



THE UNIVERSITY OF ARIZONA
Arizona Center
on Aging



Frailty 101: Helping Your Patients Age Safely in Place

Geriatric Psychiatry for Non-Psychiatrists
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Our Path Today

- About Aging in Place
- Intro to Frailty
- Frailty and Aging in Place
- Call to Action

Most Older Adults Live at Home in the Community



Just 3% of people age 65+
live in nursing homes

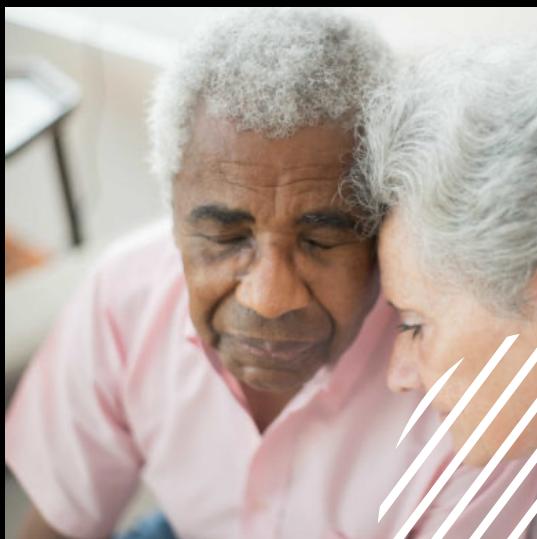
A portrait of an elderly man with white hair and a beard, resting his chin on his hand while holding a wooden cane.

**90% of older adults
want to “Age in Place”**

Independence.
Safety.
Familiarity.
Comfort.
Dignity.
Memories.
Family and Friends.
Contribute.
Community.



Aging in Place can work if the person, place, and support network are aligned.



It takes planning and coordination, and it can be challenging.

Frailty brings several barriers to Aging in Place.

Let's Talk About Frailty



Frailty 101

Usual Aging
(Very Variable)



Geriatric Syndromes and
Diseases, including:

Dementia



Frailty



What is Frailty?



Common, age-related and **unexplained precipitous** decline in function and reserve across multiple physiologic systems

Increased vulnerability, most obvious under stress, with decreased capacity to bounce back

Chronic inflammation, autonomic nervous system lability and energy dysregulation

Frailty is **NOT** usual aging



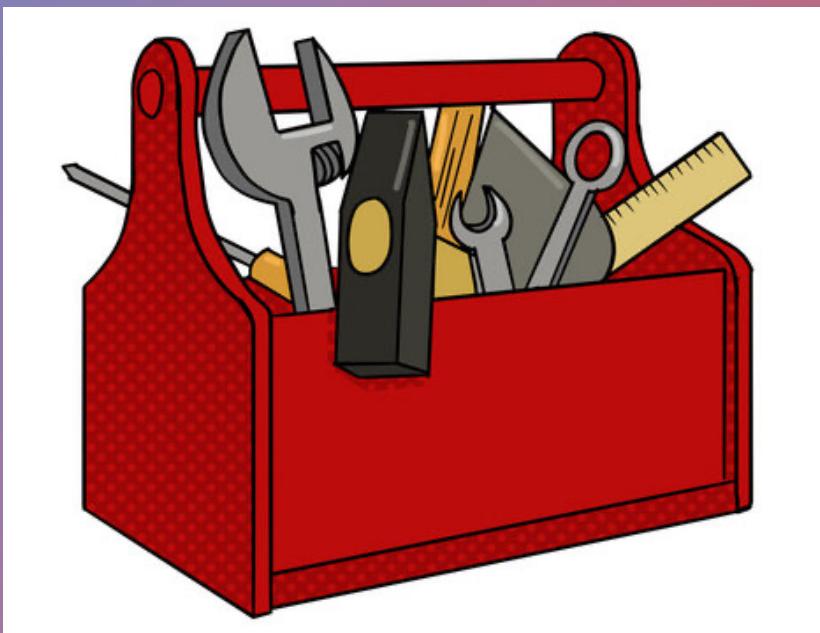
Frailty is Very Common

- 12-15% of older adults are Frail
- By age 85, over 1/3 are Frail
- More common in lower income and minoritized populations
- 1/3 of older adults are Pre-Frail



Frailty Strongly Predicts Poor Health Outcomes

- ED and Hospitalization
- Falls with hip fracture (5x)
- Cognitive impairment
- Post-op complications (2.5x)
- Disability
- Institutionalization (20x)
- Death (3-5x higher over 2-3 years)



Understanding Frailty:

Two Schools and Many Tools

- Fried Phenotype Frailty
- Rockwood Cumulative Deficits (Frailty Index)

Fried Phenotype Frailty

- Distinct **biological syndrome** of decreased reserve resulting from cumulative and accelerated declines across multiple physiologic systems
- Based on 5 biological criteria
- Different from comorbidity and disability



Linda P. Fried & colleagues, 2001

Fried Frailty Phenotype or Score

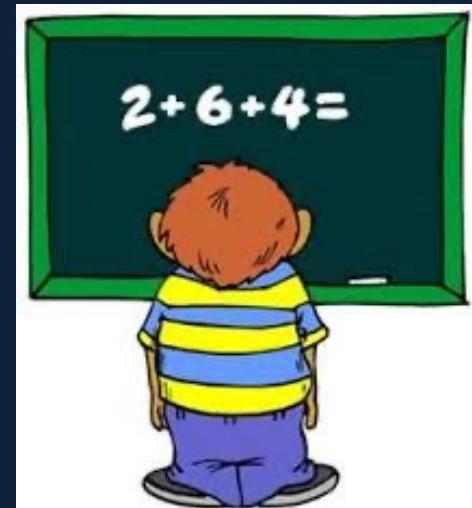
Table 1
Fried phenotype criteria and measurement indices

FP Criteria	Measurement
Weakness	Grip strength <20th percentile
Slowness	Walking time (15 feet): slowest 20% by sex and height
Low level of physical activity	Bottom 20th percentile of calculated kcal as measured by the Minnesota Leisure Time Activity Questionnaire
Exhaustion	Self-reported, based on items in the Center for Epidemiologic Studies Depression Scale
Weight loss	>10% of unintentional weight loss during the prior year

From Fried LP, Tangen CM, Walston J, et al. Frailty in older adults: evidence for a phenotype. *J Gerontol A Biol Sci Med Sci* 2001;56(3):M146–56.

Rockwood Cumulative Deficits Model

- Frailty results from accumulation of deficits (diseases, cognitive and physical impairments, psychosocial risk factors, and geriatric syndromes)
- The more things wrong, the more likely that person is frail



Frailty Index

Electronic Health Record



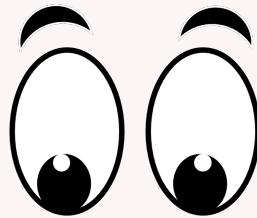
Rockwood K. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005

Clinical Frailty Scale (CFS)

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.		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).	
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.		8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.	
3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.		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.	
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.		Scoring frailty in people with dementia	
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.		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.	
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.		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.	

You Can't Tell Frailty By Looking



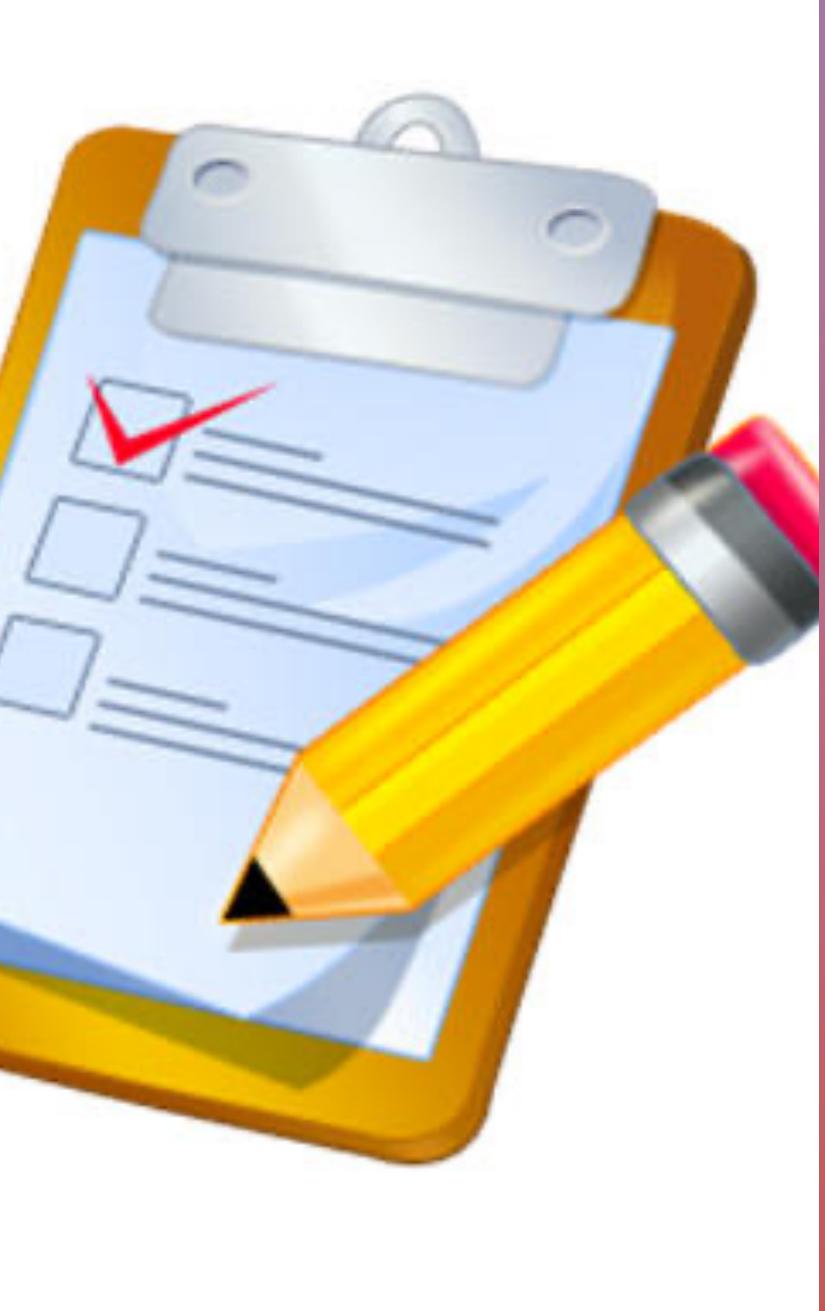
- Experienced clinicians were unable to identify frail adults (only 44% agreement of "eyeball" test to Fried criteria)





Message:
Measure Frailty with a
valid tool.

Don't assume.

A close-up photograph of a clipboard with a white sheet of paper. The paper has several horizontal lines and a small checkmark in a box at the top left. A yellow pencil with a pink eraser lies diagonally across the clipboard. The clipboard has a brown cover with a metal clip.

Many Frailty Scales

Major differences in validity, feasibility and predictive ability

- Tradeoff between most accurate risk prediction vs. best fit
- Scales measure different populations, little overlap



Why assess someone for Frailty?

- Prevent Frailty
- Risk Stratify
- Optimize health
- Goal-aligned care





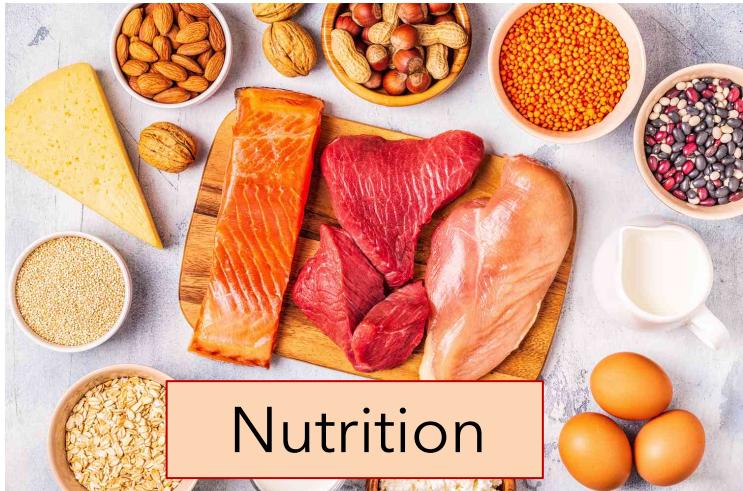
Why is Frailty Not Routinely Assessed?

- No standard definition
- No consensus on how to prevent and manage
- Not enough time or resources
- Concern about sharing diagnosis



What can
be done to
prevent or
manage
Frailty?





Nutrition



Socialization



Medication Management



Physical Activity

Multimodal Approach to Frailty



Person and
What Matters



Home
and
Neighborhood



Informal
Supports



Resources
and Services

To Age in Place,
What Should We Consider?

A photograph of an elderly woman with short blonde hair, wearing a yellow long-sleeved shirt. She is sitting in bed, facing away from the camera towards a window with dark wooden blinds. Her hands are clasped in her lap. To her left, a nightstand holds a lamp with a gold-colored shade, a small white bowl, and a cordless telephone. A framed picture hangs on the wall above the nightstand. The scene is lit by natural light coming through the window.

How does Frailty
impact on Aging
in Place?



Consider...

Depression

Higher prevalence of depression in those with Frailty.

Higher prevalence of Frailty in persons living with mild to moderate late life depression.

Need access to psychosocial support and socialization, and physical activity

Consider...

Cognitive Impairment

Frailty brings high risk of dementia.

Results in a downward spiral with very poor prognosis.

Need support for IADLs, coordination, safety and planning, informal and formal supports.





Consider...

Risks of “Usual Health Care”

Frailty strongly predicts ED and hospitalizations

High risk of hospital-associated delirium, functional decline, adverse med effects, and institutionalization

Need in-home primary, emergent and palliative team care to avoid unnecessary ED visits and hospitalization and provide care that supports “what matters most”

Consider...

Sarcopenia

Rapid loss of muscle strength and mass

Core frailty component with increased fatigue and falls

Need high protein meals (home-delivered or senior center), physical rehabilitation, and home modifications

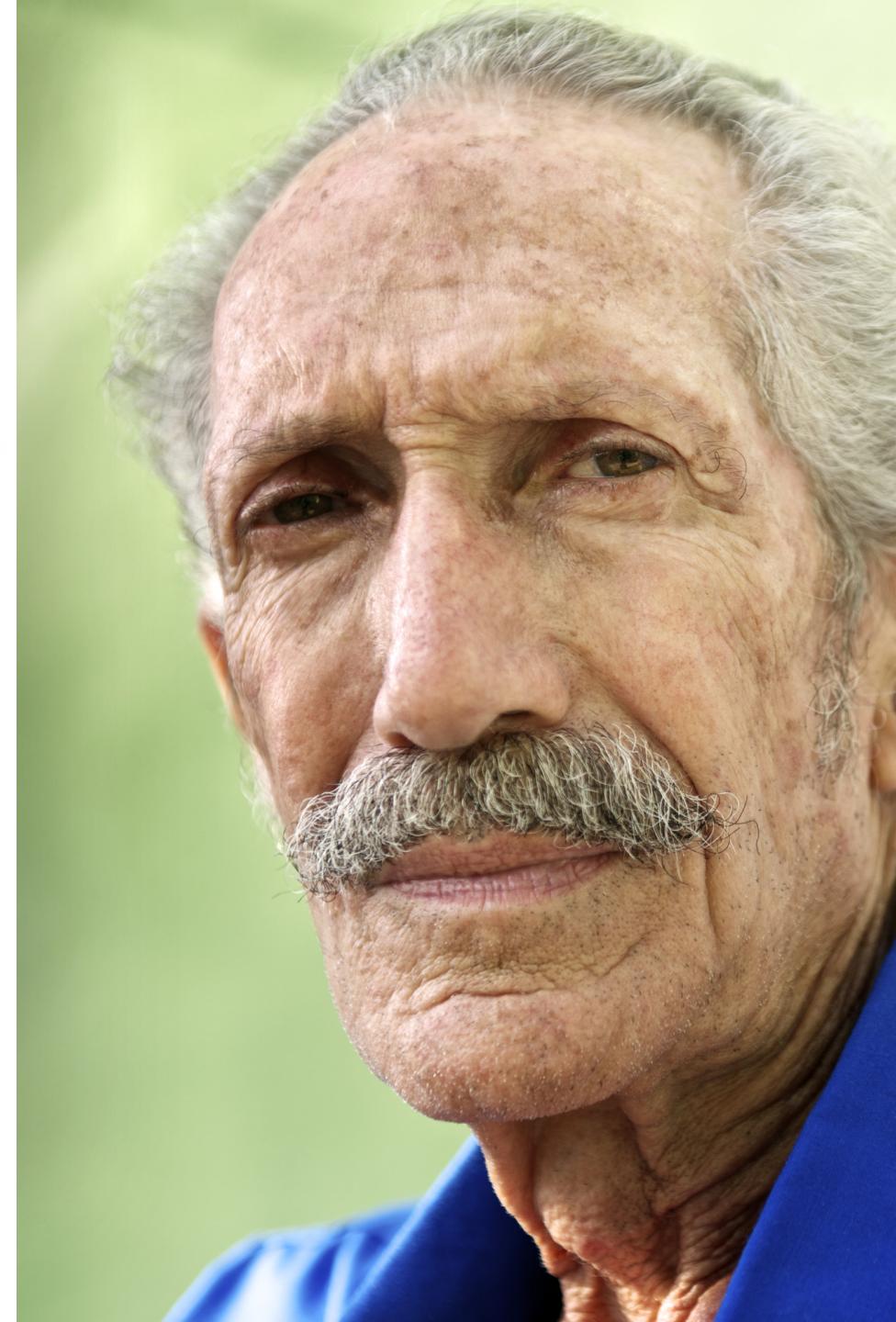


Consider...

Financial Stress

High costs of in-home care, caregiving, cleaning, home modification, meals, transportation, and other supportive care

Need resources for home- and-community based care and services



Consider...

Social Isolation and Loneliness

Frailty and progressive dependence and decline leads to social isolation and loneliness

Need access to socialization, emotional support, meaningful activity, and joy





Consider...

Caregiver Stress

Frailty brings high caregiver needs across multiple domains, including ADLs, mood and cognition, and chronic disease management

Need in-home caregiver support, home modifications and DME, senior centers, adult day health care, transportation



Aging in Place can work if the person, place, and support network are aligned.

It takes planning and coordination, and it can be challenging.

Identify Frailty to anticipate and prepare for barriers to Age in Place.

Frailty 101

- Common geriatric syndrome, a major risk factor for poor health outcomes
- Often unrecognized
- Not usual aging
- Focused assessment offers opportunity to risk stratify, reduce harm, inform management, and improve health outcomes



A Call to Action

- Frailty matters! Spread the word
- Identify frail patients using valid tools
- Anticipate and prepare for challenges
- Support Frailty research
- Provide home-and-community services to support Frail adults who wish to Age in Place





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Thank you!

