



Frailty and Special Populations

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for Frailty and Special Populations. The CPG discusses predictors and identifiers of those at risk for frailty and sources for evaluation behavioral health implications. Objectives and measurable health outcomes with respect to Care Management are included. In addition, the CPG outlines the organizations that WellCare aligns with regarding Frailty.

OVERVIEW

Frailty indicators are important for care management not only among older adults, but also for many types of chronically ill persons, even at younger ages. It also exists on a spectrum with the end stage of the continuum of frailty is failure to thrive. Frailty is often associated with advancing age, as well as an indicator in advanced chronic diseases (e.g., chronic kidney disease, heart failure, cancer, acquired immunodeficiency syndrome [AIDS]). Some have proposed that frailty be considered as either a primary condition, related to aging alone, or as secondary to other conditions. Indicators for frailty should be monitored for care management among older adults as well as those who are chronically ill. When considering a diagnosis of frailty, an important element to include is a differential diagnosis list and to rule out underlying medical or psychological issues that may be driving signs and symptoms of frailty. This may include depression, malignancy, diseases, and nutritional deficits.¹

An operational definition of frailty is important for clinical care, research, and policy planning. Despite significant work over the past decade, a clear consensus definition of frailty does not emerge from the literature. The definition and outcomes that best suit the unique needs of the researchers, clinicians, or policy-makers conducting the screening determine the choice of a screening tool for frailty. Components that commonly identify frailty, and death, disability and institutionalization include: physical function, gait speed, inclusion criteria, and cognition. Areas for further research include whether disability should be considered a component or an outcome of frailty and the role of cognitive and mood elements in the frailty construct.²

Goal-setting with patients and their families is crucial in providing care for the frail individual, establishing individual priorities, weighing risks and benefits of interventions, and making decisions regarding aggressiveness of care. As the older adult progresses along the frailty spectrum and develops more severe disease and/or disability, it becomes increasingly important to tailor medical care to the needs of these vulnerable patients while keeping the individual's values and goals in mind.³

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the International Association of Gerontology and Geriatrics (IAGG) and the Global Aging Research Network (GARN). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to Frailty and Special Populations, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);

- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval. WellCare aligns with the IAGG and GARN on the topic of Frailty. Below are highlights from their publications.

**INTERNATIONAL ASSOCIATION OF GERONTOLOGY AND GERIATRICS (IAGG)
GLOBAL AGING RESEARCH NETWORK (GARN)**

The International Association of Gerontology and Geriatrics (IAGG) and the Global Aging Research Network (GARN) published the *White Book on Frailty*. As research has found, early detection and intervention is critical to addressing frailty. The book promotes preventive interventions against disability and to provide information on how to adequately implement frailty into everyday clinical practice. In addition, the book highlights current knowledge on the identification of target population, the assessment of frail old adult, and the development of tailored intervention programs. The full report is available [here](#).⁴

Evidence Based Practice

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The Agency for Healthcare Research and Quality (AHRQ) has not published reports on this topic.

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare’s Clinical Policy Guiding Document titled *Measures of Compliance*.

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

Care Management

Predictors of High Risk Members. “Frailty” is a broad definition to describe a range of conditions in older people (e.g., general debility and cognitive impairment). Providers should consider biomedical factors that influence physiological state that can reduce the capacity to withstand environmental stresses. Examples of biomedical factors:⁵

- *Clinical* – weakness, weight loss (unintentional), viral infection, obesity, comorbidity, cognitive impairment, fatigue, anemia, inflammation
- *Pathophysiological* – insulin resistance, increased blood-clotting activity, sarcopenia, decreased VO2max, lowered testosterone

Those at risk of becoming frail are vulnerable – they are prone to dependency and their life expectancy is reduced. Such health outcomes lead to more demand for medical and social care; these lead to increased costs. As the population ages, the healthcare burden will rise. Adverse health outcomes include incident falls, worsening mobility, worsening ADL disability, first hospitalization, and death. Health conditions that can lead to increased frailty and potential treatments are noted below:⁵

Falls / Fractures

Vitamin D
Calcium
Exercise

Depression

Exercise
Social interaction
Counseling/Psychotherapy
Antidepressants

Poor Nutrition

Dietary regulation

Lowered Testosterone

Replacement therapy

Cognitive Impairment

Cholinesterase inhibitors
Exercise

Hypothyroidism

L-thyroxine

Arthritis

NSAIDs
Steroids

Type 2 Diabetes

Thiazolidinedione
Anti-glycaemics

Blood-Clotting Activity

Aspirin

Inflammation/Muscle Strength

Exercise
Statins/ACE inhibitors
Thiazolidinedione

CHD

Antihypertensives
Aspirin
Statins

Anemia

Haematinic replacement therapy
Recombinant human erythropoietin

Evaluation. The majority of frailty status screening tools have been developed based on one of two concepts:¹

1. **Physical / Phenotypic Frailty** conceptualizes frailty as a syndrome of weakness, slowness, and weight loss that is driven by altered stress response systems and age-related molecular changes. Diagnosis involves meeting three or more of the following criteria:
 - Weight loss (≥5 percent of body weight in last year)
 - Exhaustion (positive response to questions regarding effort required for activity)
 - Weakness (decreased grip strength)
 - Slow walking speed (gait speed) (>6 to 7 seconds to walk 15 feet)
 - Decreased physical activity (Kcals spent per week: males expending <383 Kcals and females <270 Kcal)

NOTE: Pre-frailty is defined as one or two of these characteristics, and not frail as having none.

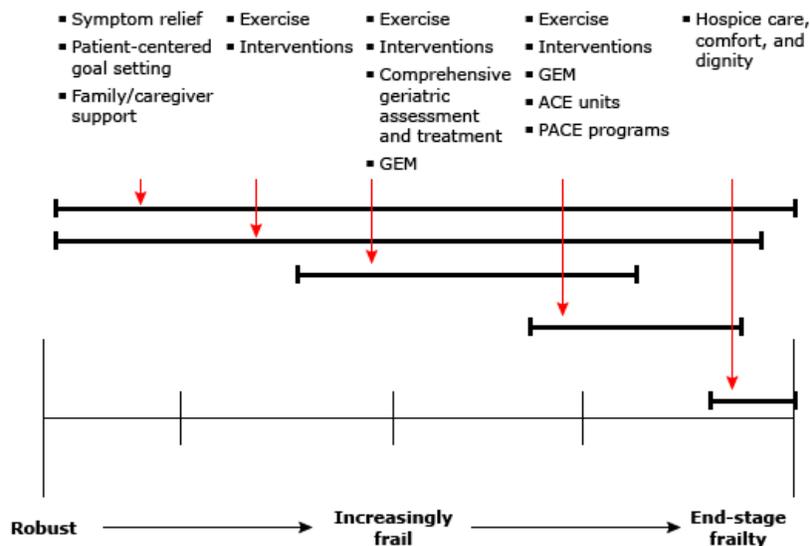
2. **Deficit Accumulation / Index Frailty** conceptualizes frailty as a cumulative burden of: physical and psychological illness, disability, and social factors. This approach combines tallies of: medical, physiologic, cognitive, and social factors.

This concept measures frailty based on the accumulation of illnesses, functional and cognitive declines, and social situations that are added together to calculate frailty. It requires answering 20 or more medical and functional-related questions – the more number of deficits, the higher the frailty score. The tool can be adapted to information available in the medical record and does not require a patient interview or exam to assess frailty.

Clinicians and patients may benefit from using a quicker frailty screening assessment tool. The FRAIL scale takes only minutes to perform and can be incorporated into the history-taking portion of an assessment.

- Fatigue – "Are you fatigued?"
- Resistance – "Can you climb one flight of stairs?"
- Ambulation – "Can you walk one block?"
- Illnesses – greater than five
- Loss of weight – greater than 5%

Interventions. Potential interventions along the spectrum of frailty in older adults are noted below:⁶



MEASURABLE HEALTH OUTCOMES

Targeted Health Outcomes (Extended Program Goals) result from successful member self-management (see Case Management Objectives).

1. Member experiences a reduction in falls with adherence to medication regimen, DME and therapies at 6-12 months post engagement. In absence of documentation, Provider and/or Member narrative/HRA data may be used.
2. Member experiences an increase in ability to complete ADLs at 6-12 months post engagement.
3. Adherence to medication regimen, when appropriate, as evidenced by pharmacy claims pre and post

- engagement at 6-12 months. In absence of documentation, Provider and/Member narrative/HRA data may be used.
4. Member maintains weight, hydration and nutrition 6 months post-engagement. In absence of documentation, Provider and/or Member narrative/HRA data may be used.

CASE MANAGEMENT GOALS

Case Goals should target specific care gaps and/or adherence issues, and measure the member's progress towards self-management and adherence which will lead to the targeted health outcomes above. Examples:

- Member will obtain and attend PCP and other specialist appointments as scheduled by provider within 60 days
- Member will be adherent to medication regimen as evidenced by pharmacy claims over last 30 days
- Member will be able to increase functional activity levels by 5 minutes each week over the next 30 days
- Member will be able to complete specific ADLs with the assistance of caregiver and/or DME within 60 days
- Specific for Members requiring hospitalization: The Member participates in provider follow-up visit within 7 days of hospital discharge

CASE MANAGEMENT OBJECTIVES

Case Management Objectives should focus on improving the Member's self-management skills up to and including:

- Addressing barriers to medication adherence
- Assisting with scheduling provider appointments or obtaining specialist referrals
- Providing education on therapies to increase functional status
- Providing education on fall risk and prevention
- Providing education on importance of maintaining nutrition and hydration
- Providing education on disease process
- Assisting with coordination of needed DME
- Assist with coordination of vision and hearing assistive devices as per benefit plan and/or available community resources
- Conduct screening for anxiety/depression as appropriate
- Educate member on age/gender/condition specific Preventive Health Care screenings and immunizations
- Assist member with transportation and making appointments for screenings and immunizations as needed
- Assist member with addressing barriers to receiving Preventive Care screenings and immunizations

Provide education on importance of reporting new or worsening symptoms to PCP/Specialist

- Care manager will send educational material on fall prevention.
- Care manager will encourage member to discuss fall risks / concerns and falls prevention with doctor.
- Care manager will educate member on ways to prevent injury such as:
 - Removing throw rugs
 - Using night lights
 - Using non-slip carpet
 - Wearing non-slip shoes both inside and outside the house
 - Using assistive devices (i.e. grab bars, hand rails, shower chairs, cane, walker)
 - Non-slip mats in the bathtub and on shower floors
 - Removing clutter from floor
 - Improve the lighting in your home
 - Don't change positions too quickly. From lying, sit for a while before you stand
 - Keep items you use often in cabinets you can reach easily without using a step stool
- Recognize members that are appropriate for Palliative Care, including triggers for Palliative Care. Educate the member and their family/designated representative on the benefits of Palliative Care: symptom management; psychosocial support when/if appropriate.

MEDICAL AND BEHAVIORAL HEALTH INTEGRATION

Many older adults lose their ability to live self-reliantly due to decreased mobility or chronic pain and are more likely to experience grief or a loss of socioeconomic status. These factors can result in loss of freedom, isolation and emotional suffering. Older adults are also susceptible to elder abuse which can not only lead to physical injuries, but to continuing psychological distress such as depression and anxiety. Older adults with depressive symptoms have poorer functioning

compared to those with chronic medical conditions. Depression also increases the perception that health is poor, and can increase medical services and health care costs. Mental Health and Substance abuse diagnoses are often under-diagnosed in the elderly population, and they also come with additional concerns regarding medications.⁷ Certain behavioral health medications such as benzodiazepines, neuroleptics and antidepressants increase the risk of falls among the elderly, and antipsychotics increase the risk of stroke by more than three times in members with dementia.⁸ It is important to ensure medications are being reviewed by Providers and pharmacists with these special populations.

MEMBER EDUCATIONAL RESOURCES

WellCare contracts with Krames/StayWell for Member educational materials utilized by Case Managers. Items are available to review with Members to address knowledge gaps. Case Managers verbally educate Members on the topics below related to asthma. (Titles may also be sent to the member).

NOTE: Links are internal for WellCare Care Management staff. Please see below for public links.

- [Preventing Falls making Changes in Your living Space](#)
- [Preventing Falls Moving Safely Out of a Chair and Bed](#)
- [Preventing Falls Moving Safely Using a Cane or Walker](#)
- Exercises to Prevent Falls
- Preventing Falls Make Your Health a Priority

Providers may wish to research the titles above related to asthma that Case Managers utilize with Members.

Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs: *Cancer: HS-1034; Fall Risk Assessment: HS-1033; Neurodegenerative Disease: HS-1032; Older Adult Preventive Health: HS-1063; Pain Management: HS-1064; Palliative Care: HS-1043; Pneumonia: HS-1062; and Traumatic Brain Injury (TBI): HS-1066.*

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

References

1. Walston JD. Frailty. https://www.uptodate.com/contents/frailty?source=search_result&search=frailty&selectedTitle=1-95. Published October 2017. Accessed November 6, 2017 (subscription).
2. Sternberg SA, Wershof Schwartz A, Karunanathan S, Bergman H, Mark Clarfield A. The identification of frailty: a systematic literature review. *J Am Geriatr Soc.* 2011 Nov;59(11):2129-38. doi: 10.1111/j.1532-5415.2011.03597.x. Epub 2011 Sep 21. <https://www.ncbi.nlm.nih.gov/pubmed?term=22091630>. Accessed November 6, 2017 (subscription).
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6. Potential interventions along the spectrum of frailty in older adults. <http://ultra-medica.net/Uptodate21.6/contents/UTD.htm?28/34/29230>. Published 2017. Accessed November 6, 2017 (subscription). Modified with permission from: Walston JD, Fried LP. Frailty and its Implications for Care. Chapter 9. In: *Geriatric Palliative Care*, Morrison RS, Meire DE. Oxford University Press, New York 2003. p.93. Copyright ©2003 Oxford University Press.
7. Mental Health and Older Adults. Fact Sheet. World Health Organization. April 2016. <http://www.who.int/mediacentre/factsheets/fs381/en/> Accessed November 14, 2017.
8. Davies, E A, and M S O'Mahony. "Adverse Drug Reactions in Special Populations – the Elderly." *British Journal of Clinical Pharmacology* 80.4 (2015): 796–807. *PMC.* Web. 14 Nov. 2017.

Disclaimer

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Easy Choice Health Plan – Harmony Health Plan of Illinois – Missouri Care – Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona – Staywell of Florida
WellCare (Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas) – WellCare Prescription Insurance

Medical Policy Committee Approval History

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