13th EUGMS
INTERNATIONAL CONGRESS OF THE EUROPEAN UNION GERIATRIC MEDICINE SOCIETY
DEVELOPING PREVENTIVE ACTIONS IN GERIATRICS

INTEGRATED GERIATRIC AND PRIMARY CARE MANAGEMENT OF FRAIL OLDER ADULTS IN THE COMMUNITY

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CONFLICT OF INTEREST DISCLOSURE

I have no potential conflict of interest to report

Background (I)

Definition

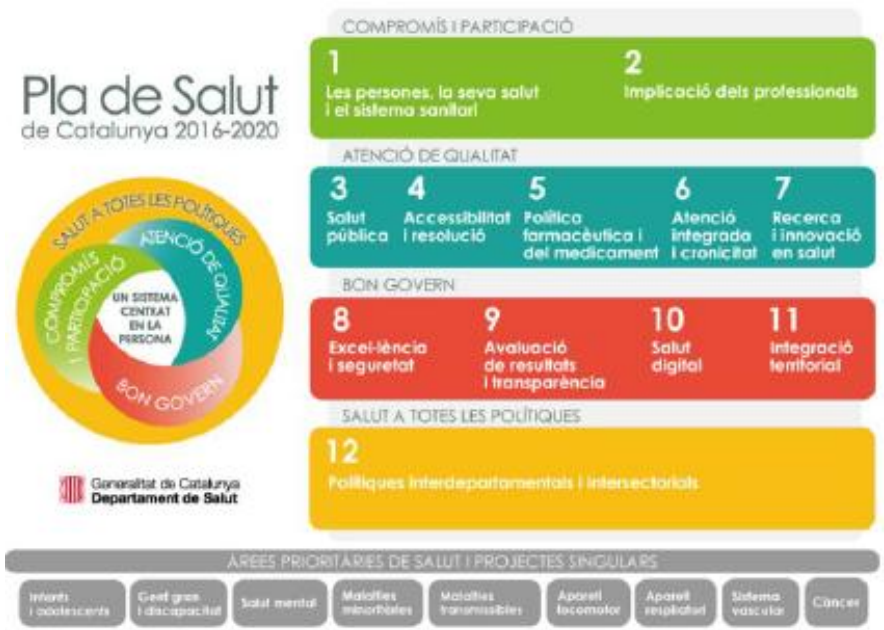
- Multidimensional clinical entity
- Dynamic state of increasing vulnerability
- Higher risk of falls, disability, institutionalization and mortality
- Determined by:
  - A decline in physiological reserve and homeostasis
  - A loss of global functional capacity
  - A loss of redundancy of systems and pathways
  - A loss of ability to respond or compensate different types of stressors

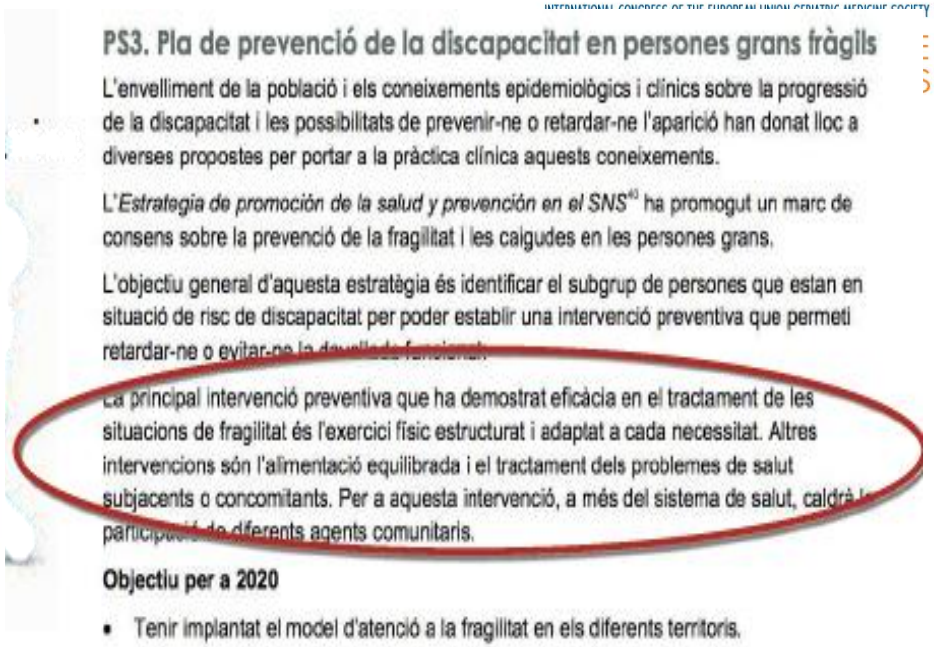
Dynamic state
Dissability risk

Background (II)

Does Frailty, could be reversible?

Introduction





PS3. Pla de prevenció de la discapacitat en persones grans fràgils

L'envelliment de la població i els coneixements epidemiològics i clínics sobre la progressió de la discapacitat i les possibilitats de prevenir-ne o retardar-ne l'aparició han donat lloc a diverses propostes per portar a la pràctica clínica aquests coneixements.

L'*Estrategia de promoción de la salud y prevención en el SNS*[40] ha promogut un marc de consens sobre la prevenció de la fragilitat i les caigudes en les persones grans.

L'objectiu general d'aquesta estratègia és identificar el subgrup de persones que estan en situació de risc de discapacitat per poder establir una intervenció preventiva que permeti retardar-ne o evitar-ne la davallada funcional.

La principal intervenció preventiva que ha demostrat eficàcia en el tractament de les situacions de fragilitat és l'exercici físic estructurat i adaptat a cada necessitat. Altres intervencions són l'alimentació equilibrada i el tractament dels problemes de salut subjacents o concomitants. Per a aquesta intervenció, a més del sistema de salut, caldrà la participació de diferents agents comunitaris.

Objectiu per a 2020

- Tenir implantat el model d'atenció a la fragilitat en els diferents territoris.

Objective

- To assess the impact on physical performance and frailty, of an integrated program between geriatrics and primary care, based on frailty screening, comprehensive geriatric assessment and development of tailored intervention.

Methods (I)

Geriatric Team

- Geriatrician
- Physiotheraphist

- Patients

Methods (II)

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Primary Care Team

- >80 years old with higher risk
  - Slowness
  - Memory complaints
  - Involuntary weight loss
  - Social risk

Geriatric Team

- Multidisciplinary assessment
  - Comprehensive Geriatric Assessment
  - Geriatrician + PT
- Specific frailty tools (SPPB, CFS)

ÀgilBCN **Tailored intervention plan** ÀgilBCN

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3 months follow-up

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Continuity with existing community resources

Methods (III)

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Primary Care Team

Geriatric Team

Tailored intervention plan

- **Pharmacological interventions**
- **Non-pharmacological interventions**
- **Physical activity program**

Pharmacological
- Review prescriptions
- Des-prescription
- Treatment conciliation

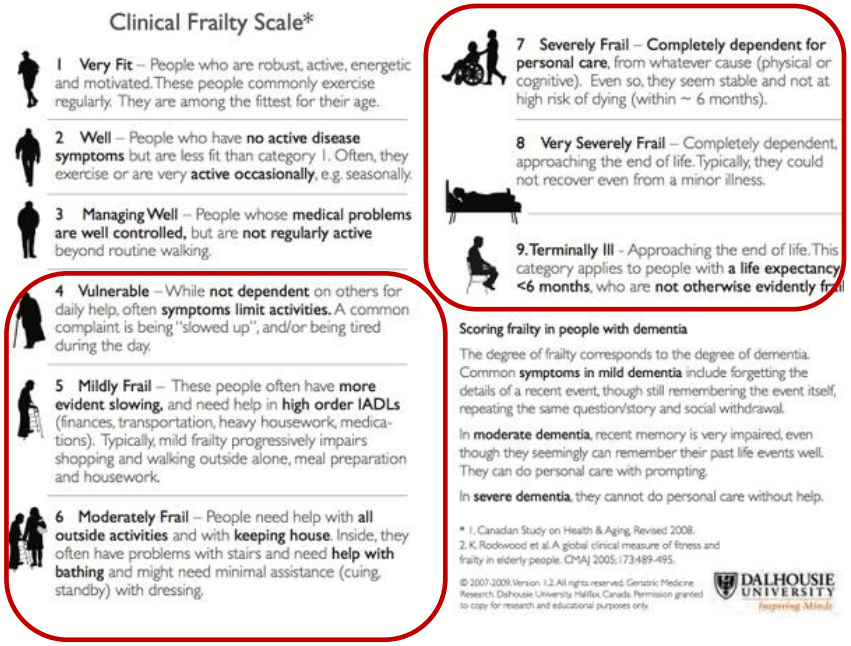
Physical activity program
- 10 sessions
  - Strength
  - Endurance
  - Flexibility
  - Socialization

Non-pharmacological
- Health education
- Patient empowerment
- Referral to Dementia Clinics

3 months follow-up

Continuity with existing community resources

Results (I)



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.

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DALHOUSIE UNIVERSITY Inspiring Minds

Rockwood et al, CMAJ 2005

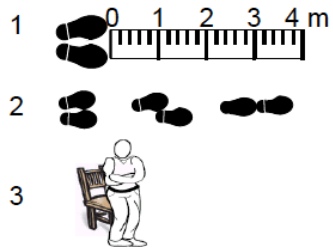
Characteristics	N=106 included
Age	81.78 ± 5.07
Woman	71.7% (76)
Charlson comorbidity index	1.5 (1-2)
Cognitive impairment	24.5% (25)
CFS vulnerable or frail	61.3% (65)
Barthel Index - ADL	95 (85-100)
Lawton Index - IADL	6 (3-8)
Lives alone	40.57% (43)
Self-perceived Health status - Low	28.3% (30)
Polypharmacy (>5 drugs)	84.91% (90)
Physical activity	25.47% (27)

Results (II)

Frailty Characteristics	Total N=106
Physical Function (SSPPB) (0-12)	6.65 ± 2.77
SPPB - Gait speed (m/seg)	0.65 ± 0.19
SPPB - Chair stand test (seg)	15.97 ± 10.52
SPPB- Balance impairment	53.77% (57)

Intervention	N=106
Physical activity	93.4% (99)
Health education	97.17% (103)
Referral to Dementia Unit	19.8% (20)
Pharmacological changes	64.54% (61.54)

SPPB. Short Physical Performance Battery:



Frailty Characteristics Of finishers	At baseline (N=51)	3 months Follow-up (N= 51)	Improvement	p
Physical Function (SSPPB) (0-12)	6.96 ± 2.23	8.61 ± 2.14	1.65 ± 1.79	<0.001
SPPB - Gait speed (m/seg)	0.65 ± 0.25	0.76 ± 0.15	0.11 ± 0.12	<0.001
SPPB - Chair stand test (seg)	16.71 ± 9.70	14.75 ± 6.48	1.95 ± 1.22	0.1157
SPPB- Balance impairment	54.90% (28)	23.52% (12)	16 improve	0.008
Number of drugs	8.12 ± 3.66	8.07 ± 3.5		0.2721
Antipsychotic withdraw		29.41% (15)		

Discussion

Main limitations

- Lack of continuity of "therapeutic exercise"
- Lack of psychological support and formal cognitive intervention
- Lack of control group

Short term plans

- Continuity through co-designed exercise program in the community
- Assessment of long-term outcomes (adherence to physical activity, hospitalizations, number of drugs)
- Evaluation of the implementation process (end-users, professionals)

Conclusions

- A multidisciplinary and comprehensive geriatric intervention in frail older community-dwellers could improved physical function.

- Specific tailored interventions could reversed frailty at 3 months.

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Thanks!

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