

Post-Event Summary Report

Name of Event: Reducing Frailty in Aging

Date of Event: Saturday, June 18, 2005

Location of Event: Marymount University, Ballston Center; Arlington, Virginia
(Include city and state)

Number of Persons attending: 66

Sponsoring Organization(s): Marymount University Department of Physical Therapy and Department of Health Care Management. Support from the following organizations allowed us to offer this event free of charge: American Physical Therapy Association; American Optometric Association; American Society for Clinical Laboratory Science; Marymount University, Sigma Theta Tau – Eta Alpha Chapter; Sunrise Senior Living

Contact Name: Rita Wong, PT, EdD

Telephone Number: 703 284-5982 **Email:** rita.wong@marymount.edu

Priority #1

Establish a systematic interactive approach to effectively and efficiently screen older adults for the presence of risk factors that contribute to the development of frailty; and to manage health problems leading to frailty to reduce the projected burden on the health care system.

Priority #2

Establish a systematic, coordinated support structure that maximizes the ability of frail, or near-frail individuals to function independently in the least restrictive environment and contribute productively to society.

We consider both priorities essential in assisting persons in the baby boom generation to age well and in a way that decreases health care costs and increases individual quality of life. The two priorities are inter-related. Thus, the issues and barriers surrounding them, and the recommended solutions are closely linked and are best discussed together.

The Issue

Frail, vulnerable older adults are “the group of patients that present the most complex and challenging problems to . . . all health care professionals. Frailty isa physiological state of high vulnerability for adverse health outcomes.”¹ Frailty is associated with decreased physiological reserve, disability, mortality; and high health care costs. Frailty is not an inevitable

consequence of normal aging. Most people who become frail have multiple comorbid health conditions affecting several body systems (cardiac, endocrine, neurological, immune, etc.) These conditions interact with the normal aging process and, often, a sedentary lifestyle, to produce negative outcomes: disability, dependency, falls, need for long term care, and mortality.”¹⁻⁵

Commonly recognized signs and symptoms of frailty include musculoskeletal weakness, poor endurance and fatigue, slow motor performance, weight loss or under-nutrition, low physical activity level, unsteady gait and/or slow gait speed, and potential cognitive impairment. The onset of frailty is usually gradual with the slow accumulation of small losses across numerous body systems. The near-frail have very little room to ‘slide’ before they become frail. The frail have even less room before their systems fail. Currently, our system for screening, diagnosing, managing, and preventing frailty is poorly organized and, in some cases, nonexistent. Individuals with early signs and symptoms of frailty that may be easily managed through proactive interventions such as muscle strengthening programs, gait and balance training, and patient education, are often ignored and their symptoms attributed to “normal aging”. The lack of coordinated and early care leads to progressive disability, decreasing quality of life, and higher health care costs.

Sixty-six (66) participants attended Marymount University’s Aging Agenda event *Reducing Frailty in Aging*. Participants were organized into four small discussion groups related to frailty in the elderly. All four groups identified: 1) a need for greater coordination of services for the at-risk and frail individuals; and 2) a more proactive health promotion component to health services as key strategies to maximize personal independence and improve quality of life while decreasing health care costs for the frail and the near-frail.

An aggregate list of concerns identified by the groups include:

1. Our health care system has little integration or coordination of services among health care providers. Our system encourages unnecessary polypharmacy, over-utilization of health care, increased costs of care, and poor health outcomes. This lack of integration, or coordination, results in reactive, fragmented care, which is associated with increased frailty and other poor health outcomes.
2. Individuals at risk for frailty are often not identified early enough to make a substantive impact on the downward trajectory of functional decline. Many health care practitioners have the knowledge and skills to provide frailty screening and risk prevention/management services that can change the downward trajectory. However, we lack frailty screening tools; financial incentive to provide widespread screening services; inadequate integration among providers to share information and coordinate care that can avert frailty.
3. The public is largely unaware of frailty as a medical syndrome. To that end, individuals do not seek or access screening and/or risk prevention services.
4. From the perspective of health care practitioners, frailty screening and risk prevention services are not marketed to the public due to lack of incentives at multiple levels, e.g., payers, providers, employers and consumers.
5. Scientific research suggests that frailty may be deterred; however there are few demonstration projects and no clinical guidelines to direct practitioners.

When someone is on the edge of frailty, it only takes a very small decline in function to drop them below the level of physical activity independence. Similarly, it also requires only small improvements in function to allow an individual to move from partial dependence to independence in performing daily physical activities. A safety system that ‘catches’ physiological losses, and remediates and/or accommodates them prior to loss of functional abilities is a conservative, cost-effective approach to substantially decreasing the financial and human costs of frailty.⁶

Barriers Related to These Issues

The principal barriers threaded throughout all group discussions included:

1. The current health care system is episodic and reactive in nature. As such, care for the elderly is neither comprehensive nor coordinated.
2. The current health care system is focused on illness management. Prevention, integration and access to the full spectrum of practitioners for health management is not currently covered.
3. There is no efficient structure in place to effectively support screening for frailty or for comorbid health conditions that contribute to development of frailty, or for coordinating delivery of services if an impairment is identified.
4. Although most healthcare practitioners will provide a fairly consistent definition of frailty, frailty is not universally recognized within the medical and research literature as a specific syndrome with unique characteristics and best practice management strategies. No practice guidelines or clinical pathways exist for management of this very common and potentially devastating syndrome.
5. Negative age bias continues to impede progress in developing and implementing frailty reduction and accommodation programs. Frailty is perceived by many (health care practitioners, older adults, insurers, legislators, etc) as an unavoidable part of aging that cannot be modified. In addition, many persons have very low expectations of the ability of older adults to contribute to society and to their preferences for active engagement in daily activities.
6. Demonstration projects that use a systematic, well-coordinated approach to managing frail individuals are limited to end-of-life care; they do not focus on early intervention; and may be expensive to manage as initially set forth.
7. Inadequate numbers of health and social care providers are interested in working with older adults to meet the growing demand. Thus, even when programs are developed, staffing is a substantial issue.

What Solutions do you Recommend?

Participants at the event agreed on the following as broad solutions to the issue of frailty reduction:

1. We must identify frailty as defined in the current research literature as a medical syndrome,¹ and assign funding for research and presentation of best practices to guide health management.
2. We must implement multidisciplinary services to provide high-quality, cost-effective care to the growing elderly individuals with a focus on prevention of frailty.
3. Such a system will include:

- a. Geriatric care coordination as a covered service that is in addition to primary care services;
 - b. Technology and other support systems for patient self-monitored health assessment and reporting;
 - c. Medical informatics systems that support seamless transitions between and among practitioners;
 - d. Access to frailty screening and prevention services that are publicized and paid for;
 - e. Linkages between non-traditional practitioners with traditional health care providers; and
 - f. Funded research initiatives that result in evidence-based clinical practice guidelines for prevention and management of frailty.
4. We must review education of entry-level health care providers in all disciplines to ensure frailty is a part of the curriculum along with the special needs for health coordination for the elder population.
 5. We believe that the Medicare system must include mechanisms that optimize coordination and integration of care, prevent the onset and progression of frailty and appropriately reimburse qualified health care practitioners for these services.

Systems-Integrated Example

The following is proposed as the key components of a systems-integrated approach for co-management of frailty prevention and intervention.

Assumption 1: Frailty will be commonly recognized as a health risk. Patients and practitioners will screen for and seek prevention strategies to reduce the incidence of frailty.

Assumption 2: The patient will be knowledgeable of health and wellness and will be a strong self-advocate in care management. Consumers will utilize technology to access health information resources and to augment communication with providers.

Assumption 3: Qualified practitioners, in addition to physicians, will be entry points for patients for prevention and management of frailty. Qualified professionals will include but will not be limited to: 1) nurse practitioners; 2) physician assistants; 3) physical therapists; 4) health and wellness specialists, e.g., exercise physiologists; 5) nutritionists; 6) medical laboratory technologists; 7) Optometrists.

Assumption 4: Screening and prevention services will be covered services.

Assumption 5: Evidence-based practice guidelines will direct health and wellness care provided by qualified practitioners.

Frailty comanagement teams are established to provide screening, evaluation, and intervention in a direct access environment and with the patient as a central partner on the team. These teams provide integrated services that carefully target the primary needs of the patient. Three examples follow:

1. The medically stable patient with a primary complaint of weakness and gait deficits is comanaged by a physical therapist, case manager, and nurse practitioner with the assistance of health and wellness professionals and nutritionist/dietician.
2. The individual who is overweight, has diabetes, and poor endurance is comanaged by a nutritionist/dietician, case manager, and health and wellness professional, with the assistance of medical laboratory personnel and physical therapists.
3. The individual with an unstable medical condition is comanaged by the physician, case manager and nurse practitioner/physician assistant with the assistance, as indicated, of medical laboratory personnel, physical therapist, and nutritionist.

References

1. Fried LP, Ferrucci L, Darer J, Williamson JD, Anderson G. Untangling the concepts of disability, frailty, and comorbidity: implications for improved targeting and care. *J Gerontol A Biol Sci Med Sci*. Mar 2004;59(3):255-263.
2. Joseph C, Kenny AM, Taxel P, Lorenzo JA, Duque G, Kuchel GA. Role of endocrine-immune dysregulation in osteoporosis, sarcopenia, frailty and fracture risk. *Mol Aspects Med*. Jun 2005;26(3):181-201.
3. Stookey JD, Purser JL, Pieper CF, Cohen HJ. Plasma hypertonicity: another marker of frailty? *J Am Geriatr Soc*. Aug 2004;52(8):1313-1320.
4. van den Biggelaar AH, Huizinga TW, de Craen AJ, et al. Impaired innate immunity predicts frailty in old age. The Leiden 85-plus study. *Exp Gerontol*. Sep 2004;39(9):1407-1414.
5. Leng SX, Cappola AR, Andersen RE, et al. Serum levels of insulin-like growth factor-I (IGF-I) and dehydroepiandrosterone sulfate (DHEA-S), and their relationships with serum interleukin-6, in the geriatric syndrome of frailty. *Aging Clin Exp Res*. Apr 2004;16(2):153-157.
6. Gill TM, Allore HG, Holford TR, Guo Z. Hospitalization, restricted activity, and the development of disability among older persons. *Jama*. Nov 3 2004;292(17):2115-2124.