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# Doing What Matters…Keeping Older Well at Home project

This article is the second of a series of four articles on frailty, prepared by Dr Chris Bollen of BMP Consulting for the Gold Coast Primary Health Network as part of the frailty early intervention program.

General Practice has an important role in supporting relationships with older people trying to remain independent and well at home.

GPs and practice nurses perform 75+ health assessments in the home and surgery, and together they are involved in the care planning and team care arrangements for access to appropriate services based on the older person's needs. Additionally, nurses are increasingly involved in the care coordination of the older person with complex needs. (e.g. DVA program)

However, GPs and nurses receive no formal training to understand the science behind 75+ health assessments, and to target such assessments for the most "at risk".

## Comprehensive Geriatric Assessments

There is well researched evidence that Comprehensive Geriatric Assessments (CGS) which review medical, functional, psychological and social needs – improve outcomes for older people. However, although the term "Comprehensive Geriatric Assessment" is well known in geriatric medicine, it is lesser known in General Practice, where most older people are seen.

## Health Assessment Templates

Over the last 24 years, considerable evidence has been published about how to support older people to be healthy and well. Unfortunately, there are very few objective assessment tools in health assessment templates in commonly used clinical software programs, and these have not changed since 1999.

Current 75+ health assessment templates do not include:

- Assessment for undernutrition (see RACGP Silver Book 5th edition)
- Discussing the concepts of frailty and sarcopenia (measured by 4 m walking speed tests and grips strength plus the benefits of resistance exercise),
- Herpes Zoster/Shingles vaccination for those aged 70-79, and
- Single dose Pneumococcal 13 vaccination at age 70

The British Geriatric Society and the UK RCGP has produced an excellent guide (Frailty hub – search Fit for Frailty), which uses comprehensive geriatric assessments to help GP's to identify the patients who need extra care and support to remain well.

## Improving the 75+ health assessment

Identifying opportunities for improvement in the 75+year health assessment is a useful quality improvement activity for GPs and the practice team.

Having a good template which provides a suite of objective assessment tools enables optimal decision making about preventing or reducing the impact of common issues such as:

- Falls
- Osteoporosis
- Cognitive impairment
- Incontinence
- Mobility difficulties
- Weight loss/poor nutrition
- Polypharmacy
- Physical inactivity
- Low mood
- Visual problems
- Social isolation/loneliness

## How to improve the 75+ health assessment

Review the 75+ health assessment and consider the following:
a) What are the goals of the older person?
b) What cognition screen was used?
c) Which nutrition screen was performed? (not just "adequate nutrition? Yes/no!"
d) How many times has the person's weight been recorded in the last 12 months? What was the trend? If weight loss was noted, what action has occurred?
e) How was mobility assessed? What objective assessment occurred (e.g. 4m walk test)?
f) How was muscle health assessed? What objective assessment occurred (e.g. grip strength and five timed sit-to-stands)?
g) What mobility or strength deficit was noted? What recommendations occurred?
h) How many medicines is the older person taking?
i) What is the person's eGFR?
j) Has an annual kidney health check been recommended (creatinine, eGFR, Blood pressure and urinary ACR)?
k) Is the person taking any renally cleared medications?
l) Was a Home Medicine Review requested?
m) Does the health assessment review osteoporosis risk?
n) Does the health assessment check for immunisations relevant to the age group (e.g. shingles, pneumococcal 13 and 4 x COVID)?
o) How was the older person's mood assessed? What was noted and recommended?
p) What is documented in the social history of the person? Does this information transfer to all referral letters and care plans?
q) What legal documents have been documented to support the older person's choices should a loss of capacity occur (e.g. Advance Directive, EPOG, EPOA)?

## Personalised shared care planning

The health assessment should be used to develop a personal shared care and support plan outlining treatment goals to optimise medical conditions, management plans to optimise wellness and plans for urgent care.

This should always include discussions around advance care directives and potentially, an end of life care plan.

## MBS item numbers

The same nurse/GP should do the health assessment (707), care plan (721) and team care arrangement (723) to avoid duplication and to provide maximum value to the patient and to the practice.

Complex patients will need a three-monthly review of care plan and team care arrangement (732s), which is often underutilised.

To monitor progress, nurses can utilise item number 93203 for phone calls to patients with an existing care plan.

## The FRAIL Scale

Wellness, reablement and restorative approaches are emerging as powerful ways to help older people improve their function, independence and quality of life. Early identification of people who are pre-frail or frail and who could benefit from these approaches, is an important preventive activity in contemporary general practice.

Remember that the simple questions for the FRAIL scale from Professor John Morley (Geriatrician, St Louis, Missouri) require only a yes/no response:

| | | |
|---|---|---|
| F | Fatigue - Are you feeling tired or fatigued? | Yes = 1 |
| R | Resistance - Do you have difficulty walking a flight of stairs? (overcoming the resistance of body weight against gravity) | Yes = 1 |
| A | Ambulation - Do you have difficulty walking around the block? | Yes = 1 |
| I | Illnesses - Do you have 5 or more chronic conditions? | Yes = 1 |
| L | Has there been loss of weight of 5% or more over the past 12 months? | Yes = 1 |

If the older person scores 2, they are pre-frail, and 3+ indicates they are frail. Both pre-frail and frail patients will benefit from immediate discussion of:

- their goals in life, and the barrier(s) to achieving them!
- their mood, assessing for any medical cause of fatigue (e.g. anaemia, heart failure, or
- chronic kidney disease).
- resistance muscle exercises such as sit-to-stands at home.
- increasing intake of protein (aim for at least 1.2g/kg bodyweight) - eggs for breakfast!

- the appropriateness of their medications - a GP, pharmacist or geriatrician can review using this excellent guide to deprescribing.
- vitamin D to assist in retention of muscle strength.

Finally, ensure that reversible medical conditions are addressed in the health assessment recommendations, and consider referral to geriatric medicine specialists where frailty is associated with significant complexity, diagnostic uncertainty, or challenging symptom control.

This series on care of older people in General Practice will continue in the next newsletter. Please forward any questions to chris.bollen@bmpconsulting.com

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