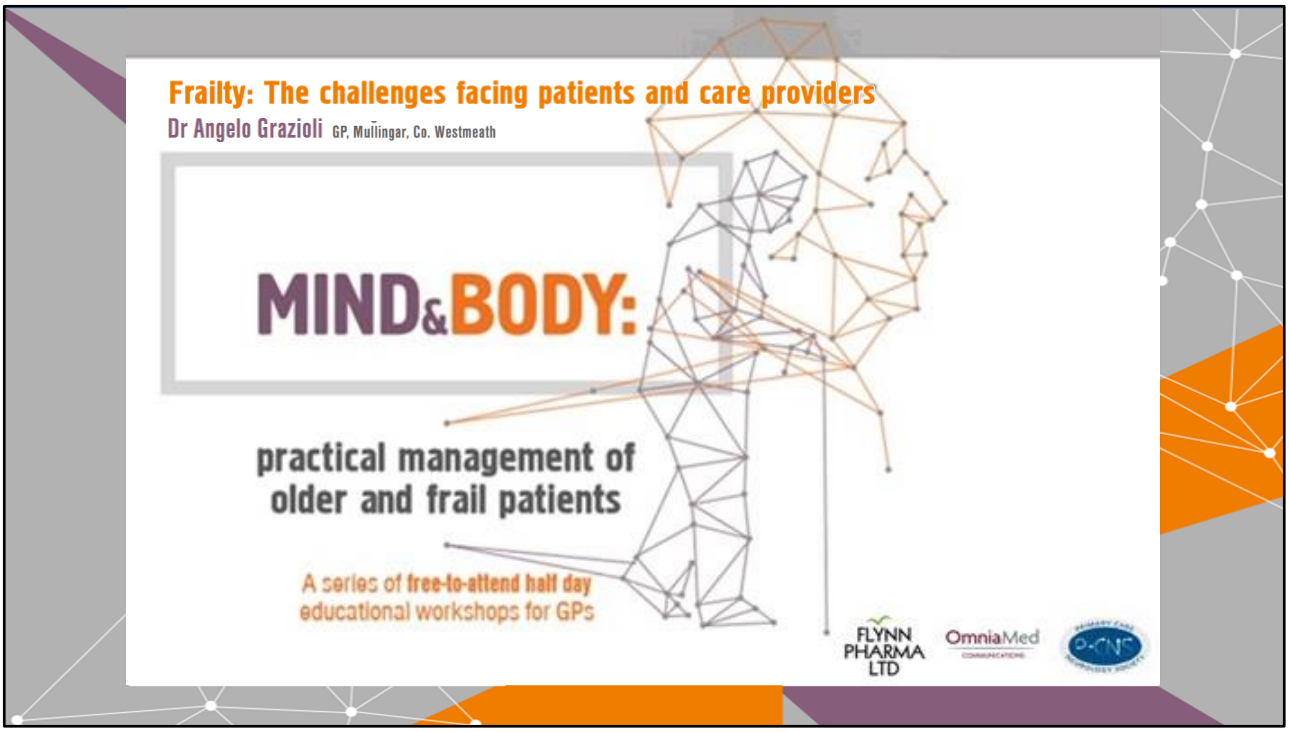

Frailty: The challenges facing patients and care providers
Dr Angelo Grazioli GP, Mullingar, Co. Westmeath
MIND&BODY:
practical management of older and frail patients
A series of free-to-attend half day educational workshops for GPs
FLYNN PHARMA LTD
OmniaMed

Greetings

Because I am the first speaker today, I think it falls to me to open the day with a brief review of the top challenges facing GPs in the primary care of the elderly.
Frailty is a simple enough concept, but in practice it is a complex condition for the GP to investigate and manage.

CGA

Comprehensive Geriatric Assessment

So, I will present a very brief overview of the Comprehensive Geriatric Assessment, which spans the full range of issues to be
considered,
investigated,
treated and
monitored by the GP dealing with the elderly, and especially the frail.

Hopefully you will find the most encouraging take-home news today to be the discovery of a very useful
one stop resource
for GPs aiming to engage in viable quality care of the elderly
based on a CGA framework.

But , most importantly, we will look at how this can be done within the reality of time, resources and financial constraints of primary care practice.

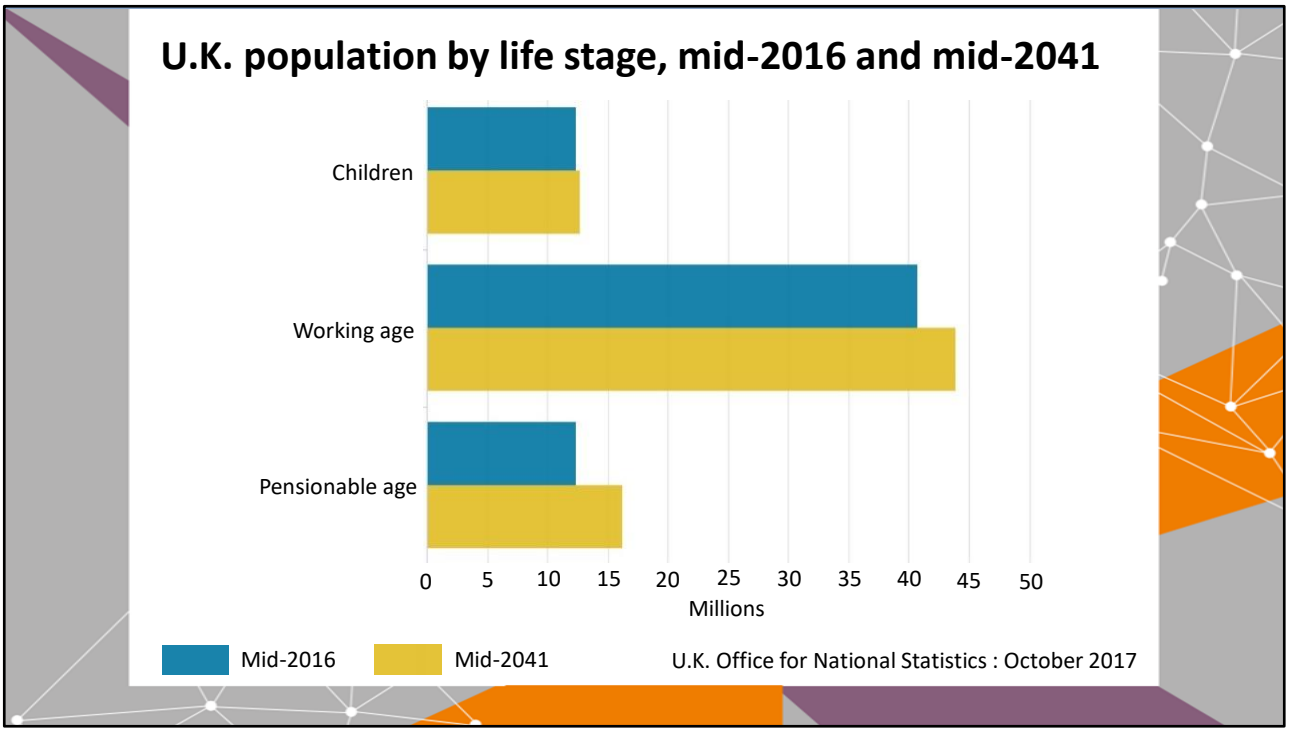
Now, we probably have a cumulative few centuries of GP years in practice represented here today, and all of you will all have come across and dealt with Frailty so my aim today is to take a very hands on practical look at frailty
so as to have you review your current approach
and have you leave here today with a very clear idea of what you can realistically and viably achieve in your own unique practice environment to better care for the frail.

So to that end, I will illustrate the process by outlining a real life case scenario involving the diagnosis and ongoing management of frailty, triggered by an incidental finding of a fall.
I will show you that, in an entirely GP led scenario, you can do all that is required by bringing your frail patient back to your surgery just 4 times if you have minimal outside support and are relying entirely on yourself and your nurse.
Of course, in reality most of you will have access to a local MDT or other support structures that you can draw upon to do some of the work, So as I speak, no matter where your practice is located you will be thinking
" that task I can outsource "
" this part I could easily do myself "

Now that is an ambitious agenda
I know

So gird up your loins and focus your attention
Here we go

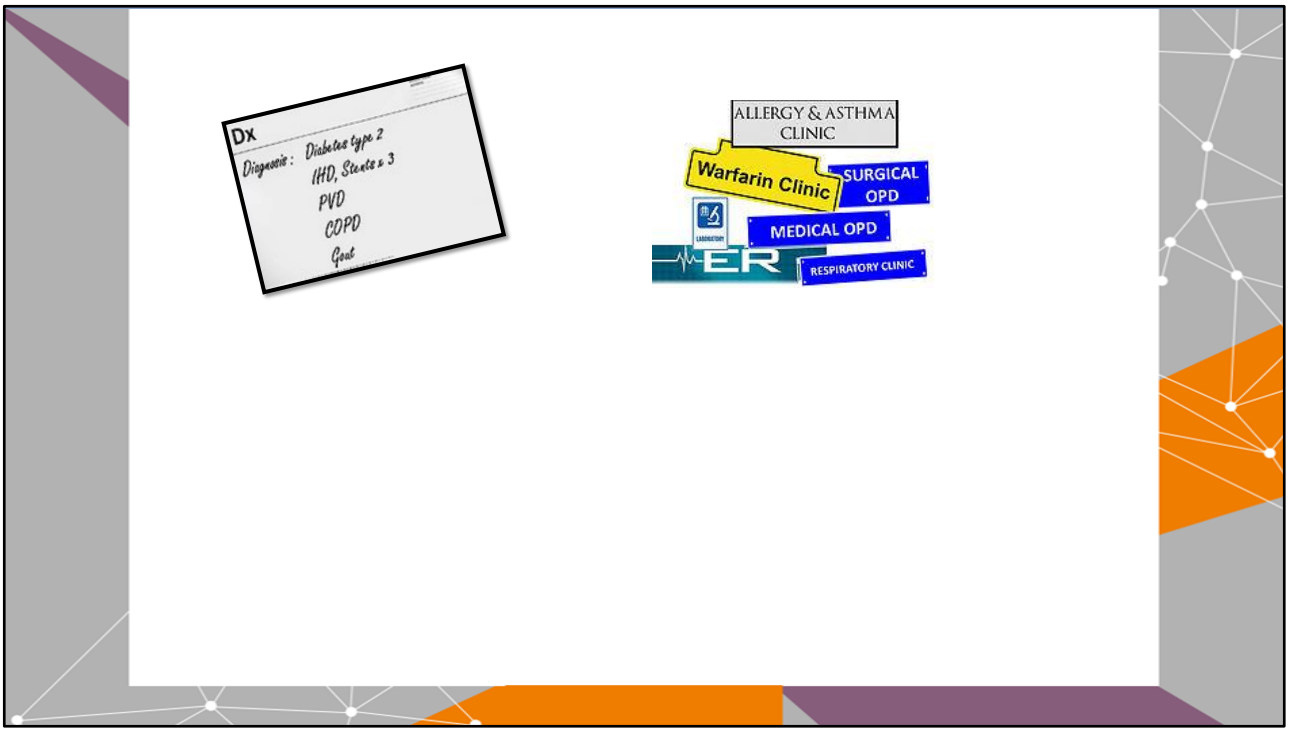
In just 30 years time, an expected 2 billion people aged 60 and over will challenge governments and health-carers worldwide.



In the UK the number of pensioners currently roughly equals the number of children. By 2041, in spite of the expected rise of the State Pension Age to 67, pensioners will outnumber children.

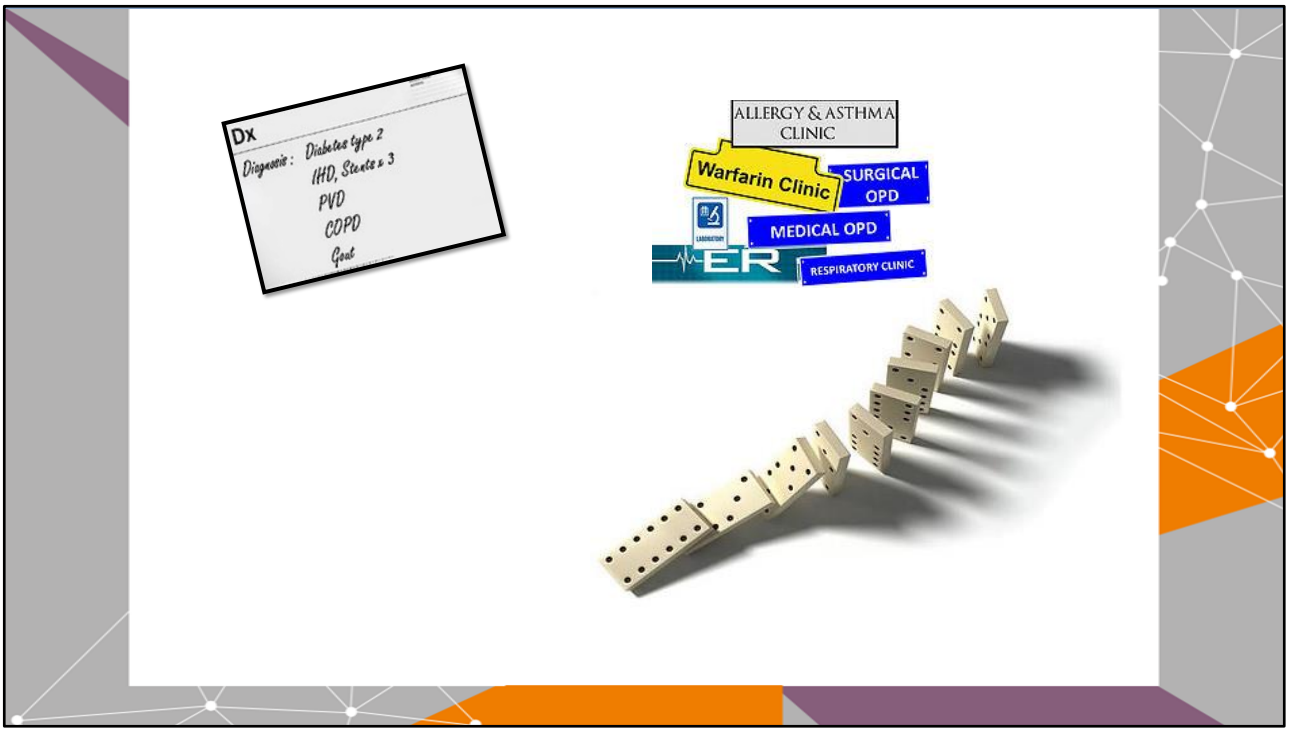
This means that care of the elderly will continue to make up an increasingly higher proportion of the workload of the GP.

These older people will often experience multiple health problems.

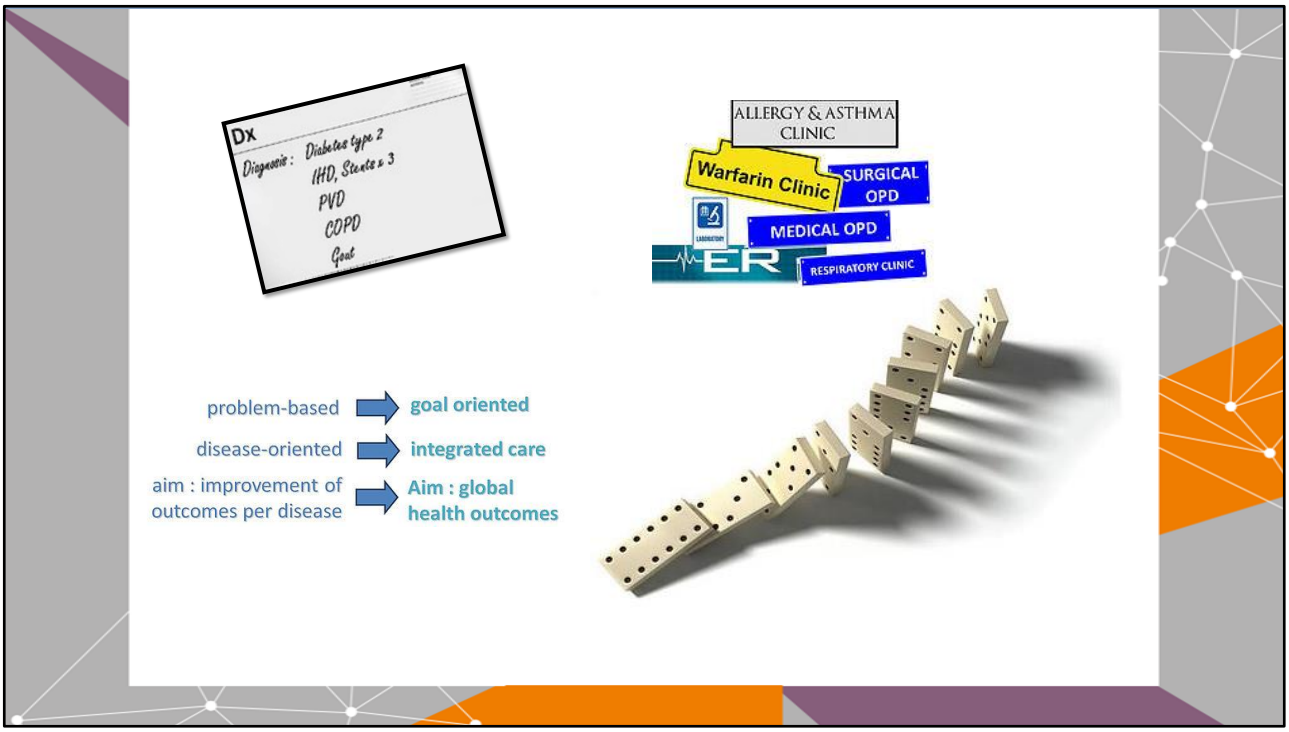


In recent decades, these multiple health problems have been approached in a problem-based,
disease oriented fashion,
with different health-carers tackling individual issues separately,
often with little, if any, communication and co-operation between them.

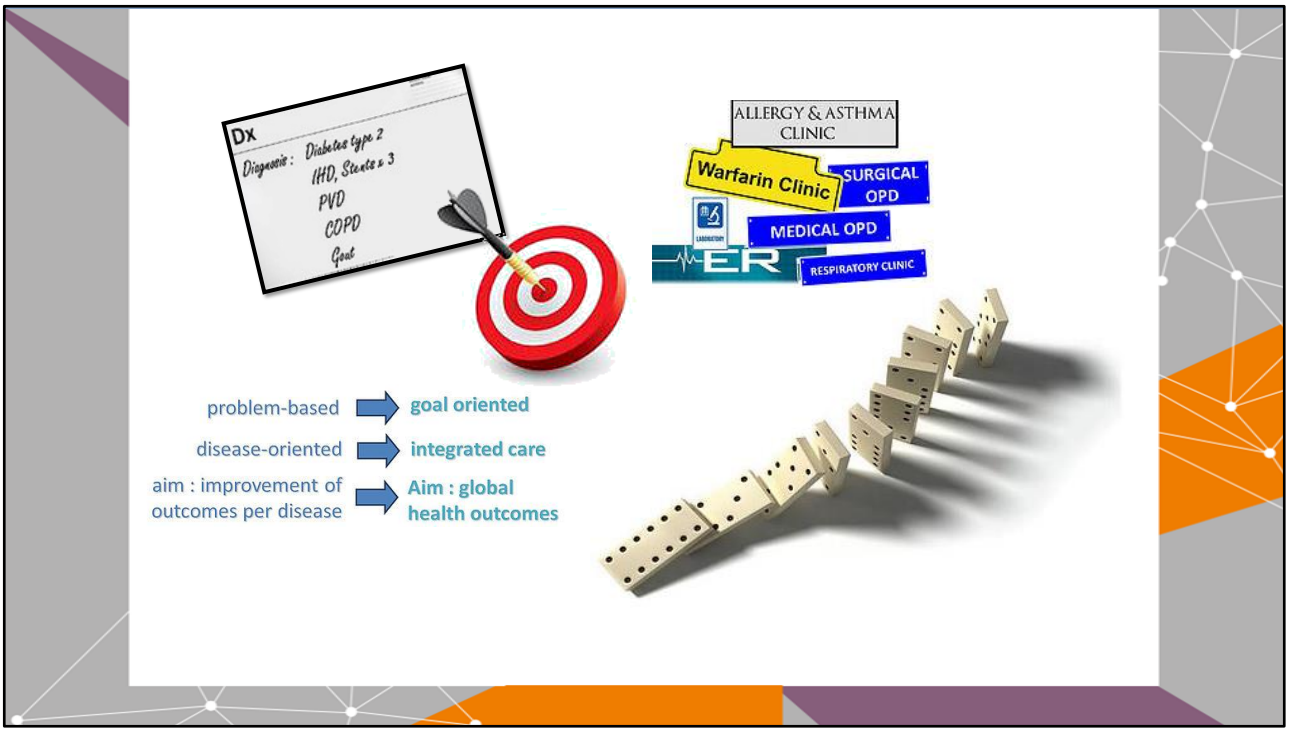
Now, there are 2 realities which undermine optimum outcomes in this traditional problem-based, disease-oriented model of care
particularly as it is applied to care of the elderly.



The first reality is that,
particularly in the elderly,
one disease and its management often influences the prevention, the diagnosis, the impact and the treatment of other diseases
so, for example :
diabetes control
may influence the sequelae of Peripheral Vascular Disease
which may reduce the need for diuretics and antithrombotics
which may require adjustment of cardiac medication and lassatives
and may hence reduce the risk and incidence of falls
which may reduce the need for analgesics
which may improve liver function
which will... and so on and so forth in an ongoing domino effect.



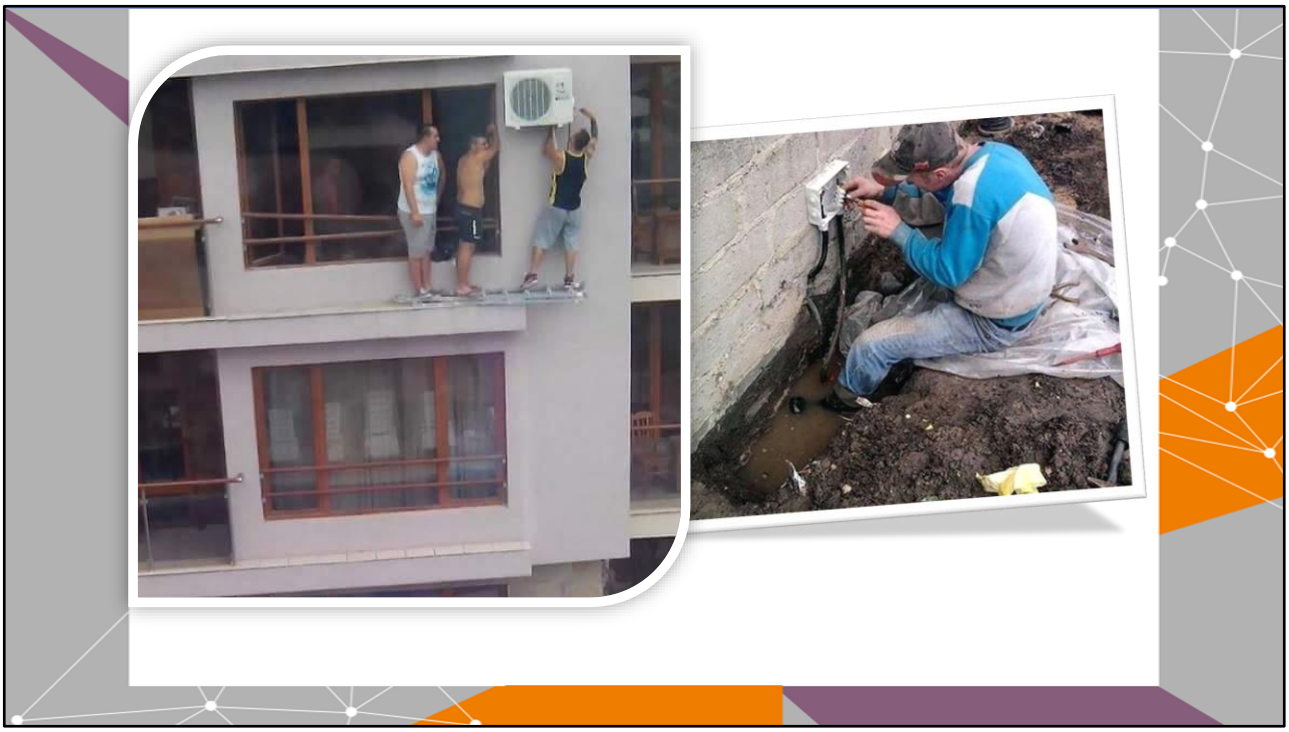
This means that care of the elderly needs to shift from the old problem-based and disease-oriented model towards more goal-oriented and integrated care.



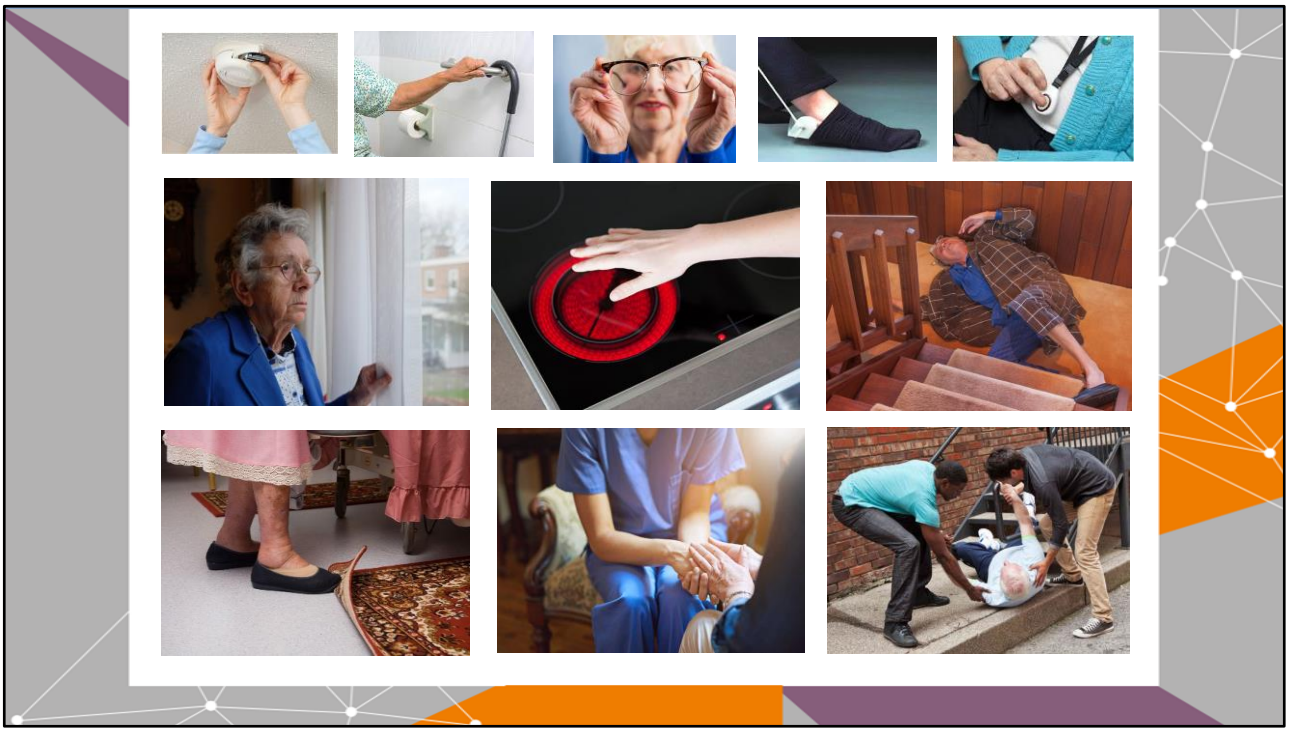
A delivery of care which aims to achieve more than simply improving outcomes per disease
but aims instead at more global health outcomes such as
- learning new skills
- changes in behaviour
- access to community support
- and more appropriate, unconflicting medication and treatment plans

A more goal-oriented and integrated care delivery of the elderly strives to achieve for each individual
- informed agreement of treatment goals
- the identification of support needs
- the consequent targeted development and implementation of action plans
- and the monitoring of progress
within a continuous process of reassessment and adjustment of the plans to meet the unique personal needs and circumstances of every individual.

So, the first characteristic of optimum healthcare delivery to the elderly is that the care is personalised.



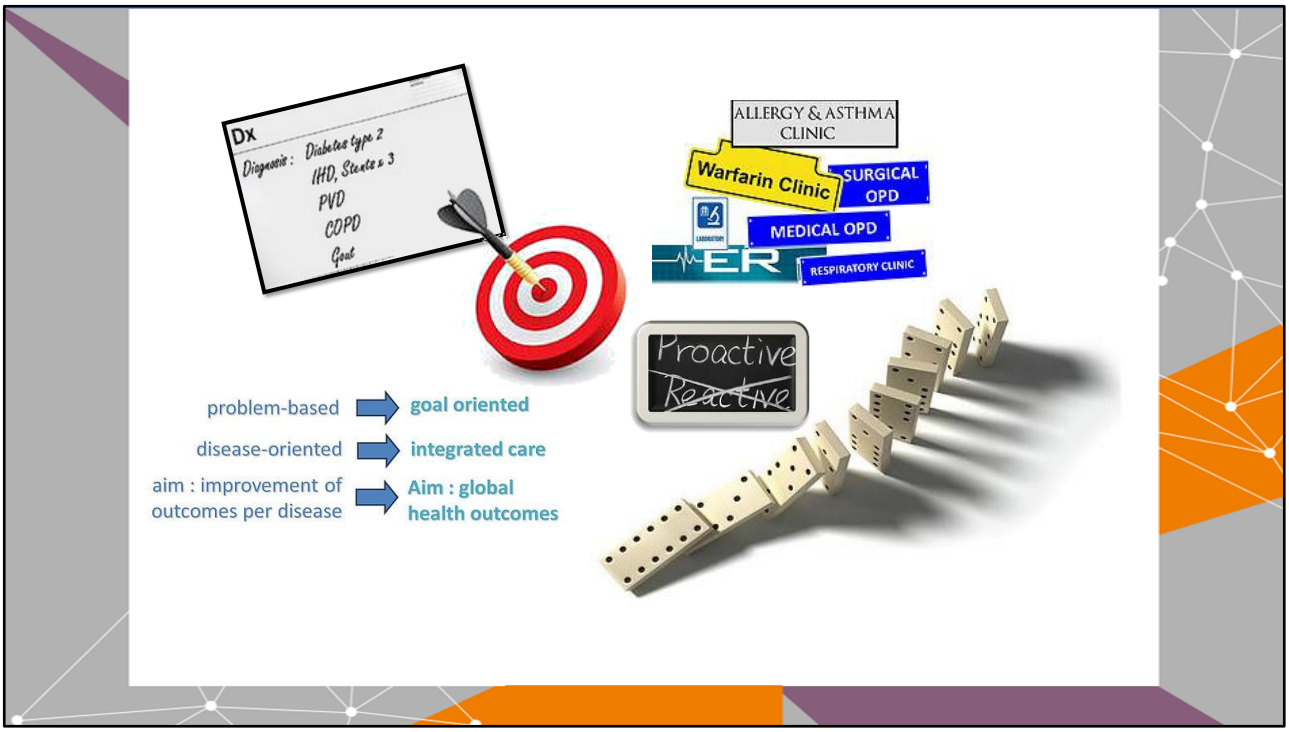
The second reality that cannot be ignored in the delivery of optimum healthcare to the elderly is that prevention is always better than cure.



The GP is often the very first health-carer to suspect the presence of physical, functional, mental or social problems.

So, optimum healthcare includes the investigation and treatment of the underlying problems before they escalate or multiply.

I have never once failed to find glaring safety hazards in the home of my elderly patients whenever I have taken the time to look for them,
and not infrequently in the nursing homes too.



Optimum healthcare of the elderly has to be
not only personalised,
but also proactive.

Proactive health care
- Helps reduce the burden on Emergency Departments
- Helps reduce Hospital admissions and Nursing Home admissions
- Helps effectively identify, monitor and manage frailty
- and Helps improve and prolong quality of life both at home and in residential care.

Comprehensive Geriatric Assessment

It is obvious then that the scope of such optimum care of the elderly is therefore very broad.

Which is where the Comprehensive Geriatric Assessment comes in handy as it covers all aspects of health and well-being of the elderly person.

Comprehensive Geriatric Assessment

A multidimensional holistic assessment
of an older person
which considers health and wellbeing
and formulates a plan to address issues
which are of concern to the older person
(and their family and carers when relevant)
arranges interventions according to the plan
and then reviews the impact.

The Comprehensive Geriatric Assessment
is by definition
a multidimensional holistic assessment
of an older person
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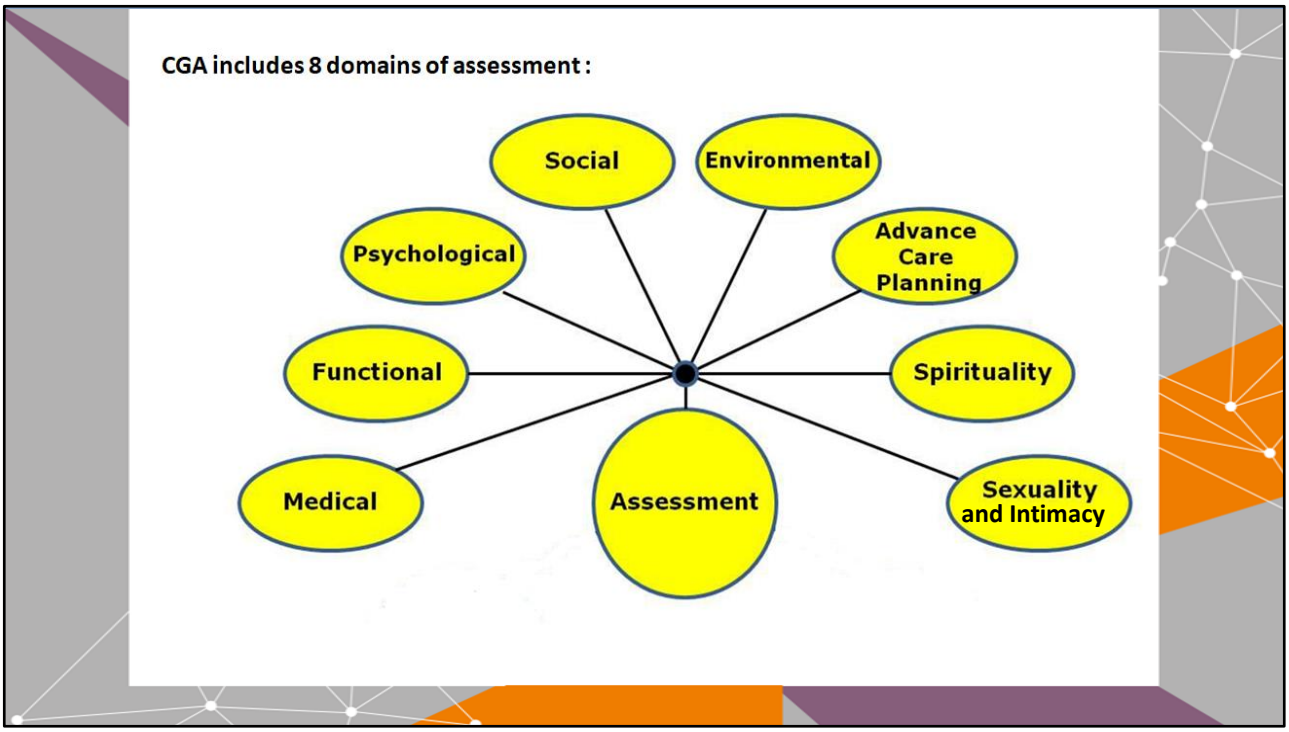
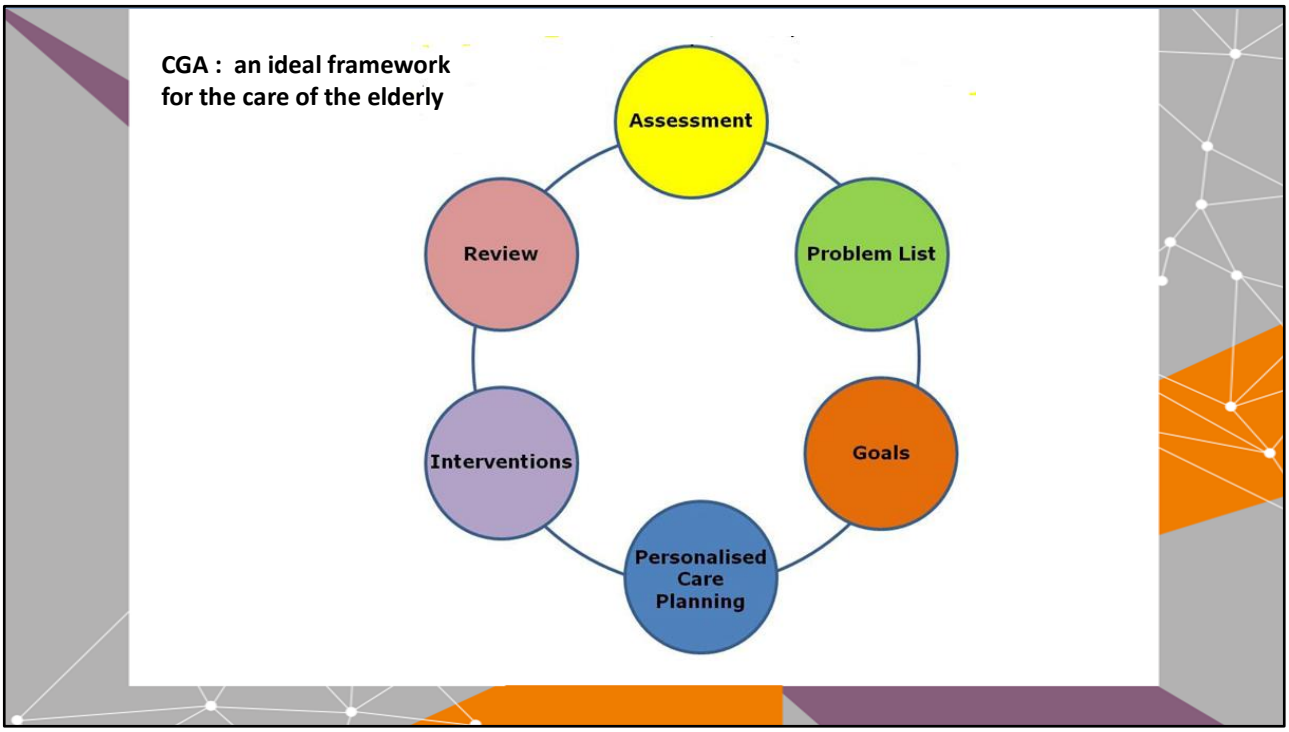
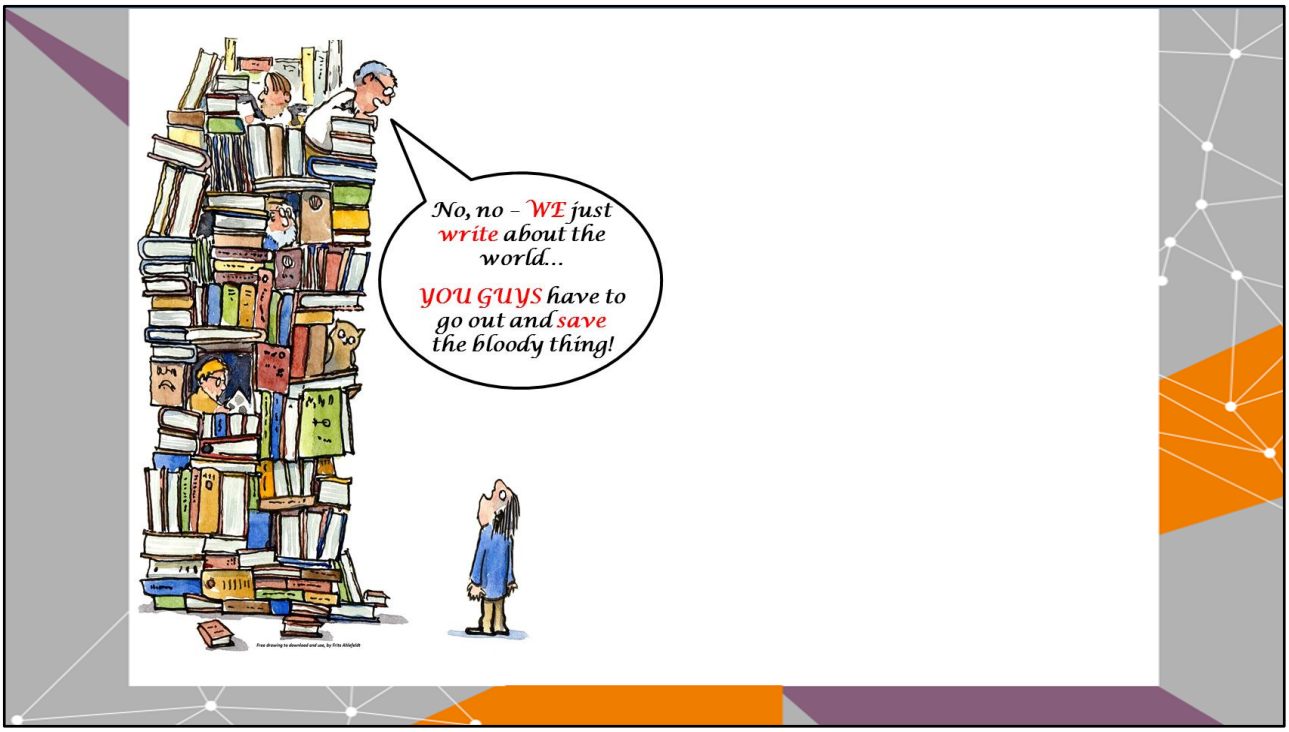


It includes 8 domains of assessment :

- medical
- functional
- psychological
- social
- environmental
- advance care planning
- spirituality
- sexuality and intimacy



From this assessment flows a formulated plan of action for the elderly person and carers to improve and monitor and maintain optimal health and function,
with a problem list and goals arising from the assessment
and leading to a personalised care plan
and both proactive and reactive interventions
which are periodically reviewed and reassessed
in an optimum cycle of elderly care.



And most of you right now are thinking
whoa !
Stop right there !
that is ivory tower speak.

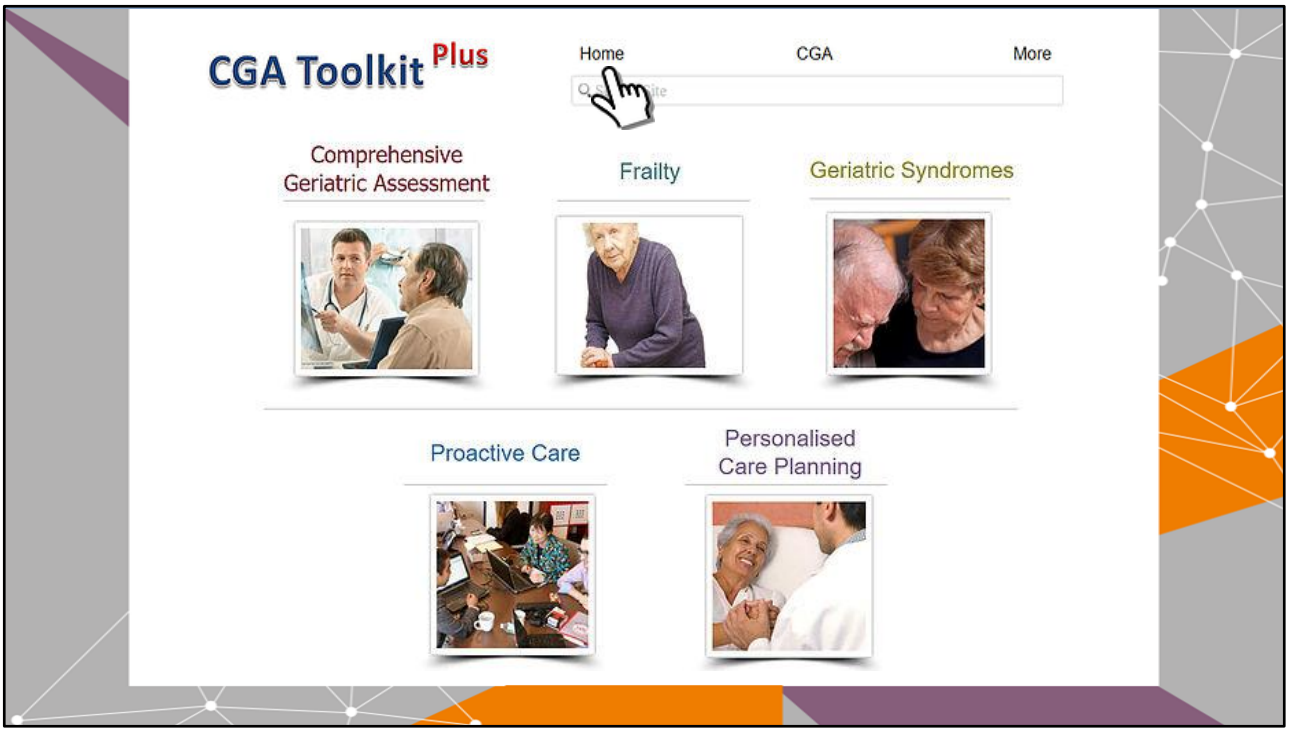
In my practice I have to contend with
- rapid access demands and waiting lists
- continuity of care and increasing patient expectations
- workforce shortages and commissioning complexity
- relationships with an imperfect wider system
- and bottom line funding and profitability issues

so come on, get real !
I have 10-15 minute consultations
and I hardly have time to keep up with my paperwork, let alone search the literature to try to understand the complexities of the CGA !

So
OK
let's get down to the practical.

Starting by pointing you to CGA toolkit Plus
a unique one stop kit packed brimful with resources
all evidence based
and fully referenced
with customisable tools for the GP
all with appropriate instructions
and ready to print and use
as well as materials for patients and carers
all to be used in the proactive, personalised primary care of the elderly
based on a CGA framework

I hope you are all still with me and keen to explore viable action plans,
so I am going to walk you through the structure of the toolkit now, because that will further define and illustrate the exact content of the CGA and the task at hand.

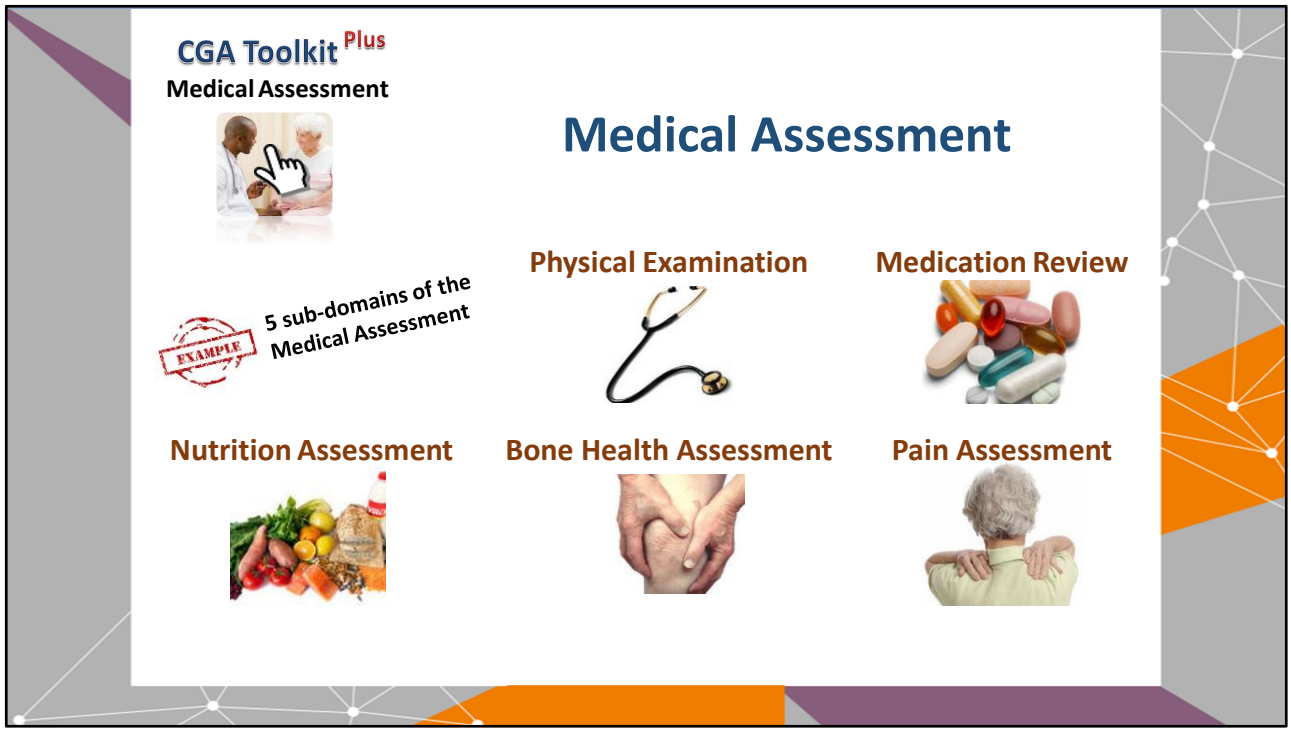


In the Toolkit's Homepage you will find access points to the 5 main sections of the Toolkit
each section presenting definitions, explanations and resources for

- Comprehensive Geriatric Assessment
- Frailty
- Geriatric Syndromes
- Proactive Care
- Personalised Planning

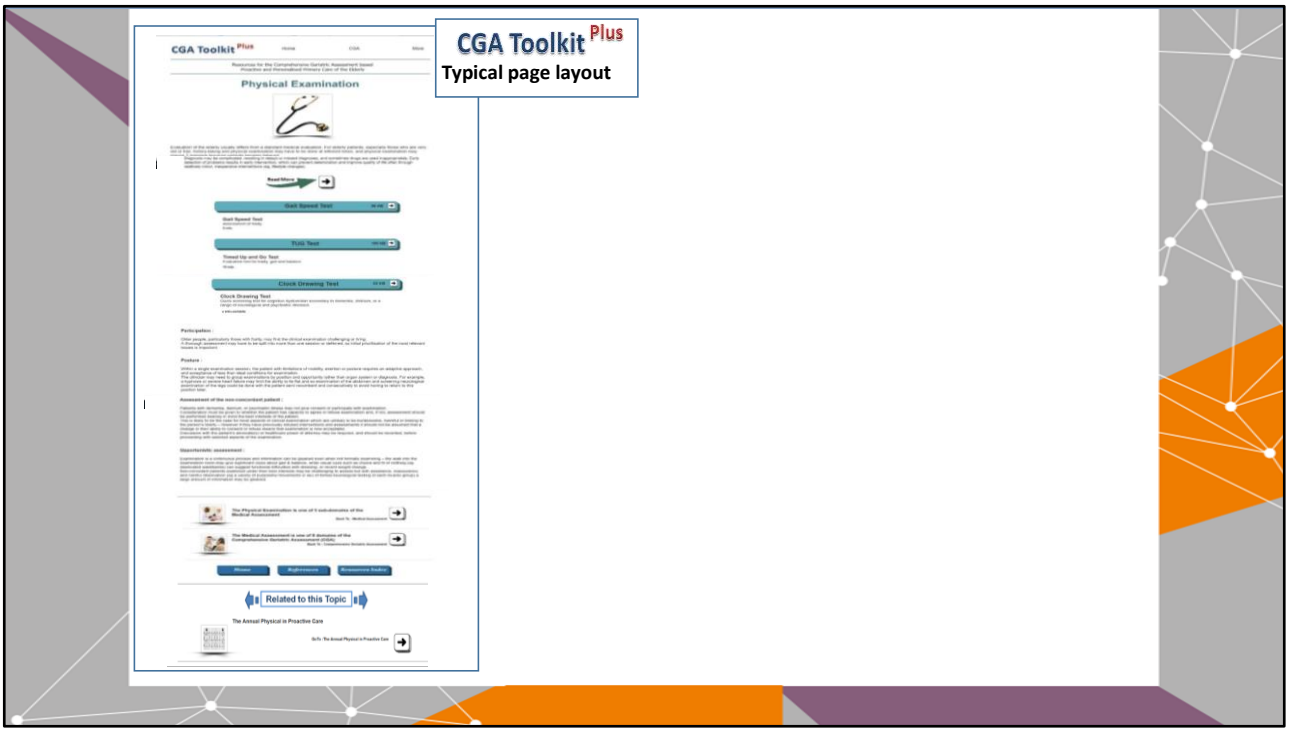
Where appropriate, the sections are divided into domains.
For example,
the CGA page offers you entry to the 8 domains of assessment in a CGA

- Medical Assessment
- Assessment of Functioning
- Psychological Assessment
- Social Assessment
- Environmental Assessment
- Advanced Care Planning
- Spiritual Wellbeing Assessment
- Sexuality and Intimacy Assessment

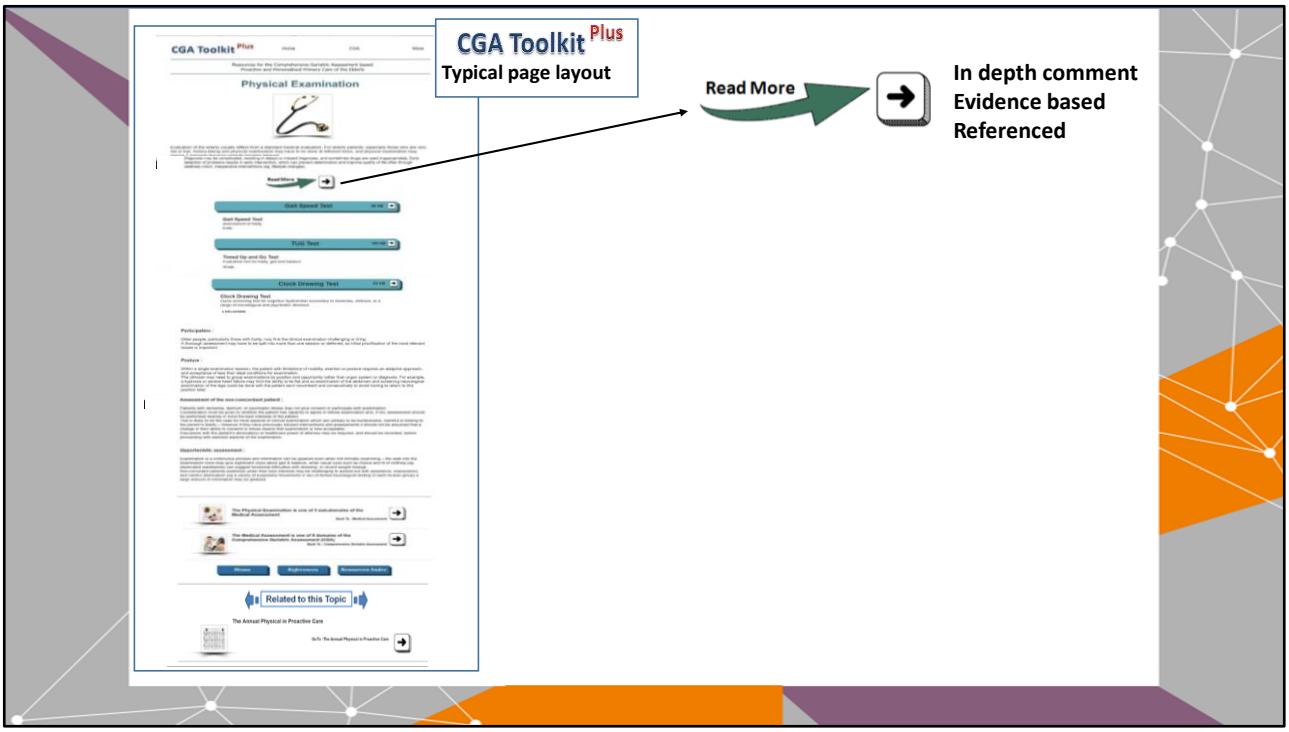


You will find some of these domains further subdivided into sub-domains for example
the Medical Assessment page offers entry to the 5 sub-domains of Medical Assessment, which are :

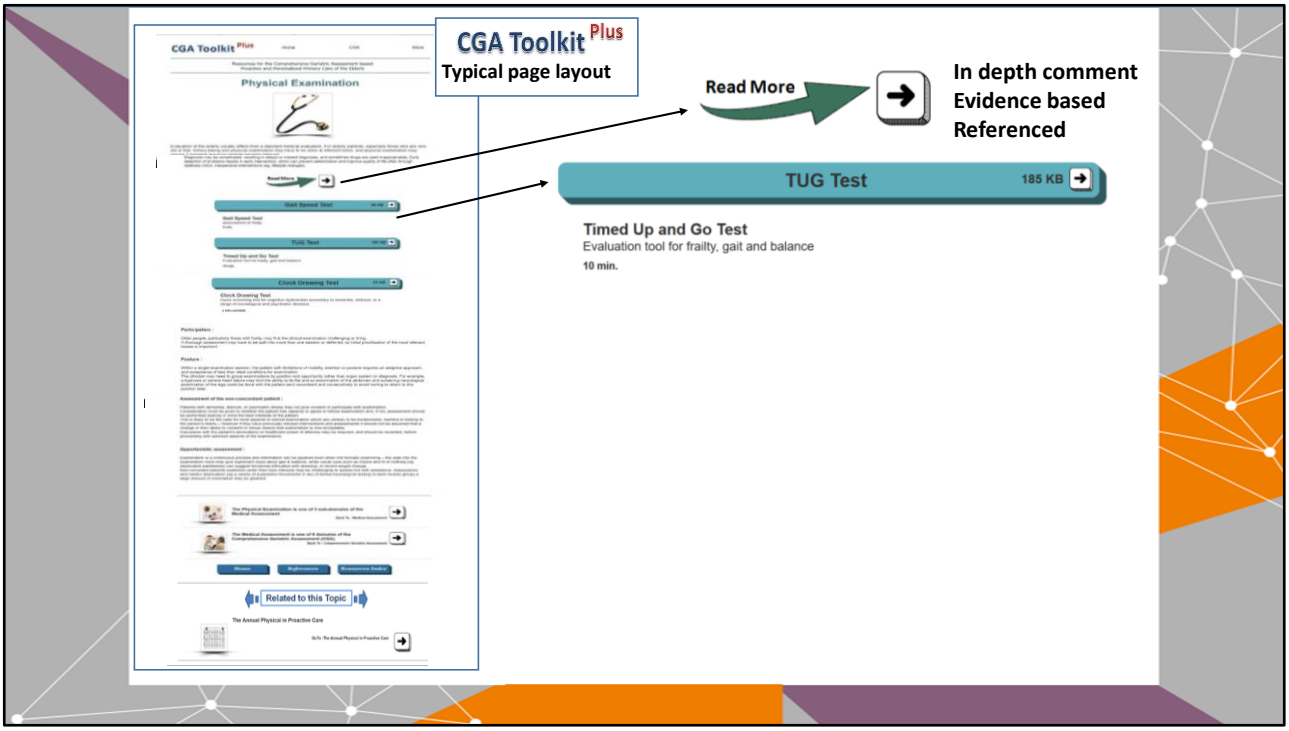
- Physical Examination
- Medication Review
- Nutrition Assessment
- Bone Health Assessment
- Pain Assessment



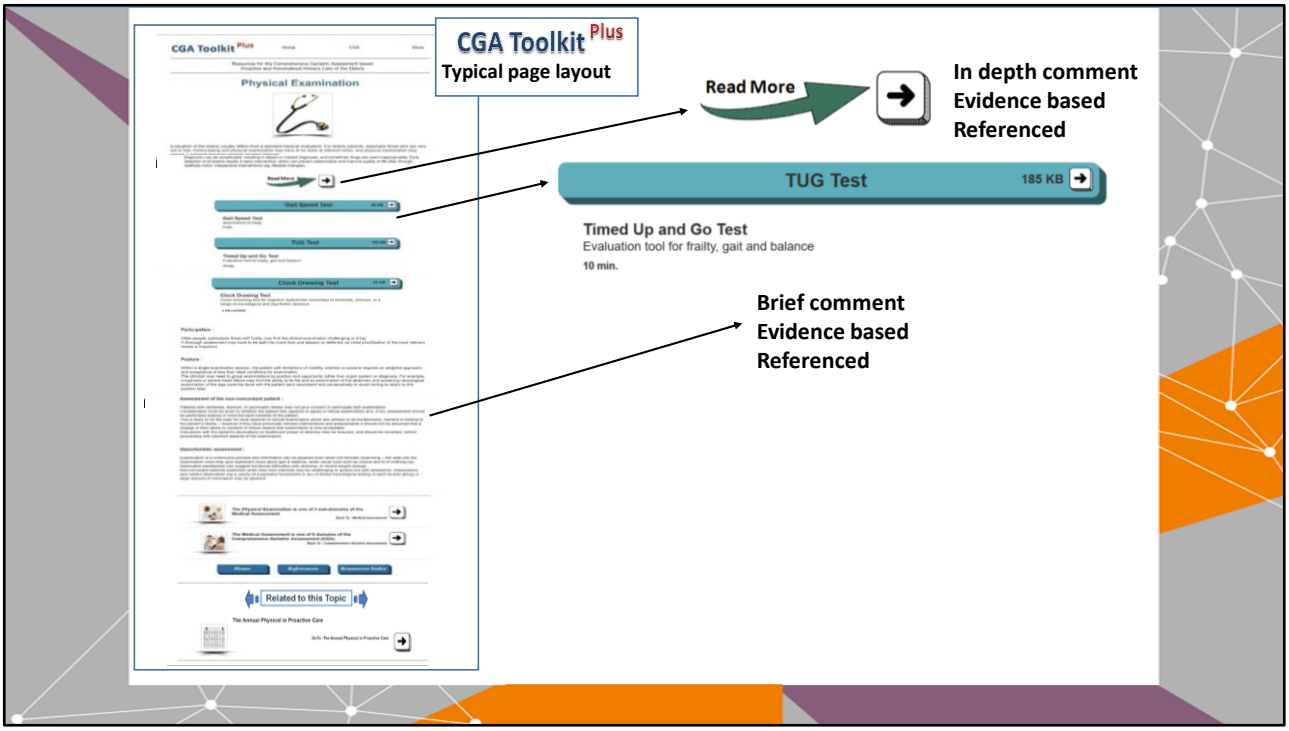
The layout of each section is uniform and consistent throughout the Toolkit, with a brief definition
followed by



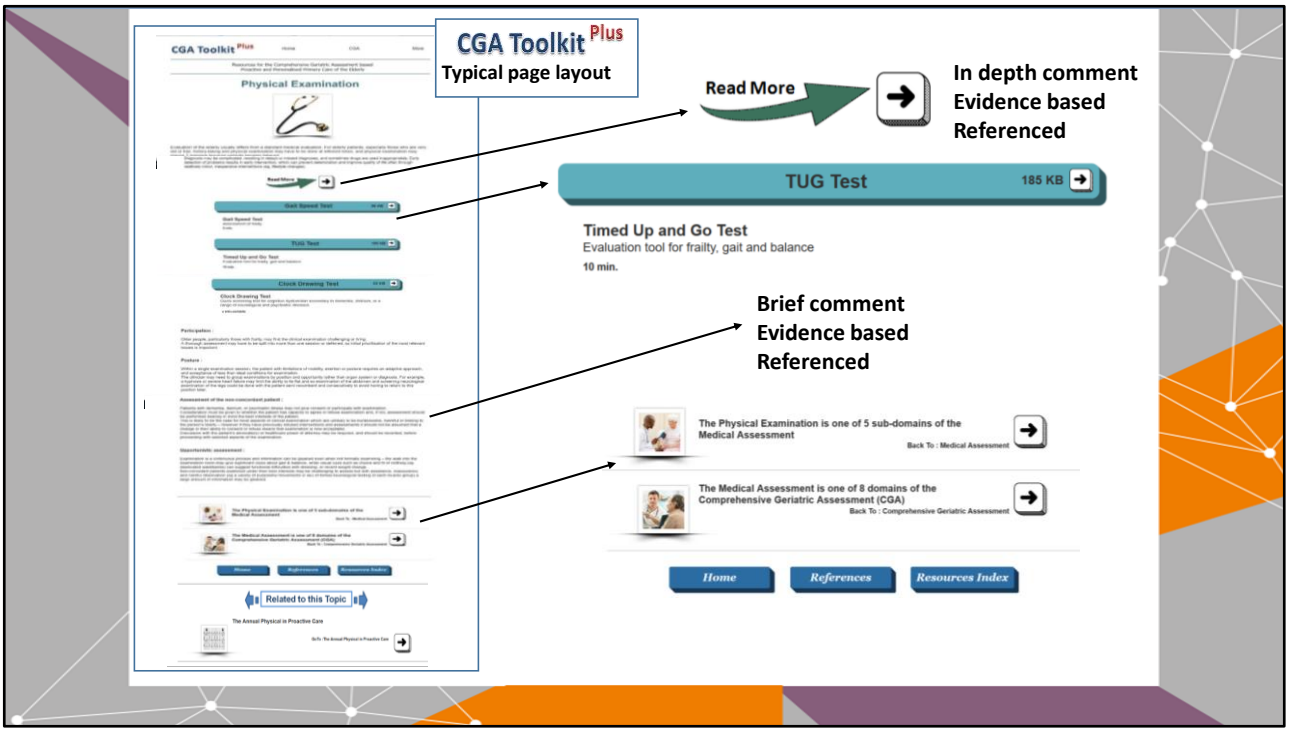
A Read More section,
providing more in-depth insights and information about the topic at hand.
If you are not too familiar with a particular section
or want a quick review to refresh and focus your thoughts
the Read More section is great to regain sharp perspective.



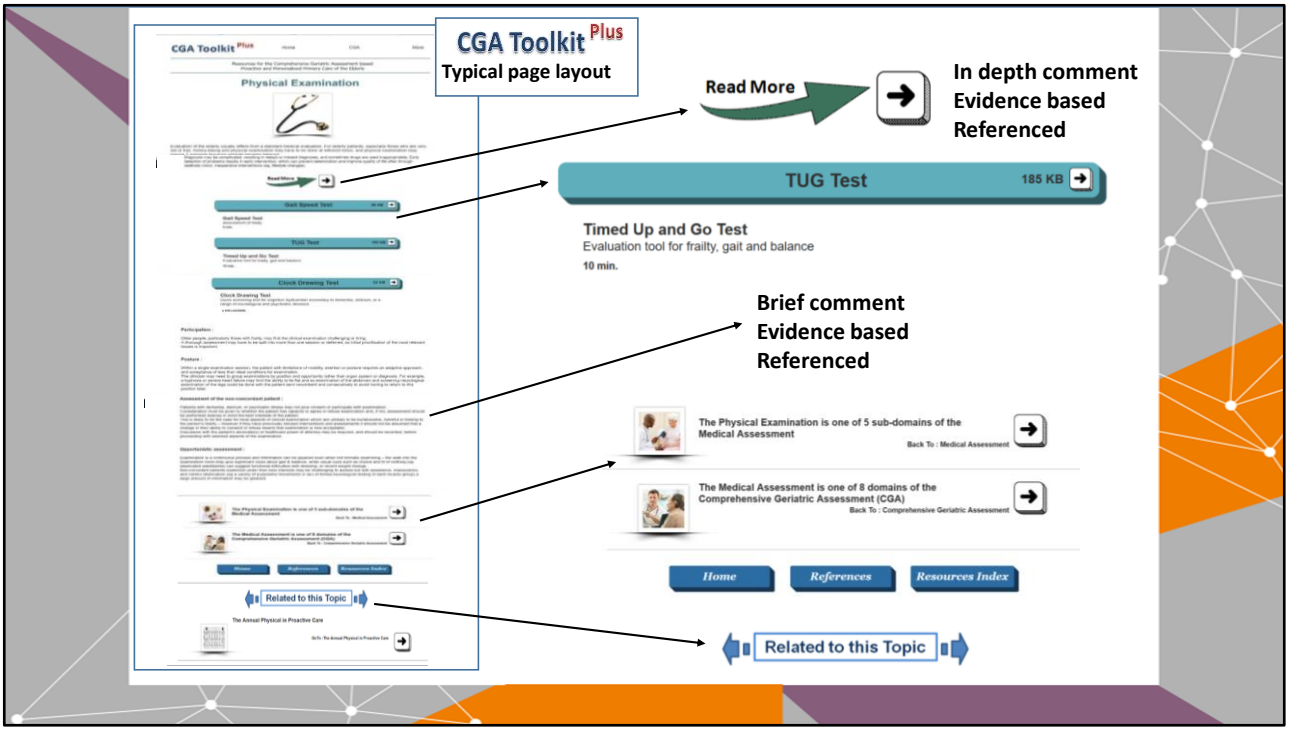
There is access to appropriate selected tools



Brief introductory insights and information



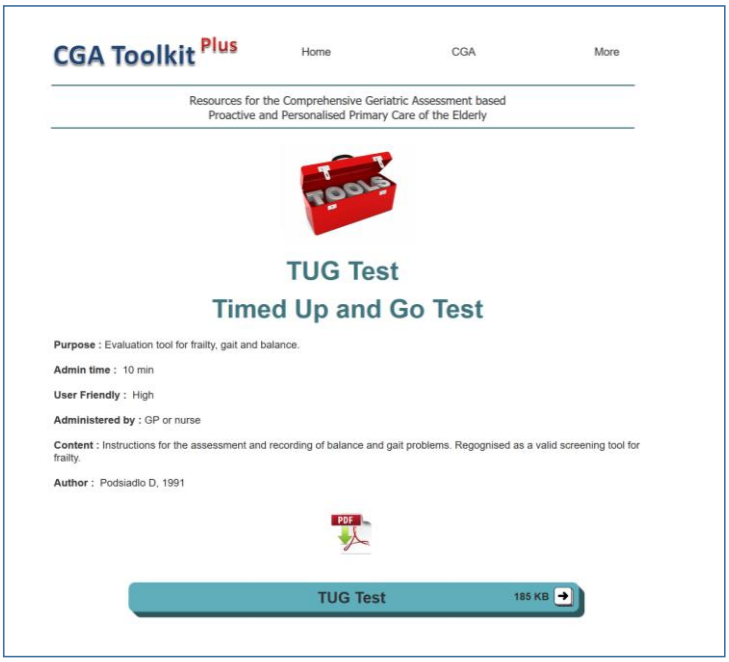
Links to references
the majority of which are directly linked to the original source journal articles or documents
so you can reassure yourself the information is quality, up to date and evidence based



And there are links to other materials related to the topic at hand.

All tools are annotated :

- **Purpose**
- **Admin. Time**
- **User Friendly**
- **Administered By**
- **Content**
- **Author**



Most useful for your planning is the discovery that
All tools are annotated with information about

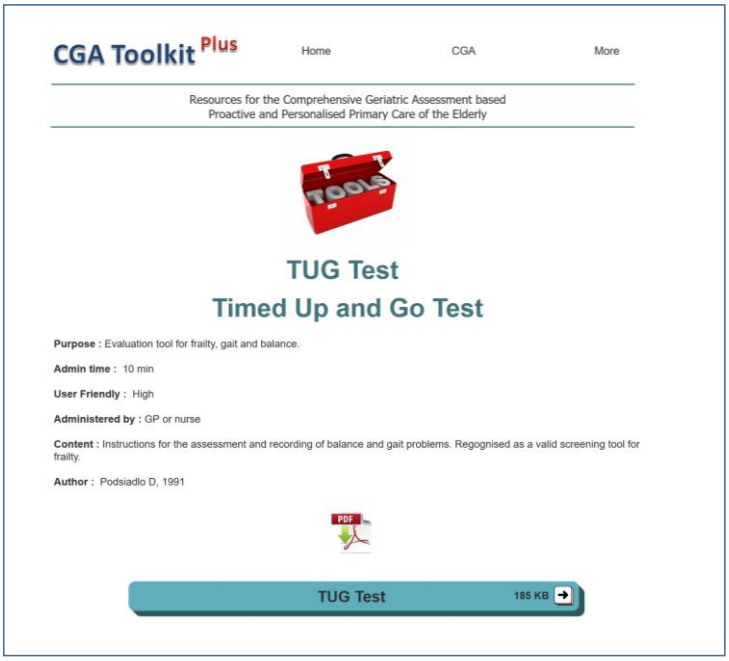
- the purpose of the tool
- the time it takes to administer it
- an indication of how easy or difficult it is to administer
- the actual content of the tool
- and details of where it comes from

All tools are annotated :

- **Purpose**
- **Admin. Time**
- **User Friendly**
- **Administered By**
- **Content**
- **Author**

All tools come with instructions for :

- **Administration**
- **Scoring**
- **Interpretation**



And, saving you a huge amount of time spent in research, you will be pleased to discover

All tools come with detailed instructions for

- administration
- scoring
- interpretation

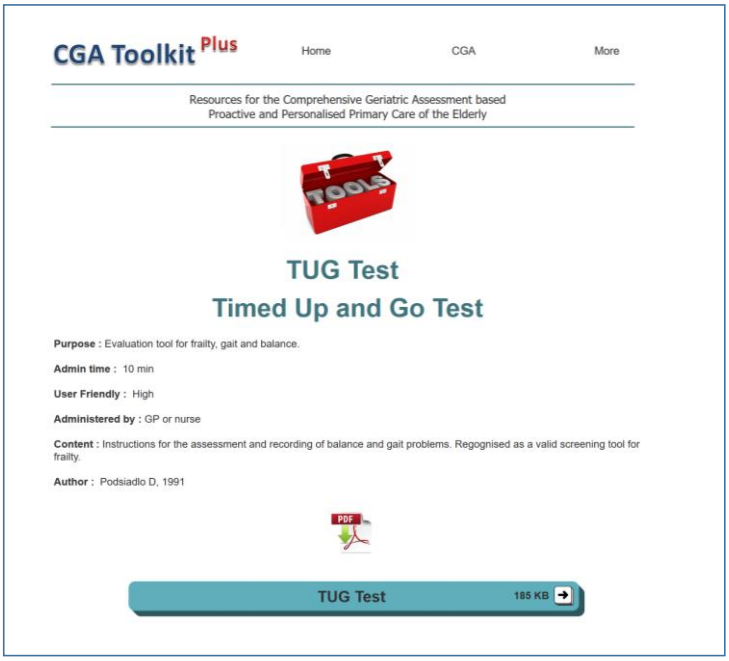
All tools are annotated :

- **Purpose**
- **Admin. Time**
- **User Friendly**
- **Administered By**
- **Content**
- **Author**

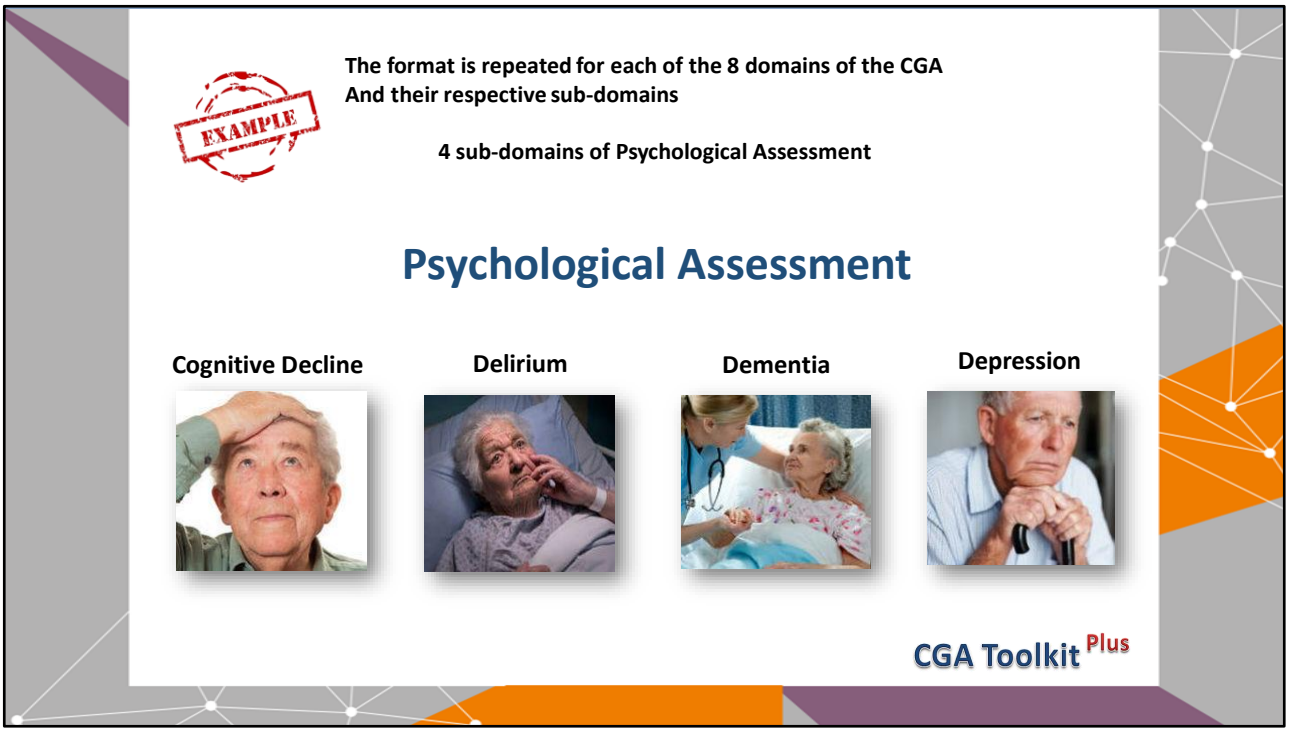
All tools come with instructions for :

- **Administration**
- **Scoring**
- **Interpretation**

All tools are Immediately downloadable and ready for use

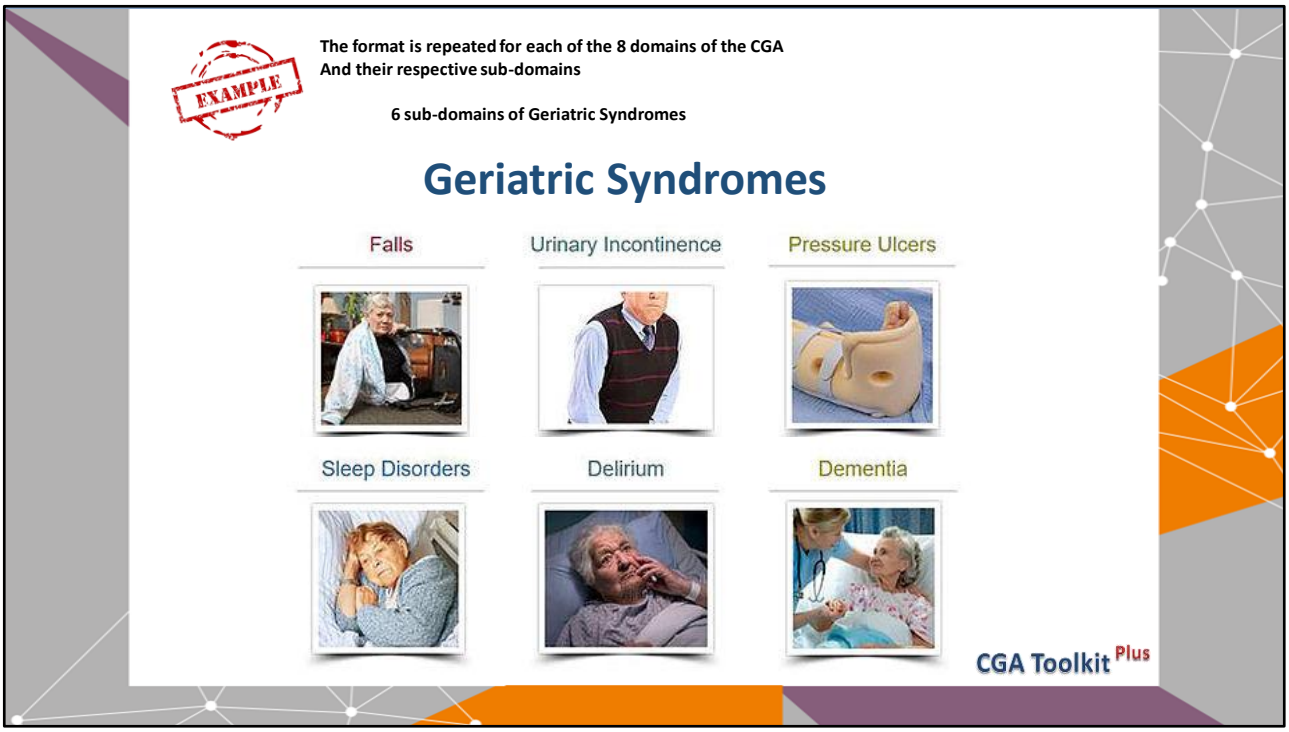


and all are immediately downloadable and ready for use.



This uniform format is repeated for each of the 8 domains of the Comprehensive Geriatric Assessment
So, for example
the Psychological Assessment domain of the CGA
includes 4 sub-domains

- Cognitive Decline
- Delirium
- Dementia
- Depression



The Geriatric Syndromes domain of the CGA includes 6 subdomains

- Falls
- Urinary Incontinence
- Pressure Ulcers
- Sleep Disorders
- Delirium
- Dementia

The Toolkit comes with a comprehensive Resources Index which affords you easy access to all tools

- on paper
- computer based tools
- and tools for mobile devices, both Apple and Android

Some sectors carry additional resources such as a
- brief Keep it Short and Simple summary
- Patient and Caregiver handouts
- spotlight videos and narratives of practices that have successfully implemented various aspects of CGA based care of the elderly
- and selected best guidelines and reviews for the more complex topics

Besides the CGA, CGA Toolkit Plus includes information and tools pertaining to :

Proactive Care

Aimed at providing the best care and support for people with complex health and social care needs, Proactive Care is a process whereby an individual's needs are assessed and evaluated, eligibility for service is determined, care plans are drafted and implemented, services are provided and needs are monitored and re-assessed.

All sections maintain the Toolkit format and are always evidence based and referenced

There is a section dealing with the theoretical and practical issues pertaining to Proactive Care

Besides the CGA, CGA Toolkit Plus includes information and tools pertaining to :

Personalised Care Planning

Personalised Care Planning is a collaborative process in which a conversation, or series of conversations, between a patient and a clinician lead them to jointly agree on goals and actions for managing the patient's health problems, in a way that is consonant with the patient's values and concerns.

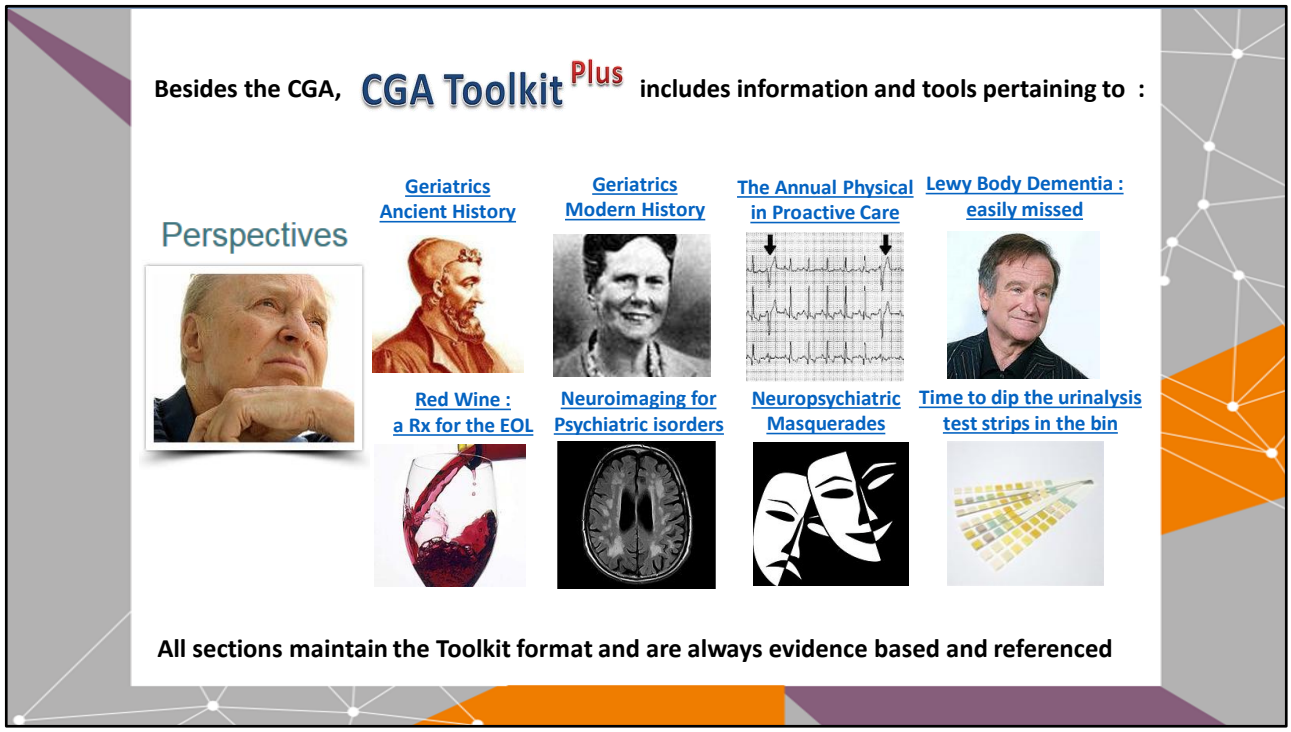
All sections maintain the Toolkit format and are always evidence based and referenced

and there is a section delving into Personalised Care and Support Planning for those who live with long term conditions

There is a section with insights, guidelines and resources for GP's and caregivers facing thorny issues such as :

- discussing tough issues
- considering assisted living
- when to stop driving
- alcohol problems
- elder abuse

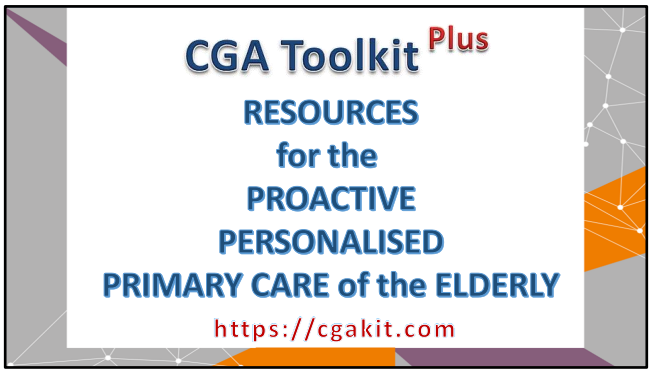
and much more



and there is a section with matters for broader education and reflection which includes

- a very interesting review of the ancient and of the modern history of geriatrics, showing the art is ancient but the science and the discipline is only a century old
- plus a bunch of other thought provoking issues

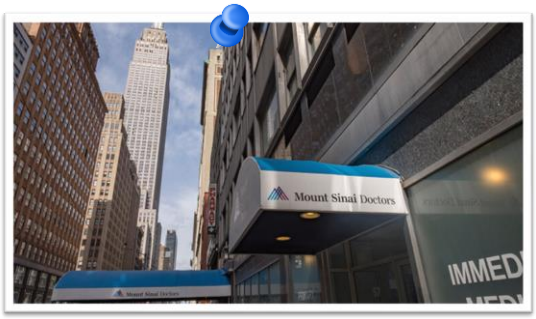
and of course there is a What's New section for regular users to zero in on the most recent new additions and updates
which in the field of geriatrics come fast and frequent



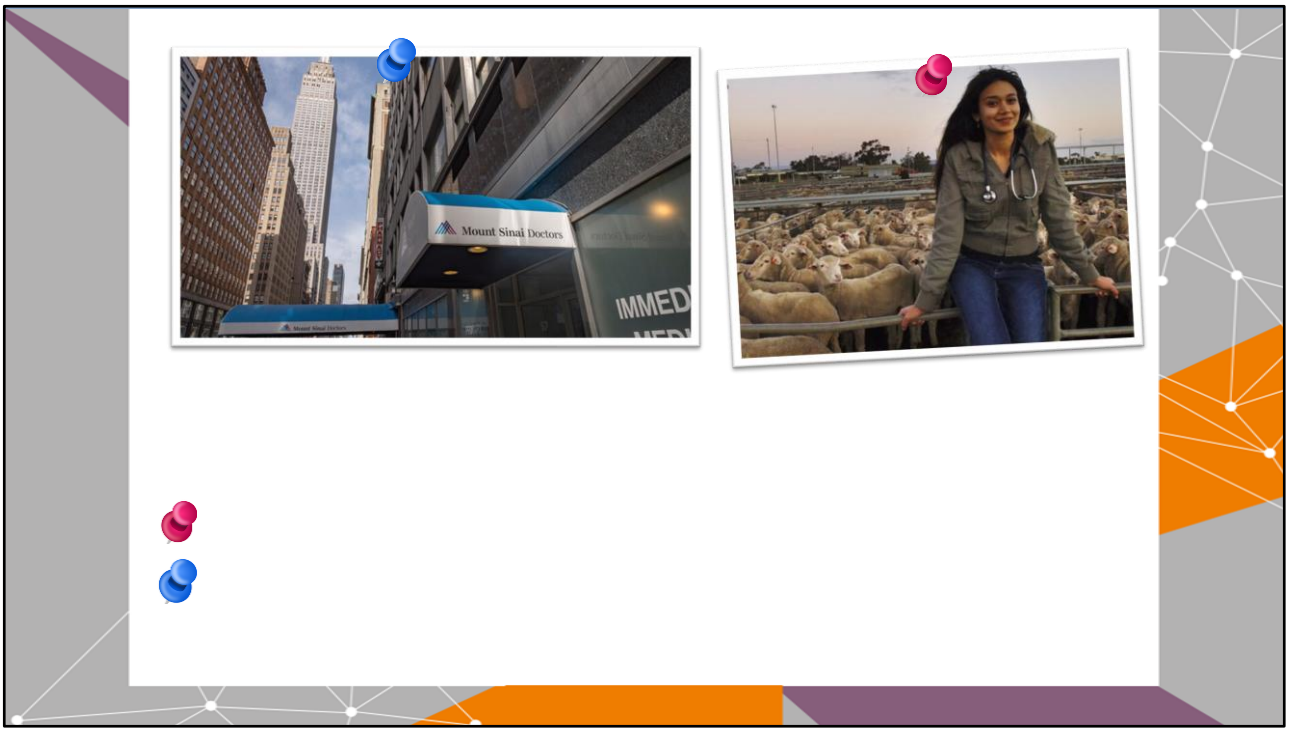
There you have it
CGA Toolkit Plus
currently attracting an average of 2000 visitors a month
with 300 of the 2000 monthly visitors being direct hits from people who have bookmarked the site and are accessing it directly rather than off a web search.
The toolkit is the core resource for the work of a NGO in America
and is currently the subject of a doctoral thesis in Asia

Oh, and best news of all
it is completely free to access
and completely free to use
no sign-up or subscription fees at all

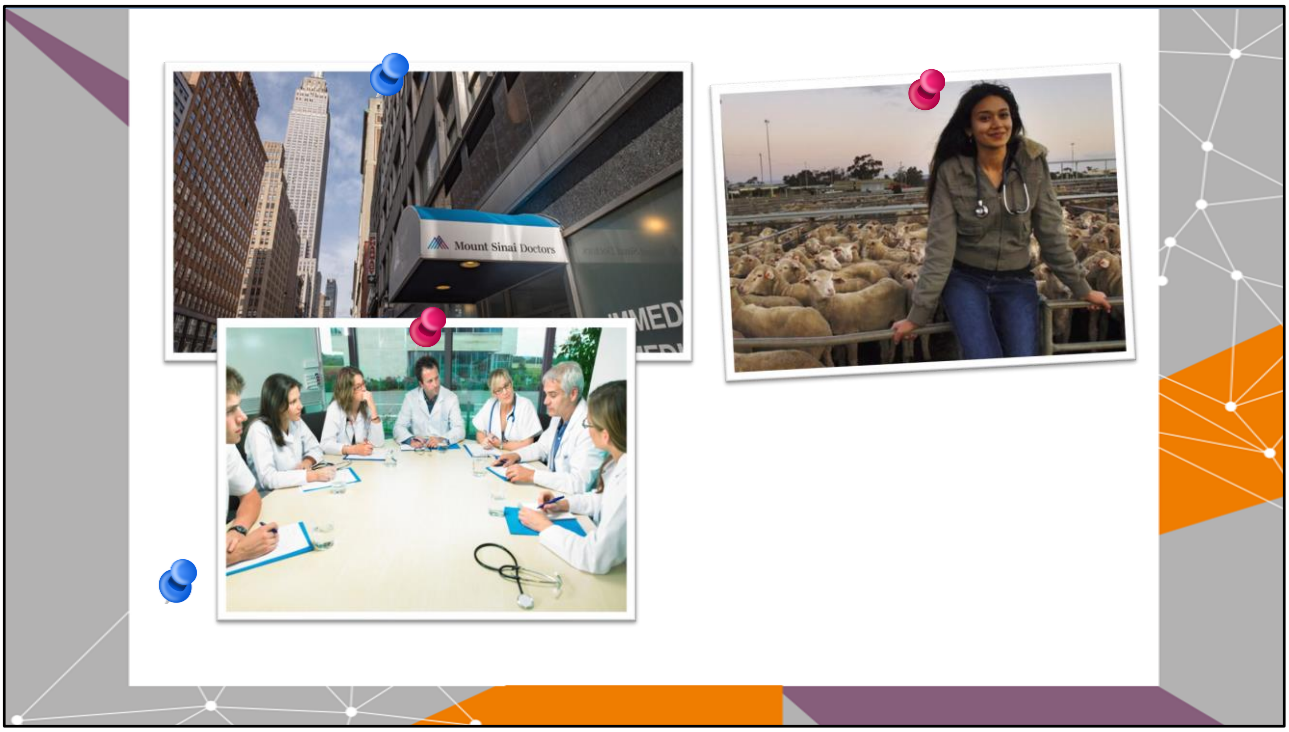
Well, good for you ! you say
Now can you go back to the ivory tower slide
because now I am also overwhelmed by the toolkit itself
and I cannot see how all that can possibly be implemented in any one of the different primary care settings in the U.K.



My practice, for one, is in a busy urban environment
I do have access to geriatricians, but I feel that when I refer both my patients and I are subject to long waiting list
and most frustratingly I lose the lead in the care of my elderly patients and then perennially struggle to integrate the specialist's feedback into my broader management of the multiple co-morbidities



And what about me in my solo remote rural practice ?
I do not have access to an MDT
and I have few resources available to me within easy reach
My elderly patients do not travel well and I would like to do as much of the work as possible in-house.



Well, at least you are on your own,
I have to make it all happen in my 4 partners and 3 nurses town practice
We have leads for diabetes and respiratory disease and all the usual chronic diseases, but no one is confident to take on a geriatrics lead as it all seems too complex and poorly remunerated.

Yeah, same here,
and I have a further problem in that most of my geriatrics are in nursing homes and almost never make it out of there to my surgery
I get to see them once every week or two
How can I possibly fit in this proactive, personalised, CGA based care ?

That is the real GP world out there
Whatever the setting. what we all we have in common is
unbelievable time constraints,
heavily burdened resources,
and the challenge of keeping all ultimately financially viable

So, can you really realistically engage in a more CGA based Proactive Personalised Care for your elderly patients in your own
unique practice ?

Yes you can,
even if you have access to minimal external resources,
and most definitely yes, if you are lucky enough to have access to supportive external resources.

But you will have to accept that ultimately the key to success here is as always to first of all delegate tasks to properly trained and equipped nursing staff

leaving you the GP free to concentrate on clinical examinations and decision-making

and gradually expanding the supporting team according to locally available resources

while always retaining you the GP as leader and co-ordinator,
in a continuous cycle of high quality care
which becomes increasingly more sophisticated as the system is streamlined, refined and expanded in keeping with your own individual practice's resources and local support system

Frailty

Let's look at how this would work out in the diagnosis and management of Frailty.

Frailty

Frailty is a medical syndrome with multiple causes and contributors that is characterized by diminished strength, endurance, and reduced physiologic function that increases an individual's vulnerability for developing increased dependency and/or death'.

CGA Toolkit Plus includes information and tools pertaining to Frailty

All sections maintain the Toolkit format and are always evidence based and referenced

Frailty by definition is a medical syndrome
with multiple causes and contributors
that is characterised by diminished strength, endurance, and reduced physiologic function
that increases the individual's vulnerability for developing increased dependency and/or death

Frailty – a complex syndrome of increased vulnerability

Frailty

Risk factors

Chronic diseases :

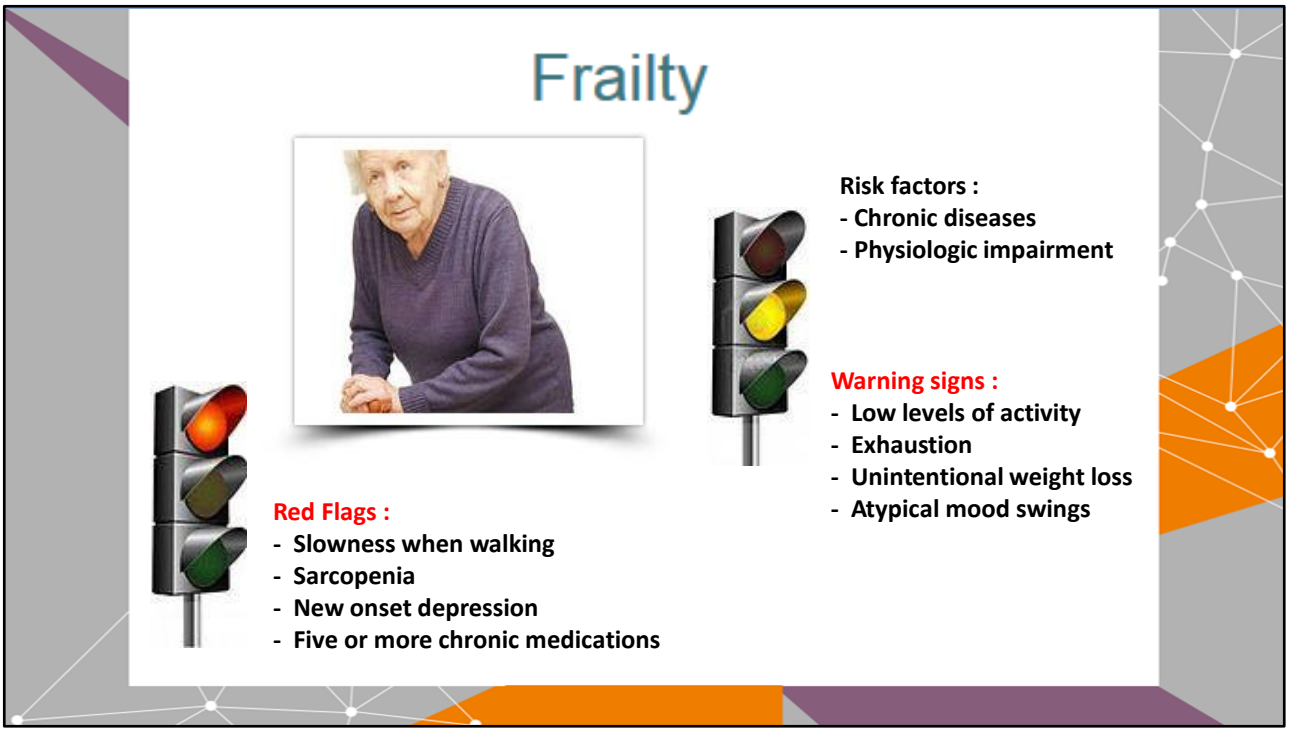
- Cardiovascular disease
- Diabetes
- Chronic kidney disease
- Depression
- Cognitive impairment

Physiologic impairments :

- Activation of inflammation and coagulation systems
- Anemia
- Atherosclerosis
- Autonomic dysfunction
- Hormonal abnormalities
- Obesity
- Low vit.D
- Environment related factors (in home and neighbourhood)

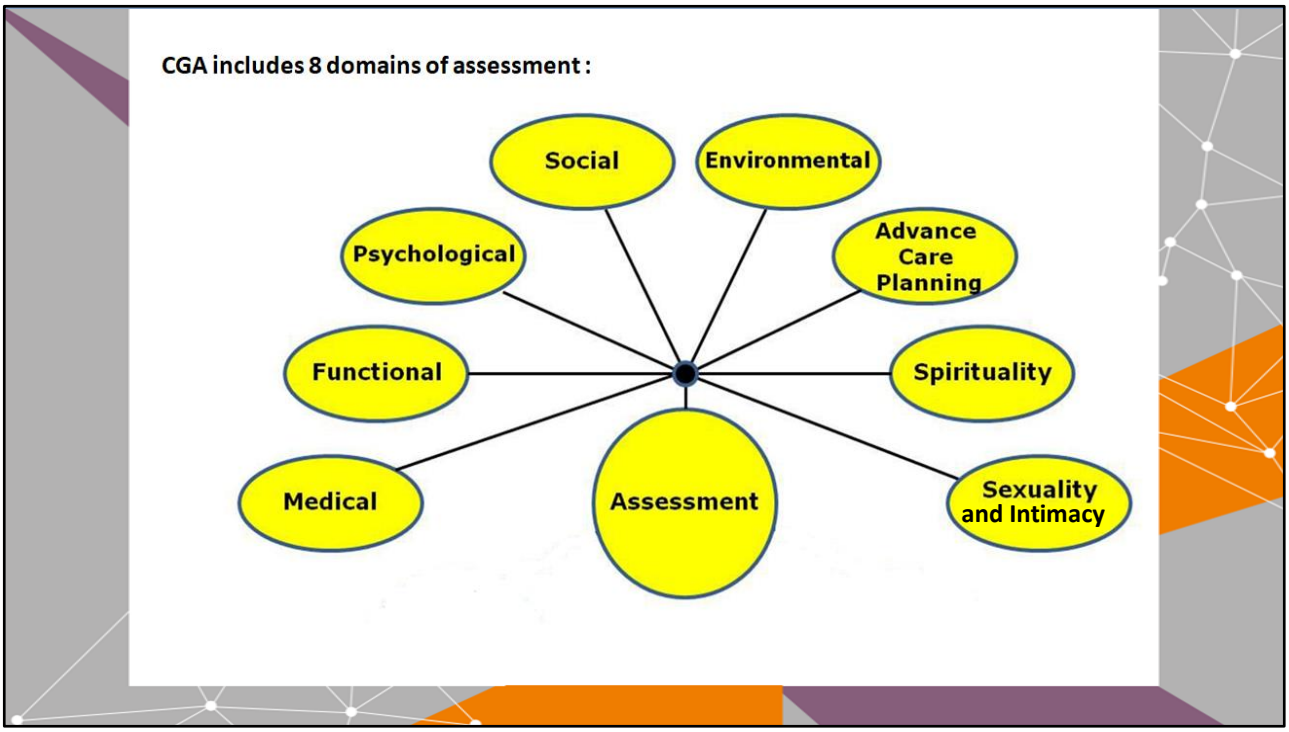
Risk factors for Frailty include chronic diseases such as
- cardiovascular disease
- diabetes
- chronic kidney disease
- depression
- cognitive impairment

as well as a range of physiological impairments

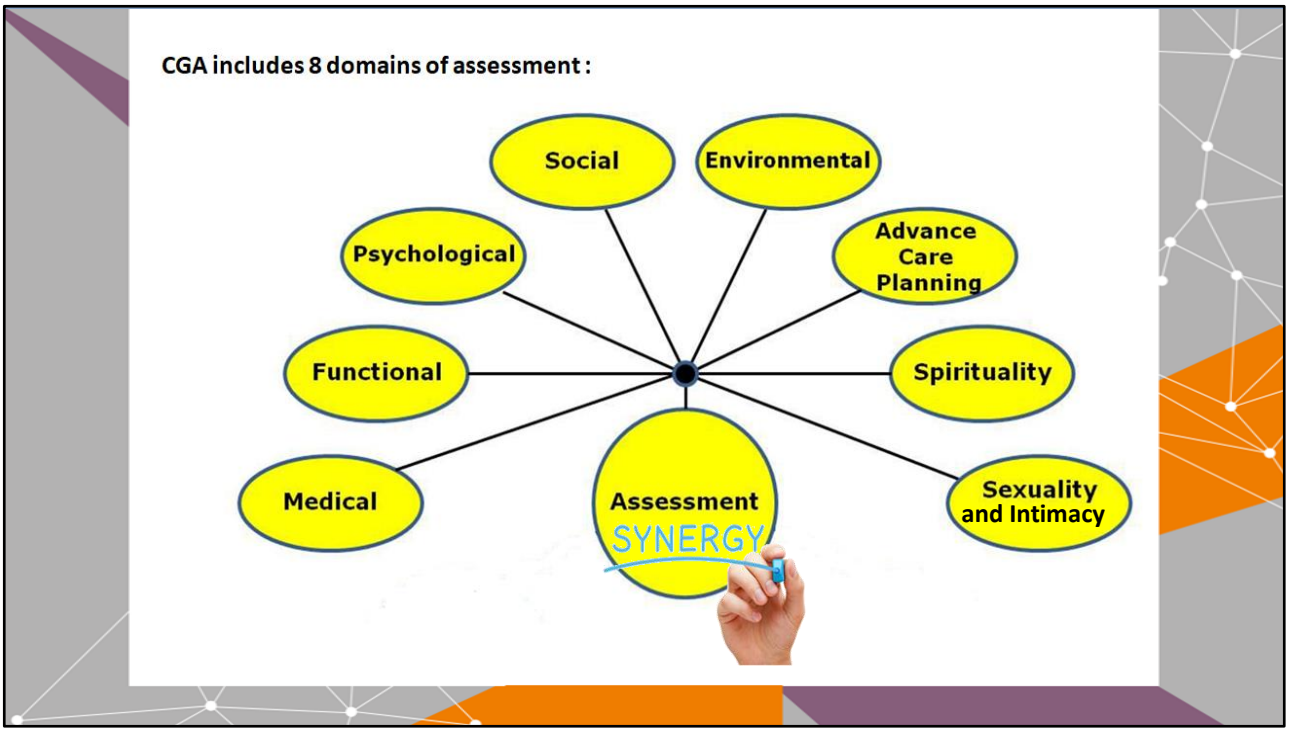


warning signs include :
- low levels of activity
- exhaustion
- unintentional weight loss and
- atypical mood swings

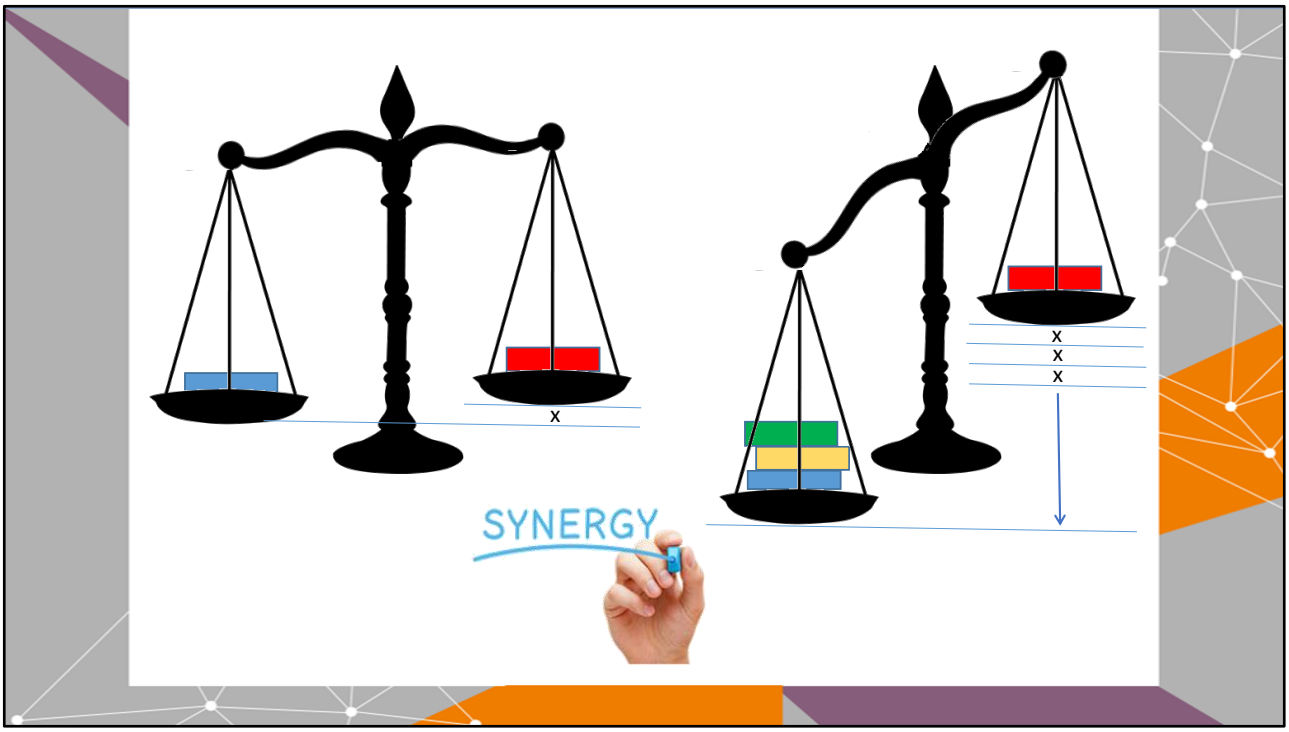
and red flags to look out for are :
- slowness when walking
- sarcopenia
- new onset depression and
- five or more chronic meds



It is evident then, that Frailty presents diagnostic and management challenges in all 8 domains of the CGA.



Interestingly, with Frailty, the effect of the contributing factors is synergistic.
and independent of co-morbid chronic diseases
and also independent of actual age.
You will find that the cumulative effect of contributing factors is greater than the sum of the effect of individual abnormalities which, on their own, may be relatively mild.



The implication of this is that interventions that affect multiple systems may yield greater, synergistic benefits in prevention and treatment of Frailty than interventions that affect only one system.

So, for example :
manage fall risk and you will see x% improvement in Frailty
manage fall risk AND mild cognitive impairment AND sarcopenia,
and you will see not 3x improvement,
but a dramatic10x improvement.

Dealing with co-morbidities has a huge impact on Frailty and quality of life,
hence the validity of the broader CGA based approach.

Let's see how this all works out in a case presenting with Falls associated with Frailty
and how indeed you can cover all the work required
by bringing your patient back to the surgery just 4 times.

To fully illustrate the process, I am going to place you in the most remote rural practice possible
with very little external resources you can draw on in the immediate vicinity
You tick off in your mind as we go, those tasks you can delegate in whatever more well resourced setting you actually do operate from.

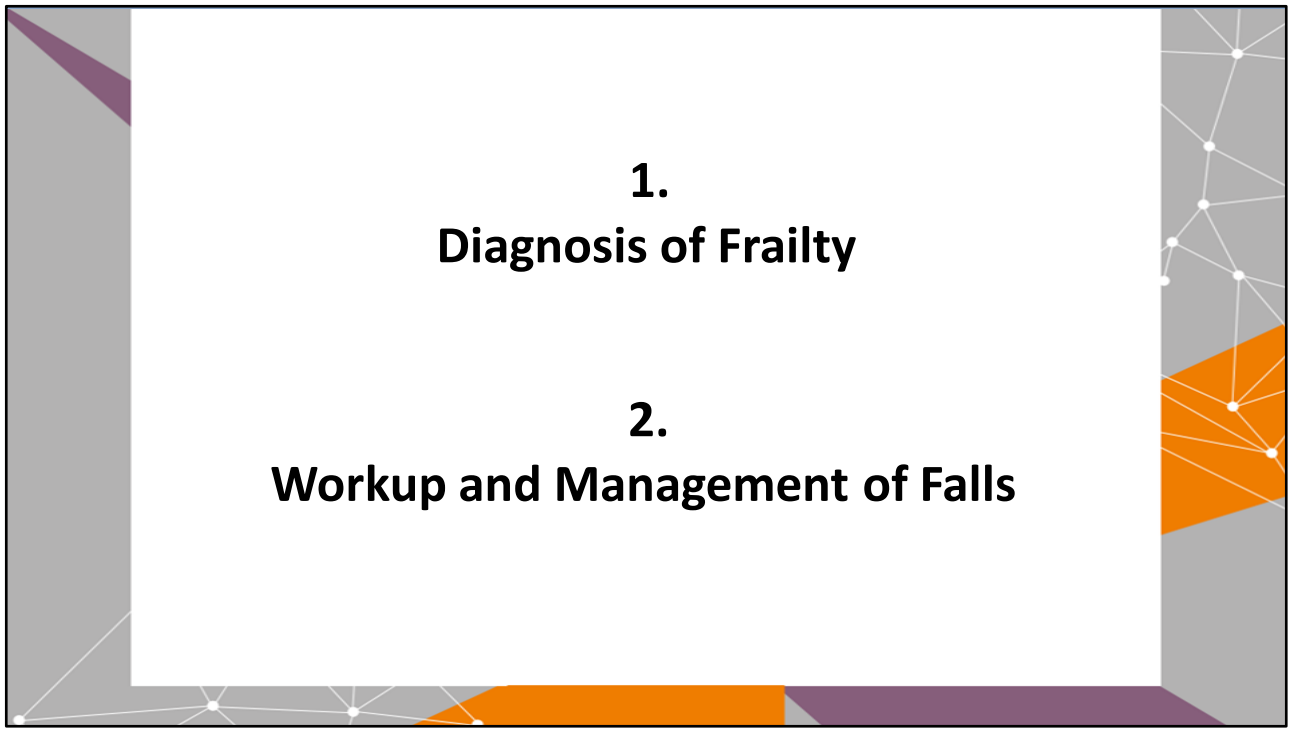
Mary,
is a 72 years old widow living alone at home,
who attends you complaining of a sore throat and slight fever.

Standard examination leads you very quickly to the diagnosis and management of the presenting uncomplicated URTI.

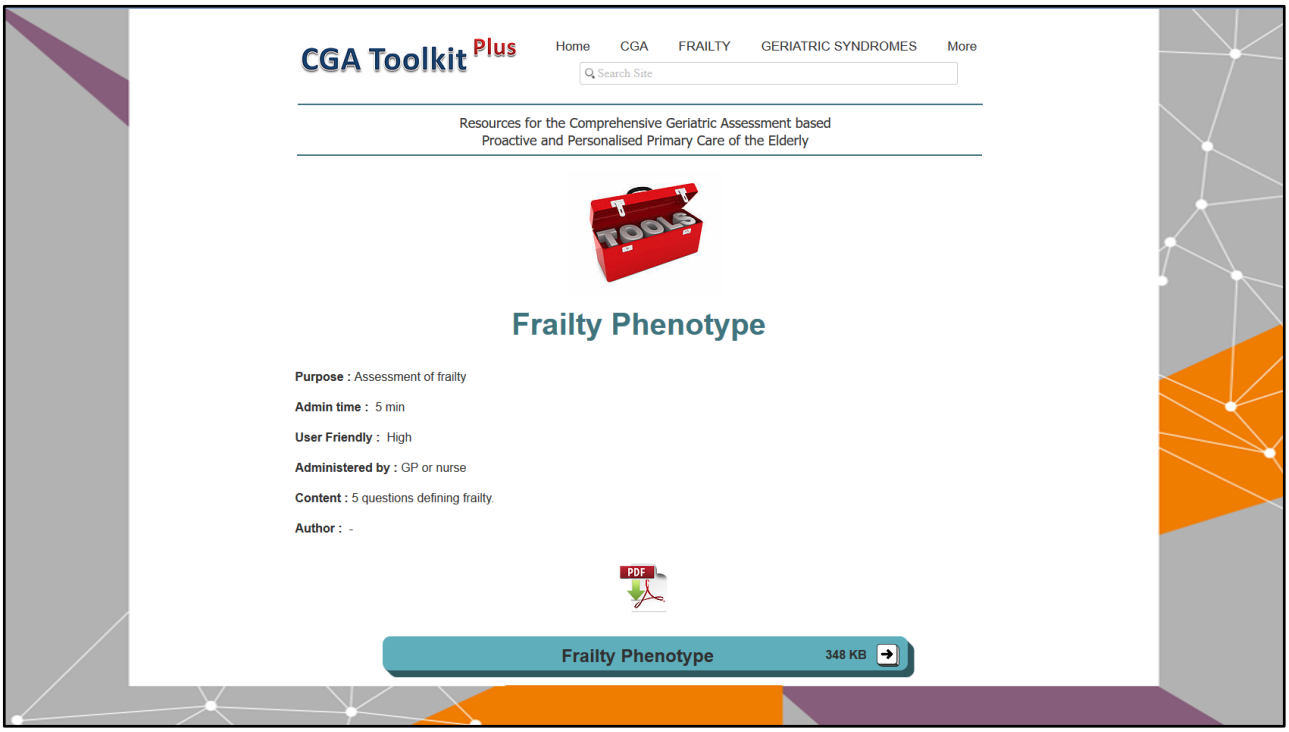
In the course of this routine examination though, you notice recent bruises on Mary's right shoulder, elbow and ribcage in the mid axillary line.

Mary tells you that she had sustained the bruising in a fall 4 days earlier in her kitchen,
but she is unable to describe exactly how and why she fell,
stating simply
"I have been feeling tired lately and must have tripped over my own feet again,
it happened in the same way about 3 months ago you know, but I did not hurt myself badly so I did not bother coming to see you, doctor".

When you called Mary in from your waiting room you had noticed that her gait had seemed cautious and slow,
so you suspect Mary might be exhibiting signs of Frailty manifesting early with Falls.



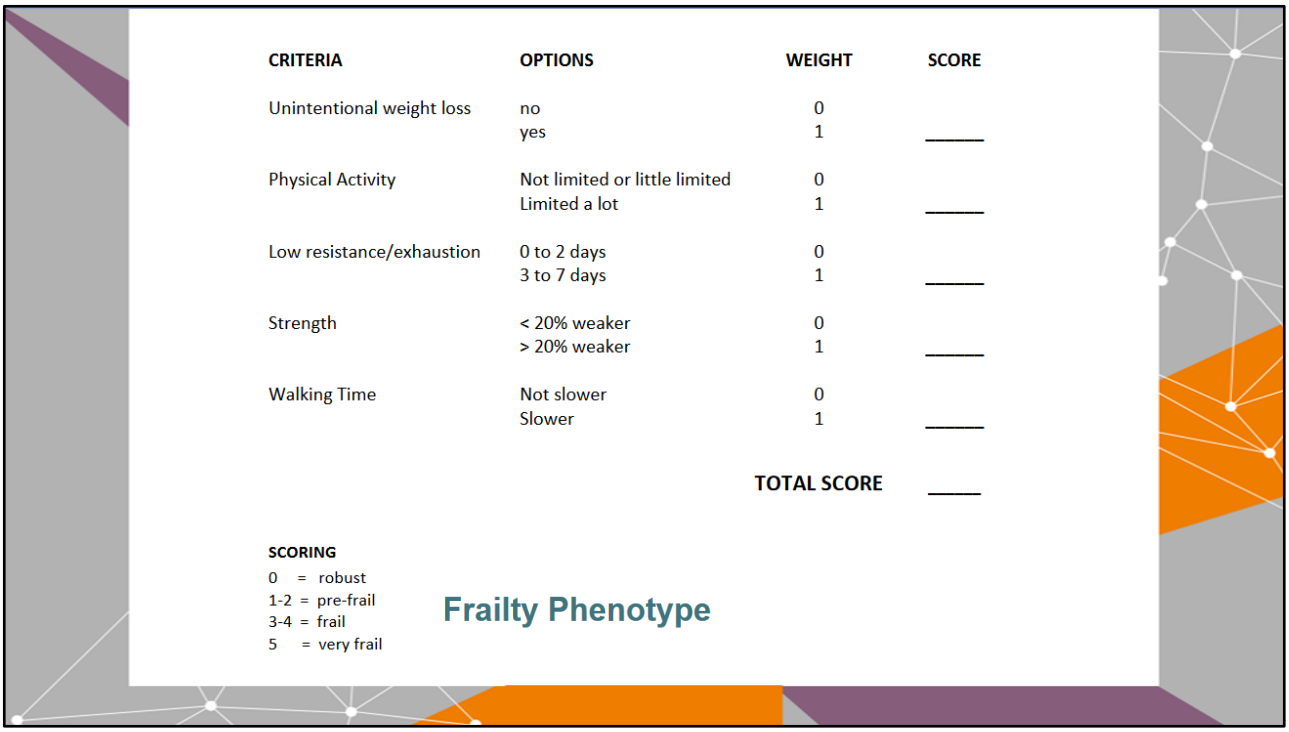
There are 2 question you want need immediately answered at this point
does Mary meet the criteria for Frailty ?
and
what workup and management is required for the falls ?



You have already spent time on the presenting URTI
so for now you very simply and briefly carry out a Frailty Phenotype test.

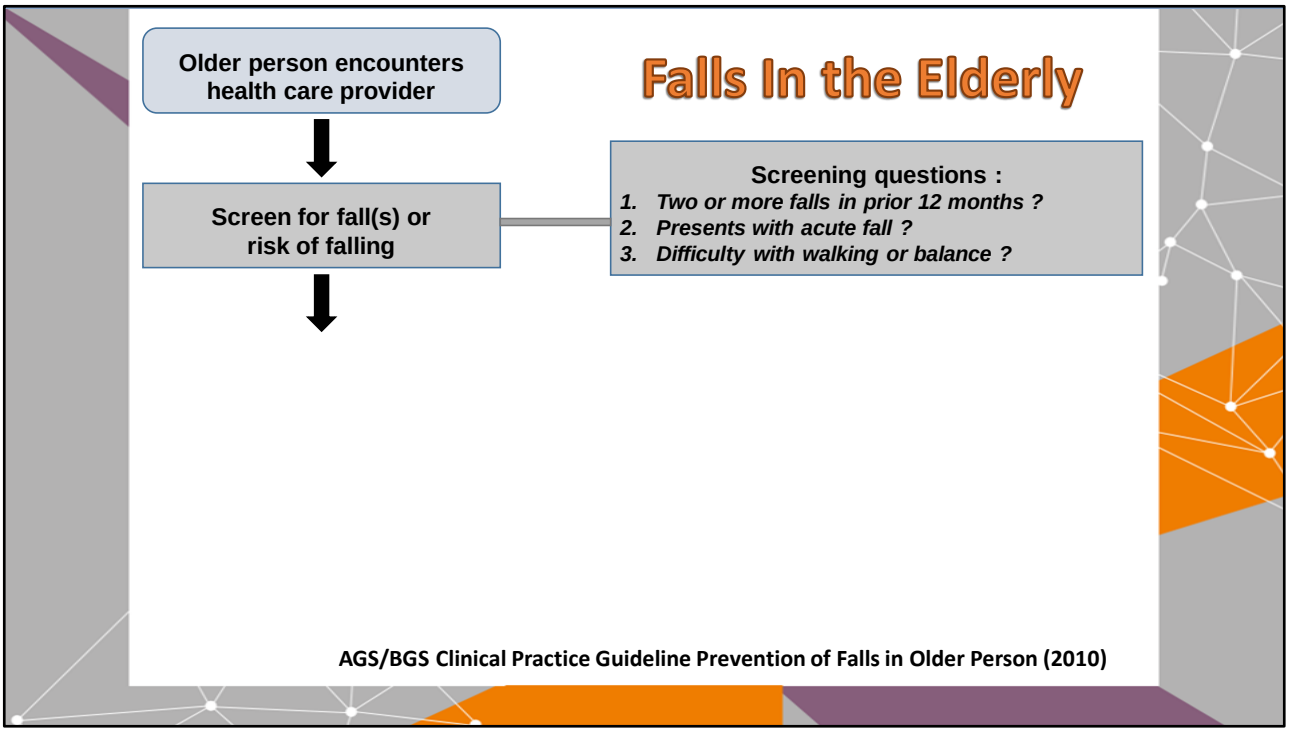
The Frailty Phenotype test
is a quick 3 to 5 minute screening evaluation for the presence and severity of Frailty

it is very user friendly
and easily administered by a GP or nurse.



It looks for
- unintentional weight loss
of more than 5% , or more than 4,5 kg over the past year
- health imposed reduction of physical activity
such as shopping, sport activity or other activity such as mowing the lawn, raking, gardening etc.
- the frequency that, in the past week, the individual felt that everything she did was an effort or she could not "get going"
- the slowing down of the walking pace
and it looks for
- hand grip strength
estimating if it appears 20% weaker than expected in an individual of the same age
there is a table for more accurate measurement with a dynamometer, but that is not essential, and a subjective assessment is sufficient

Mary scores 3 out of a maximum of 5
placing her in the Frail range of results
and confirming you suspicion that her two falls were related to Frailty.



As for the falls, there is a straight forward algorithm you should be following as per American and British Geriatric Society guidelines

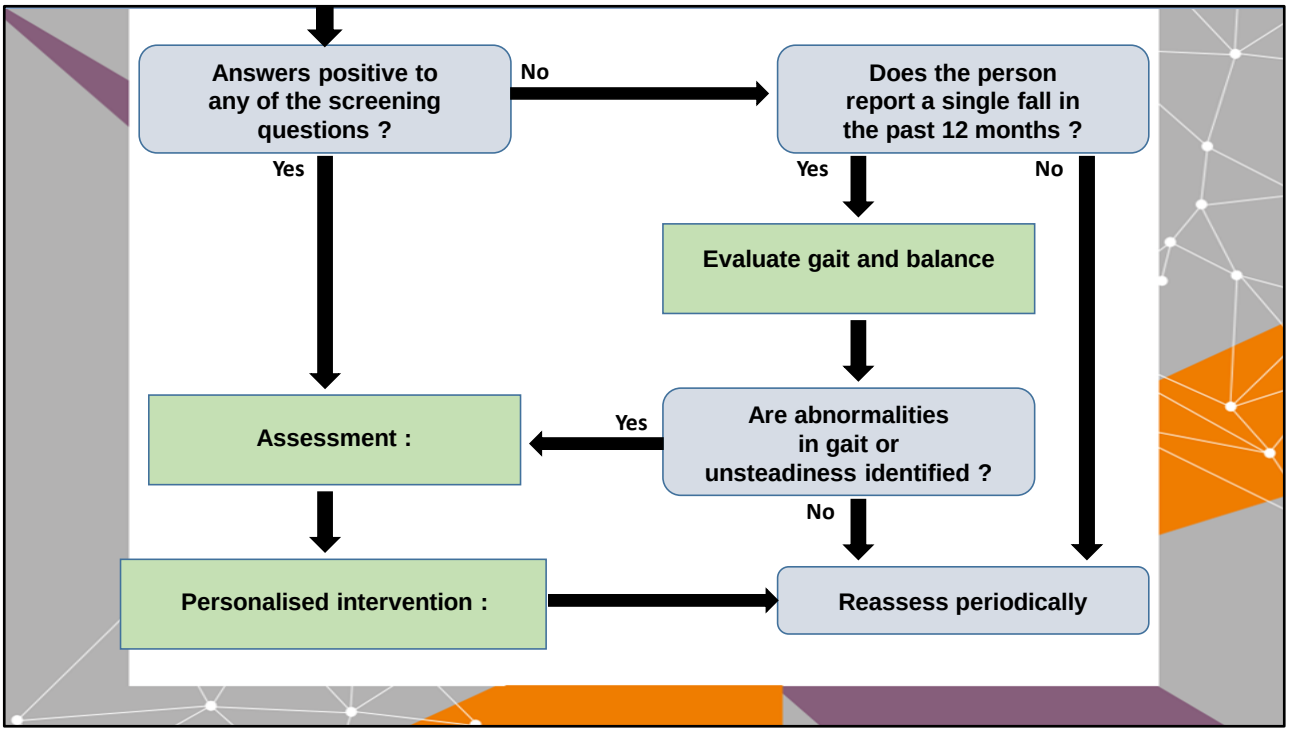
You already have the answer to the 3 screening questions:

- Mary has had 2 or more falls in the past 12 months
- she presents with an acute fall
- and she does have difficulty with walking and balance

so you know you will have to bring her back for a proper falls workup.

You close this standard 15 minute consultation by

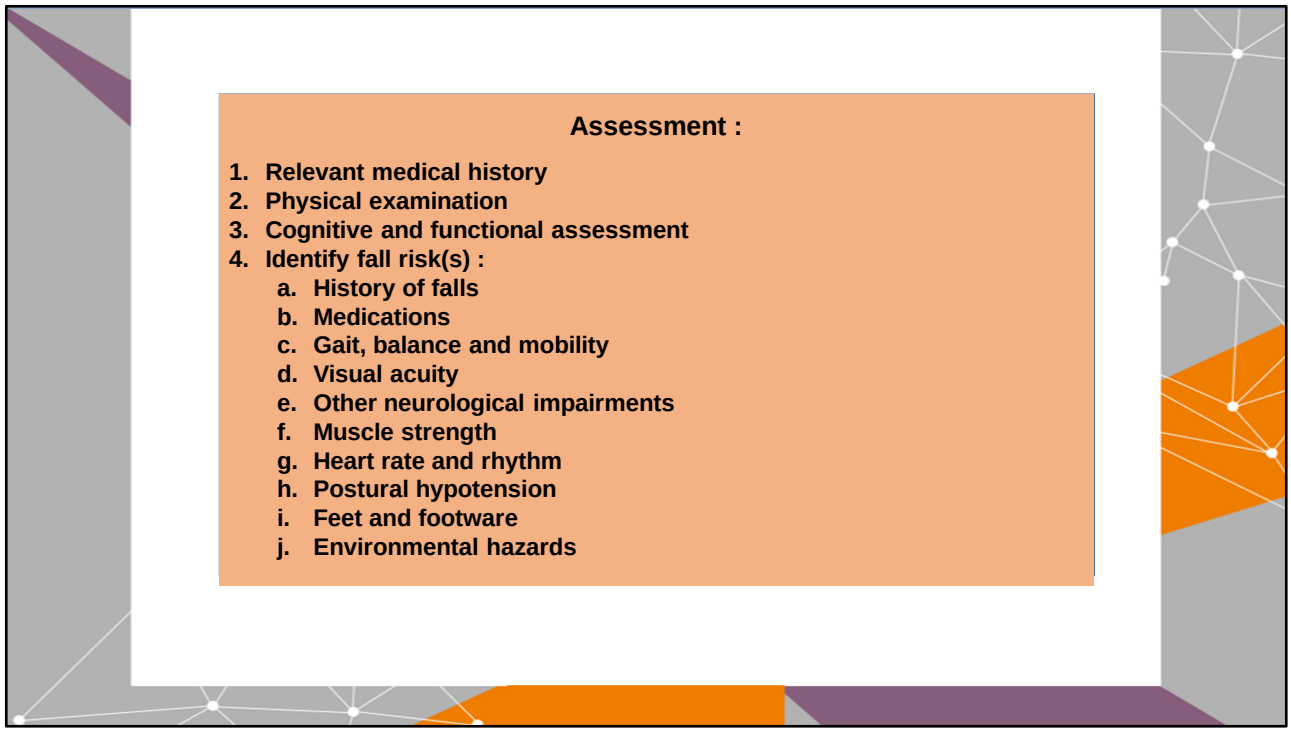
- reassuring Mary that no serious damage appears to have been caused by the fall
- but that she is statistically at risk for further falls
- you stress the importance of investigating this further
- and you requested Mary see the practice nurse :
- Three days later for some initial tests
- and one week later (when recovered from URTI) for ECG and Blood screen.



So what could be required for the workup and management of falls ?

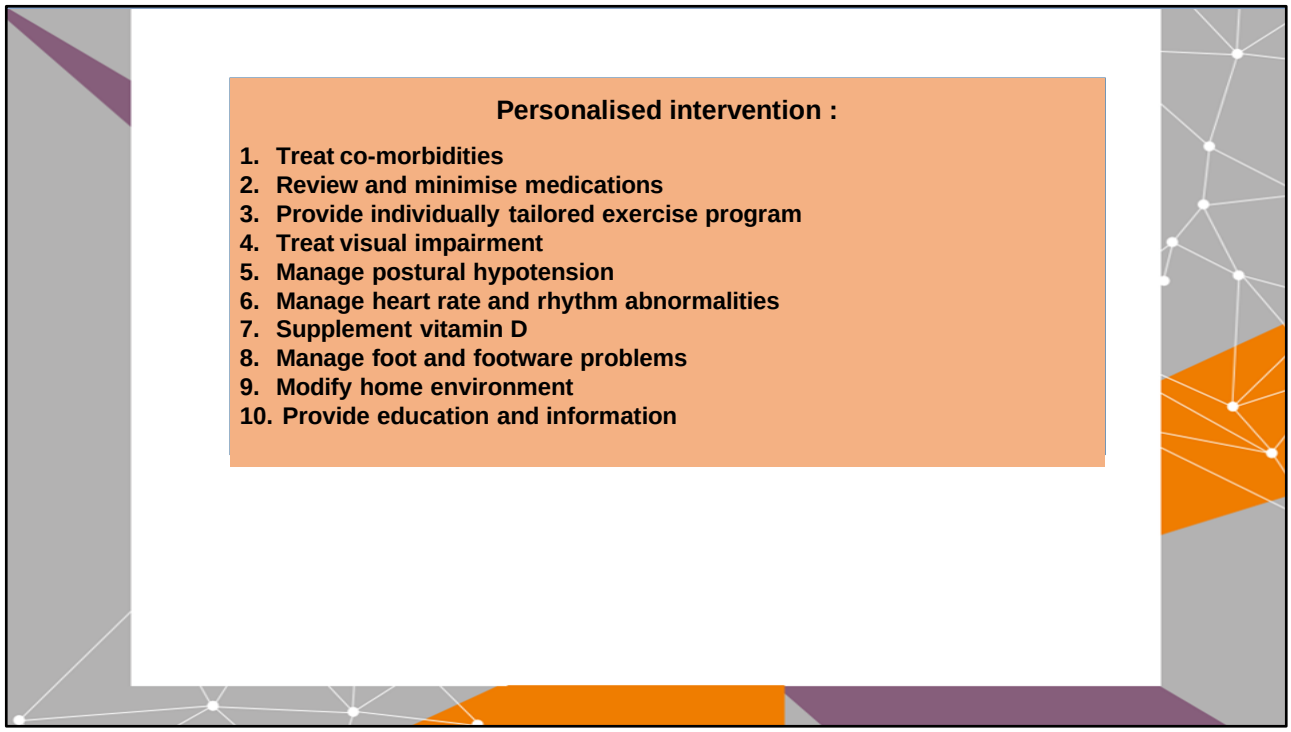
Had this been Mary's only fall you would simply evaluate her Gait and Balance using a test such as the Timed Up and Go test
and would have proceeded to a full Assessment only if the TUG test showed sufficiently compromised Gait and Balance.
(the right branch of the algorithm)

However all three screening criteria were met here so you will need to activate the practice protocol for Falls Assessment
aiming for a personalised intervention to meet Mary's needs.
(the left branch of the algorithm)



The American and the British Geriatric Societies guidelines define an appropriate falls Assessment as including :

- a relevant medical history
- a tailored physical examination
- cognitive and functional assessment
- and a personalised identification of falls risks, inclusive of
    - history of falls
    - medications that could increase the risk
    - gait, balance and mobility
    - visual acuity
    - other neurological impairments
    - sarcopenia
    - heart rate and rhythm abnormalities
    - postural hypotension
    - risk enhancing feet and footware issues
    - and environmental hazards in the home and neighbourhood



Appropriate personalised interventions arising from the Assessment may include :

- treatment of the co-morbidities
- and correction of the individual risks identified
- with plenty appropriate education and information provided along the way

Trigger event

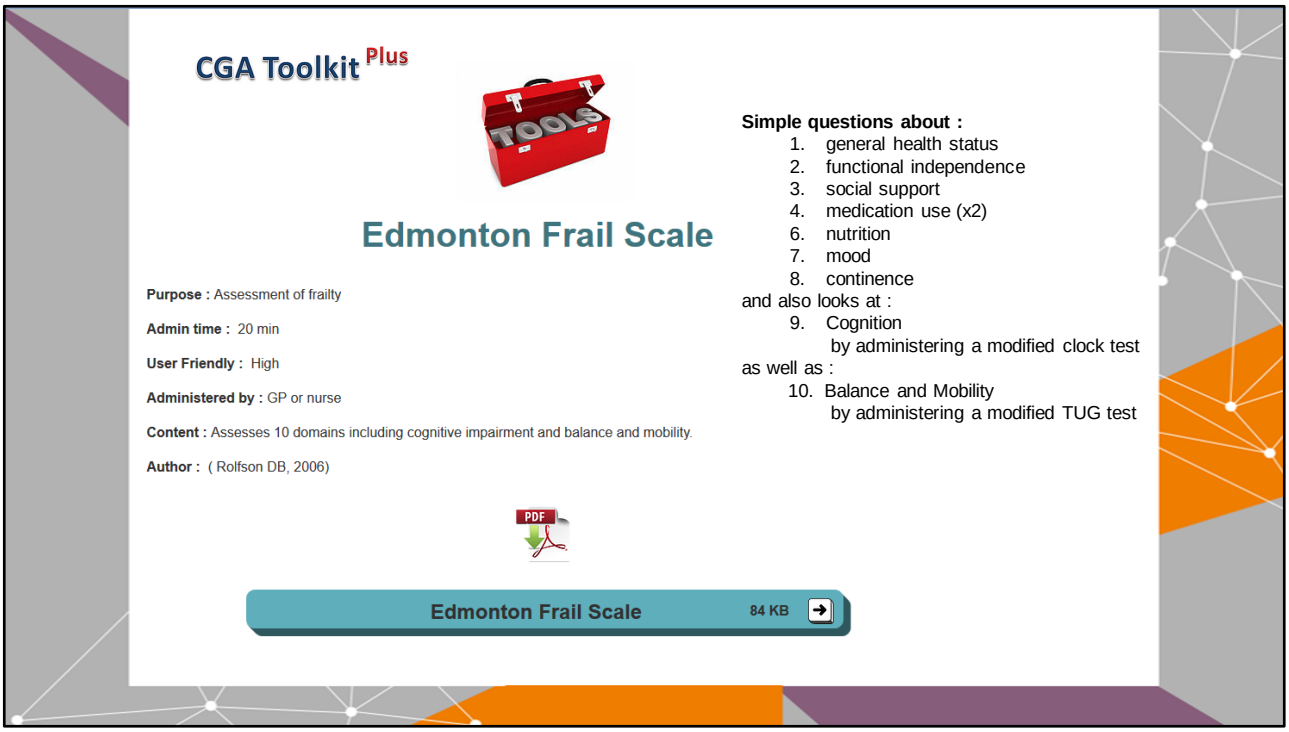
Frailty Phenotype test

Work-up

Edmonton Frail Scale
FRAX score

Patient education :
Alerted to risk of falls and fractures
Educated re Frailty

3 days later Mary comes back for her 1st return visit as arranged to see the nurse who administers the Edmonton Frail Scale
and the Frax score



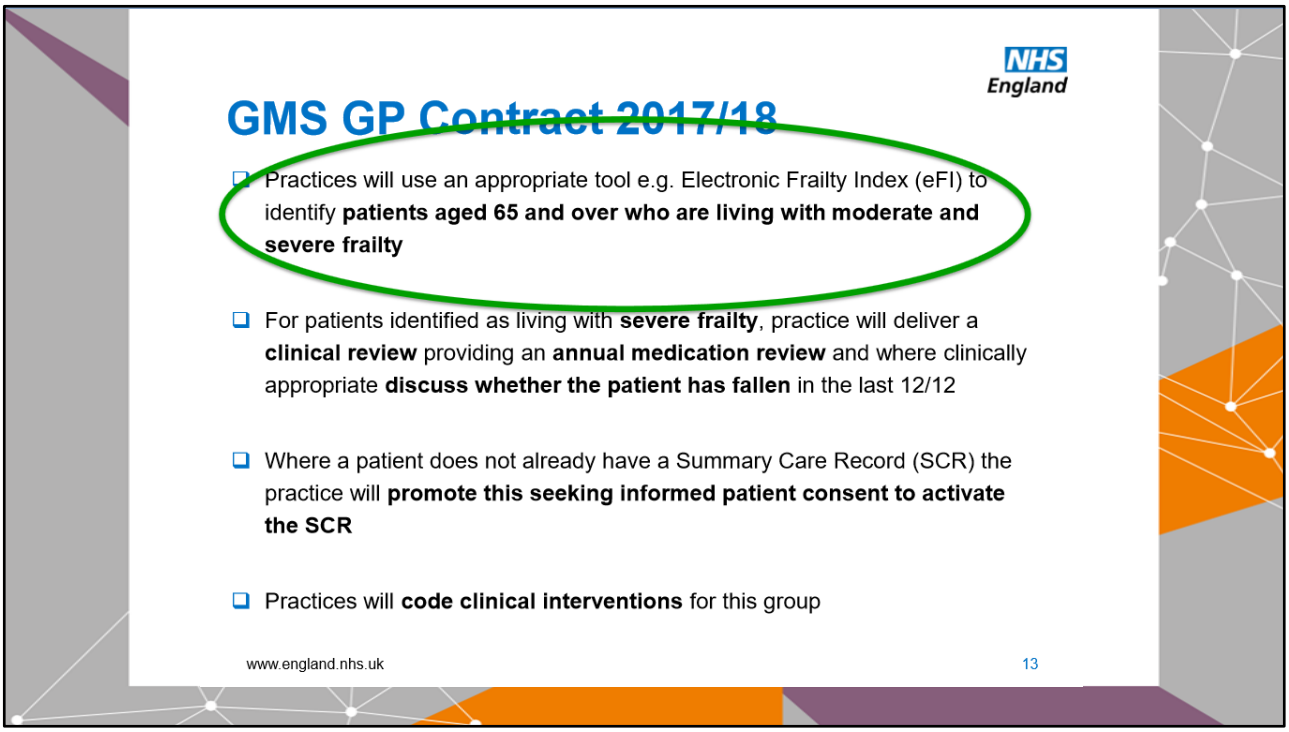
The Edmonton Frail Scale
Is a neat, easy to administer evaluation of the presence and degree of frailty.
It asks 8 simple questions pertaining to :
- general health status
- functional independence
- social support
- medication use
- nutrition
- mood
- continence

and also looks at :
- cognition, by administering a modified clock test

as well as
- balance and mobility, by administering a modified Timed Up and Go test

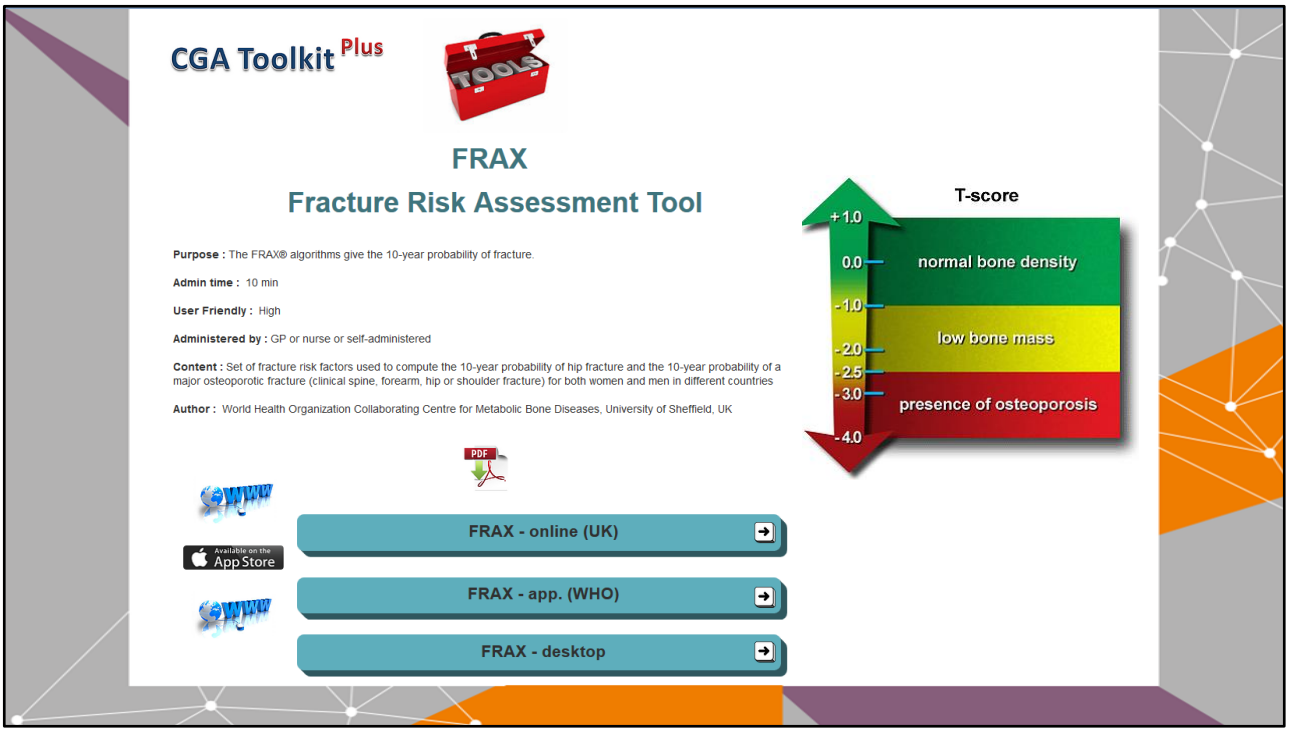
It is not as complex as it sounds, and it is actually very quick and simple to administer.

In this more definitive diagnostic tool
Mary scores in the moderate frailty range



As you know, in the UK the GMS GP contract requires that practices use an appropriate tool to identify patients over 65 who are living with moderate to severe frailty.
Those with severe frailty are to undergo an annual medication review and a falls review.
All are to be informed about the Summary Care Record and are to be coded appropriately.
The eFI is available to practices using any one of the most common Electronic Medical Record systems,
and it uses existing primary care data from the health record, so theoretically it requires no further data collection from you or your staff.

In the Republic of Ireland we are currently proudly emerging from the 18th century and still busy bringing fast internet services to the larger towns,
In the Midlands where I am located, only 10% of practices have access to fast fibre internet
so we dream of Electronic Frailty Indeces and Summary Care Records,
and plod on with our Edmonton Frail Scale,
defensively pointing out that the Electronic Frailty Index is unique to the UK and not yet available in any other countries worldwide.
You are very lucky in that respect in the UK.



Back to your nurse who has access to the online FRAX tool
and is familiar with its use.
So she quickly obtains a score without inputting Dexa scan data.

Mary scores in the Low bone mass range, or osteopenia.

So the nurse emphasises the importance of attending a few days later for the taking of bloods for the ECG.

and then ends this 30 minute initial appointment with a few words of encouragement about the reversibility of many aspects of Frailty and the possibility of improvement in quality of life.

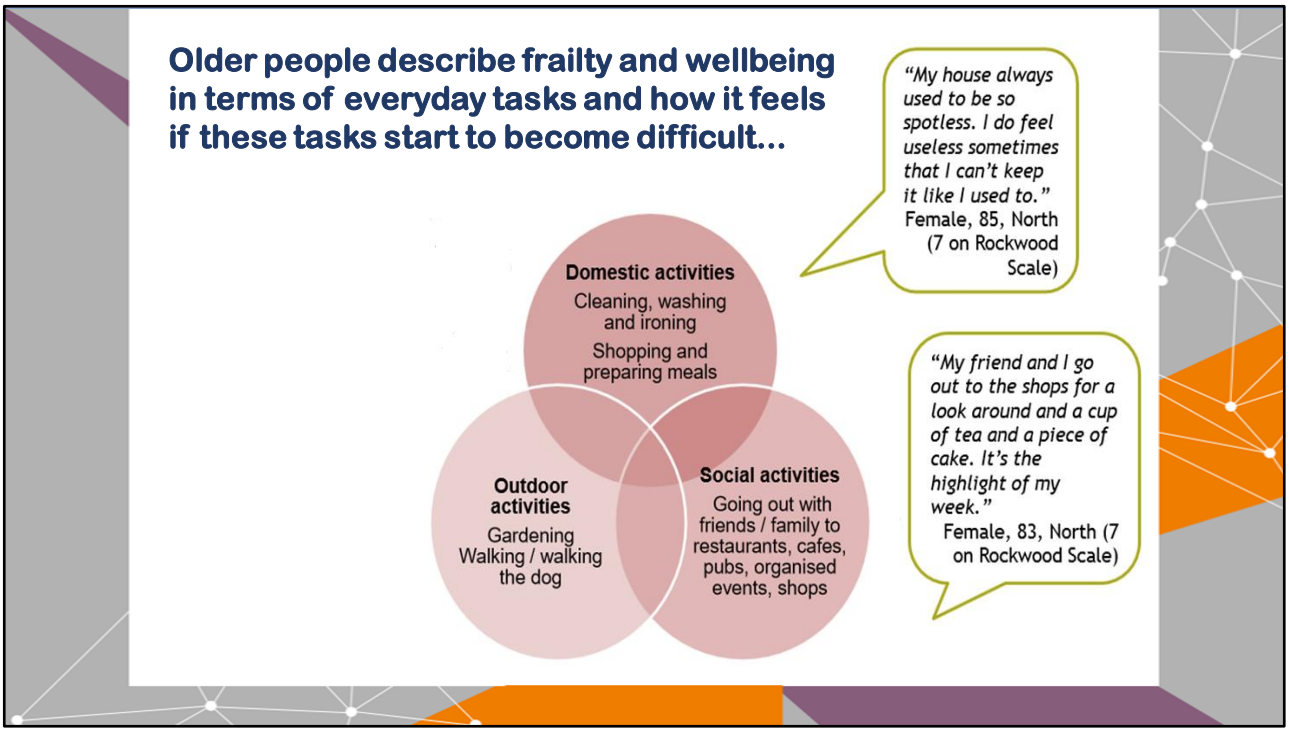
She hands Mary a copy of one of the 2 booklets in stock which outline this.

Older people describe frailty and wellbeing in terms of everyday tasks and how it feels if these tasks start to become difficult...

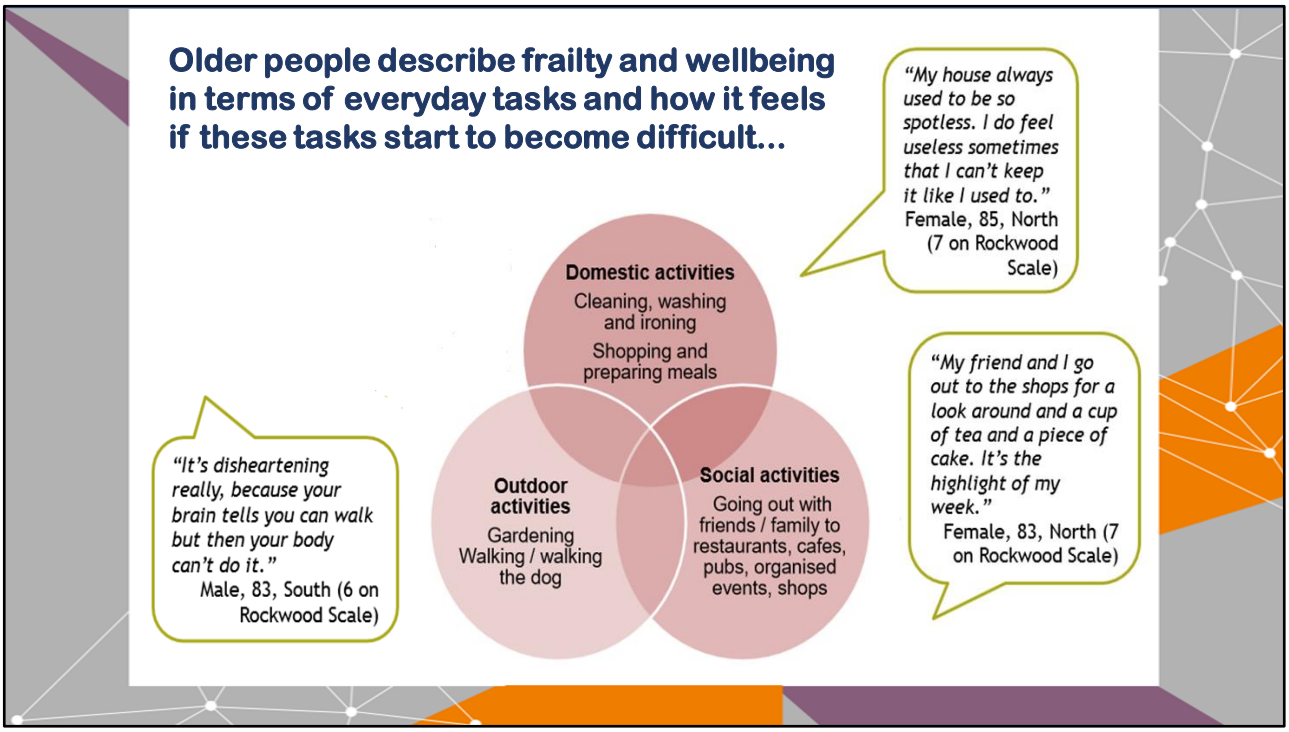
The nurse is mindful, in this introductory talk to Mary about Frailty, of the fact that older people tend to describe Frailty and wellbeing in terms of everyday tasks and how it feels when domestic and social and outdoor activities are impaired

Older people describe frailty and wellbeing in terms of everyday tasks and how it feels if these tasks start to become difficult...

"My house always used to be so spotless. I do feel useless sometimes that I can't keep it like I used to." Female, 85, North (7 on Rockwood Scale)



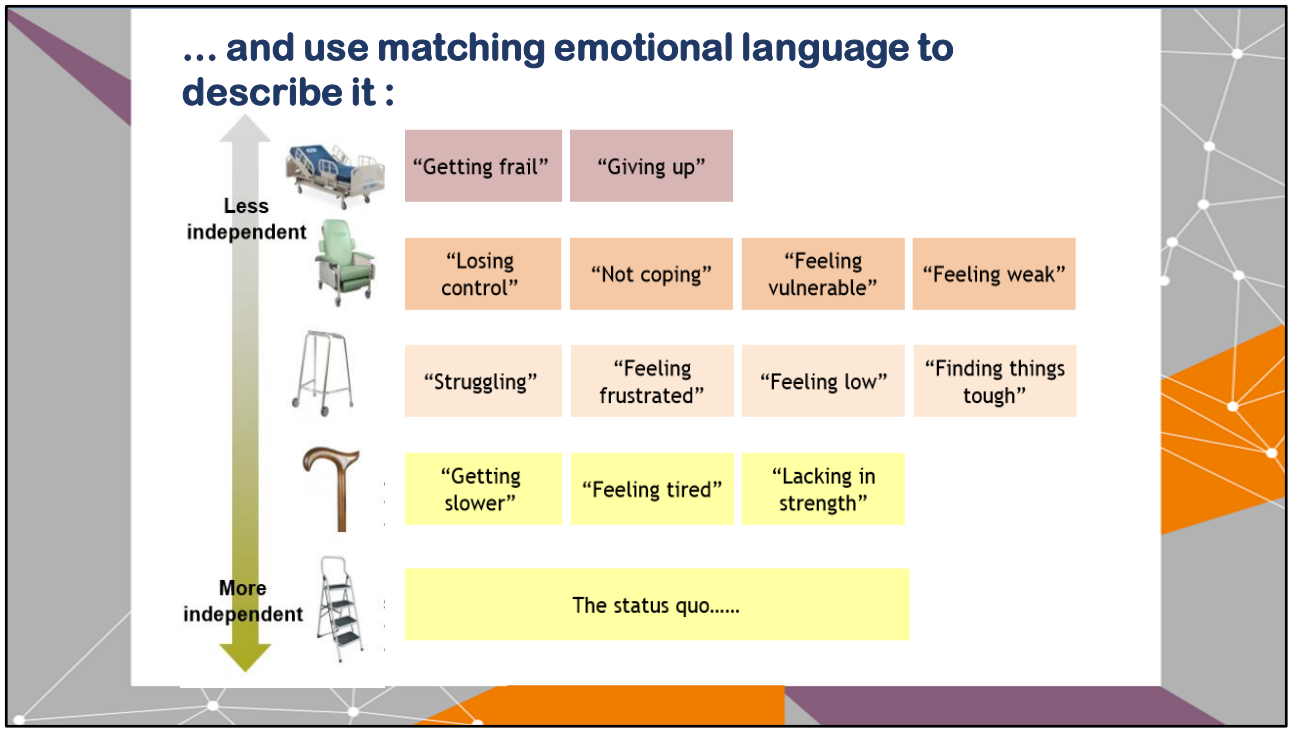
my friend and I used to go out to the shops for look around, and a cup of tea and a piece of cake



your brain tells you can do it, but your body can't make it

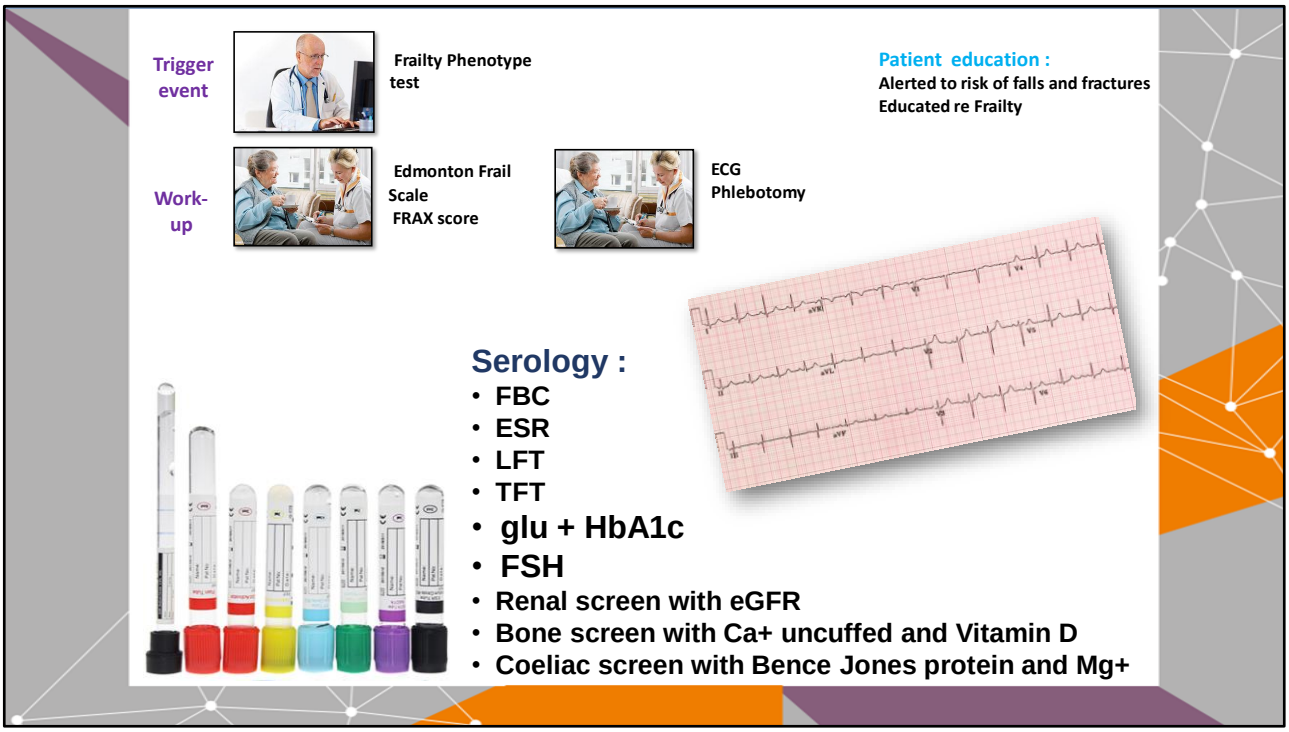
it's very annoying... I can't do the things I used to do

Older people tend to conceive of their ability to live independently as a spectrum, from more independent to less independent



and use matching emotional language to describe it

- lacking strength
- feeling frustrated
- losing control
- wanting to give up



The second visit to the nurse is brief.

The ECG shows no abnormality.

Blood is drawn for the standard bone health screen, inclusive of
- uncuffed calcium
- vit D
- coeliac screen

because Coeliac Disease may cause minimal symptoms (anemia, tiredness) without obvious bowel symptoms, but a gluten free diet in these cases would improve osteopenia and osteoporosis
- Mg+

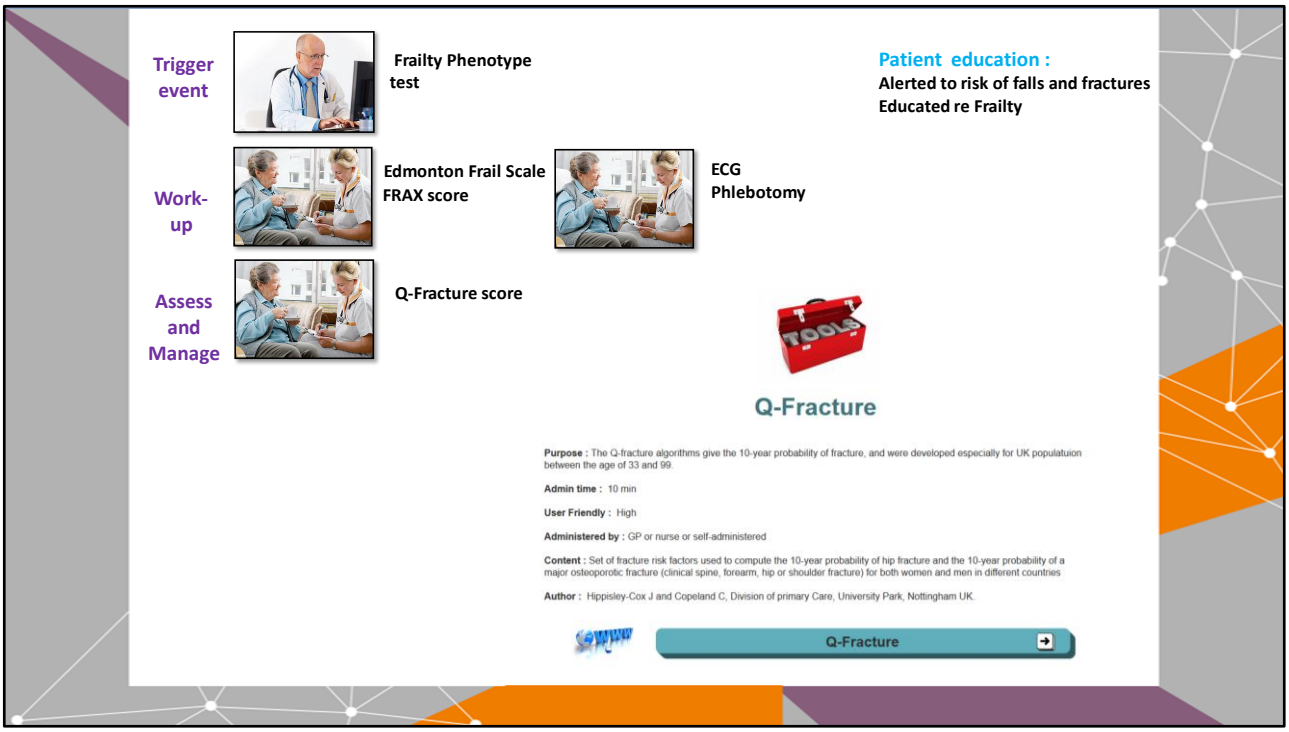
which is low in malabsorbtion syndromes
- and Bence Jones protein

which is low in Multiple Myeloma

When you reviewed the results you find that :

- vit D is low, but all other results are normal

in light of this you ask Mary be booked for a quick visit to the nurse for a Q-fracture assessment
this to happen on the same day, immediately before an appointment with yourself for the physical examination and review



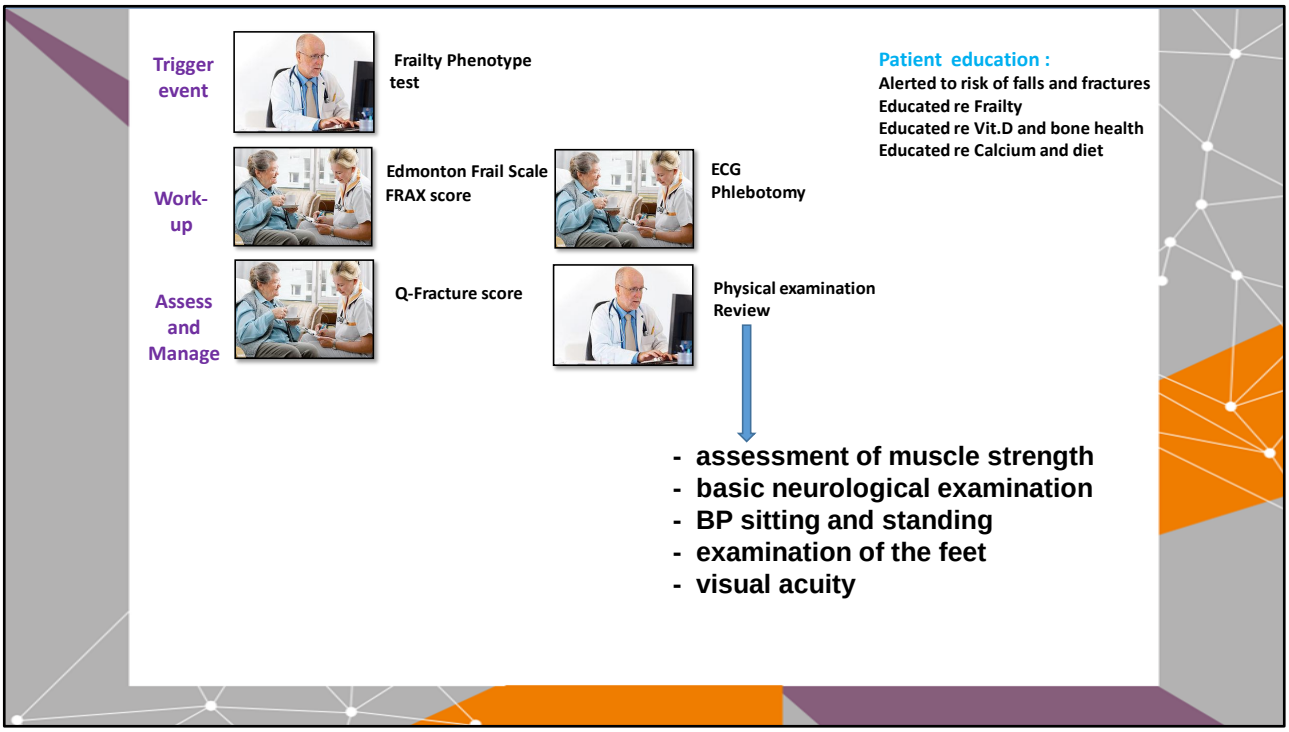
This is now the third visit to nurse,
and takes place 3 weeks after the initial trigger visit for the URTI when you first noticed the bruises from that most recent fall

The nurse accesses the online Q-risk calculator
and determines that Mary has a
10 year wrist shoulder or spine fracture risk of 26%
and hip fracture risk of 22%

so she prints the concise 4 page pamphlets containing information on
- vitamin D deficiency and
- calcium rich food list

and briefly shows Mary their layout and content.

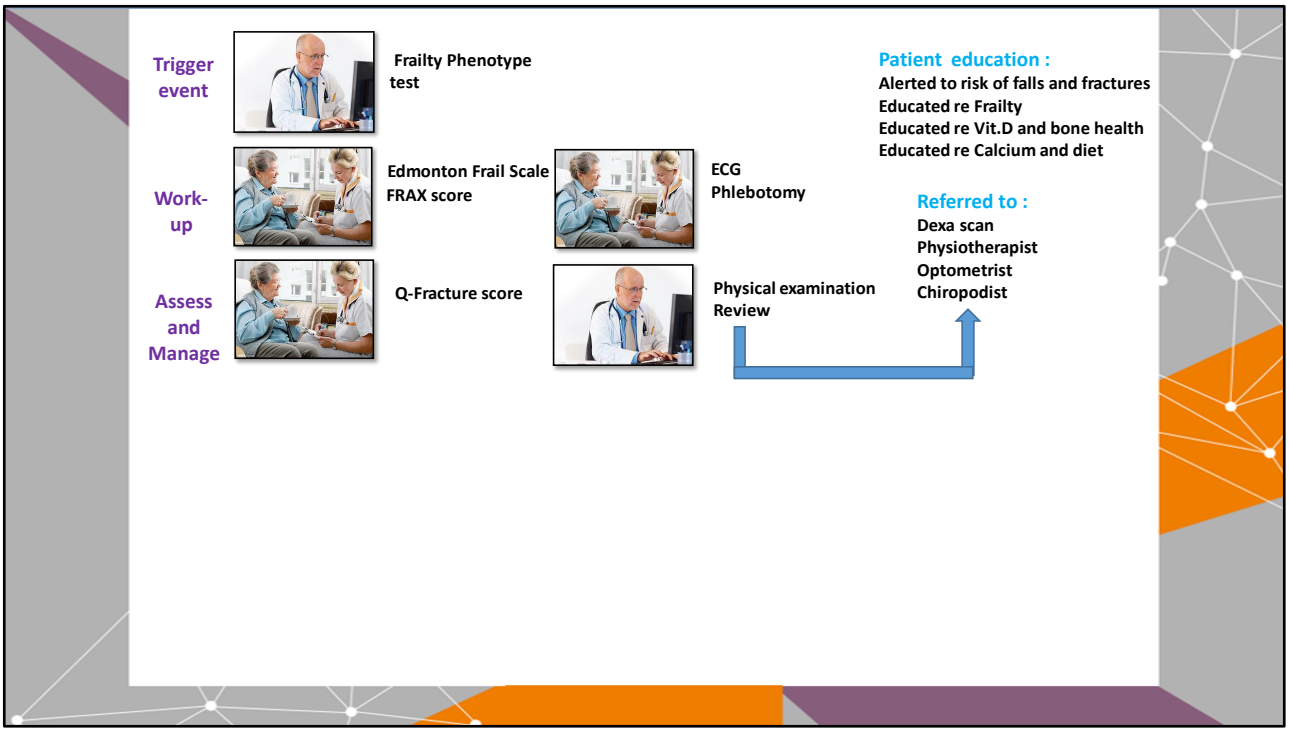
Both pamphlets can be found, ready to print, in the CGA Toolkit Plus as are the other two booklets we mentioned earlier about Frailty



Transferring directly from the nurse's room to your consulting room Mary now presents to you for her physical examination.
You are mindful of the recommendations for Assessment contained in the algorithm for investigation of falls in the elderly
so you specifically home in on

- assessment of muscle strength
- a basic neurological examination
- BP sitting and standing
- examination of the feet
- and visual acuity

You find generalised reduced muscle strength and tone
with hand grip strength particularly reduced
bunions and calluses on both feet
and slightly reduced visual acuity

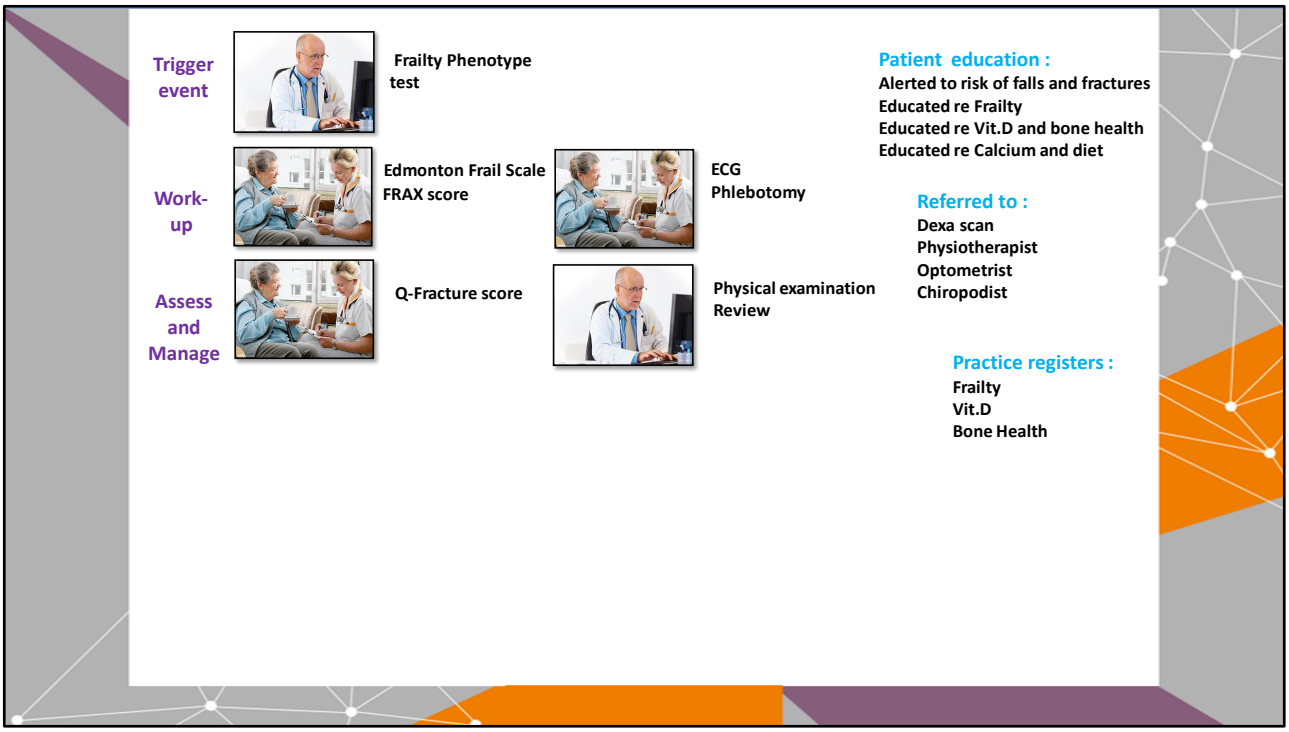


As you review the findings so far with Mary, you refer her
- for a Dexa scan

to document the course of the Osteopenia in the face of the expected treatment to come
- to a physiotherapist

for muscle strengthening exercises
- and to a chiropodist

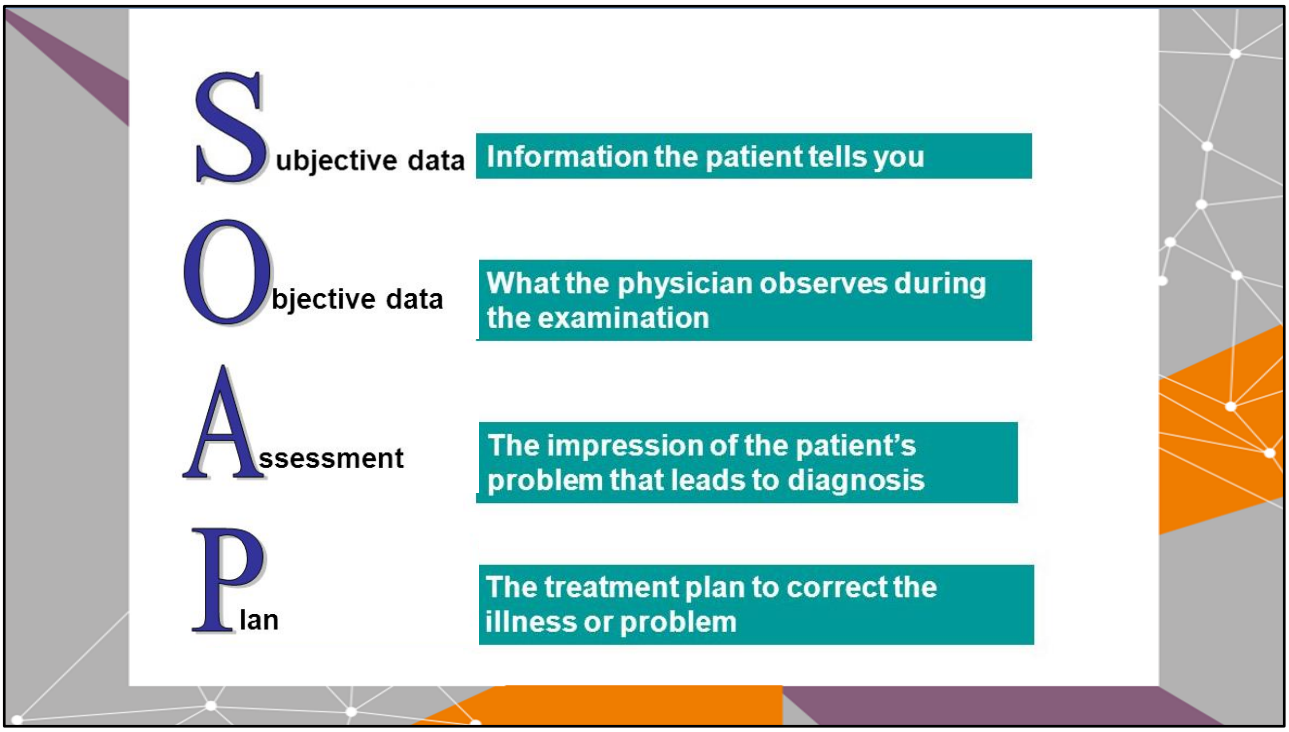
for the bunions and calluses



and you add Mary to the practice
- Frailty register
- the vit D register
- and the Bone Health register

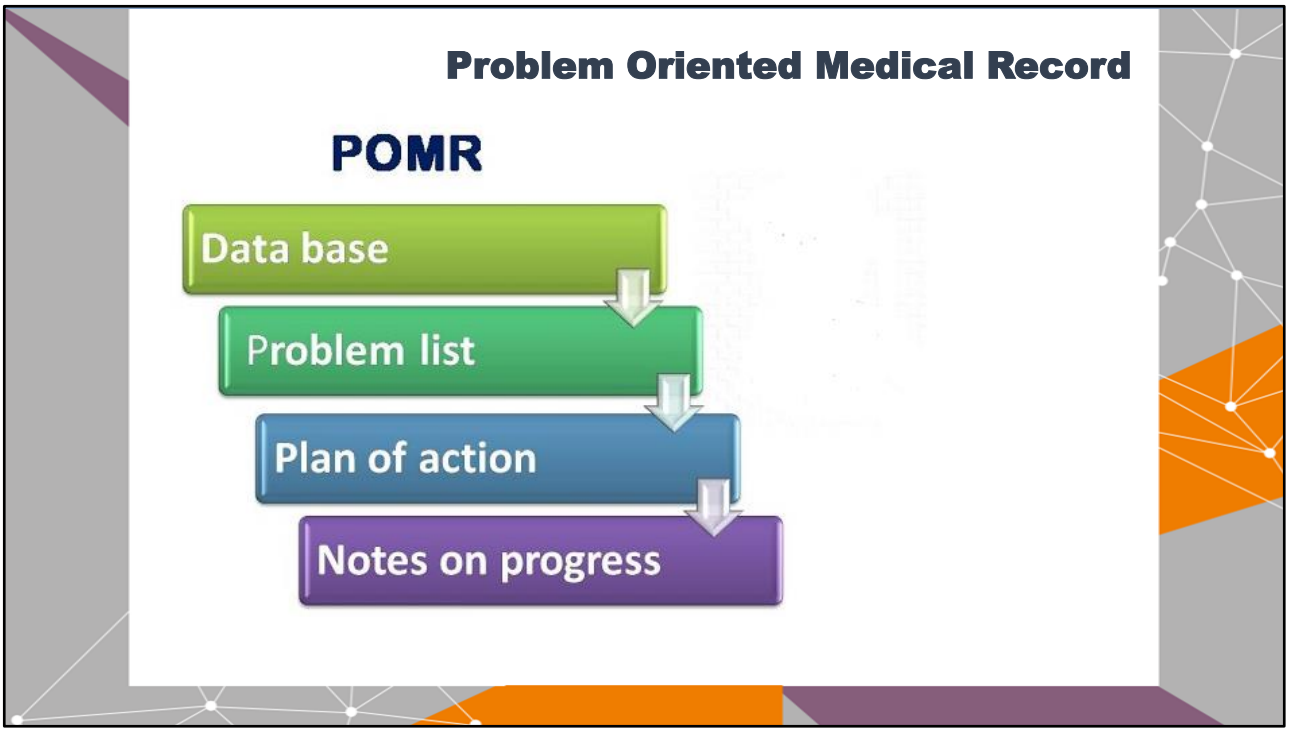
explaining to Mary that this means she will be recalled periodically for monitoring and managing these aspects of her health.

Interesting here the recent USA metanalysis of vit D efficiency which concludes that the recently ever so popular vit D screening and supplementation should be avoided. A bit of a shocker that, considering the huge increase in vitD screening and prescribing in recent years.
I am still a bit dubious about that one as I would swear to good results in terms of improved energy levels and general sense of wellbeing in many of my treated vitD deficient patients.
You can find that 2018 article and all the data in the CGA Toolkit Plus.



A word, at this point, about record keeping systems

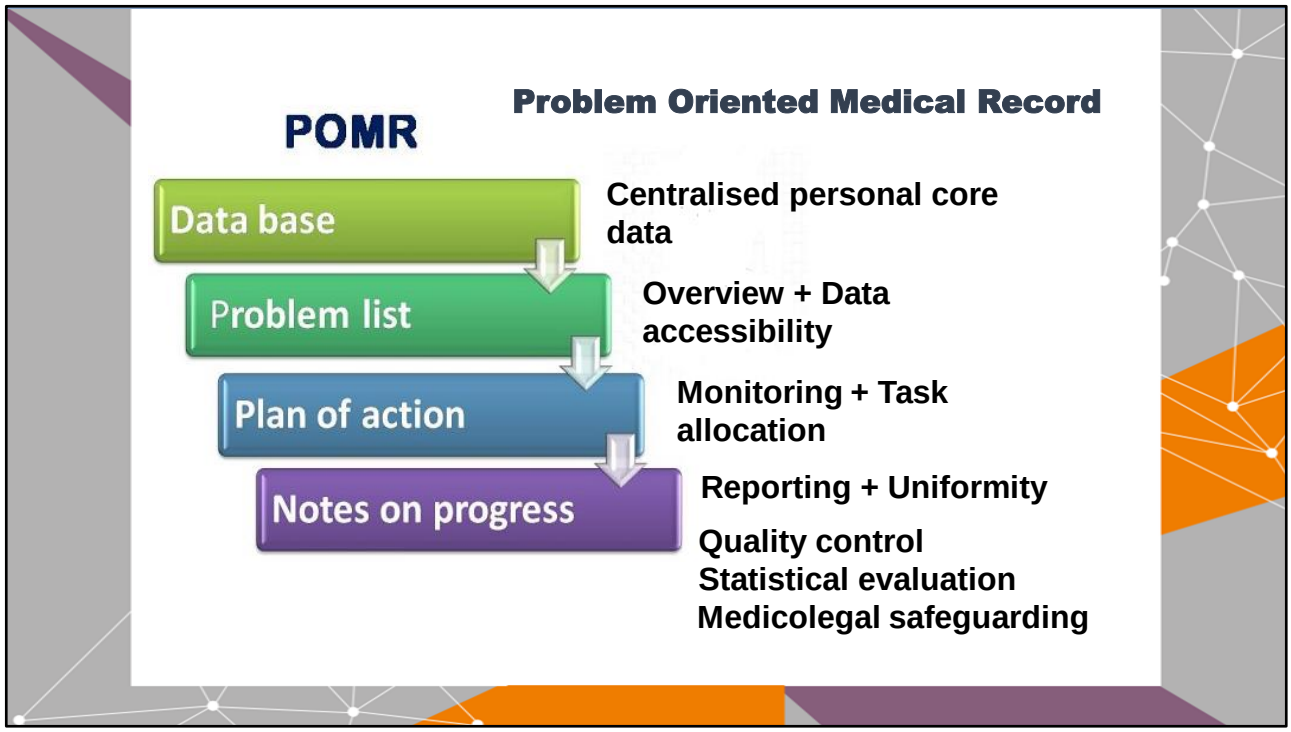
Most Electronic Medical Record systems in GP practice are structured for SOAP annotation
but, as we have seen, this focus on one problem at a time is inadequate in the elderly who present with multiple co-morbidities.



That's why, the Problem Oriented Medical Record is more appropriate to the care of the Elderly in that it provides

- a data base
- problem list
- plan of action
- and progress notes

which is much more suitable for managing several problems at once.



in that it allows for
- centralised personal core data
such as demographic data and preferences, caregiver details, and social circumstances
- and it allows for accessibility and overview
at a glance to crucial data which is required for the informed clinical decision making process (such as medical and surgical history, and key lab and imaging results)
You need that simultaneous overview of all the data, for example, when you do a medication review
- The POMR allows for ease of monitoring
of multiple co-morbidities
- and it facilitates tasks allocation
to different health-carers such as GP, practice nurse and external third parties and specialists
The POMR then makes it easy to integrate feedback from each of these third parties into the one central record
- which in turn makes it easy to compile uniform reports
and referral letters
- and when the need arises, makes it easy to survey the data-set for quality control and statistical evaluation
- while also providing built in proof of diligence and informed decision making
for the medico-legal safeguarding which is so essential in the face of the complexities of care of the elderly

In the toolkit, you will find both
- a brief CGA template in POMR format
- as well as a more comprehensive and detailed template named AGEDAT-G1

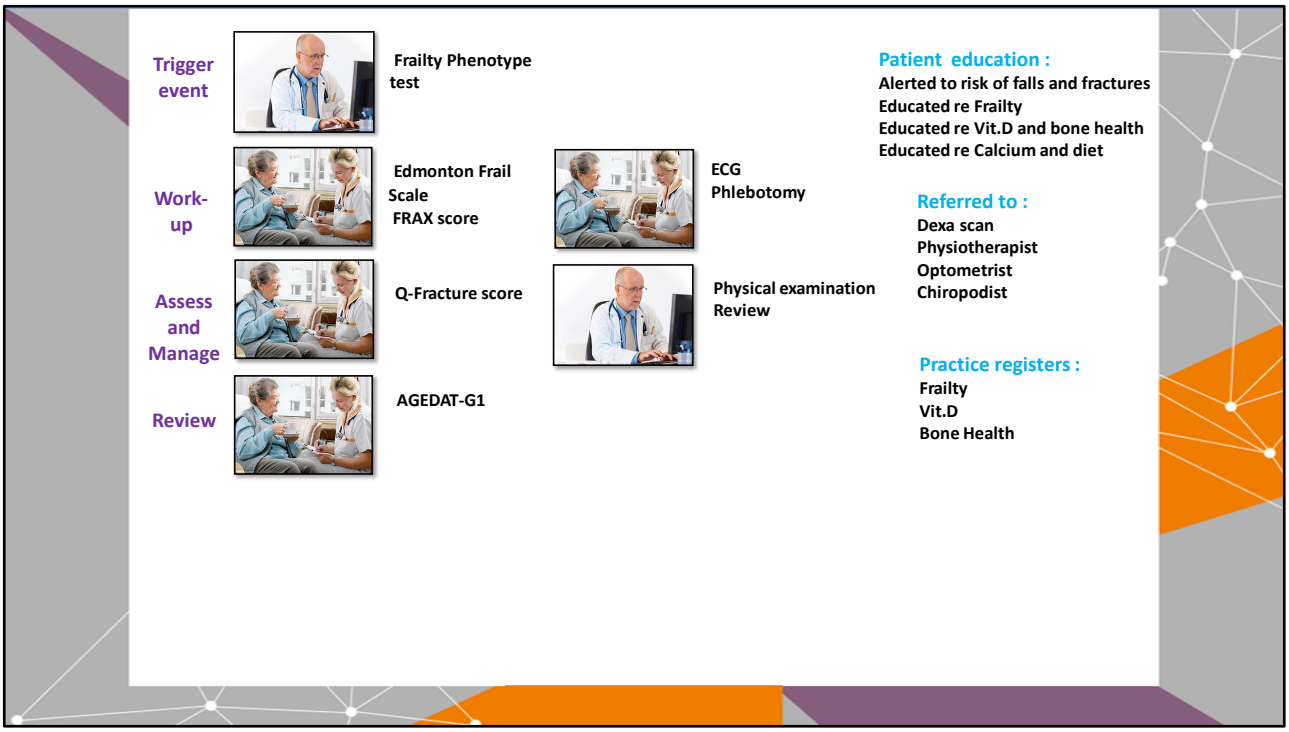
Both the brief and comprehensive templates can be used in their given format, or you can adapt them
to suit your particular existing practice dynamics and
to suit the Electronic Medical Record currently in use in your practice

Now, let's be clear :
Changing from a SOAP to a Problem Oriented Medical Record format is NOT mandatory in the care of the elderly, but it does have distinct advantages.

Each GP needs to work out if he wants to adapt or upgrade his Electronic Medical Record system to accommodate Problem Oriented Medical Records for the elderly patients
and, if so
what the best way would be to achieve this in that GP's own unique circumstances.

Some EMRs allow for custom templates to be created,
and some are accessible remotely on a tablet when visiting nursing homes and private homes.
Others are not,
and therefore require 2 paper copies of the Problem Oriented Medical Record to be printed and taken along on domiciliary visits,
with a the first copy left in the nursing home's record file,
and the second copy taken back to the surgery for manual update of the GP's Electronic Medical Record.

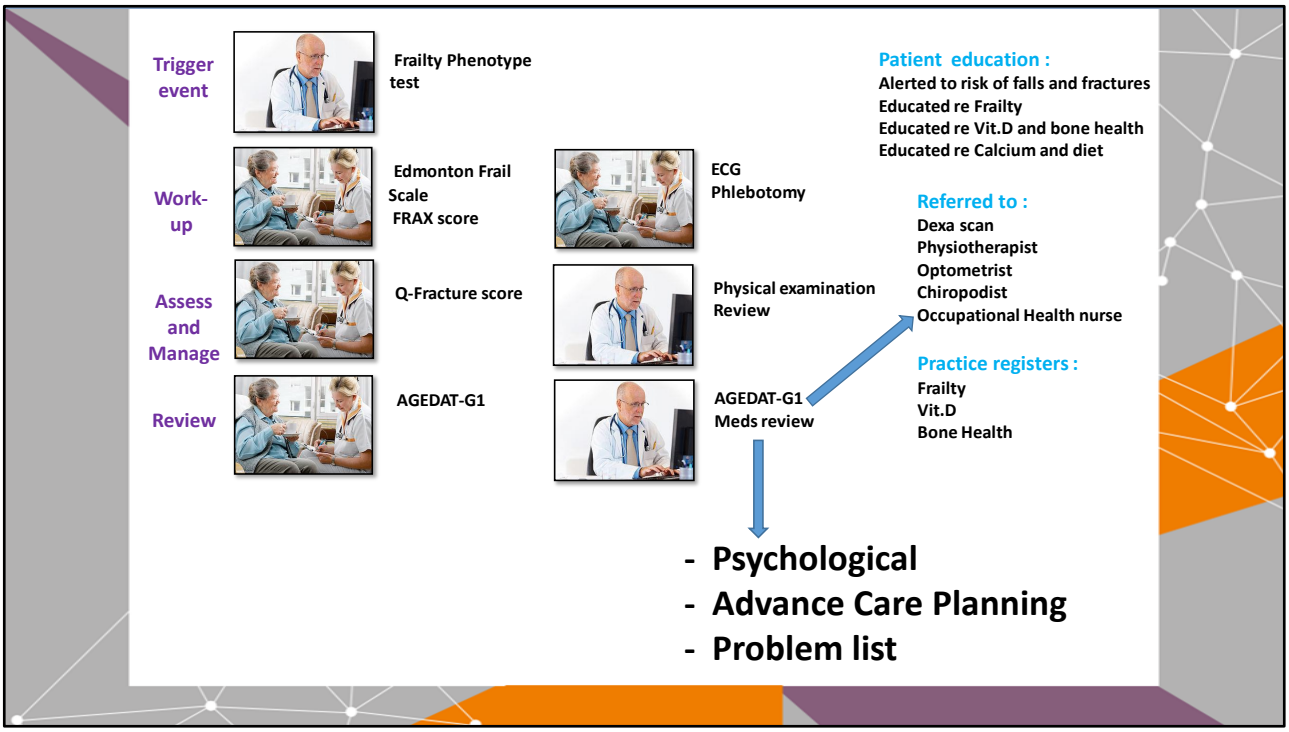
You need to make your own plans in that regard.



In the 4th and last visit to the nurse
the nurse enters most of the AGEDAT-G1 data
except for the sections for :

- Psychological
- Advance Care Planning, and
- the Problem List

which she leaves for you to fill in.



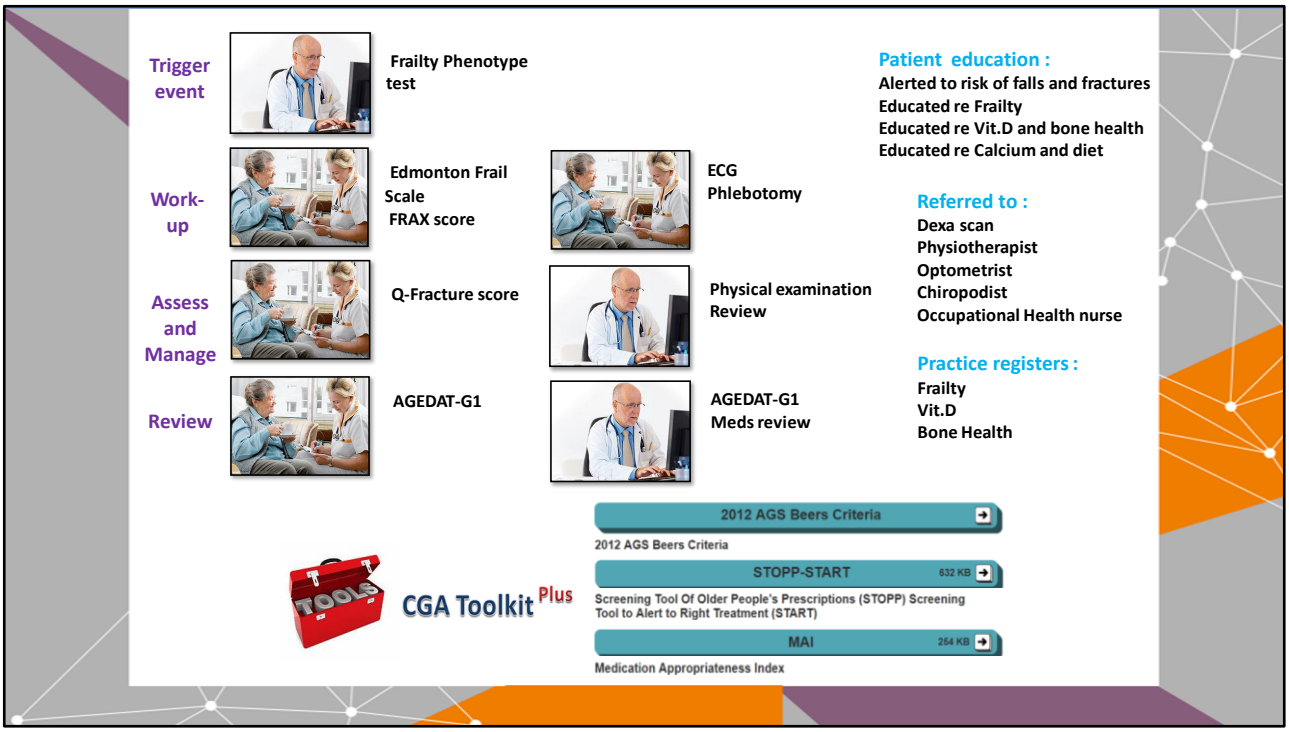
This is the second visit to you after the protocol was initiated.
On this occasion you annotate
- the Psychological section as - no immediate need for mental state evaluation
- the Advance Care Planning section as - no concerns about capacity
- and the Problem List - with entries for Frailty, Osteomalacia and Low VitD

In the Social and Environmental section of the record,
you notice that Mary has told the nurse
- "I love my 3 cats but they are always under my feet"
- and "It is getting more and more difficult to get up the stairs at my back-door"
- and "It is bothersome to have to go downstairs at night to go to the toilet"

So you refer Mary to the district Occupational Health nurse for a domiciliary Environmental Assessment.

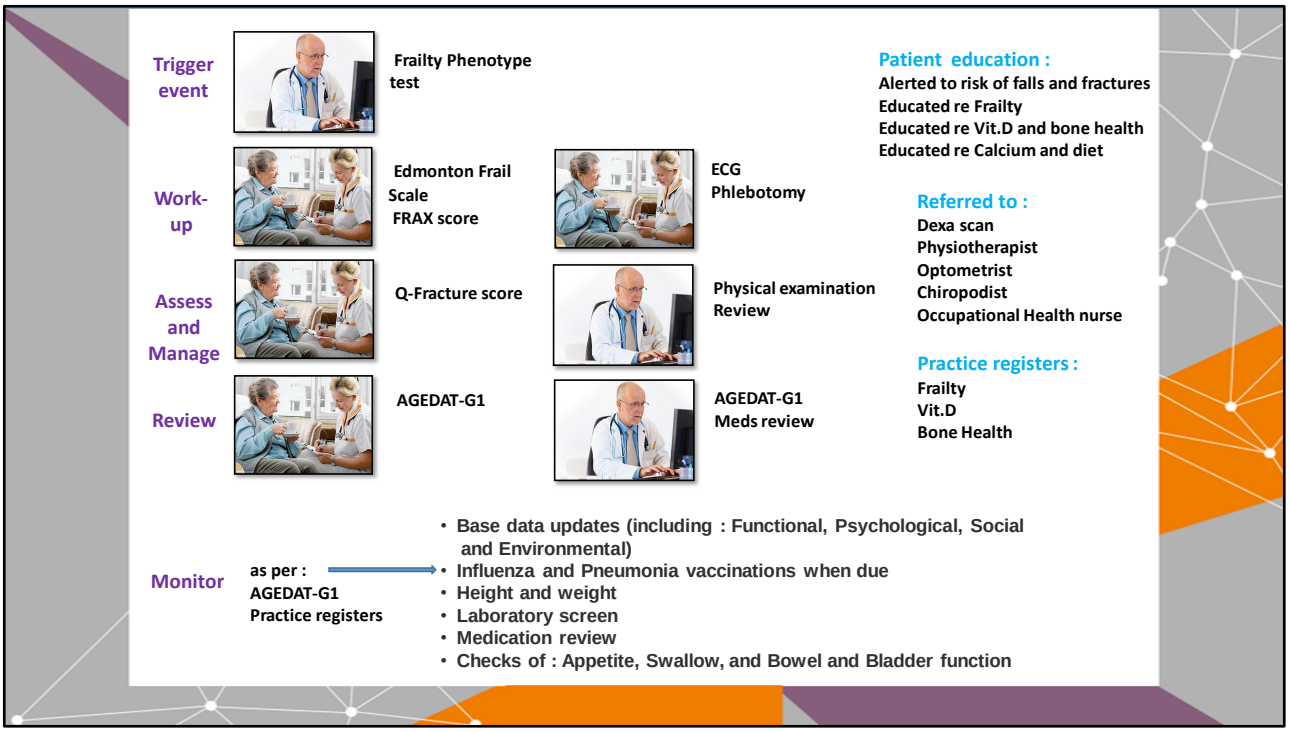
In due course this results in Mary having
- The dining room downstairs converted into a bedroom so she would not have to hazards the stairs on a daily basis
- The downstairs toilet fitted with rails and converted into a tiled bathroom with the inclusion of an open sit down shower
- hand rails also installed at the front door steps
- several loose rugs removed in the lounge
- and loose electrical wires in the house all neatly tacked down along the walls

all of which helped reduce the risk of further falls.

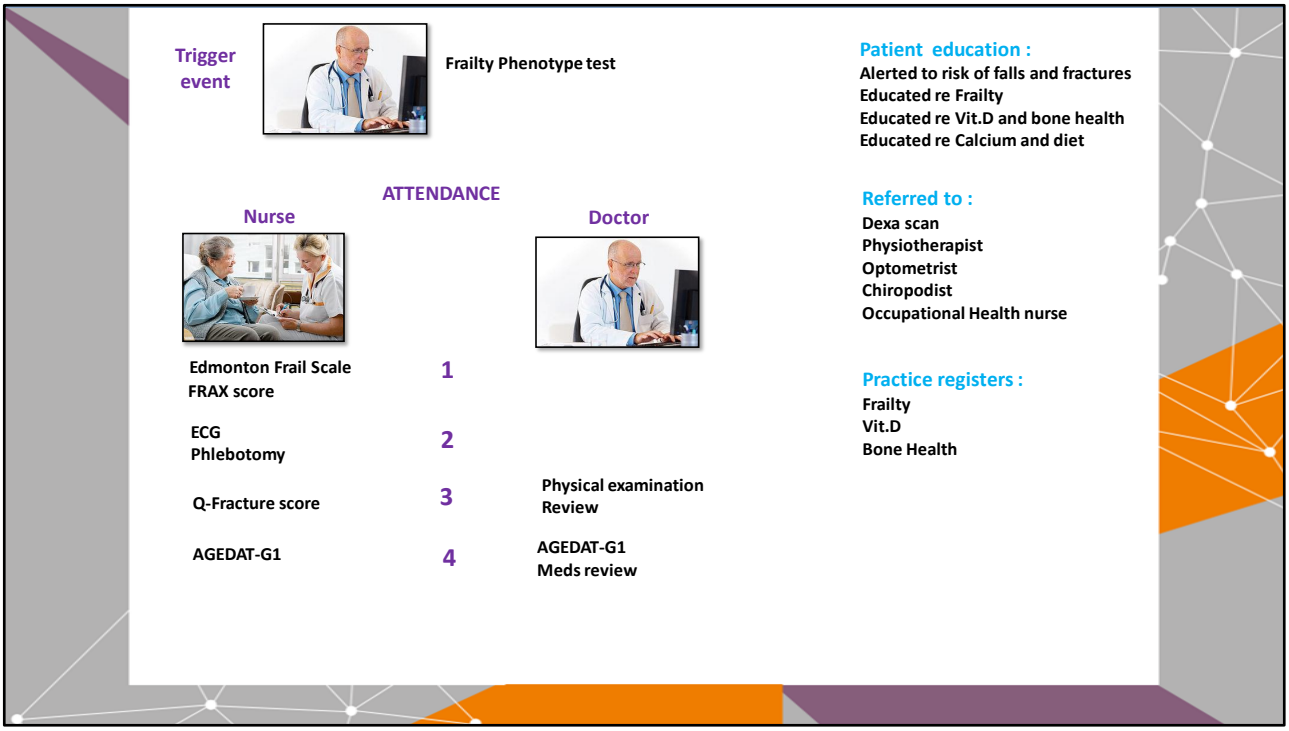


You then do a medications review utilising the appropriate tools.
You'll all be familiar with the Beers Criteria and the STOPP-START guidelines for meds reviews
You :

- Stop the regular codeine containing analgesic Mary was using, as codeine is known to increase fall risk
- and you start Mary on a daily VitD supplement



Monitoring, in the months and years that follow are determined by the AGADAT-G1 record
- and by the Frailty, Vit D and Bone Health registers
both of which flag annual and biannual reviews



So, there you have it :
After the original consultation for an Upper Respiratory Tract Infection, where evidence of a fall was an accidental finding,

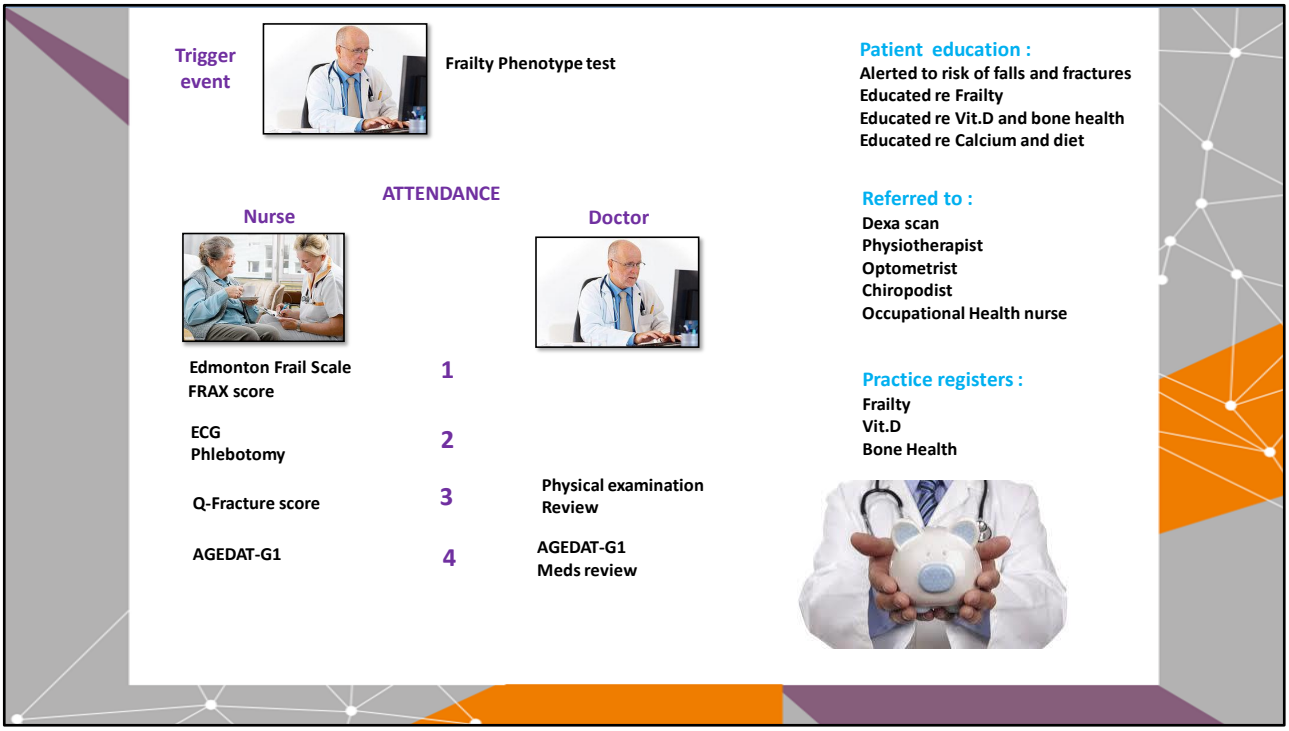
Mary attended the surgery 4 times
seeing the nurse on each of those occasions, and the doctor twice.
That's not bad from the patient's point of view - 4 visits to the doctor's surgery.

Each of those consultations was within the standard consultation time frame of the practice and that's not bad... indeed, that is vital, from your time and resources point of view.

Mary certainly received an excellent service and care
In the course of these 4 visits to the surgery,
Mary received educational material and reviews of
- her risk of falls and fractures
- frailty
- vit D and bone health
- and calcium and diet

she was referred
- for a dexa scan
-and to a Physioterapist, Optometrist, Chiropodist and Occupational Health nurse

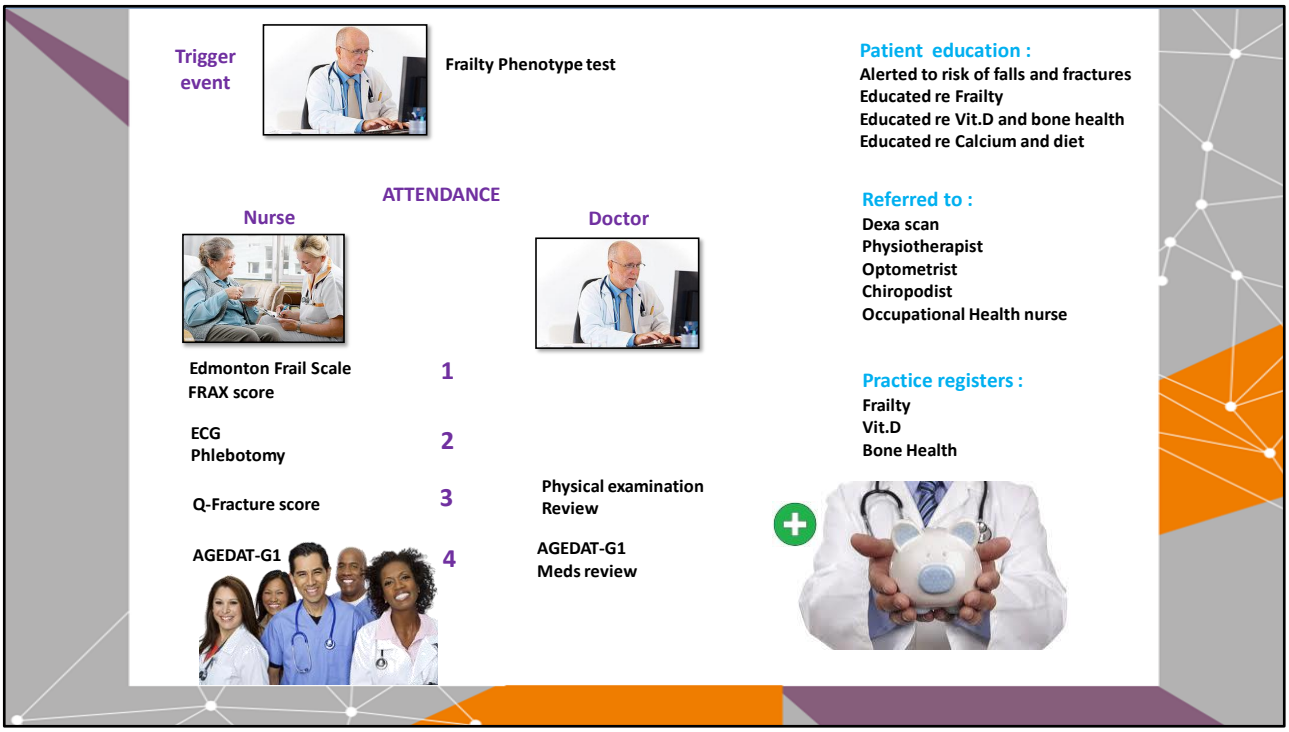
and she was placed on the practice's Frailty, Vit D and Bone Health registers.



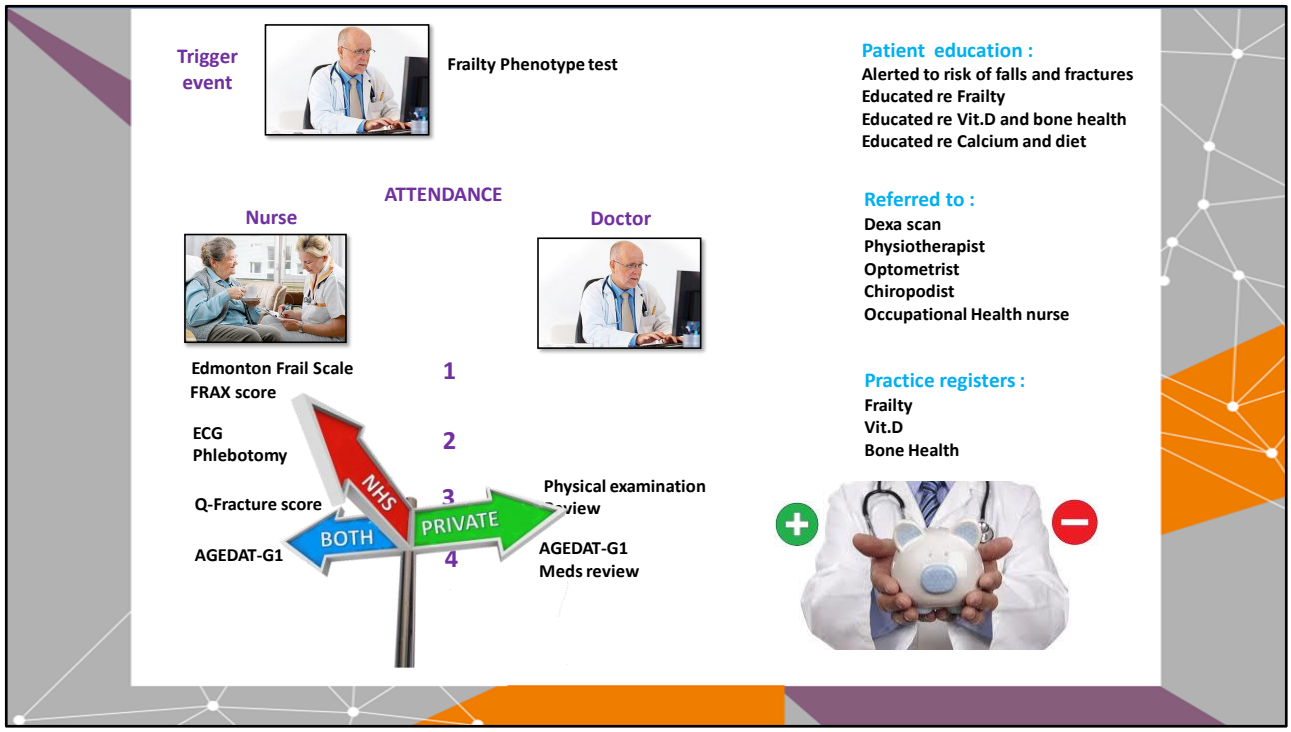
.... but .... the burning hot question is ....
wonderfully diligent and effective as all that is... is it all financially viable for the GP ?
We get uncomfortable talking finances openly and we prefer to do so privately, sharing in hushed tones our personal mix of charges, rebates, tax deductions and other money saving tricks.

But ultimately we all want to know : what is the bottom line ?
Is it all ultimately financially viable ?

The short answer is :
directly : no - not in any hugely significant way



Now, remember the case scenario discussed has been a worst case scenario for a practice stuck out in the middle of nowhere with very few local resources to take some of work off the hands of the GP and the practice nurse.
Most of you would already have made a mental note of portions of this which you can outsource, hopefully within reasonable time frames and without too much loss of control.



Be that as it may
In both UK and ROI the 2 GP visits are part of the capitation fees
GMS or PMS
and the 4 nurse visits and incidental costs are largely carried by the practice, subject to the usual financial arrangements you may have in place there.

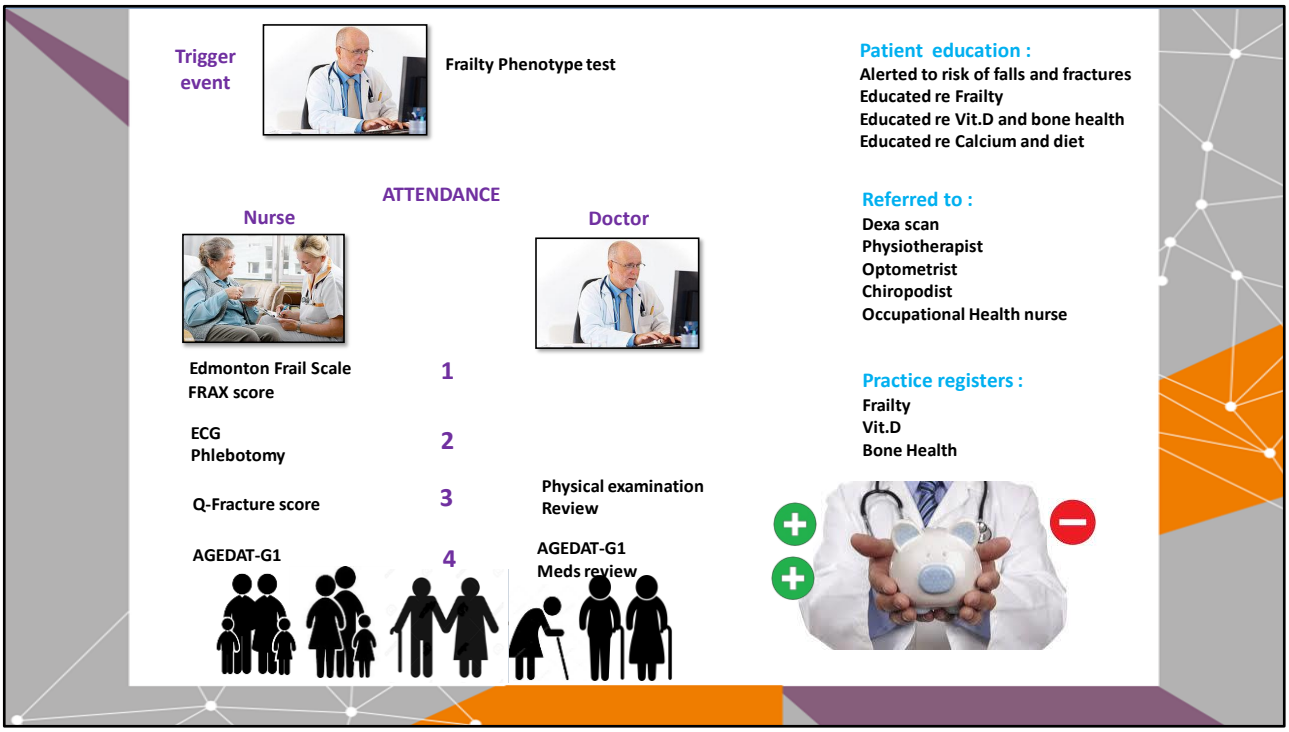
In the ROI the GP can charge extra for the ECG
and some practices will offer an immediate phlebotomy service for a fee, which will avoid the inconvenience of having to attend the local free phlebotomy state service.

In the UK these modest extra fees for ECG and phlebotomy are not such a viable proposition, and there are no QOF rewards or fee structures directly associated with the Frailty and falls workup described.

As things currently stand in the UK and ROI...
is this a service which can be provided within a realistic time and resource frame by the GP ?
yes
definitely yes
As things currently stand in the UK and ROI...
Is it a directly financially viable service ?
Well, it will not bankrupt you, but it is not going to directly significantly improve the monthly net income figure either.

So what benefits does the GP practice derive from the whole exercise?

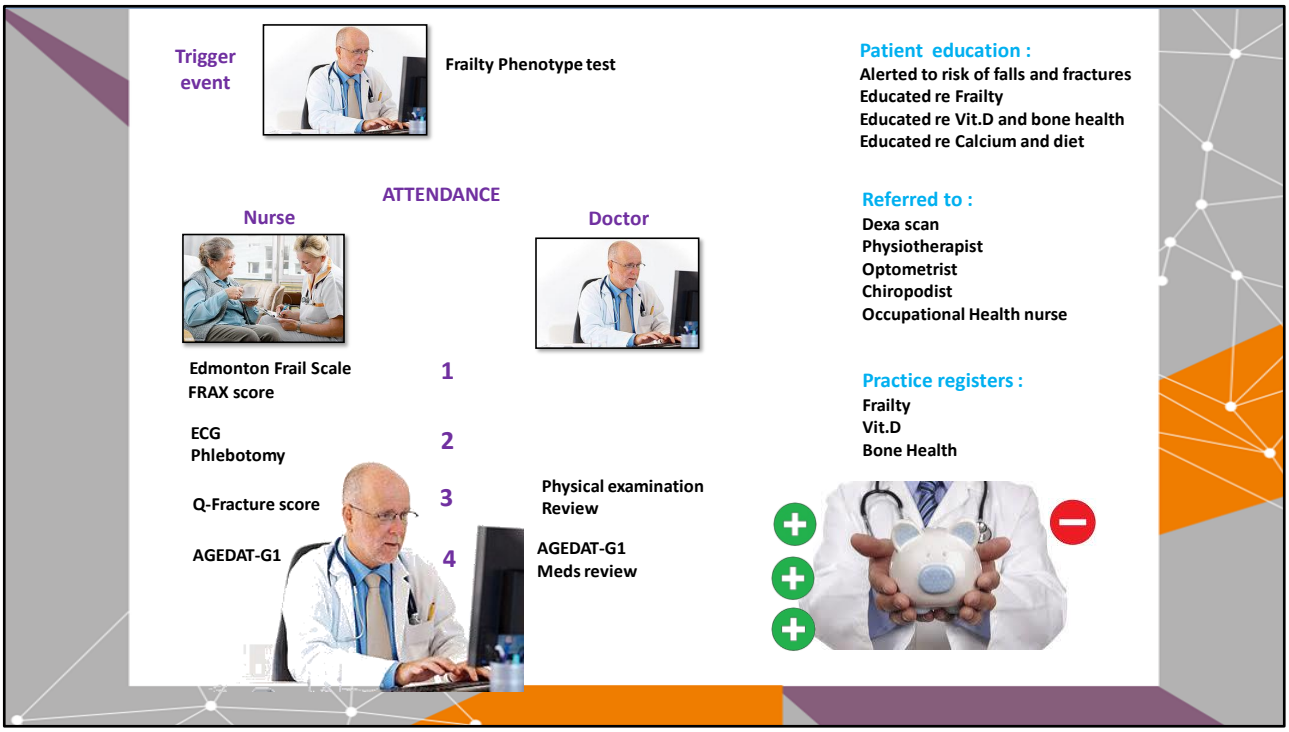
There are distinct indirect benefits



I found all my patients deeply appreciative of the structured care provided.
One of my real life Marys was so happy with the care she received from me along the lines we discussed, she went about singing my praises to her family and friends.
As a result, in the 6 following months
Mary's 2 adult children and their family (4 adults and 3 children) transferred to my practice
and 5 other elderly patients (2 couples and one widower),
all friends of Mary, also transferred to my practice.
Other practices which have moved towards a more Proactive personalised CGA based care of their elderly patients have reported similar outcomes.

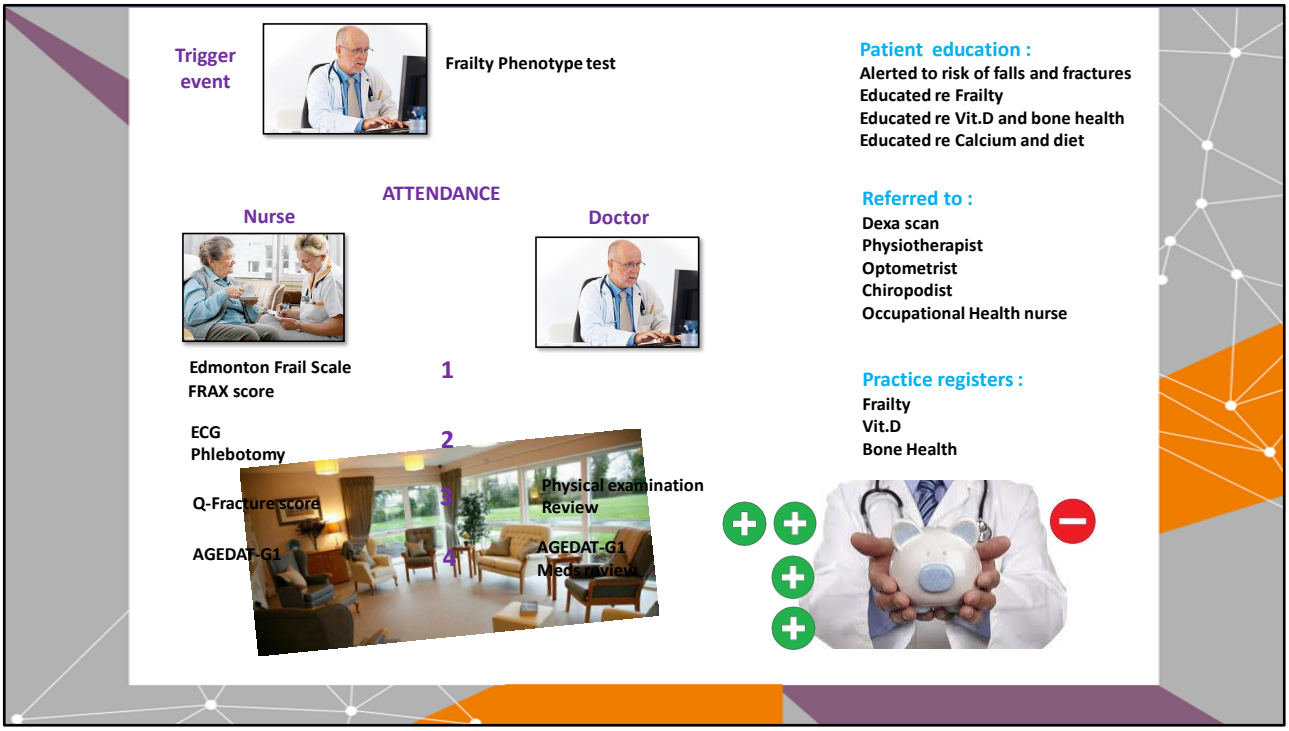
If you are already operating to full capacity and not taking on any new patients you will see this as a drawback rather than a bonus.

But, be that as it may, the reputation enhancement and the extra patients ranging in age from babies to elderly, certainly represents for many significant growth and, indirectly, the potential for income for years to come.

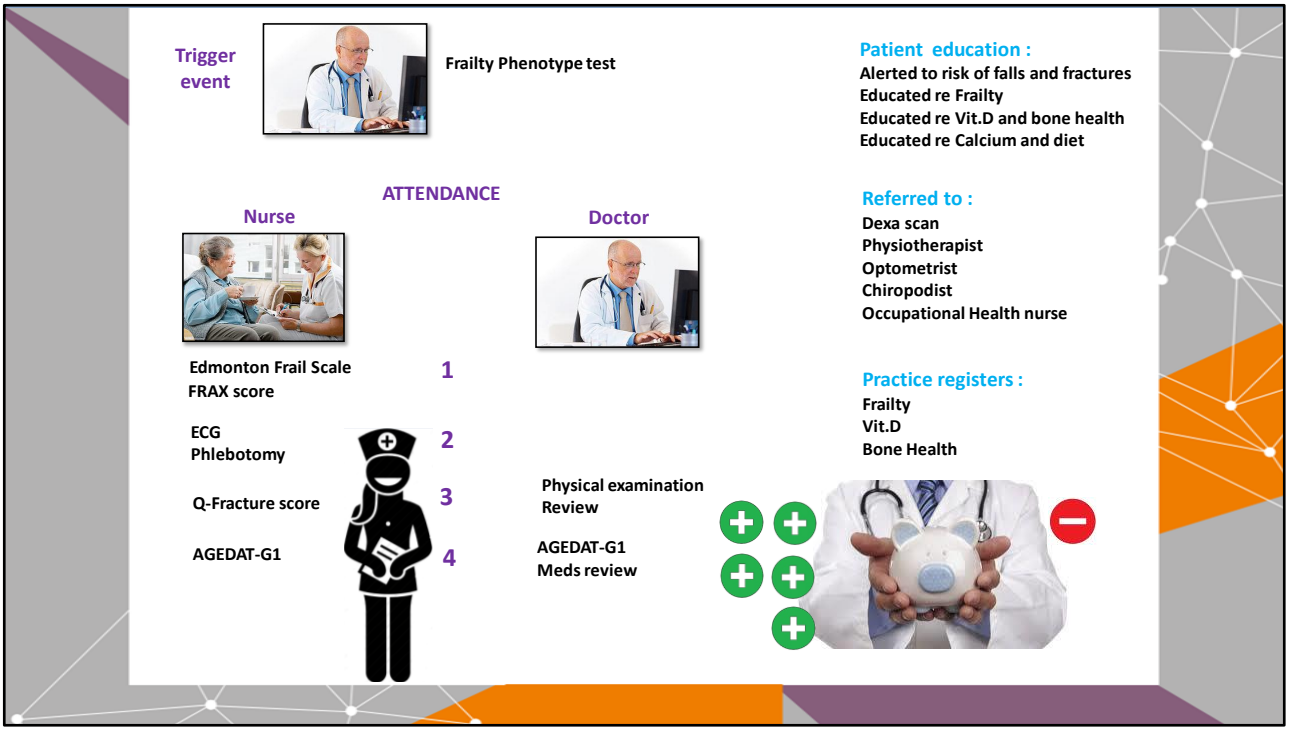


It does all become so much simpler and smoother if you have access to efficient MDTs and carer organisation.
However, many GP practices in the UK and ROI do not have access to geriatric and falls teams in their immediate vicinity, and those that do are often hampered by long waiting lists and by poor communication structures which result in the GP losing control of the overall management of the patient, and, often lead to demands from these specialist teams for extra follow-up monitoring and management work from the GP which take up as much time and resources, if not more, than if you had done the work yourself..

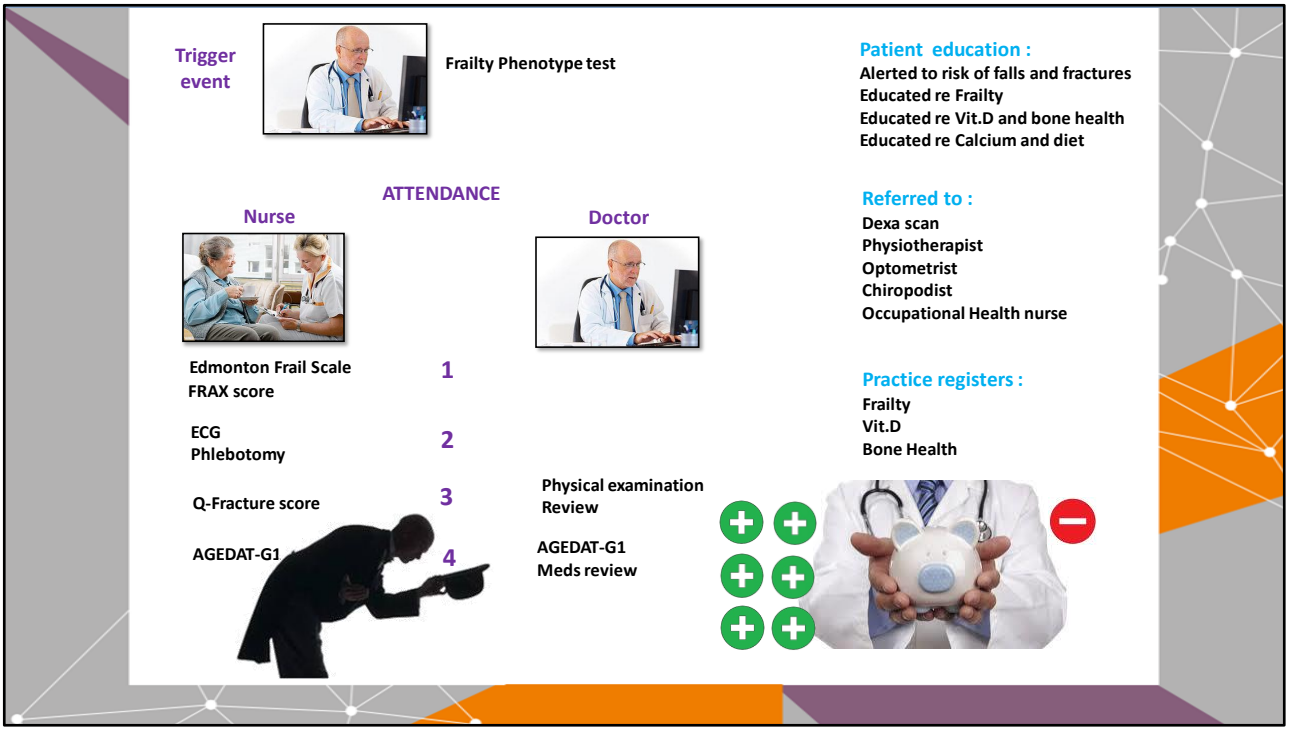
Devising protocols for the in-house management of Frailty and Falls Risk, allows you the GP to retain control of the overall management of the patient
but, most importantly,
also greatly streamlines and rationalises your workload.



The benefit of this becomes strikingly evident when you organise for the protocols to be executed in the nursing homes you serve.
You will find that not only is the quality of your care for your nursing home residents greatly increased, but you will also find that soon the delegated monitoring aspects of the protocols free up a huge amount of your time there, with nursing home staff doing much of the work, allowing you to spend significantly more clinical time with the patients.



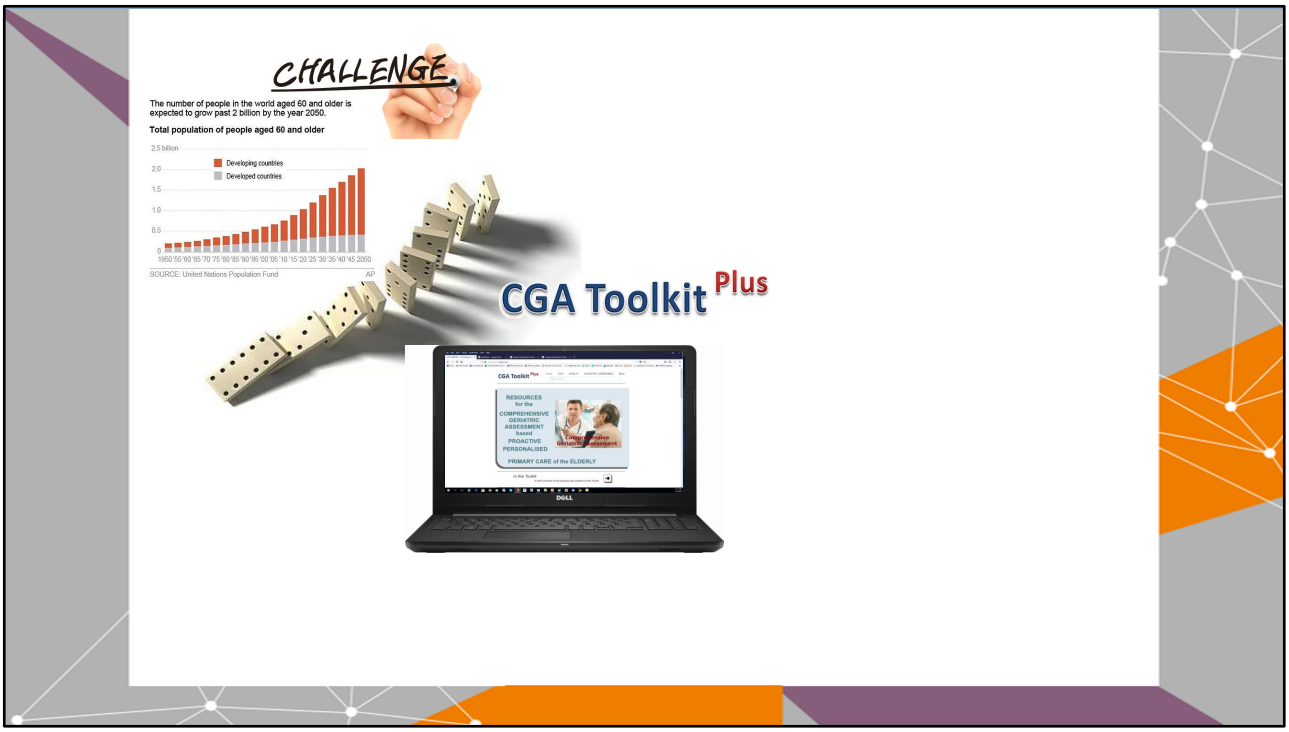
A common finding in the practices that have walked this route is that, given proper training, and clear protocols and accessible resources, the vast majority of nurses is extremely happy with their role in the practice's Frailty and Falls protocols.
Almost all report feeling that this adds an extra dimension of care and satisfaction to their work and are keen to expand their skill set further by becoming proficient in the administration of more of the diagnostic processes and tools, and in the attendant patient educational processes.



What is especially gratifying for practices that have switched over to Problem Oriented Medical Record keeping for the elderly, are the comments received from several specialists who make a point of stating that they seldom if ever receive such detailed and focussed referral letters from GPs.

The referrals are automatically generated from the Problem Oriented Medical Records,
and once you start you will find yourself encouraged to develop even more customised record templates and your own protocols for other aspects of geriatric care such as the geriatric syndromes

In summary then :
The challenges of caring for the elderly
in modern day primary care , in various settings...
Can't escape the reality that soon elderly patients will outnumber children.



The challenges can be met by the judicious use of selected and validated tools and protocols.

Protocols that are suitable for GP led, surgery, nursing home and private home interventions.

I believe that a more and more GP led delivery of Primary Care services is inevitable, both in the UK and in the ROI... and it will all be spearheaded by the demand for geriatric care in the years to come.

The elderly outnumbering the children..... there is no way specialist Geriatric services can grow to the extent that they can meet that volume of Primary Care needed, no matter how large and efficient the number of supportive organisations such as AgeUK and NGOs.

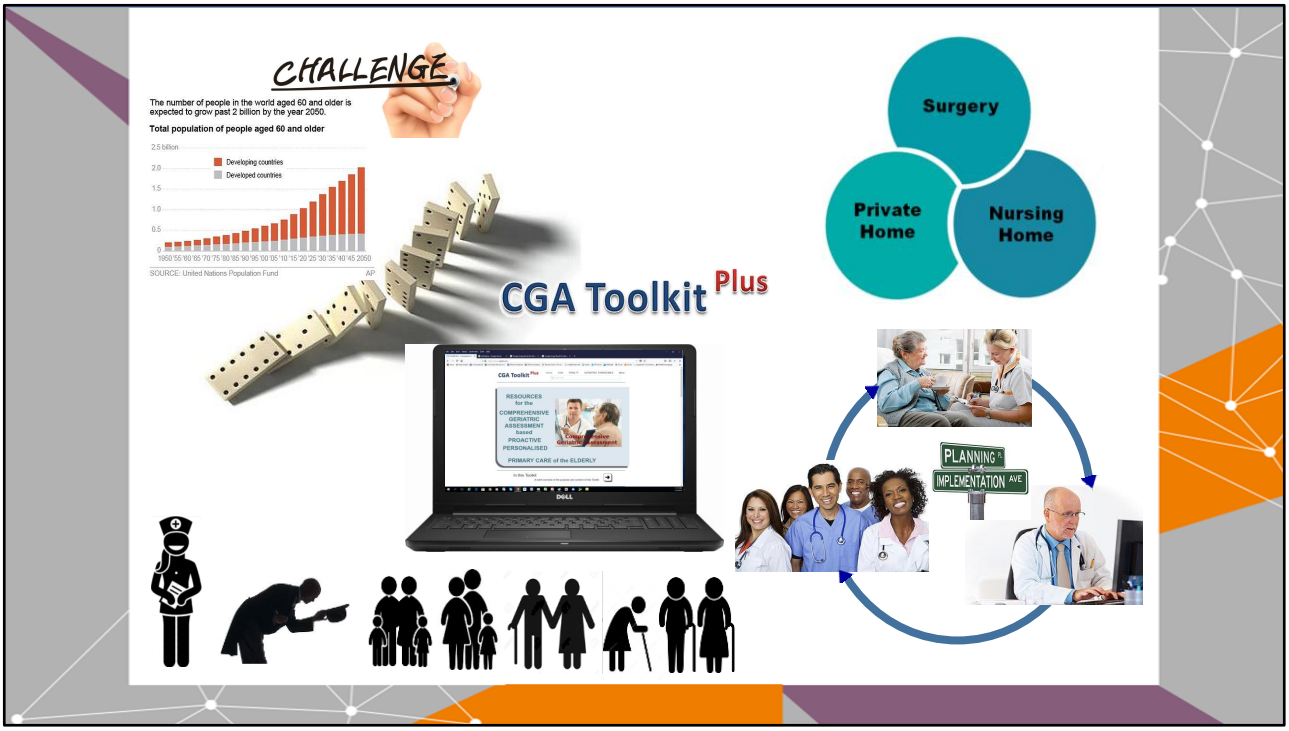
Looking at the Sustainability and Transformation Partnerships program plan for Primary Care for Manchester as an example, we see it acknowledges about 500 GP practices, 450 dental, 300 optometry and 700 pharmacy services, with 90% of the NHS patient contacts taking place therein.
It acknowledges 9 out of 10 GPs feel their heavy workload impacts negatively on the quality of care they deliver.
It acknowledges Primary Care practitioners have a critical role to play, and looks to expand the availability of Health Trainers, neighbourhood volunteer support workers, and district nurse and health visiting services, endorsing and promoting personalised, proactive care.
It acknowledges that successful delivery will need new, innovative, evidence-based contracting models and pricing mechanisms.

Specific funding for GPs engaged in the quality management of the elderly we have outlined here today is inevitable, but not yet a reality.
The STP for Manchester and the actual Integrated Care System delivery interestingly mentions Dementia Care, but not a word about Frailty... but that must come soon.

Now, you all sitting here today will be divided into two very distinct camps.
On the one hand there will be some of you who hate devising and working by protocols.
You handle what presents to you on a case by case basis and find the 10-15 minute consultation already far too short to engage in any meaningful preventive care, with too little time to extensively examine the patients, let alone engage in even the briefest of diagnostic tools such as the Frailty Phenotype and Frax and the likes.
You will see the details I presented of each of the minimum 4 nurse and 2 GP consults required for Frailty and Falls workup and management as totally unrealistic and proof that this is unattainable in GP practice in the UK today.
Hell, you probably switched off by consultation number 2.
And that's OK
All you need to do is diagnose Frailty, or come across falls, and refer to the nearest Geriatric service, and let the system take care of it.
Encourage the patient to contact the nearest AgeUK or local NGO, and you will have done the best you can for starters, and you will be there to support whatever management arises from that.

But some of you value protocols and a highly structured approach to the more chronic and complex conditions you treat, and are perennially engaged in developing and fine-tuning your practice team of GPs and nurses in a highly efficient integrated machine.
You will be thrilled to discover a centralised resource such as the toolkit, and will already have resolved to utilise more of your local external resources in a way that retains your GP lead, greatly reduces diagnostic and management delays, and keeps your patients at home and out of the ERs and wards.
If you can do it for the broad ranging Frailty and Falls, then you can do it for all the geriatric syndromes and the other less complex aspects in the CGA spectrum.

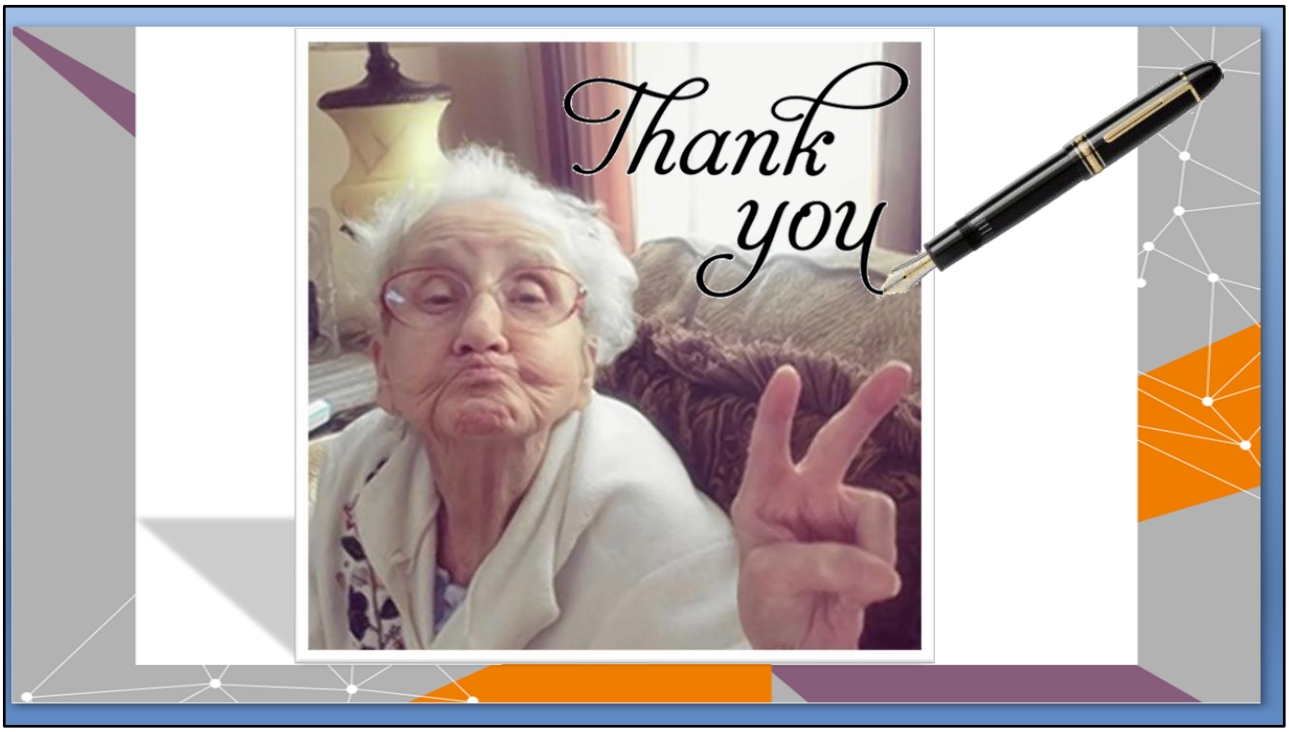
I hope most of you are left encouraged by the realisation that CGA based Proactive Personalised care of the elderly is very much possible in your own practice especially if you ensure appropriate allocation of the workload to in-house staff
and referrals for interdisciplinary assessment and treatment where possible
with protocols developed and tailored to your individual practice's own dynamics, resources and local supporting infrastructure



Your development of your own locally tailored protocols will yield
high quality care
satisfaction
and enhanced reputation in the community
all in a realistically time sensitive fashion,

As things currently stand, perhaps more indirectly, rather than directly profitable, but with a host of associated benefits for practice and patients.

For those GPs who decide to meet the challenge, a distinctly viable possibility.



Thank You