Services for Seniors Health to AVOID Frailty

White Rock/South Surrey

Public Board Meeting, Fraser Health

February 26, 2020

Dr. Grace H. Park

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- **Early-frail seniors are becoming more frail *unnecessarily***


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Frailty Guide

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.

DALHOUSIE UNIVERSITY *Inspiring Minds*

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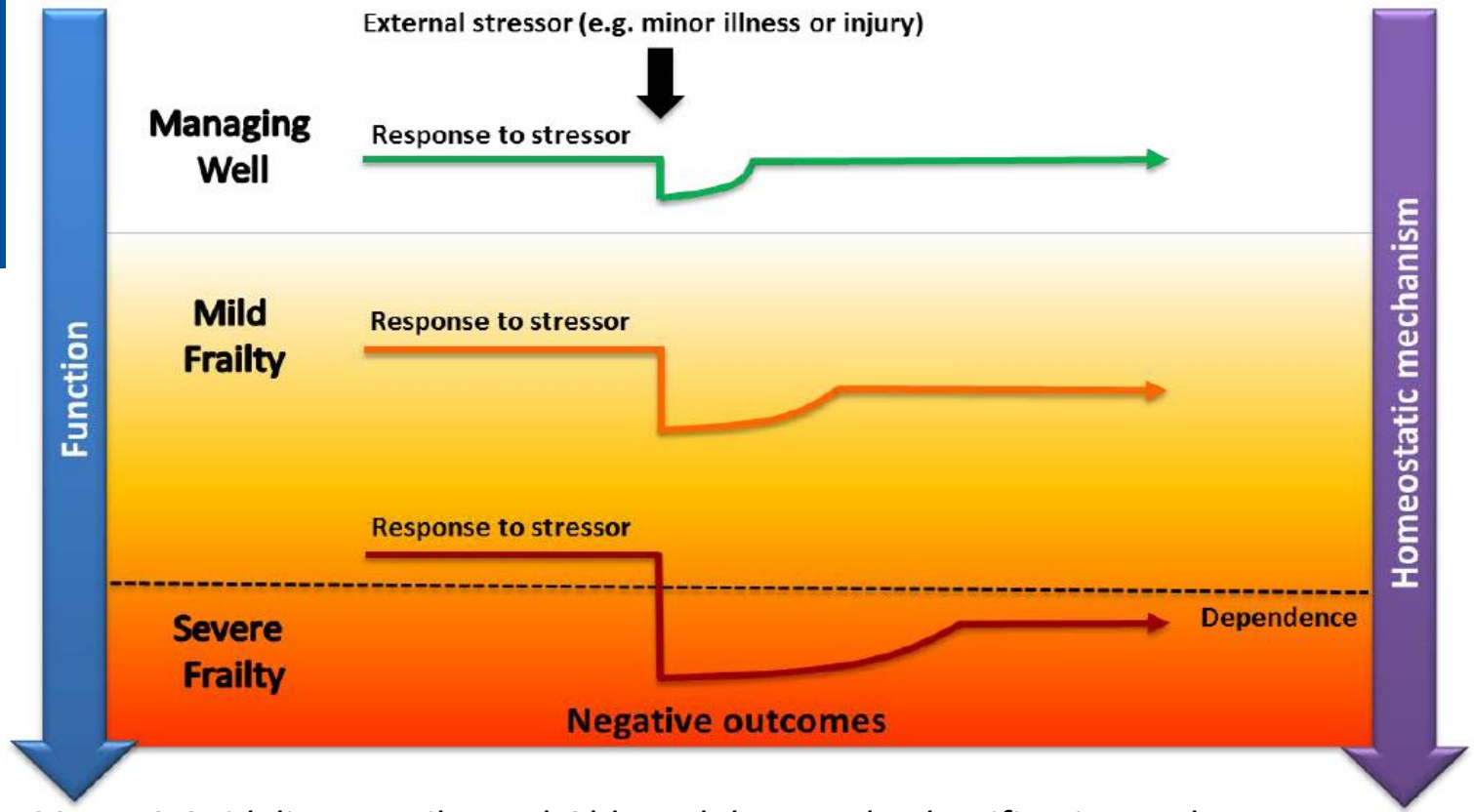

2017 BC Guidelines: Frailty and Older Adults – Early Identification and Management

Managing well: A fit older adult who, following a minor stressor, experiences a minor deterioration in function and then returns to homeostasis.

Frailty: A frail older adult who, following a similar stressor, experiences more significant deterioration and does not return to baseline homeostasis. With more severe frailty, this may lead to functional dependency or death.

AVOID

- Activity:
  - Not just for the super fit
  - Park and Rec classes
  - Get Up and Go
  - Day programs
  - To get your heart beating and strengthen muscle and challenge balance
- Coaching
  - Motivation, goal setting
  - Increase confidence

AVOID

- Vaccination
  - Reduced ability to fight infection
  - High dose flu shot
  - Pneumovax
  - Shingles
  - Hepatitis A,B
  - Booster shots diphtheria, tetanus, pertussis

AVOID

- Optimize Medication
  - Reduce number of meds (1:4 on 10 or more meds)
  - Reduce dose of meds
  - Monitor for possible drug interaction
  - Monitor for harm for seniors by class of medication
  - Even over the counter medications, vitamins, supplements

AVOID

- Interaction
  - Social isolation leads to poor health, premature death, dementia
  - Risk factors for social isolation
    - Living alone
    - Major life transition; death of a spouse
    - Small social network, geographical isolation
    - Health issues: impaired mobility, depression, low self esteem, dementia

AVOID

- Diet and Nutrition
  - Food security
  - Financial security
  - Food choice; Food is medicine, calcium, vitamin D
  - Ability to ingest, swallow
  - Nutritional needs of elderly

Measuring Frailty
Frailty Index

- Considers the cumulative effect of multiple factors indicating physical and cognitive decline.
- Predicts survival, risk of disease progression, need for institutionalization and use of healthcare services.
- As we age, we begin to accumulate deficits. 4.5% increase frailty per year; doubling time 15 years
- Those with less deficits are more fit; those with more deficits are more frail.
- Socially vulnerable suffer more at any level of frailty

Early Identification of Frailty at Primary Care

- Identify frailty early – GP/NP assessments
- Opportunity for intervention before frailty too advanced
- Reverse components of frailty with evidence based assessments – identify health deficits; comprehensive assessment
- Develop a care plan addressing health deficits and connecting with health protective interventions

Social Prescribing

- Health Protective Factors:
  - Healthy diet
  - Socialization
  - Exercise
  - Caregiver support

- Seniors Community Connectors (SCC)
  - Aware of Community Based Seniors' Services (CBSS) resources; hired through United Way
  - GPs refer directly to SCC to include; socialization in community activities, exercise venues, community kitchens etc.
  - Community peer coach works with SCC.

Seniors Come Share

Subscribe | Volunteer | Donate | Contact | Search | 604.531.9400

Seniors Come Share Society

WHO WE ARE | WHAT WE DO | WAYS TO GIVE | WORK WITH US | RESOURCE DIRECTORY | EVENTS | BLOG

What We Do

For over 40 years Seniors Come Share Society has been dedicated to providing older adults and their families with the services, programs, and resources necessary to remain *educated*, *engaged* and most importantly *empowered* members of our community.

Through our Community Support, Better at Home and Day Programs, many of your needs can be met under one roof.

Community Support

604-531-9400

View More

Better At Home

604-536-9348

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Day Programs

778-735-0955 ext 252

View More

https://www.comeshare.ca/what-we-do

Our Community

- **Social Capital**: Appraisal of community resources that can be accessed to improve Quality of Life: indirectly influence individuals subjective and objective measure of isolation – mediated by perception of Safety and Social Cohesion

- **Social Cohesion**: Mutual Community Trust and Solidarity (King 2006)

Health and Social Services Integration

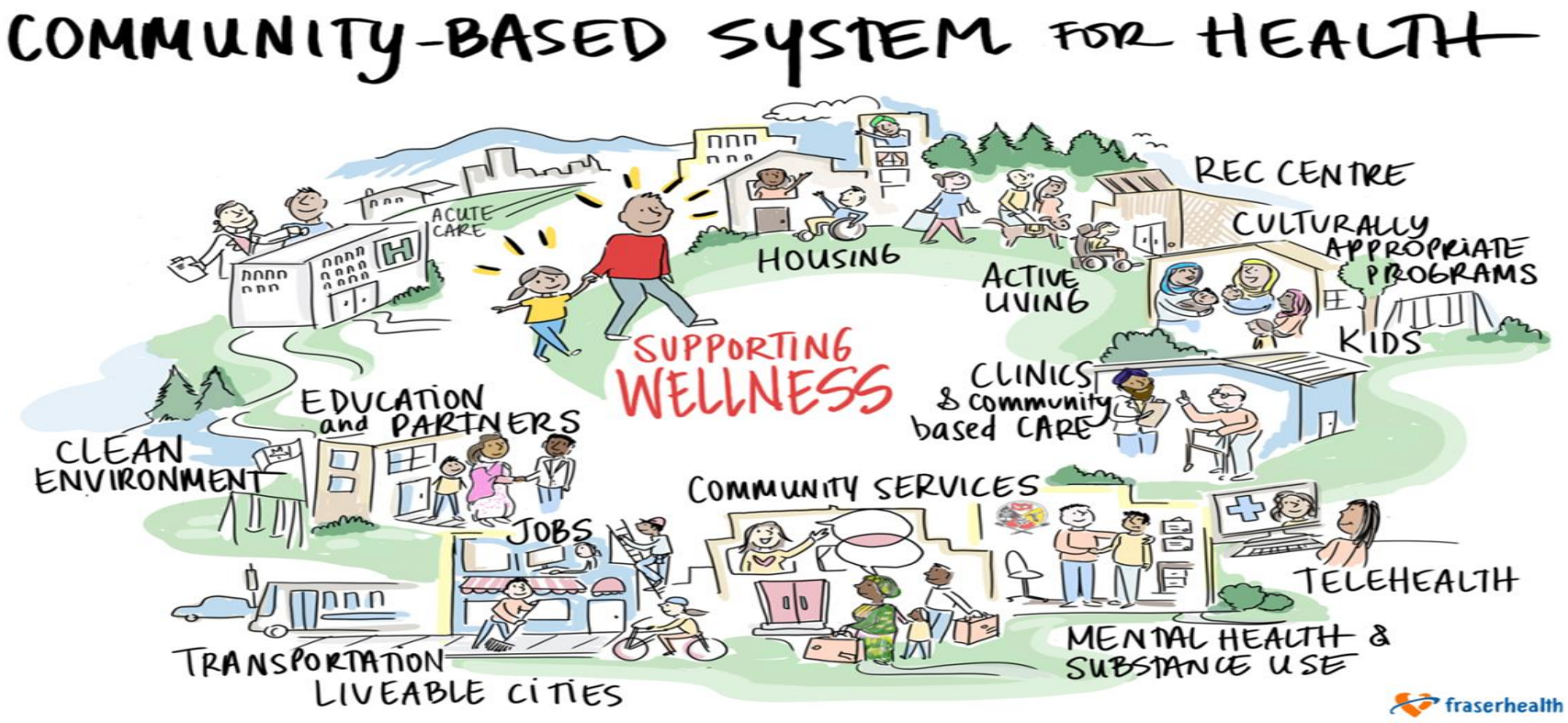
- CARES in Fraser Health Authority; an example
  - Integration of primary care and community social services sector
  - Project to identify and prevent frailty to promote healthy aging and self management (independence)
  - Through United Way partnership and funding
  - Creation of a point of contact for PCPs

Seniors Community Connector

- **Social Prescription program**
- Work with local hospital and community foundation to develop social capital and social cohesion

Primary & Community Care Redesign and CARES

Supporting "at risk seniors" in their communities



Community Capital, Community Cohesion

How do we AVOID Frailty

- Call to Action:
  - Community and Health Services collaboration, upstream early interventions and community supports integrated with health authority services as needed, long term care absolutely last place
  - Working together; It takes a village to age well
  - Blue Zone – lifestyle, diet, socialization – they don't work to live longer, longer fit life ensues because it is their way of life

Questions & Discussion

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Social Isolation Affects Health

Social Risk Factors	Health Risk Factors
Living alone	Impaired mobility
Major life transition – loss of partner, employment Loss of resources; limited or low access to transportation, financial limitation to travel and participate	Severe chronic disability Loss of Health Abrupt
Being a caregiver	Psychological, cognitive vulnerability - dementia
Living in rural setting Relocation to be near children	Low self esteem
Neighborhood, community limitations	addiction
Small social network	depression
English as second language	Compromised self efficiency
Minority group, LGBTQ, religious, cultural	Frailty