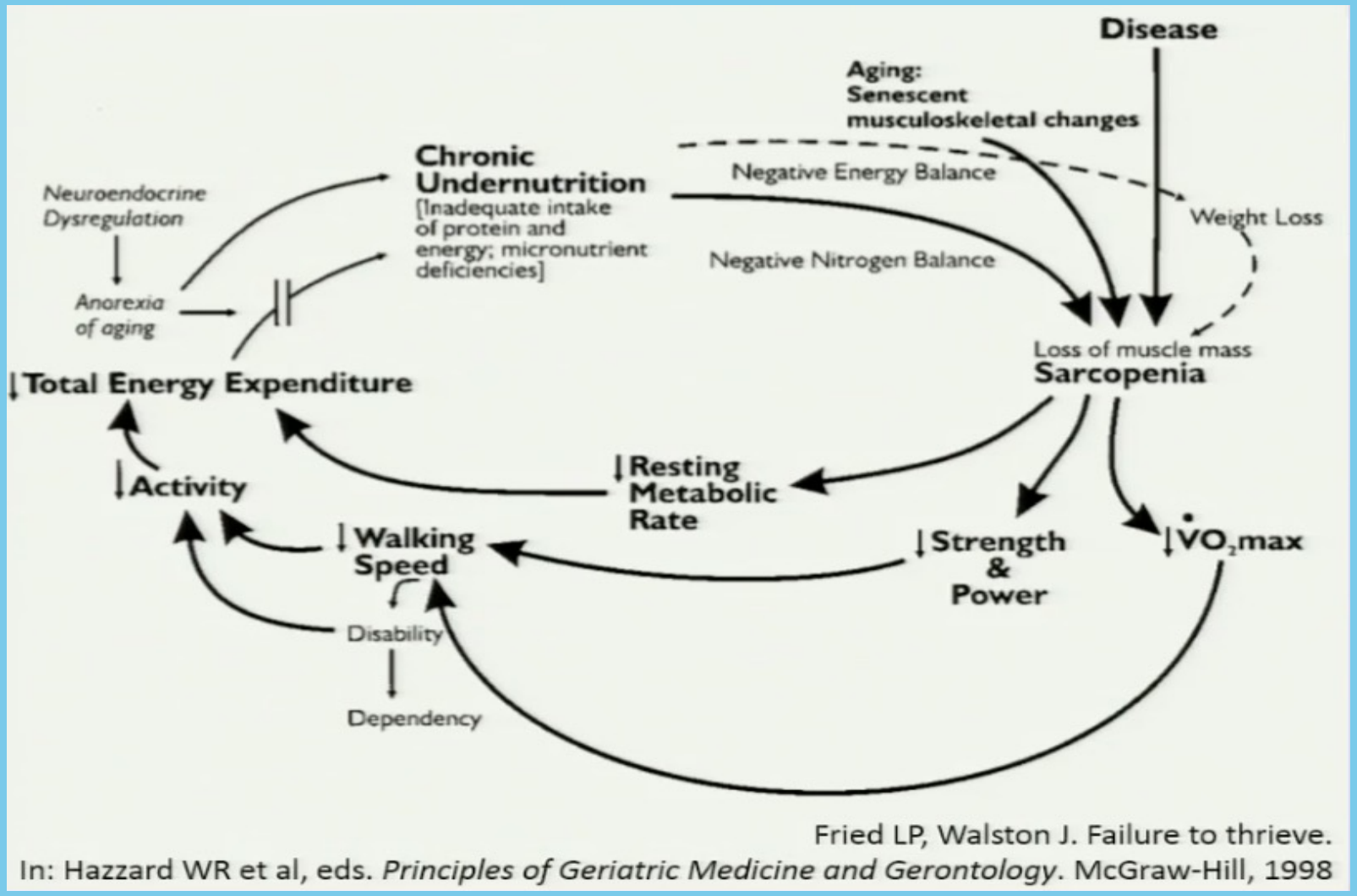
Who is at risk?

Unhealthy lifestyle in later life is related to worse physical performance: findings from the Hertfordshire Cohort Study







Fried LP, Walston J. Failure to thrieve.
In: Hazzard WR et al, eds. *Principles of Geriatric Medicine and Gerontology*. McGraw-Hill, 1998

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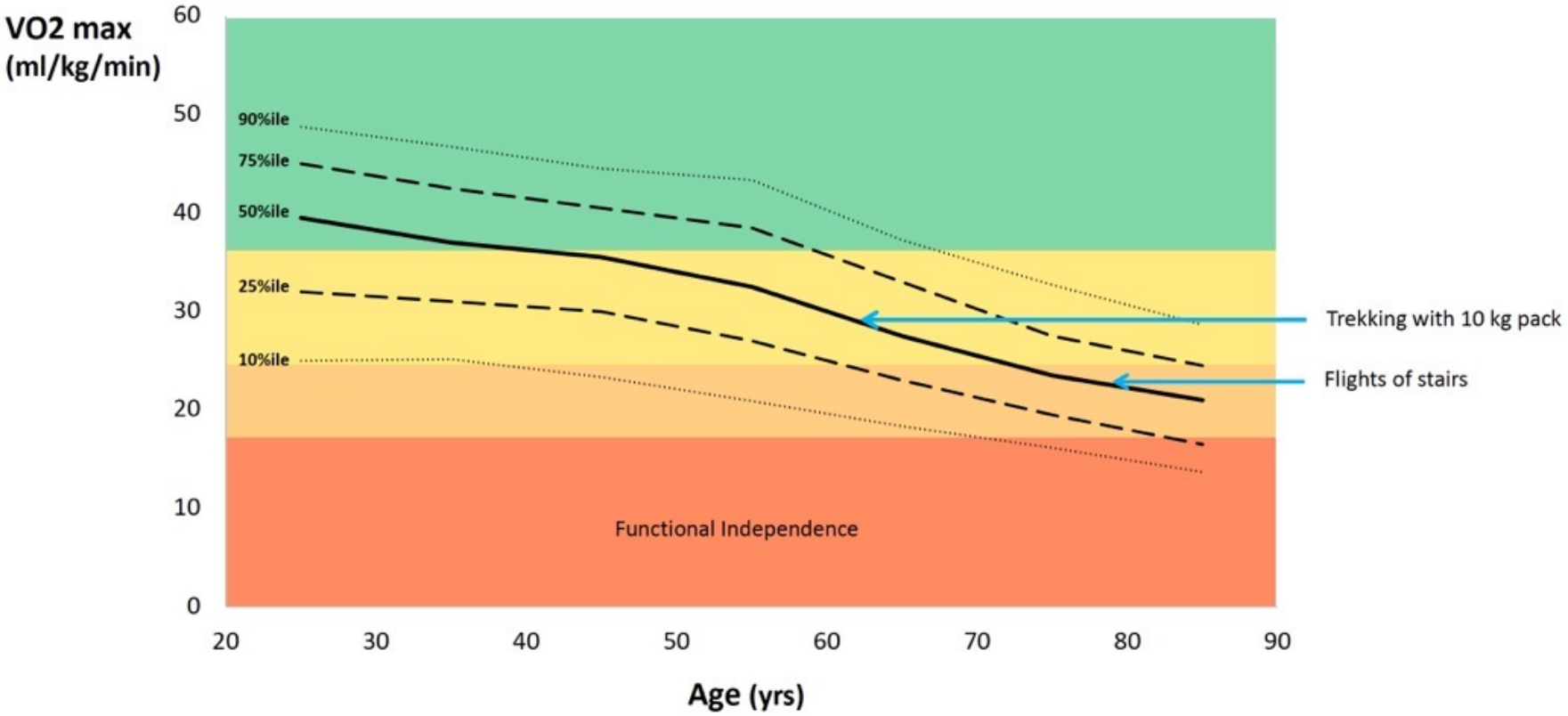
Fitness Forecaster



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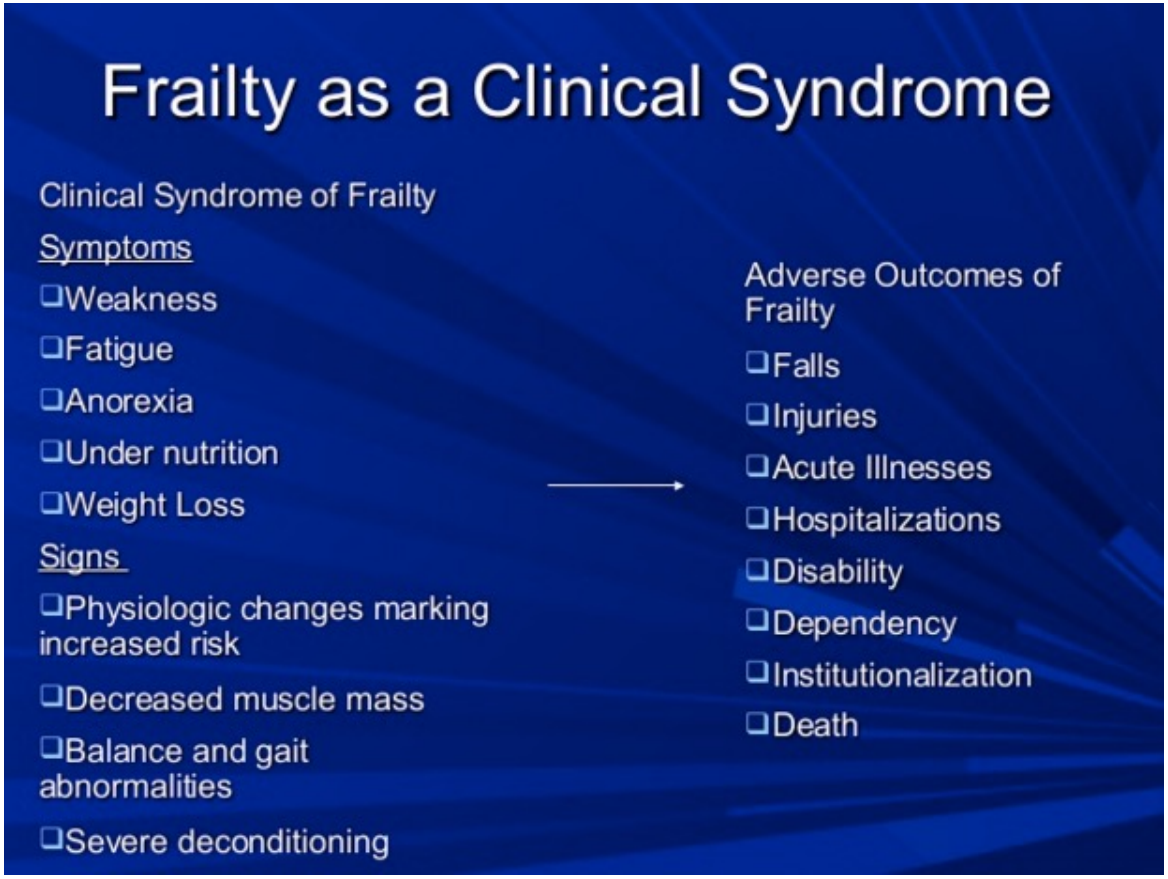
Frailty: why important?

Some bad news	It's not a disease
Some more bad news	It affects the whole body
Even more bad news	Every person is different
The worst of news	Several things wrong at once

So, frailty lies beyond the comfort zone of Guideline Based-Medicine

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

Why recognize frailty?

- Fit → prevent the onset of frailty!
- Mild frailty → reverse it!
- Moderate → stabilize to prevent deterioration!
- Severe……?
- ***The Asia-Pacific Clinical Practice Guidelines for the Management of Frailty 2017***

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 **Vitamin D** if Vit D deficient

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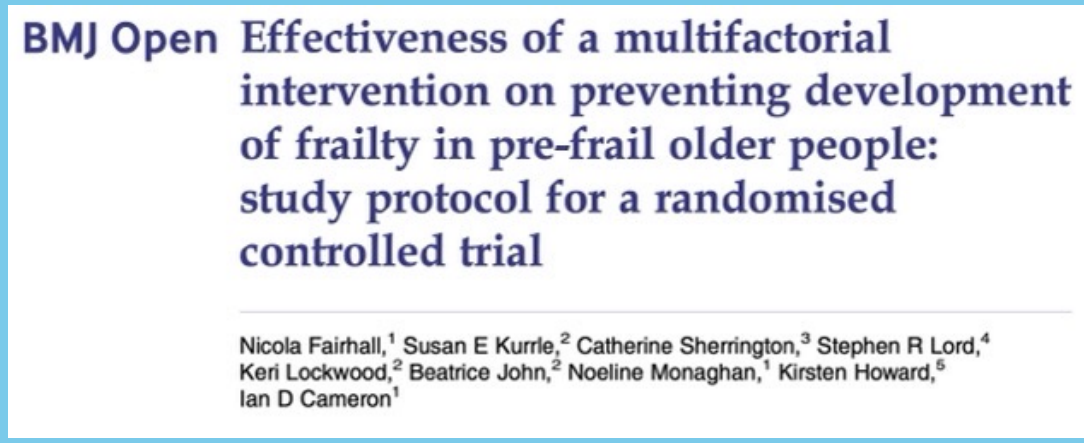
What can be changed?



Potentially reversible areas:

- Weakness,
- Slowness,
- Low energy expenditure

Cameron, Kurrle et al 2015 → intervention reduced frailty and improved mobility BUT……

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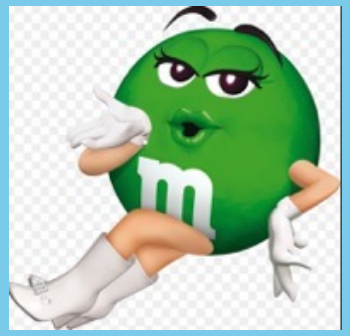
75+
5Ms 3Ds 1F

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



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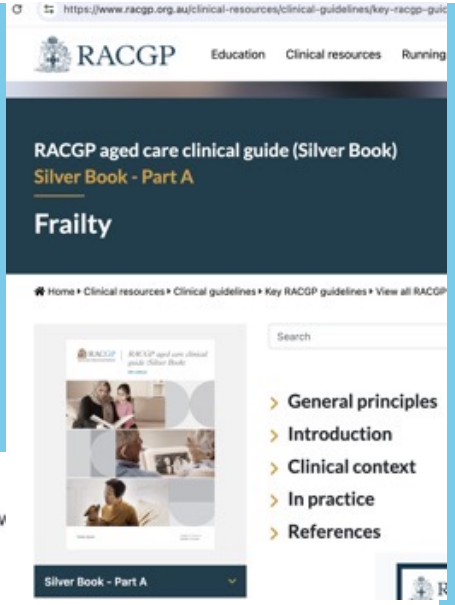
Identifying Frailty

RACGP Guides



Health assessment and preventive care

- Conduct a thorough health assessment and manage prev
  - hearing
  - vision
  - continence – bowel and bladder
  - constipation
  - falls risk
  - chronic pain
  - wound care and prevention of pressure injuries
  - nutrition
  - oral health
  - mental health, including risk assessment and management
  - sexuality
  - alcohol and other drugs.
- Define frailty and be familiar with validated assessment tools.
- Consider neglect and abuse.
- Conduct assessments of functional, cognitive, decision-making and driving capacity.
- Screen for cancer, and recognise the diminishing value of some screening activities in older patients, including for the following cancers:
  - cervical
  - breast
  - bowel.
- Recommend and administer immunisations (age appropriate).
- Screen for and manage osteoporosis.
- Enquire about and assess safety in the home, identify concerns and act appropriately.

In practice

Diagnosis

Consider assessing frailty annually. There are many instruments available, and two broad models of frailty have been described:[20]

- Frailty phenotype model – hypothesised to have an underlying biological basis.
- Frailty index – cumulative deficit model.

The most commonly used tool for the phenotypic frailty is the Physical Frailty Phenotype, also known as the Fried or Hopkins tool.[21] Instruments to assess frailty include:

- Fried frailty indicators – frailty (three or more of the below), pre-frailty (one or two of the below) and not frail (none of the below)[22]
  - Unintentional weight loss (≥4 kg in the past year)
  - Self-reported exhaustion
  - Weakness (reduced grip strength)
  - Slow gait speed
  - Low physical activity
- Frailty index – based on the accumulation of illnesses, functional deficits, cognitive decline and social circumstances, it involves answering >20 medical and functional questions[23]
- Clinical Frailty Scale – helpful scale that takes very little time
- Edmonton Frail Scale[1]
- other useful simple tests with variable specificity and sensitivity[24]
  - Slow walking speed (>5 seconds to walk 4 m)
  - Timed up and go test (>10 seconds to stand from a chair, walk 3 m, turn around, walk back to the chair and sit down again).

All patients admitted to a residential aged care facility (RACF) should be screened for risk of malnutrition and, if at risk, referred to a dietitian.[25] The following tools are useful in screening for malnutrition:

- Malnutrition Screening Tool (MST)[26]
- Malnutrition Universal Screening Tool (MUST)[27]
- Mini Nutritional Assessment – short-form (MNA-SF)[28]
- Subjective Global Assessment (SGA).[29] This includes a physical assessment of lean body mass and fat mass; useful for patients with fluid retention (eg ascites, oedema) in whom body mass index (BMI) may not reflect nutritional status. To be completed by an accredited dietitian.[29]

Easy to recognise??

Marathon aged 85 and 102!

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How to identify?

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What would be useful in a screening tool?

- Quick
- Easy to use
- Easy to understand for patient, doctor and nurse
- Could be used in waiting room or before visit
- Validated
- Can then act on it as the evidence is compelling
- The tool helps describe what is next required

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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)

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- protein/calorie supplementation
- vitamin D

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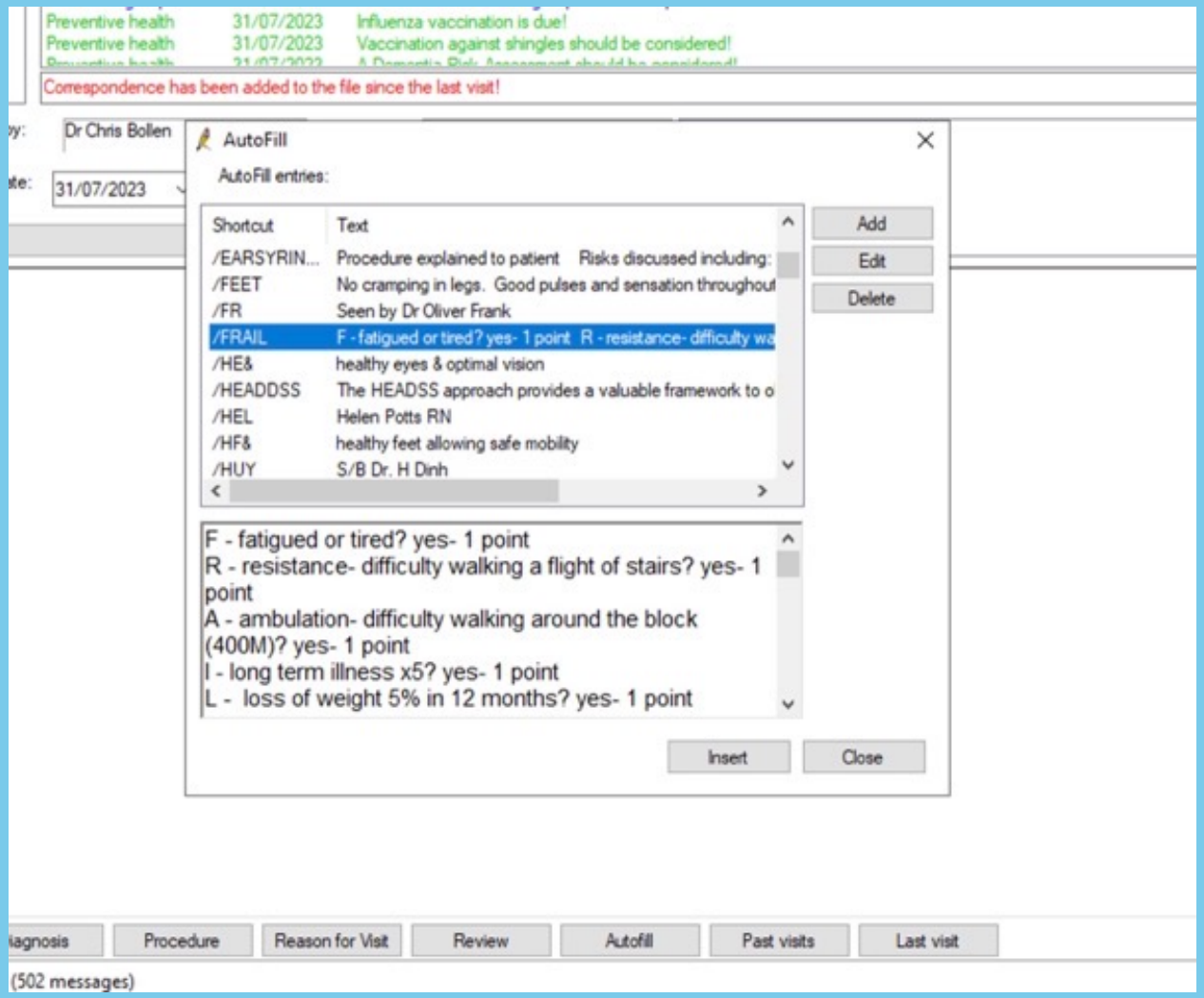

/FRAIL

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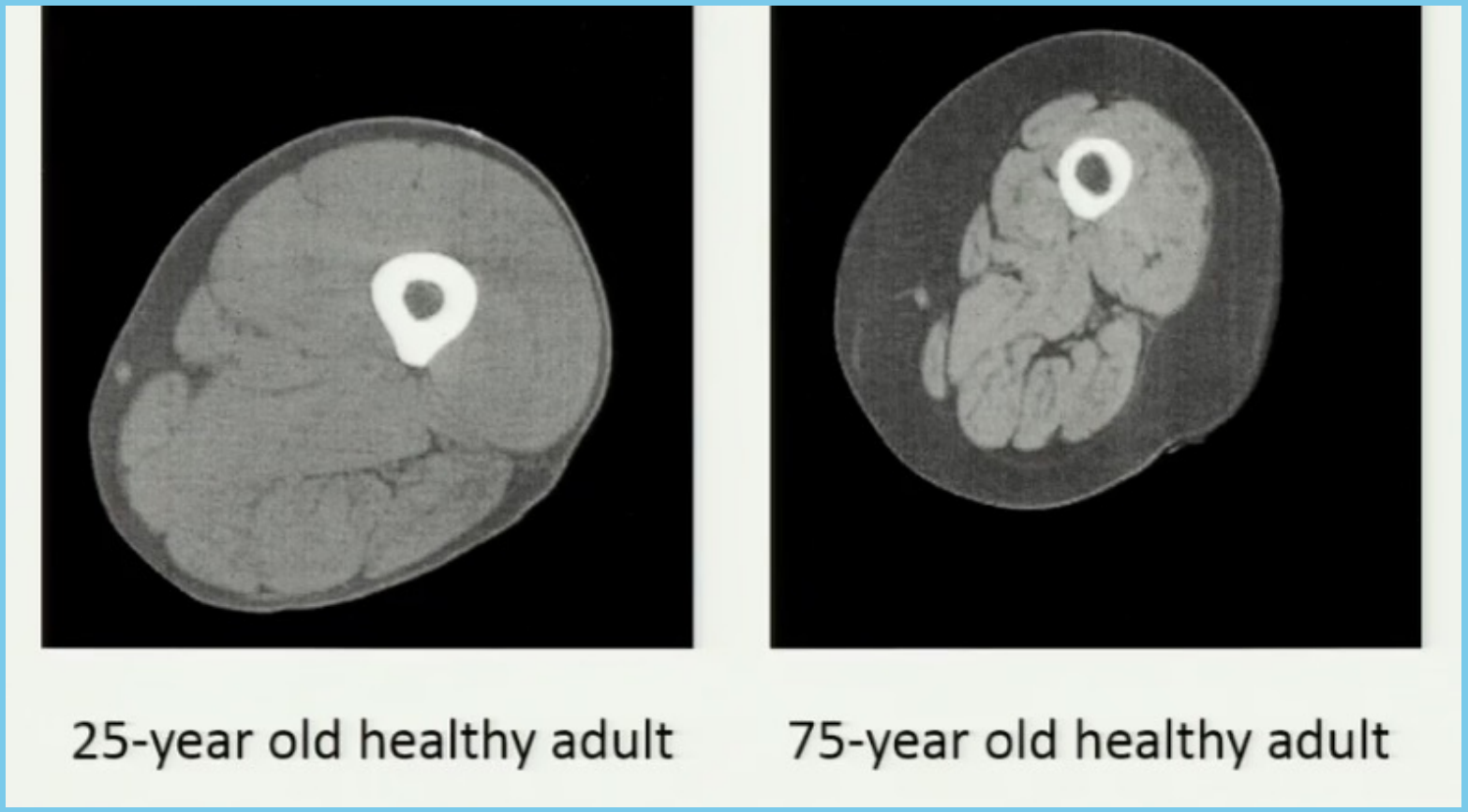
Assessing Sarcopenia

Sarcopenia engagement tool!



Loss of **MASS** and **FUNCTION**

Engage your patients by creating the concept of "Muscle Health Checks" to support a proactive approach to Healthy Ageing

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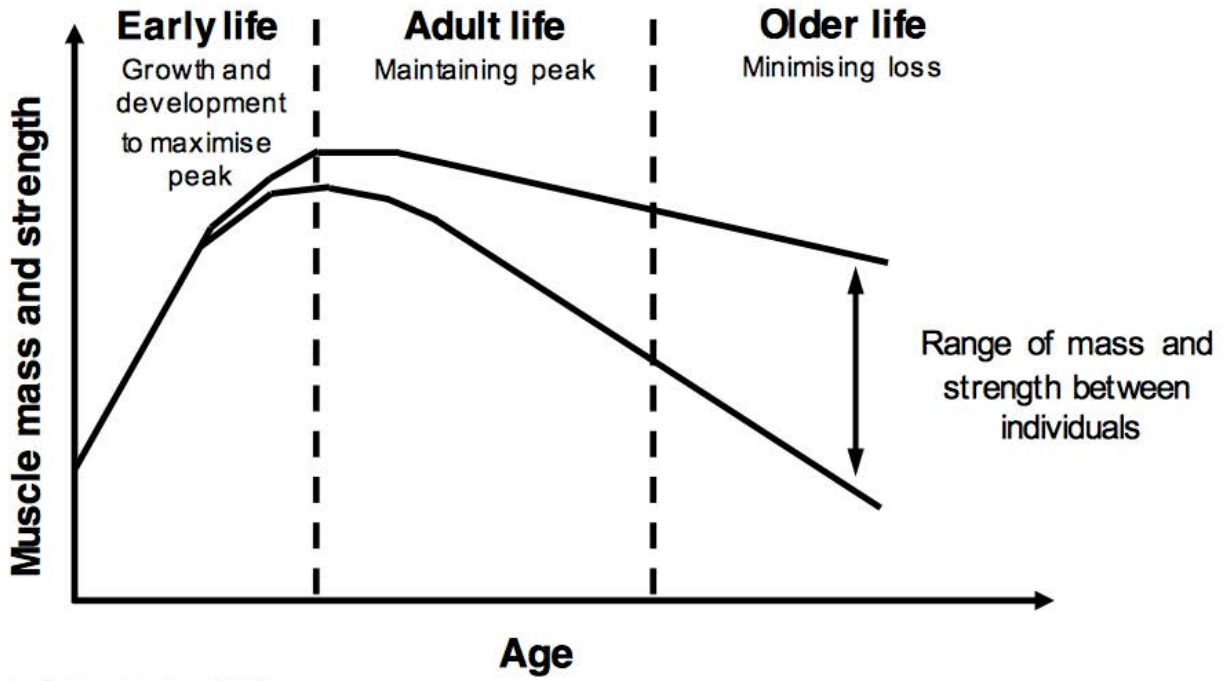
A lifecourse approach to skeletal muscle function



Sayer AA et al Age Ageing 2013

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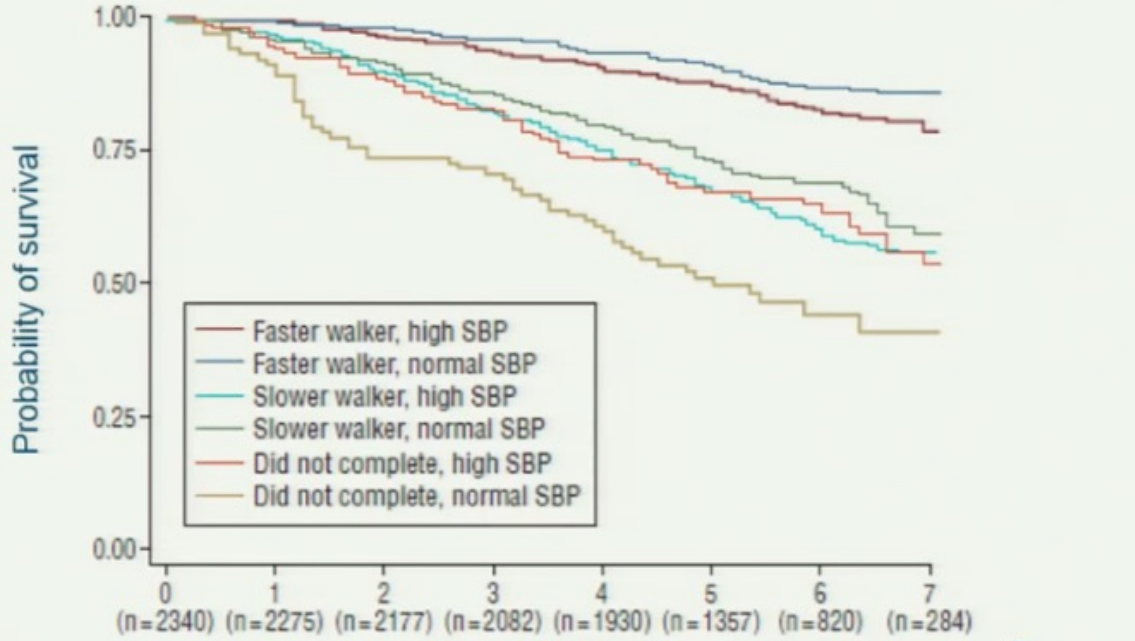
GAIT SPEED AS VITAL SIGN IN OLD AGE

Arch Int Med 2012; 172: 1162-68



efpia

imi Innovative Medicines Initiative

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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

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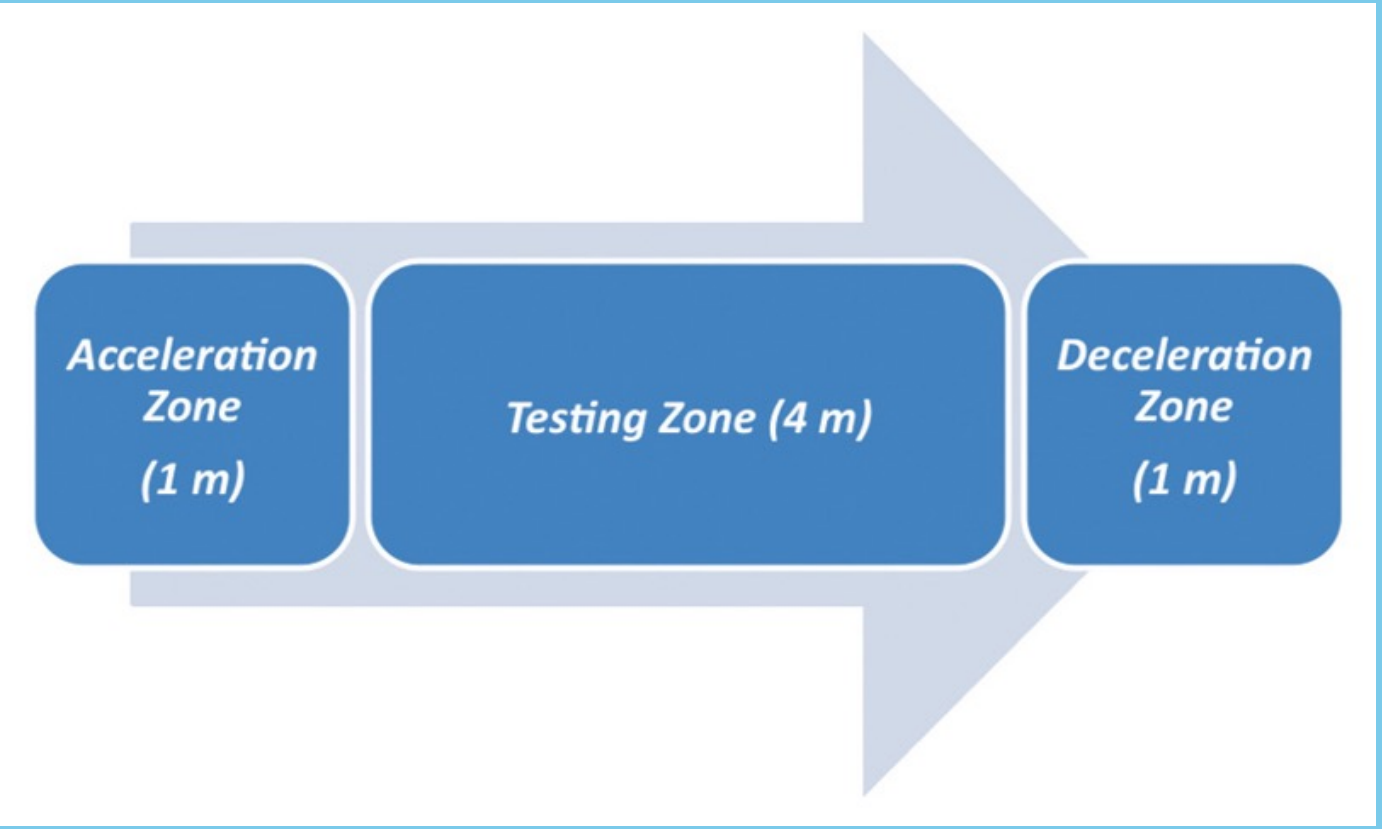

4m Walking Test

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Grip strength

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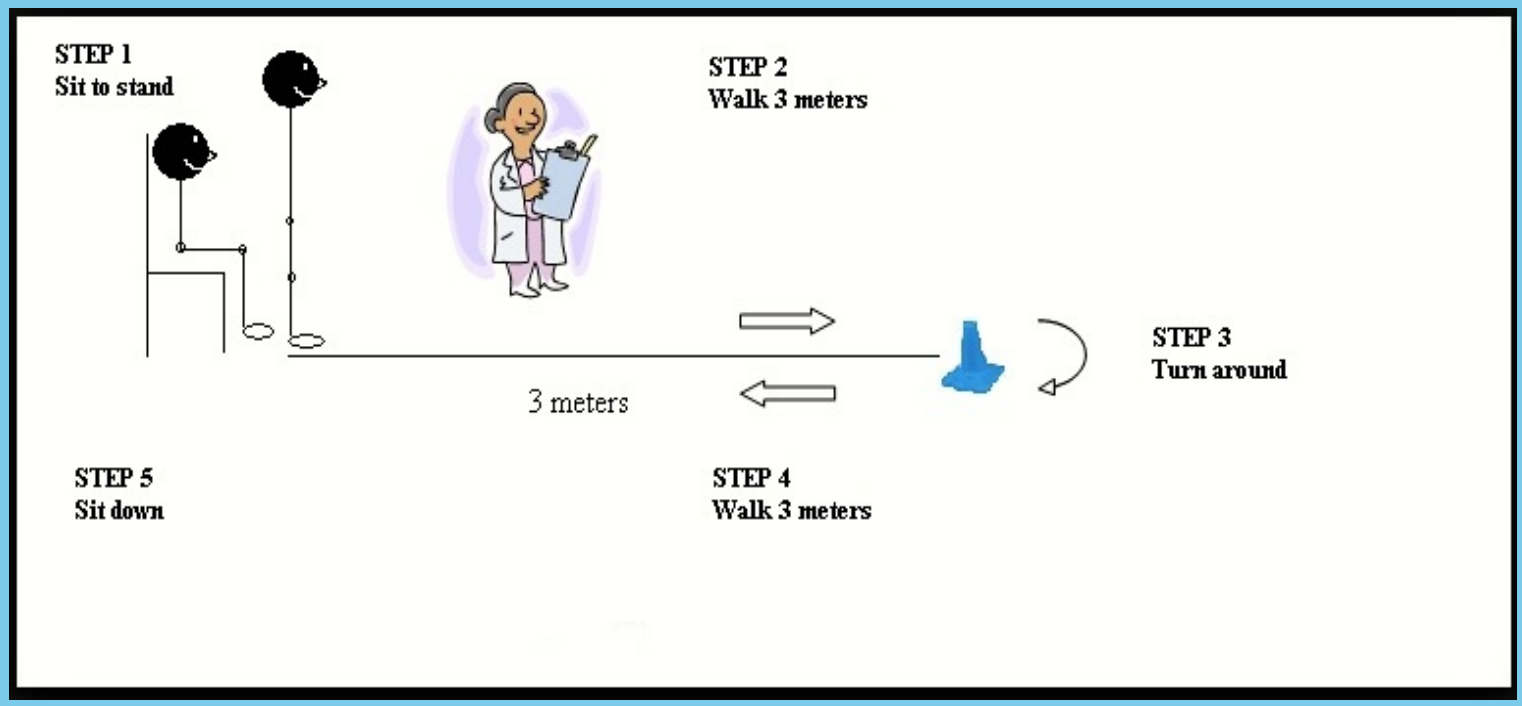
Timed Up and Go



The 5 Time Sit-to-Stand Test

Normative data for the 5xSTS test (Bohannon et al, 2010; Lusardi et al, 2003):

- 20-29 yrs ⇒ 6.0±1.4 sec
- 30-39 yrs ⇒ 6.1±1.4 sec
- 40-49 yrs ⇒ 7.6±1.8 sec
- 50-59 yrs ⇒ 7.7±2.6 sec
- 60-69 yrs ⇒ 8.4±0.0 sec (male), 12.7±1.8 sec (female)
- 70-79 yrs ⇒ 11.6±3.4 sec (male), 13.0±4.8 sec (female)
- 80-89 yrs ⇒ 16.7±4.5 sec (male), 17.2±5.5 sec (female)
- 90+ yrs ⇒ 19.5±2.3 sec (male), 22.9±9.6 sec (female)

Cut-off scores offer a number of insights into patient risk and functional ability:

Patients with a score of greater than or equal to 17 seconds have been found to have a 30% greater risk of hospitalization (Cesari et al, 2009).

Older adults are at risk of recurrent falls with scores greater than 15 seconds (Buatois, et al, 2010).

Increased fall risk in patients with Parkinson's Disease was found for scores greater than 16 seconds (Duncan et al, 2011). Similarly, those with vestibular disorders had an increased fall risk with scores over 15 seconds (Buatois, et al, 2008).

A minimal change in the score will offer a noticeable improvement in function (Duncan et al, 2011; Meretta et al, 2006). Patients who are able to decrease their score by as little as 2.5 seconds will see significant improvement.

Long term goals should be to improve the patient's score to within normal for their age bracket and to reduce the risk of falling, hospitalization, and functional decline. Minimally, the goal should be for a patient's score to be below 17 seconds.

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Table 5.3.2. Falls: Preventive interventions

Intervention	Technique	References
Screening for falls risk Case finding questions about risk factors to be used in those at moderately high risk	Ask the following three screening questions: 1. Have you had two or more falls in the past 12 months? 2. Are you presenting following a fall? 3. Are you having difficulty with walking or balance? If the answers to any of these are positive, complete a multifactorial risk assessment including obtaining relevant medical history, completing a physical examination, and performing cognitive and functional assessments • History should include: – detailed history of falls (eg how many falls?, at home or outdoors?, patient perception of causes, any fear of falling) – multiple medications, and specific medications (eg psychotropic medications) – impaired gait, balance and mobility – foot pain and deformities, and unsafe footwear – home hazards – bifocal or multifocal spectacle use – incontinence – recent discharge from hospital – chronic illness such as stroke, multiple sclerosis (MS), Parkinson's disease, cognitive impairment/dementia – vitamin D deficiency/poor sun exposure if housebound or in a care facility • Physical examination should include: – impaired visual acuity, including cataracts – reduced visual fields – muscle weakness – neurological impairment – cardiac dysrhythmias – postural hypotension – six-metre walk, balance, sit-to-stand*	32, 34–36 29, 32, 33, 37
	• investigating the causes of dizziness	

*Two simple tests are the repeated chair standing test and alternate step test. The repeated chair standing test measures how quickly an older person can rise from a chair five times without using the arms. A time of >12 seconds indicates an increased fall risk. The alternate step test measures how quickly an older person can alternate steps (left, right, left, etc) onto an 18 cm high step a total of eight times. A time >10 seconds indicates an increased fall risk. The Quickscreen assessment tool, developed and validated for use in an Australian population, includes these tests as well as simple assessments of medication use, vision, sensation and balance. This is available at www.neura.edu.au/wp-content/uploads/2016/05/QuickScreen-Information-Order-Form_1.pdf

GPCOG, General Practitioner Assessment of Cognition; MS, multiple sclerosis

ASSESSMENT

30-Second Chair Stand

Purpose: To test leg strength and endurance

Equipment: A chair with a straight back without arm rests (seat 17" high), and a stopwatch.

NOTE: Stand next to the patient for safety.

① Instruct the patient:

1. Sit in the middle of the chair.
2. Place your hands on the opposite shoulder crossed, at the wrists.
3. Keep your feet flat on the floor.
4. Keep your back straight, and keep your arms against your chest.
5. On **"Go,"** rise to a full standing position, then sit back down again.
6. Repeat this for 30 seconds.

② On the word "Go," begin timing.

If the patient must use his/her arms to stand, stop the test. Record "0" for the number and score.

③ Count the number of times the patient comes to a full standing position in 30 seconds.

If the patient is over halfway to a standing position when 30 seconds have elapsed, count it as a stand.

④ Record the number of times the patient stands in 30 seconds.

Number: _____ Score: _____

Patient _____

Date _____

Time _____ ☐ AM ☐ P

SCORING

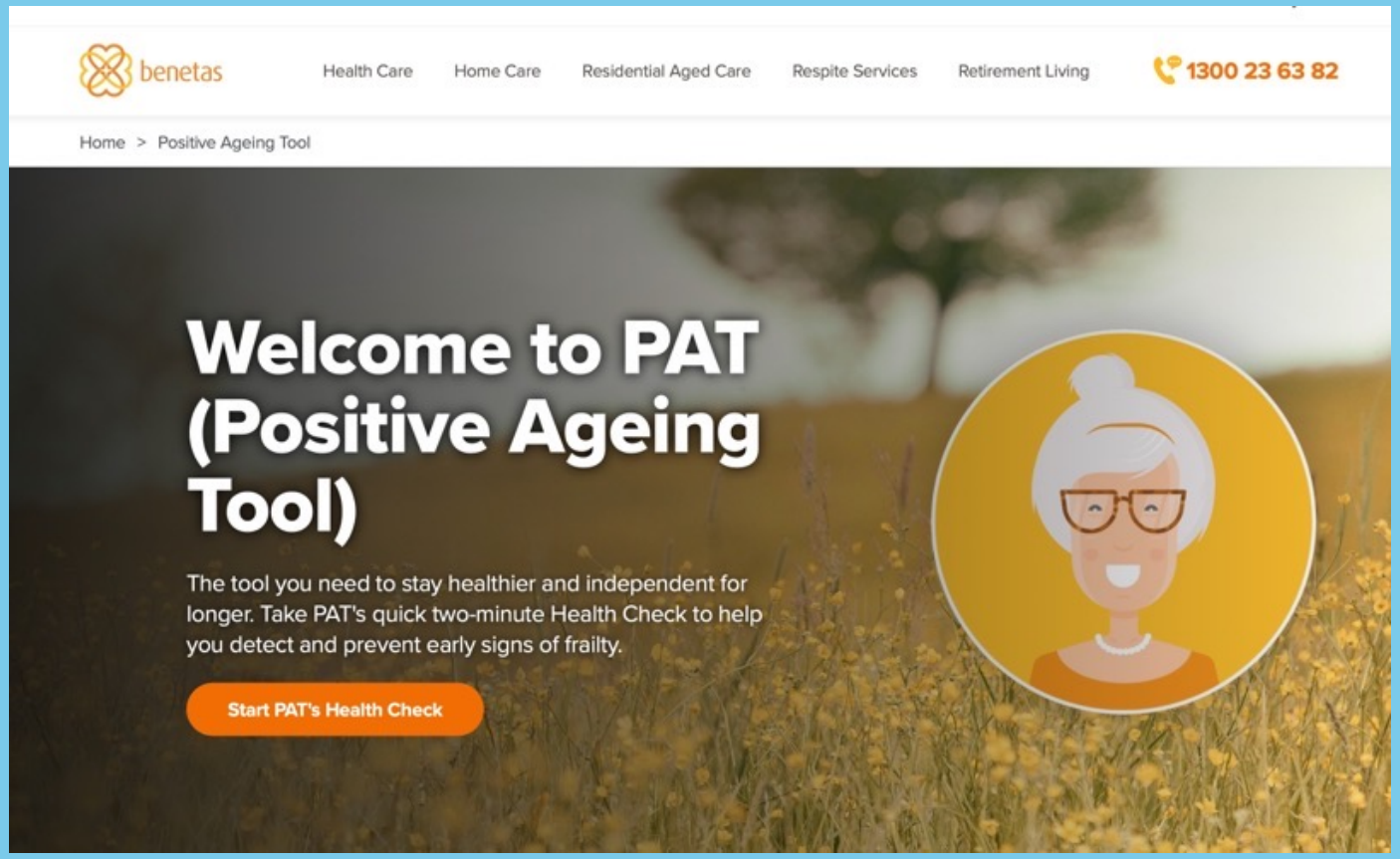
Chair Stand Below Average Scores

AGE	MEN	WOME
60-64	< 14	< 12
65-69	< 12	< 11
70-74	< 12	< 10
75-79	< 11	< 10
80-84	< 10	< 9
85-89	< 8	< 8
90-94	< 7	< 4

A below average score indica a risk for falls.

Playtime!

Our own healthy ageing and sarcopenia!



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“Now I have identified Frailty, what can I offer our patients?”

Gold Coast Frailty Management Tool- Primary Care

Frail Scale Risk Assessment

	Question	Scoring	Result
F	**FATIGUE** 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	
R	**RESISTANCE** 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	
A	**AMBULATION** 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	
I	**ILLNESS** Did your Doctor ever tell you that you have? [] Hypertension [] Diabetes [] Cancer (not a minor skin cancer) [] Chronic lung disease [] Heart attack [] Congestive heart failure [] Angina [] Asthma [] Arthritis [] Kidney disease [] Stroke or Parkinson's	0 – 4 answers YES = 0 5 – 11 answers YES = 1	
L	**LOSS OF WEIGHT** Have you lost more than 5kg or 5% of your body weight in the past year?	Yes = 1 No = 0	
		TOTAL SCORE	

SCORING: ROBUST = 0 PRE-FRAIL = 1-2 FRAIL = >3

Contact Us

Scan the QR code below to view more information on our website or contact GCPHN Practice Support to find out more about undertaking a Quality Improvement activity for Frailty within your practice.

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Gold Coast Primary Health Network

Phone: 07 5612 5408

Email: practicesupport@gcphn.com.au

www.gcphn.org.au/FrailityandHealthyAgeing

Gold Coast Primary Health Network gratefully acknowledges Sydney North Health Network for supplying the original content in this brochure.

Healthy Ageing & Frailty

Information for Clinicians

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What is Frailty?

Frailty is a common syndrome that occurs from a combination of deconditioning and acute illness on a background of existing functional decline that is often under recognised.

Frailty can affect up to 25% people aged 70 and over, this equates to approximately 20,413 people residing within the Gold Coast.

Patients living with frailty have two to three times the health care utilization of their non-frail counterparts and experience higher morbidity, mortality, and lower quality of life. Their carers can also experience high levels of stress.

Many causes of frailty can be managed and, in some cases reversed, highlighting the importance of identifying older people who are living with frailty.

You may find the following risk screen, 'The FRAIL Scale' validated by Professor John Morley and management suggestions useful to identify and treat patients aged 75+ and over.

Frailty Management / Decision Tool

	Assessment Score	Intervention	Referral/Follow Up
	FRAIL scale 0 = robust	• Encourage ongoing activity levels • Provide (Queensland Health Ageing with Vitality Guide) resource	• Re-do FRAIL scale in 12 months • City of Gold Coast Active & Healthy programs with balance/resistant component • Example of exercises in (Queensland Health Ageing with Vitality Guide) resource
	FRAIL SCALE	**If Frailty Score is positive, address underlying causes as suggested below**	
F	**Feeling fatigued most or all of the time**	• Consider screening for reversible causes of fatigue (sleep apnoea, depression, anaemia, hypotension, hypothyroidism, B12 deficiency) • Use EDWORTH scale, K10 or Geriatric Depression scale in Health Assessment	• Consider referral to Geriatrician / Specialist for complex care patients • Consider referral to Occupational Therapy for function and home review • Consider referral Psychologist using Mental Health Care Plan • Consider referral to Aged Care organisation for loneliness support (isolation can be a cause of fatigue)
R	**Resistance against gravity – Difficulty walking up 10 steps without resting**	• Consider referring to an individualised progressive exercise program with resistance and strength component	• Physiotherapy or Exercise Physiologist for exercise prescription • If has diabetes- > group session Medicare funded Exercise Physiologist • GCPHN funded programs for group exercise prescription • Gold Coast Health Falls and Balance Clinic • Gold Coast Health Mungulli Clinic
A	**Ambulation – Difficulty walking 300 metres unaided**	• Consider referring to an individualised progressive exercise program with resistance and strength component	• Physiotherapy or Exercise Physiologist for exercise prescription • If has diabetes- > group session Medicare funded Exercise Physiologist • GCPHN funded programs for group exercise prescription • Exercise options available through City of Gold Coast Active Ageing programs
I	**Having 5 or more illnesses**	• Review indication, side effects and use of medication (evidence for use of some medicines changes after 75!) • Consider discussing with pharmacist • Consider reducing/de-prescribing superfluous medication	• Pharmacist for comprehensive medication review, (HMR item 900) • Occupational Therapy for functional and home safety review • Self-management support from aged care org volunteer
L	**Loss of > 5% weight in 12 months**	• Consider screening for reversible causes of weight loss and consider • Protein and caloric supplementation/food fortification (75mg protein per day required – range of products available at pharmacy) • Advise and encourage healthy eating; provide (Queensland Health Ageing with Vitality Guide) resource	• Weigh and assess BMI – record in patient record • Dietician for diet review and management • Add Sustagen • Meal Delivery Services • Speech pathologist for swallowing review • Dentist for dental review (pain/infection/ill fitting dentures) • Occupational Therapy for functional and home cooking ability review

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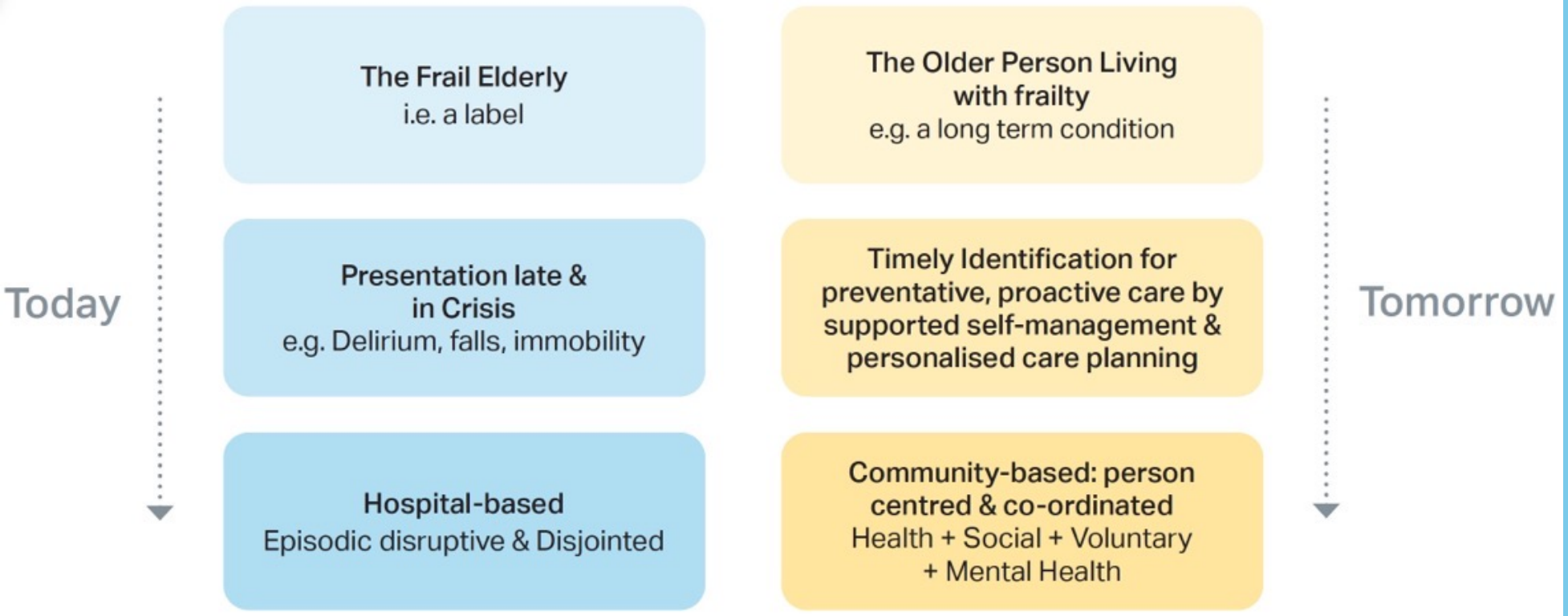
Care Paradigm for Older People & Frailty

Figure 1. Frailty is a long term Condition



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Social Prescribing

Social prescribing is the practice where health professionals, including GPs and Nurses, have the resources and infrastructure to link patients with social services – or even social groups in a bid to address the social determinants contributing to poor health and stave off the epidemic of loneliness and social isolation (Consumers Health Forum of Australia)

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Social Prescribing

- Councils (social connections, friendship clubs)
- Health Pathways
- COTA Strength for Life
- Seniors Organisation in your area
- Aqua Fitness, Dance and Music, yoga, pilates, tai chi, Zumba)
- Parkrun, Walking Netball
- Community bus
- Community Gardens

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- Pharmacists
- Podiatrist
- Physiotherapist
- Exercise Physiologist
- Dietitian
- Psychologist
- Community Care Coordinators
- Community Nursing
- Specialists- Geriatrician
- Palliative Care

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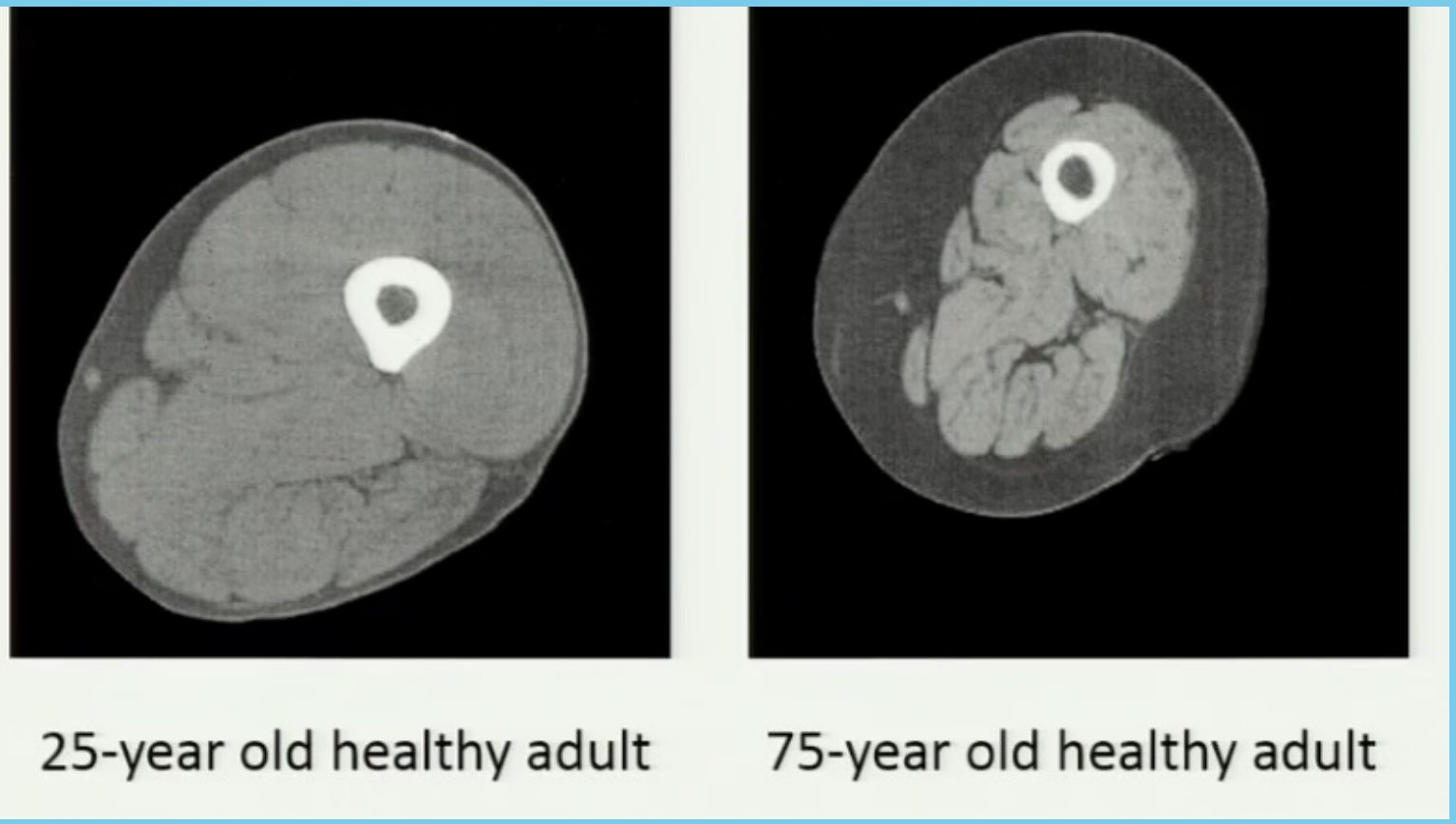
Sarcopenia engagement tools!



25-year old healthy adult

75-year old healthy adult

Improve
FUNCTION

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Balance exercise

Single leg standing

- Practice standing on one leg – near a support.
- Alternate legs.

Progression

- Start with holding for 30 seconds and progress to 2 minutes.
- Stand with eyes closed.
- Brush your teeth while standing on one leg.

Strength exercise

Sit to stand

Repeat 8 – 12 times, the last one should feel hard
Do at least twice a week

- Begin seated with feet shoulder width apart, sitting posture with a straight back
- Stand, keeping your back straight.
- Return to the sitting position, controlling your descent.
- Hands placed in a comfortable position (in lap, crossed over chest).

If you need to, start with using your hands to assist with pushing up from the arms of a chair. As your legs get stronger, you will need to use your hands less.

Progression

- Perform from a lower chair.
- Add hand weights or a backpack with weights in it.

Balance exercise

Heel raises

Heel raises help with walking and climbing stairs.

- Place your fingertips on something solid to help balance.
- Lift both heels off the floor and stand on your toes for 3 seconds, then slowly lower your heels to the floor.
- Repeat 5 times.

Progression

- Reduce your hand support (let your hands hover over your support).
- Try and do a heel raise with one leg.

Strength exercise

Wall push up

Repeat 8–12 times each, the last one should feel hard. Do at least twice a week

- Face a wall, standing a little farther than arm's length away, feet shoulder width apart.
- Lean your body forward and put your palms flat against the wall at shoulder height and shoulder width apart.
- Maintain your neutral spine.
- Slowly breathe in as you bend your elbows and lower your upper body toward the wall in a slow, controlled motion.
- Keep your feet flat on the floor.
- Hold the position for 3 seconds.
- Breathe out and slowly push yourself back until your arms are straight.

Progression

- Move feet further from the wall or perform with hands on a lower object.
- Hold your position at the wall for a longer time.

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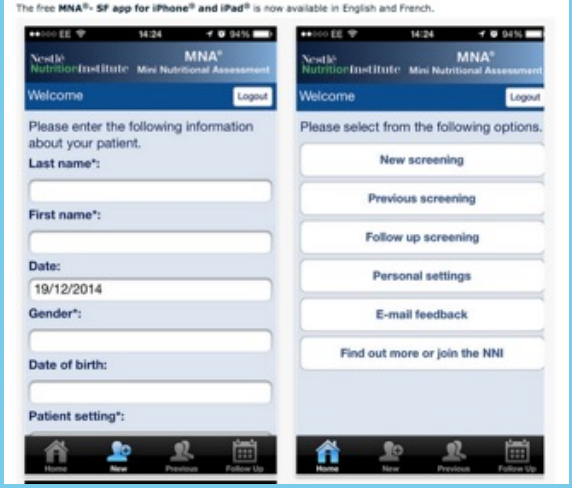
MiniNutritional Assessment (MNA)

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



Screening

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)^2

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

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Frailty Management - ↑ Protein

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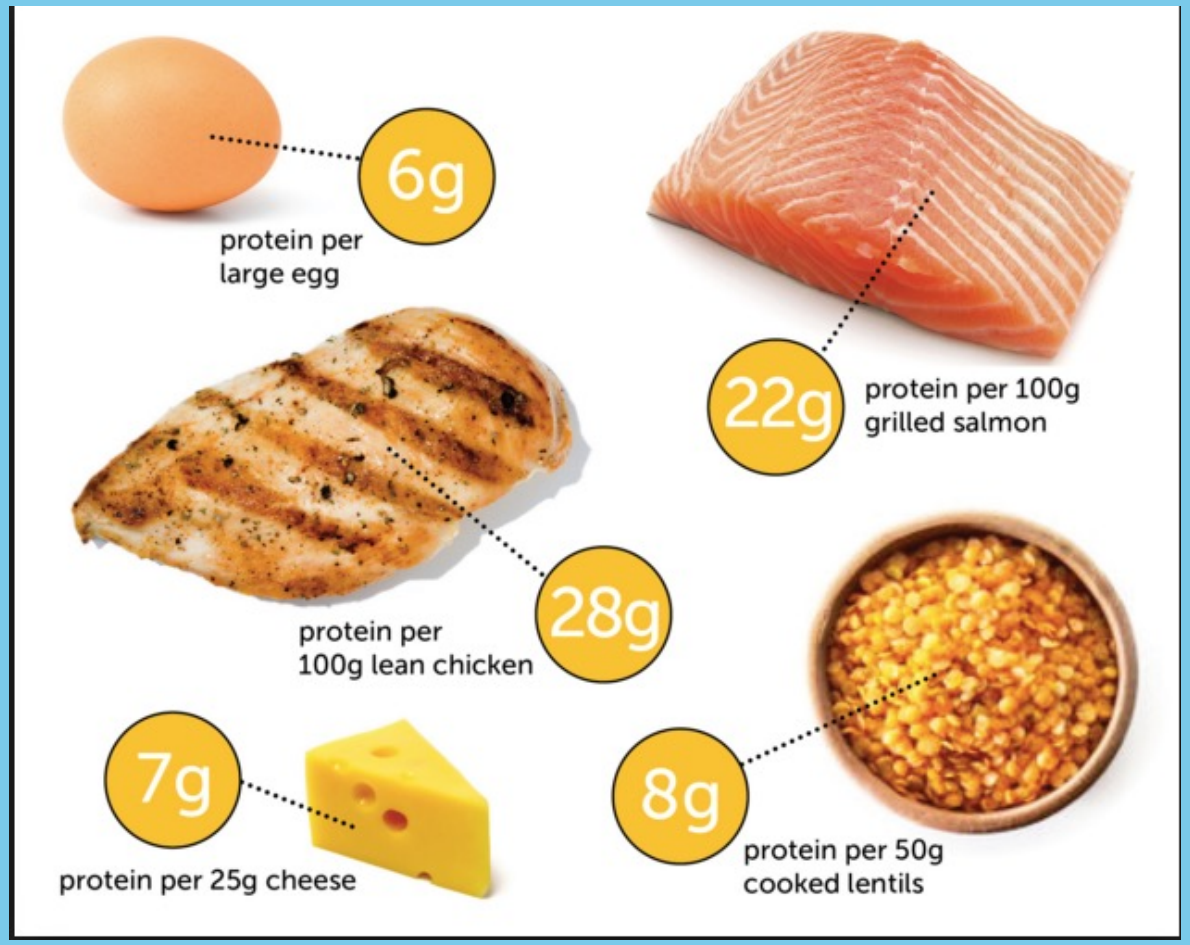
How much protein?

- Recommended 0.8gm/kg /day
- WHO for Frailty 1.25gm/kg/day
- RACF 1.2-1.5 gm/kg/day
- Eg 65kg person needs
  98 gms protein/ day
- I cup milk = 8 gms protein



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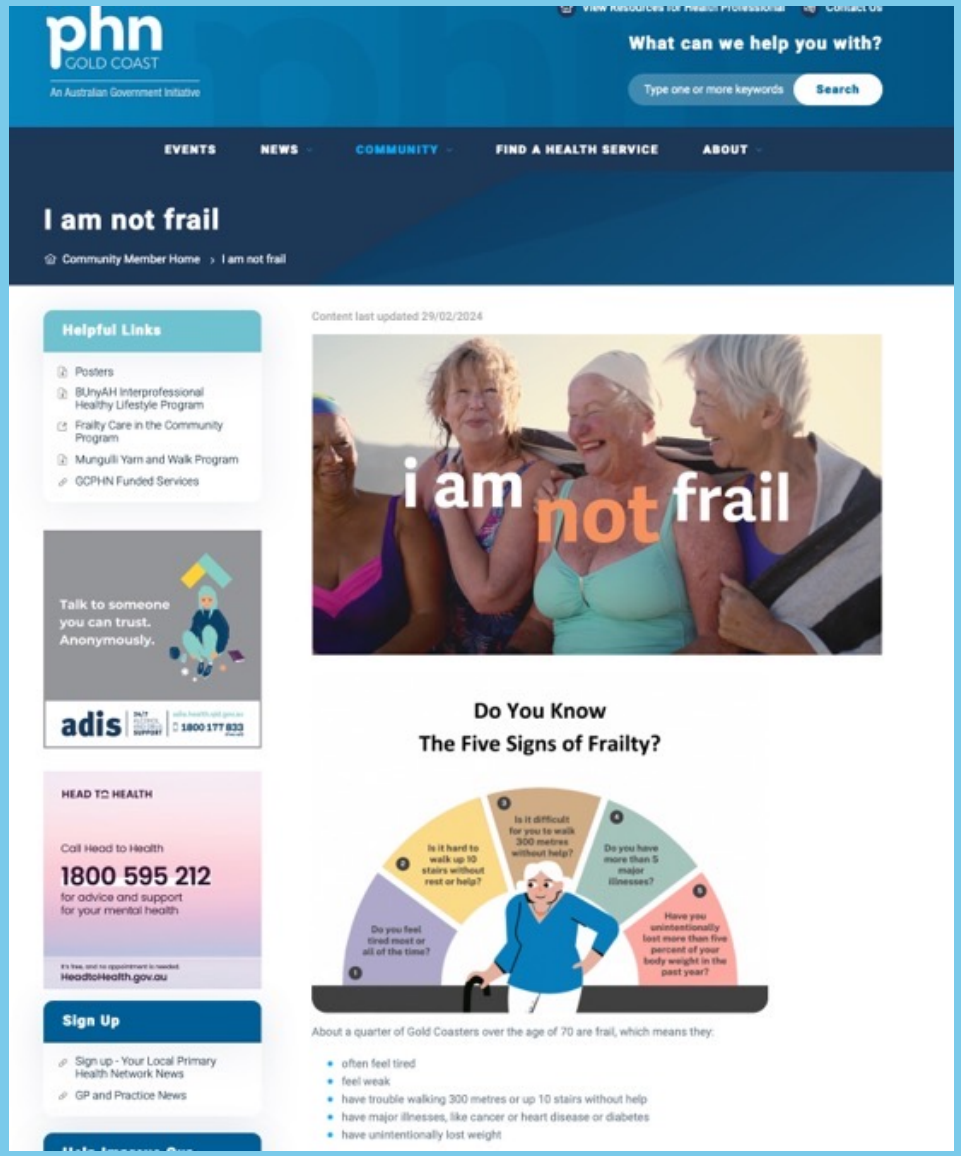
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What can we help you with?
Type one or more keywords
Search
EVENTS
NEWS
COMMUNITY
FIND A HEALTH SERVICE
ABOUT
I am not frail
Community Member Home › I am not frail
Helpful Links
Posters
BUnyAH Interprofessional Healthy Lifestyle Program
Frailty Care in the Community Program
Munguli Yarn and Walk Program
GCPHN Funded Services
Talk to someone you can trust. Anonymously.
adis
1800 177 833
HEAD TO HEALTH
Call Head to Health
1800 595 212
for advice and support for your mental health
HeadtoHealth.gov.au
Sign Up
Sign up - Your Local Primary Health Network News
GP and Practice News
Content last updated 29/02/2024
i am not frail
Do You Know
The Five Signs of Frailty?
Is it hard to walk up 10 stairs without rest or help?
Is it difficult for you to walk 300 metres without help?
Do you have more than 5 major illnesses?
Have you unintentionally lost more than five percent of your body weight in the past year?
Do you feel tired most or all of the time?
About a quarter of Gold Coasters over the age of 70 are frail, which means they:
often feel tired
feel weak
have trouble walking 300 metres or up 10 stairs without help
have major illnesses, like cancer or heart disease or diabetes
have unintentionally lost weight

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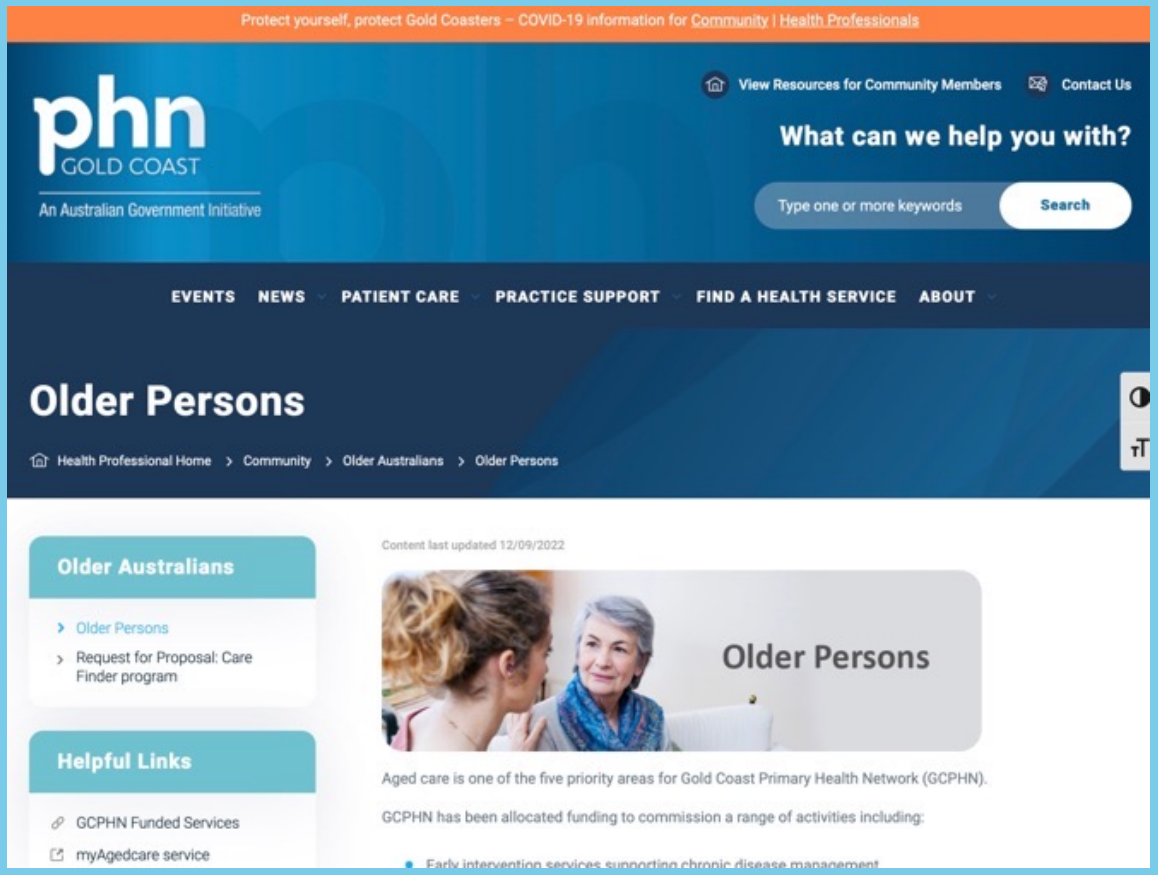
Referral options on the Gold Coast



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GCPHN Healthy Ageing Funded Programs

BUnyAH Interprofessional Healthy Lifestyle Program

This is a 12-week intensive active lifestyle program developed by Bond University Allied Health Professionals, specialising in occupational therapy, exercise science, physiotherapy, and nutrition and dietetics.

Under this program, patients engage in health education and exercise sessions twice a week, collaborating with Allied Health students and their supervisors.

The program uniquely includes a free gym membership at the centrally located Avanti Health Centre in Southport.

Follow-up care is offered at Bond University Institute of Health and Sport.

GCPHN Healthy Ageing Funded Programs

Frailty Care in the Community Program

This program offers up to six personalised support sessions over a four-to-six-month period, including home visits for high-risk participants.

An individually tailored program provides access to psychologists, physiotherapists, and other healthcare professionals.

There is a choice between individual and group sessions, or a mixture of both, to improve access to community health services and reduce isolation.

Ongoing support is available after the program finishes.

GCPHN Healthy Ageing Funded Programs

Mungulli Yarn and Walk Program

The Yarn and Walk program is a great way for Aboriginal and Torres Strait Islanders aged 18 and over to join an education-packed physical activity program.

Under the guidance of an expert team including an Aboriginal and Torres Strait health worker, physiotherapist, clinical nurse, dietician, pharmacist and nurse navigator, weekly sessions explore cultural activities, healthy eating and health information combined with light exercise and walks.

This program is exclusively for Aboriginal and Torres Strait Islander peoples aged over 18 years old.

GCPHN Healthy Ageing Funded Programs

BUnyAH Interprofessional Healthy Lifestyles Program

Frailty Care in the Community

Mungulli Yarn and Walk Program

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”

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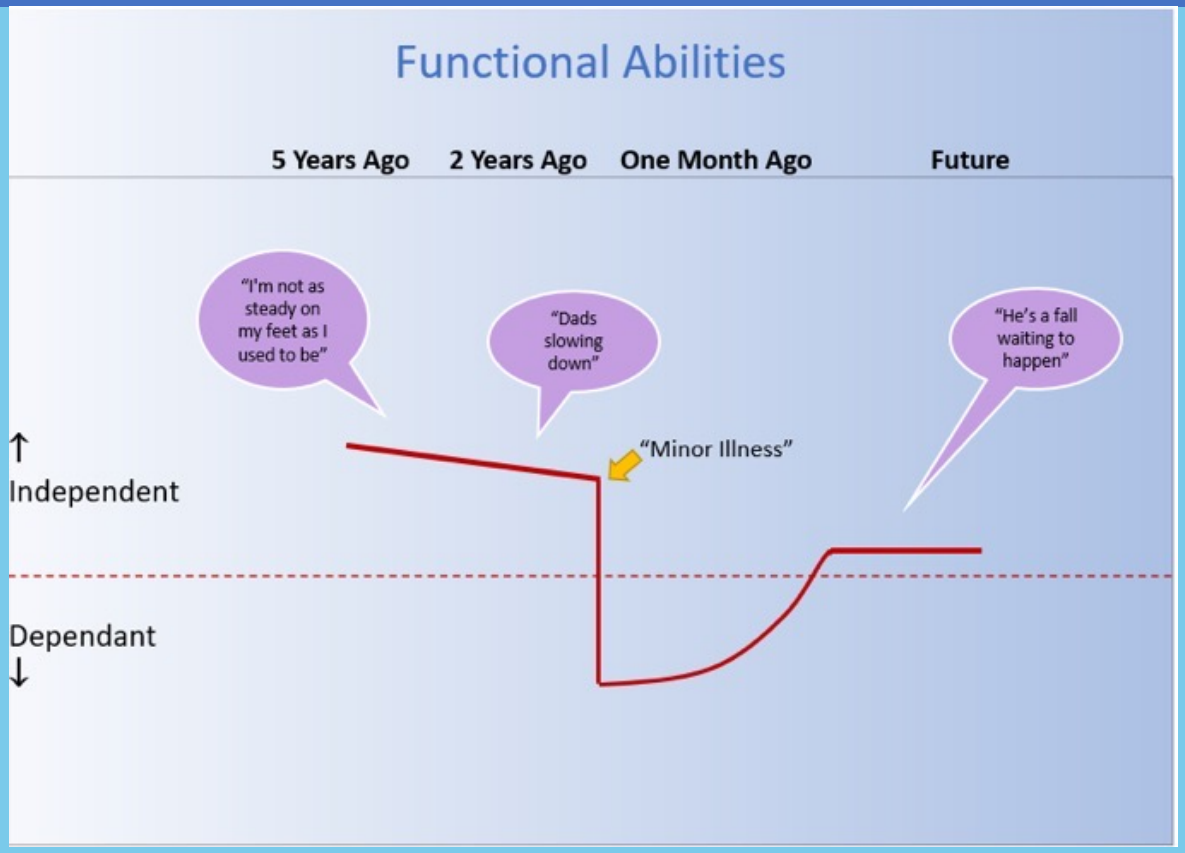
Can it be done differently?



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Summary: 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

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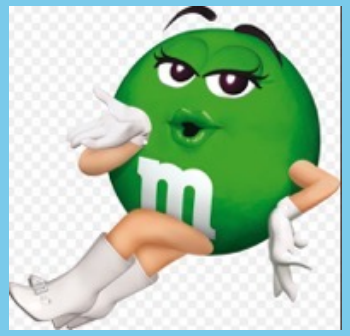
75+
5Ms 3Ds 1F

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



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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 12 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

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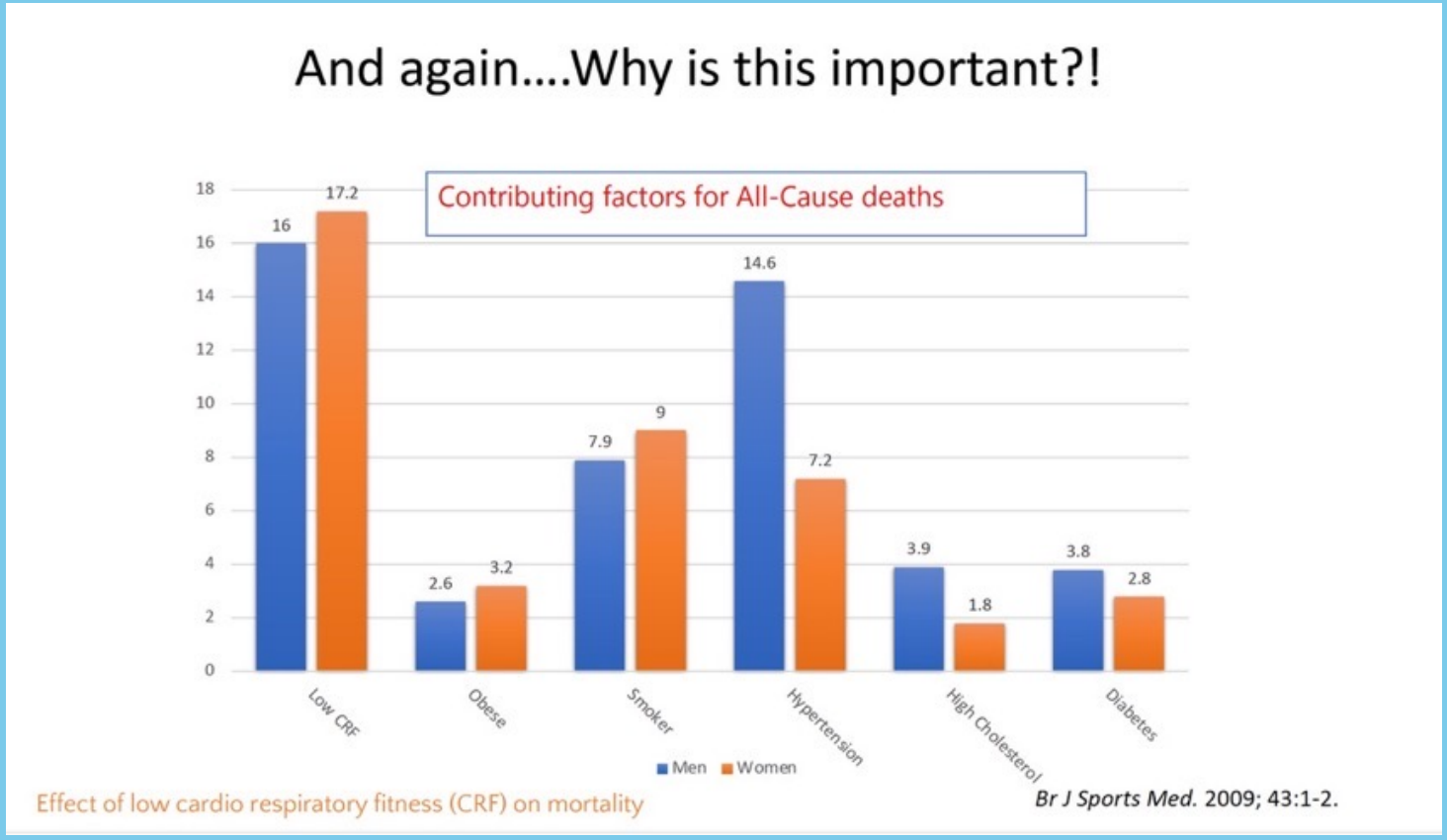
Exercise assessment and prescription……



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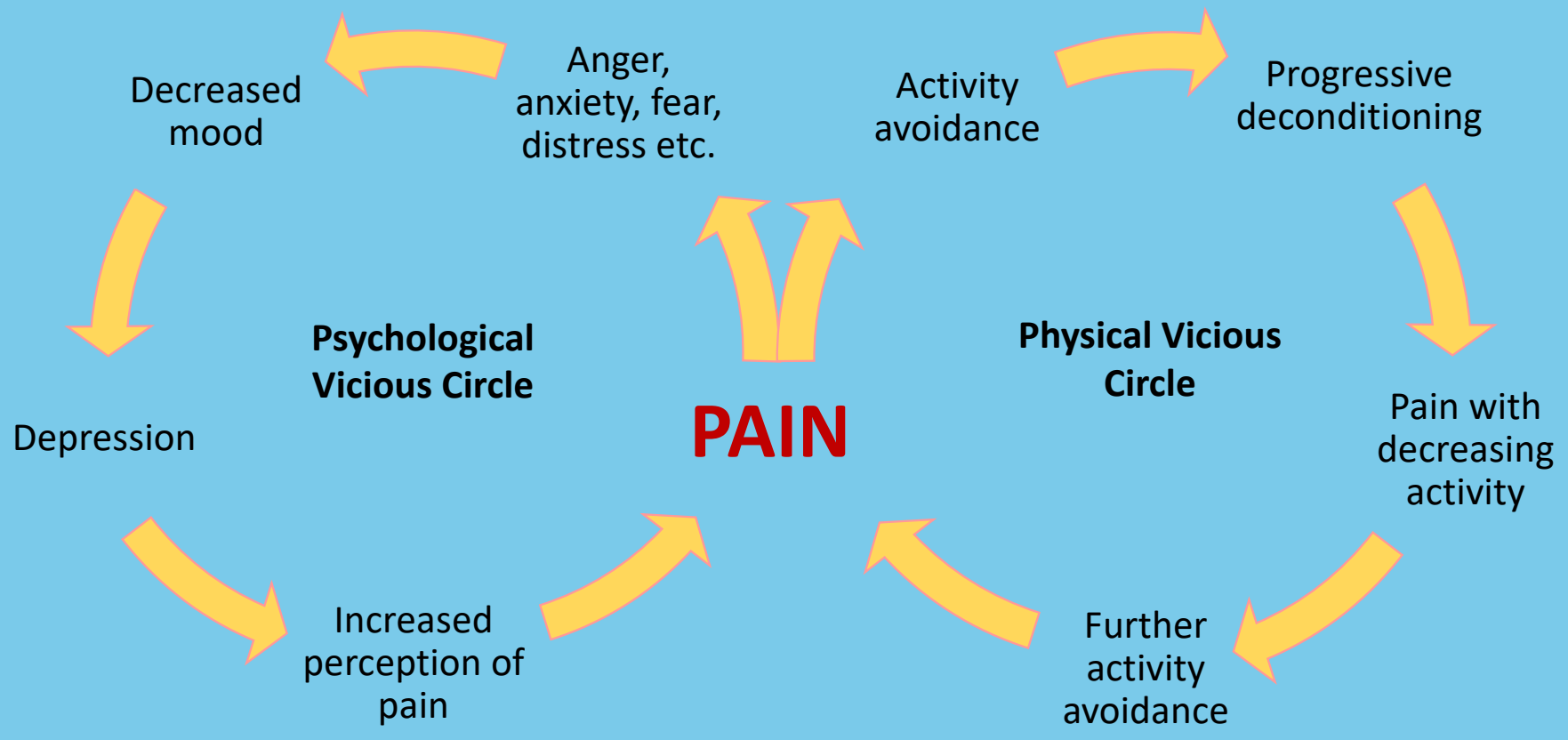
The Pain Cycle



Adapted from Cooper, Booker & Spanswick (2003)

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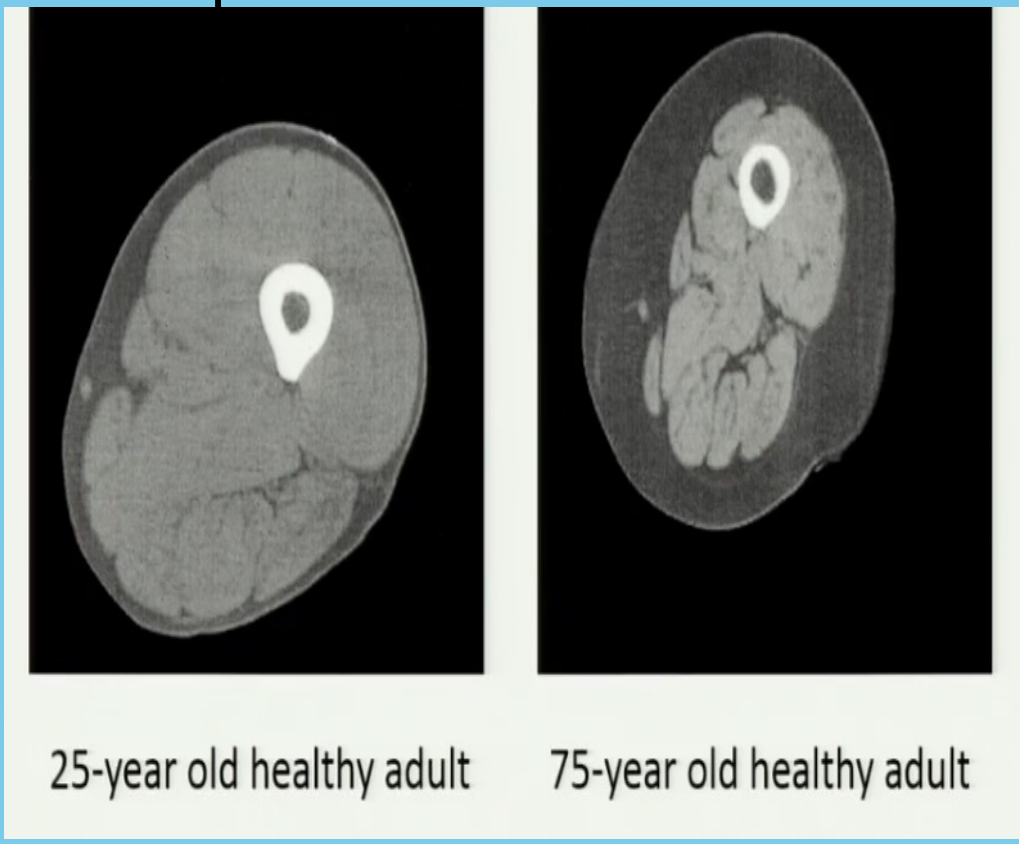
Frailty Quality Improvement Project

Frailty Quality Improvement Project

The Quality Improvement Project next steps……

- The practice visits
- Review Primary Sense Data
- 75+ health assessment audit
- Define your practice goal!
- What do you need to do to incorporate frailty assessment into everyday encounters?



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Audit Learning Objectives

1. Review practice data for people aged 75+ to better identify patients appropriate for a health assessment which includes a frailty assessment.
2. Recognise gaps in care for the patients aged 75+
3. Determine potential practice system improvements for the care of people aged 75+
4. Implement and use an evidence-based screening tool to recognise older people with or at risk of frailty.
5. Implement strategies to increase awareness and participation rates for 75+ Health Assessments in the practice population.

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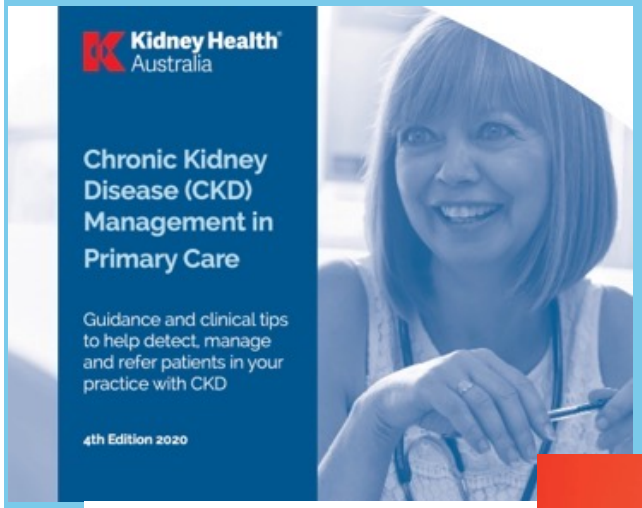
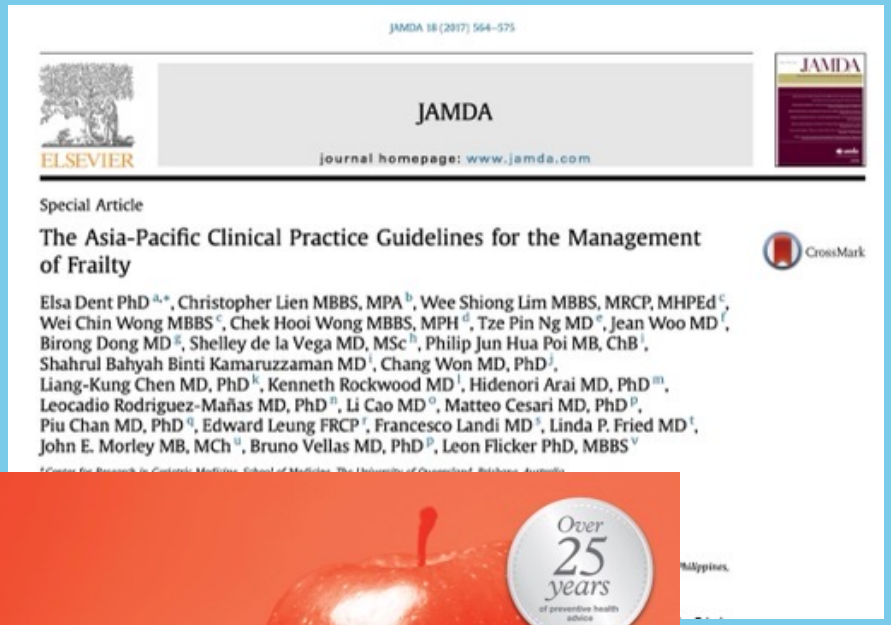
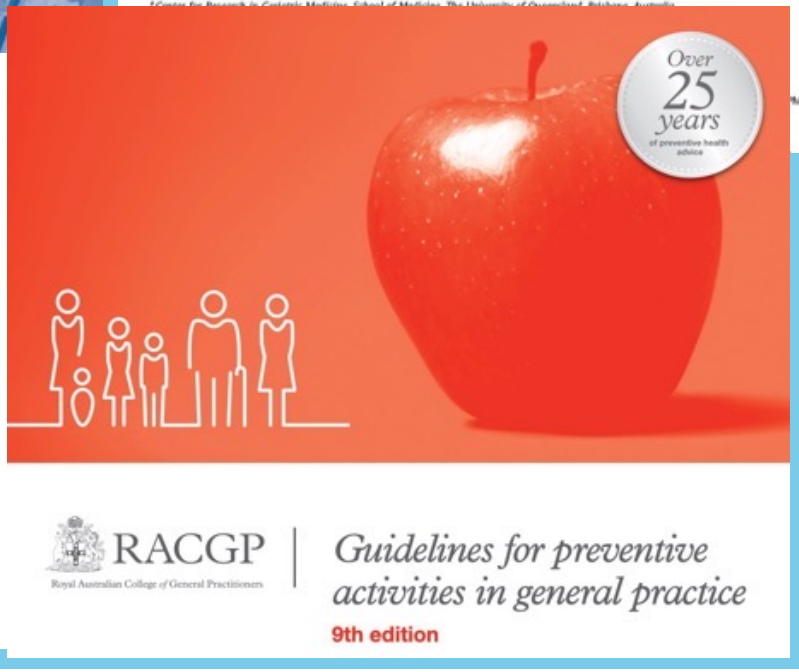
Step 2 – Identify best practice guidelines or standards and criteria





5. *Preventive activities in older age*
   - 5.1 Immunisation
   - 5.2 Physical activity
   - 5.3 Falls
   - 5.4 Visual and hearing impairment
   - 5.5 Dementia
   - References
6. *Communicable diseases*
   - 6.1 Immunisation
   - 6.2 Sexually transmissible infections
   - References
7. *Prevention of chronic disease*
   - 7.1 Smoking
   - 7.2 Overweight
   - 7.3 Nutrition
   - 7.4 Early detection of at-risk drinking
   - 7.5 Physical activity
   - References



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XXXXXXX Medical Centre – Healthy Ageing Project (Clinical Audit)

Project Measures – Clinical audit meeting #2 (July 2023) Total Patient Population = 9850	No.	% (within relevant age group)	Variation from baseline (May 2023)
1. Number and % of patients in the practice aged 65-74	1084	11.8%	-0.6%
2. Number and % of patients in the practice aged 75+	801	10.5%	-0.5%
3. Number and % of patients aged over 65 who have had an influenza vaccination in past 15 months	1002	56.1%	-3.0%
4. Number and % of patients aged 75+ who have had a pneumococcal vaccine (either 23 or 13)	23	35.1%	2.1%
5. Number and % of patients aged 75+ who have had a shingles vaccine	22	35.0%	0.1%
6. Number and % of patients aged 75+ who have had a medication review in past 2 years	54	0.2%	0.1%
7. Number and % of patients aged 75+ who have had a health assessment in the past 15 months	153	30.8%	5.3%
8. Number and % of patients aged 75+ with weight recorded in past 12 months and a height record	752	61.0%	4.2%
9. Number and % of patients aged over 75+ with a frailty diagnosis	0	0.0%	0.0%
10. Number and % of patients aged 75+ with a diagnosis of dementia	2	0.5%	0.5%
11. Number and % of patients aged 75+ with a diagnosis of CKD	56	0.5%	0.1%
12. Number and % of people aged 65+ yrs with a GPMP in past 15 months.	26	30.3%	0.6%
Please note: All data is based on the RACGP "active" patient definition			

NEXT STEPS FOR THE CLINICAL AUDIT

1. Prepare a list of patients by using the practice's clinical software, run a search and identify active patients, filtered by participating GP (if possible) on:
   - Patients aged 75+ that have been billed an MBS item 701, 703, 705 or 707 and seen by specific GP in the last 15months.
   - Patients with a health assessment billed between given dates (previous 15 months).
2. From this list, each GP will need to identify 15 of their patients to include in the audit. See document titled ***"Clinical audit procedure HA 75+"***

TIPS

- ✓ Check if your 75+ Health assessment template includes:
  - Frail scale assessment
  - Walking speed test (4m)
  - Grip strength measurement
- ✓ Consider a mini nutrition assessment if a risk factor for undernutrition exists.
- ✓ Review medications, consider de-prescribing and refer for a Home Medicine Review (HMR) where applicable.

"Building one world class health system for the Gold Coast"

For more information or support please contact the QI Team on:
Email: practicesupport@gcphn.com.au | Phone: 5612 5408

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CPD Hours-Self Logged

- For GPs , RNs and PMs involved in the Quality Improvement program, the following CPD hours can be self-logged/claimed if participation occurs.
- Workshop attendance: 2.5 hours total
  - *"Education Activity"* 1.5 hours and *"Reviewing Performance"* 1 hour.
- Practice onboarding visits: 0.5 EA and 0.5 RP
- QI Huddles: 0.5 hour *reviewing performance* and 0.5 *measuring outcomes*
- 75+ health assessment audit: 4 hrs MO + 5.5hrs RP
  - 3 virtual meetings + review 15 patients x 2 + review practice data
- Practice work: Allocate as *"reviewing performance"* for practice discussions.
- *Total: 13 hours: 2 hrs EA, 7 hours RP, 4 hours MO (plus any practice discussions on improvement)*

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Questions and Evaluation

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Thank you!

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