Frailty, Debility, Adult Failure to Thrive and Dementia: A Palliative Care Approach

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Objectives

- Begin to understand frailty as a syndrome
- Understand similarities and differences between, frailty, adult failure to thrive and debility
- Know appropriate use of palliative primary care approach and when to consult palliative medicine and consider hospice in frailty, adult failure to thrive, debility and dementia.
Dr. W. Hazzard frequently said that the determination of physiological age is a Geriatric Holy Grail

Satchel Paige once said: How old would you be if you did not know how old you were?

A working definition: a biologic syndrome of decreased reserve and resistance to stressors, resulting from cumulative decline across multiple physiologic systems and causing vulnerability to adverse outcomes, by Fried et al, J. Gerontology 2001
Frailty

- The Cardiovascular Health Study (CHS): Fried et al- Evidence for a Phenotype.
- Prospective, community-based observational study that done from 1989-1999.
- Subjects were 65 years recruited from Medicare eligibility list 1989-1990
- N = 5201 from 4 communities
Frailty

- CHS: Prospective Definition
  - Phenotype of Frailty syndrome “shrinking”
    - Unintentional weight loss >10 lb/y
    - Weakness grip strenth
    - Poor endurance exhaustion
    - Slowness walking 15 feet
    - Low activity
  - 3 or more = Frailty
  - 1-2 = Prefrailty
Baseline frailty was 6.3%
- At age 65-70 3.2%
- At age 85-89 25.9%
- 2 fold higher in women at all ages <90 y
- 2 fold higher in African Americans at each age
- Increase risk for falls
- Worsening mobility
- ADL performance
- Death
Frailty/Disability/Comorbidities

- Are there any differences?
- Similarities?
- Health care implications?
Comorbidities = the aggregation of clinical manifestations of diseases present in an individual
Frailty = the aggregate of subclinical losses of reserve across multiple physiologic systems
Per Fried et al, Untangling the concepts of disability, frailty, and comorbidity. J Gerontology 2004
They overlap but far from congruent
Disability and Frailty overlap is stronger since the functional impairment increase in both similarly
Comorbidities correlate with increase number.
What about Frailty and Failure to Thrive?

- They seem to represent a continuum of a clinical syndrome
- Failure to Thrive being the most extreme manifestation associated with a low rate of recovery and presages death.
When does Frailty become Failure to Thrive?

- The patient is no longer responsive to medical and non-medical interventions
- Unexplained severe, progressive weight loss, multiple geriatric syndromes (dementia, depression, delirium, drug reactions, anorexia, pan malnutrition, falls)
- Unable to undertake rehabilitation and follow medical recommendations
- Hypoalbuminemia/hypocholesterolemia/low creatinine are all markers of sarcopenia.
Bridge to Palliative Medicine

- No response to curative/restorative care
- Hardest to accept in patients without cancer or rapidly progressive diagnosis
- Collaboration with other specialist and supporters in assuring an optimal continuum in the transition to comfort care
General Debility
Definition

- Declining functional status with limited prognosis
- Condition may include multiple medical problems
- None of medical conditions necessarily terminal on its own
While no one knows how long anyone will live, there are certain signs that health is very poor and declining and time could be limited
Palliative Evaluation of Suffering in Debility

- **Physical**
  - Poorly controlled physical symptoms (e.g., pain, anorexia, asthenia)

- **Emotional**
  - Distress in the face of physical decline
Palliative Evaluation of Suffering in Debility

- **Social**
  - Distress from need for additional supportive services

- **Spiritual/Existential**
  - Existential angst
  - Feeling of hopelessness
Symptom Management
- Development of plan of care to palliate symptoms not relieved by disease-modifying treatment

Advance Directive Discussion
- Document surrogate decision maker(s)
- Educate and guide about treatment preferences
- Appropriate in any debilitating illness

Assess Eligibility for Hospice Referral

Truth-Telling to Patient/Family
Aids in symptom management
Allows time to access community resources
Fosters preparing and planning care
Helps avoid lurching from crisis to crisis
Can be difficult in individual case

“Would I be surprised if patient died in the next 6 months?”

yields a more accurate answer than

“Will this patient die in next 6 months?”

If you would not be surprised, assess palliative care needs
Because of the severity of your illness, you and your family are eligible for the assistance of hospice at home” is preferable to

“You have a prognosis of less than six months; therefore, I am referring you hospice”
It is not what you say but how you say it!

- http://www.youtube.com/watch?feature=player_detailpage&v=3Lazy26m1lo
Example of Life-Limiting Illness

- Combination of diagnoses in 84 year-old
  - Moderate to severe dementia
  - Progressive heart failure
  - Chronic renal disease

- Status despite medical management
  - Unintentional weight loss
  - Confined to bed

- Patient and/or family choose palliation
  - Relief of symptoms and suffering vs cure
Markers for Poor Prognosis in Debility

- Disease Progression
  - Of one or more of underlying diseases
  - Although none yet considered terminal

- Increased Dependence

- Need for Home Care Services
Markers for Poor Prognosis in Debility

- Multiple Emergency Room Visits
- Multiple Hospital Admissions

are signs that disease-modifying treatment is inadequate to

- Control symptoms
- Relieve suffering
- Prevent decline in function
Case and Question

- An 83-year-old man who lives in a skilled nursing facility is admitted through the emergency department for aspiration pneumonia. This is the third hospitalization for aspiration pneumonia in several months. You are called to provide consultation to assist in goals of care. He has advanced dementia and is able to sit upright while being fed but had been choking more frequently with feeding attempts prior to the admission. He has shown a progressive, slow functional decline and has lost approximately 10% of his body weight in the past 3 months. The patient’s daughter expresses concern that he is being starved through neglect at the skilled nursing facility and needs better nutrition.
Case and Question

- What would be the best intervention at this time?
  - Request bioethics consultation to discuss ethically permissible options.
  - Request chaplaincy consultation for anticipatory grief.
  - Request an esophagram.
  - Request gastroenterology consultation for placement of a gastrostomy tube.
  - Request speech-language pathology consultation.
Functional Decline Objective Measures

- Activities of Daily Living (ADL)
  Development of dependence in at least three ADL’s in the last six months
  - Bathing
  - Dressing
  - Feeding
  - Transfers
  - Continence
  - Ability to walk unaided to the bathroom
Functional Decline Objective Measures

- Karnofsky Performance Status
  - Karnofsky Score 50% or less with decline in score over last 6 months

- KS 70%
  - Cares for self
  - Unable to carry on normal activity or active work

- KS 50%
  - Requires considerable assistance
  - Requires frequent medical care
Functional Decline Objective Measures

- **Unintentional Weight Loss**
  - Greater than or equal to 10% of body weight
  - In the last 6 months

- **Albumin**
  - Less than 2.5 mg/dl
  - Always combine this measure with other evidence of decline
Palliative Care Consult
Indications

- Unrelieved Suffering
- Functional Decline
  - Any combination of measures of decline or markers for poor prognosis
- Consideration of Hospice Referral
Symptom Control
  • Assessment
  • Plan

Treatment Planning
  • Assist to define goals of care
  • Assist to develop plan that melds symptom management with disease-modifying treatment

Assist with Advance Care Planning

Determine eligibility for hospice care
Palliative Care in General Debility

Consult Often and Early
Dementia
Dementia Causes Suffering

- Physical
- Emotional
- Social
- Spiritual

Both the person afflicted with dementia and the person’s family will experience suffering in any or all of these domains.
Most patients and families living with dementia would benefit from the Palliative Care approach to the assessment and treatment of their suffering.

Suffering has multiple domains and is best addressed in an interdisciplinary process.
Dementia and Hospice Care

A select subset of all patients with dementia will qualify for services through the Medicare Hospice Benefit.
The Physician’s Role

- Evaluation and diagnosis of dementia
- Search for reversible causes (rare)
- Management of current medical problems
- Sensitive revelation of the diagnosis and prognosis
- Assist in defining Goals of Care
The Physician's Role
Medical Management

- Management of acute, often recurrent and infectious illnesses
  - Pneumonia
  - UTI

- Management of co-morbid illness
  - Treatment may be more difficult, especially in the advanced stages of dementia
The Physician’s Role
Late-Stage Dementia

• Evaluation of key markers of late-stage dementia
  • Inability to walk independently
  • Fewer than six intelligible words
  • Decline in oral intake and nutritional status
  • Frequent ER visits and hospital admission

• Management of late-stage dementia

• Transition to hospice care
Functional Assessment Staging

Stages

1. No difficulties
2. Subjective forgetfulness
3. Decreased job functioning and organizational capacity
4. Difficulty with complex tasks, instrumental ADLs
5. Requires supervision with ADLs
6. Impaired ADLs, with incontinence
7. A. Ability to speak limited to six words
   B. Ability to speak limited to single word
   C. Loss of ambulation
   D. Inability to sit
   E. Inability to smile
   F. Inability to hold head up
Pain

- Pain from complications of dementia is often under-treated due to difficulty with self-reporting

Infections

- Pneumonia
  - Aspirations and atelectasis
- UTI
  - Diapers and indwelling catheters
An 85-year-old man with advanced dementia is discharged back to his long-term care facility and nursing home from the acute hospital after being admitted for aspiration pneumonia. At baseline, he is bedbound and unable to feed himself, with only a few words of intelligible speech. He has lost 20 pounds over the past 6 months, despite hand-feeding at his nursing facility. He has also had multiple infections in the past 6 months, three of which have precipitated similar hospitalizations. He no longer recognizes his daughter, who is his only remaining family member and healthcare proxy. His daughter feels that her father suffers with each hospital admission, and she does not want him to be rehospitalized in the case of future infections or other medical issues. The admitting hospital team and social worker have suggested that the daughter admit her father to hospice in the nursing home, upon discharge from the acute hospital setting.
Which of the following is the most accurate with regard to hospice care in the nursing home setting?

- Hospice agencies receive reduced payments from Medicare for long-term care or nursing home residents, compared with home hospice patients.
- Dementia patients are not eligible for hospice services in the nursing home setting because dementia is not a terminal diagnosis.
- Nursing home residents receiving hospice services must have do-not-resuscitate orders.
- Hospice and non-hospice residents experience improved pain and other symptom management in nursing homes with a hospice presence.
- Nursing home residents on hospice have a shortened life expectancy compared with nonhospice residents with the same diseases.
Dementia

Physical Suffering

Pressure Ulcers

- Incontinence
- Immobility
- Restraints
- Poor hygiene
- Decreasing nutritional status
Dementia
Physical Suffering

Asthenia

- Falls
- Bed or chair confinement
- Medical interventions and iatrogenic injury
  - Nasogastric tubes and PEG tubes
  - Foley catheters
  - IV’s
  - Restraints to protect other interventions or to prevent attempts to get up
Dementia
Emotional Suffering

**Depression**
- May benefit from treatment with SSRI

**Cognitive Loss**
- May benefit from treatment with medications like Aricept in early-to-moderate stages
- May cause unacceptable side effects without benefit
Delirium

- Wandering and sun-downing
- Often worsened by even a minor illness
- Disturbance of sleep-wake cycle disrupts home
- Usually less intense in familiar environments
Dementia Caregiver Suffering

- Depression
  - Referral for treatment
- Fatigue
  - Respite
- Anger
  - Support groups
- Guilt
  - Spiritual counsel/ support groups
Dementia Social Suffering

- Loss of independence
- Family struggles with role reversal
- Declining health or death of spouse complicates care
- Loss of financial resources
- Need to change location of care
Dementia
Social Suffering

Need to Change Location of Care

Home  →  Assisted Living Facility

Hospice Care  ↑

→

Nursing Home  ↓
Guilt
Anger
Inability to maintain relationship with faith community
Feelings of abandonment
Patient can help make decisions

- Surrogates for decision-making
- Preferred locations of care
- Feeding tubes
- Resuscitation and other aggressive interventions
Family and caregivers discuss decisions

- Transitions to other venues of care
- Response to complications and progression of illness
- Feeding tubes
- Resuscitation attempts
Prognosis and Care Needs

Prediction by Fast Scoring

- Development of incontinence
  - Usually will require transfer from ALF to nursing home

- FAST Score of later stages of 6 or 7
  - May predict a less than six-month survival
  - Qualifies patient for referral to hospice
A 79-year-old woman with a known history of Alzheimer’s-type dementia is a resident of a nursing home. As a physician at the local inpatient hospice, you are asked to evaluate her for eligibility for hospice care. She has not been ill or required hospitalization recently. You find her to be a pleasant woman who spends most of her time in bed or in a chair. She cannot ambulate without staff assistance. She speaks rarely and in 3- to 4-word sentences. She expresses very little emotion but seems to like to pick out her own clothes every day (often unmatched). She shows little if any indication that she experiences discomfort or pain even when receiving injections or having blood drawn.
Case and Question

- Which of these findings would support her eligibility for hospice care?
  - Inability to ambulate independently
  - Inability to experience pain
  - Mismatching of clothes
  - Vocalization in short sentences
Key Indicators for Limited Prognosis

- Loss of ability to ambulate independently
- Fewer than six intelligible words
- Declining oral intake
Prognosis and Care Needs

Key Indicators for Limited Prognosis

- Markers of advanced dementia predict
  - Frequent ER visits
  - Frequent hospital admissions
Prognosis and Care Needs

Key Indicators for Limited Prognosis

- Markers should prompt...
  - Discussion with surrogates of limited prognosis
  - Review or development of Advance Care Plan
  - Consideration of hospice referral
Frailty, Failure to Thrive, debility and dementia are all complex and create significant decline important to recognize by all physicians in order to include palliative medicine early on in the progression disease.

Interdisciplinary approach is essential in providing the best care for all these global signs of decline.

Although the goals of palliative care in the elderly are the same as those in younger individuals, older persons often live with and die from chronic illnesses that are preceded by long periods of physical decline and functional impairment.
Case and Questions

- A 78-year-old woman with chronic obstructive pulmonary disease (COPD), heart failure, diabetes, and mild cognitive impairment has been discharged to a skilled nursing facility to receive subacute rehabilitation after an acute hospitalization for heart failure exacerbation. She previously lived alone, with relatives and neighbors checking on her daily; they managed most of her instrumental activities of daily living (eg, shopping, housekeeping, preparing meals, setting up medications, managing finances). Prior to this acute hospital admission, she had become increasingly unable to care for herself; she had self-reported exhaustion, low physical activity, and difficulty bathing. She is currently unable to ambulate short distances safely, and the physical therapist predicts that she will need long-term care if she does not have significant improvements with subacute rehabilitation. The patient is thin and has unintentionally lost about 15 pounds in the past year; extremely slow gait speed is noted on assessment.
What can you predict about this patient, given what is currently known about frailty?

- She would benefit from cancer screening to prevent further morbidity.
- She has significantly increased risk of death in the next 2 years.
- She will not be able to live in her home in the future, even with increased assistance.
- She will not survive an ICU stay if she is rehospitalized for COPD or heart failure exacerbations.
- She is at decreased risk for falls, disability, and long-term nursing home stay.
Case and Question

A 95-year-old woman who has had Alzheimer’s disease for the past 10 years experienced the onset of cough, agitation, and fever 10 days ago. Aspiration pneumonia was successfully treated with antibiotics. She is bedbound in a nursing home and requires assistance with all activities of daily living. Because she has lost more than 10% of her weight during the past 6 months, the family asks about placing a gastrostomy tube for feeding.
Case and Question

Which of the following is the most accurate statement regarding this patient’s life expectancy?

- The patient’s life expectancy is longer than 6 months.
- The patient’s life expectancy is not correlated with recurrent fevers.
- The patient’s life expectancy will not change regardless of treatment intensity.
- The patient’s life expectancy will double with placement of a feeding tube.
- The patient’s life expectancy will increase with use of antibiotics.
Case and Question

- An 82-year-old woman with advanced multi-infarct dementia is referred by her PCP to home hospice. She has been confined to bed for the past six months and can only say "help" and "no." Her family desires to care for her at home and accepts that her death is near. They spend more than four hours each day hand-feeding her, and have told their priest that they will ask that a feeding tube be placed, should she become unable to eat.
Case and Question

Which of the following is the most appropriate next step?

- Ask the family to complete a detailed advance directive form before certification
- Certify the patient for home hospice benefits on the basis of dementia and initiate discussion about goals of care.
- Decline to certify the patient for home hospice because the prognosis is greater than 6 months if a feeding tube is placed.
- Suggest a meeting with the physician, pastor, and family to discuss tube feedings and advanced dementia before certifying for hospice.
References

References

- Goldstein NE, Morrison RS. Treatment of pain in older patients. Crit Review Oncology and Hematology 2005; 54:157
Questions?

- Thank you for your attention!