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Frailty First- Screening & Management in the Emergency Department

Strategies to Avoid Unnecessary/Prolonged Hospital Admissions and ALC rates

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Older Adults & ED Use

- Older adults comprise **20-40%** of total ED presentations[1]
  - High proportion for falls and chronic conditions.
- Frailty is common among ED cohorts
  - with prevalence as high a **62%**.[2]
- Population-level data reveals that these trends will likely continue, with a rising number older adults living with frailty, and requiring complex care.

[1]Canadian Association of Emergency Physicians (2022)
[2]Eagles et. Al (2020)

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Why It Matters?

- Older adults living with frailty experience higher rates of adverse outcomes including functional decline, extended hospital stays, in-hospital mortality, and ALC designation.[1,2]

- ALC reduction continues to be a Provincial and thereby a priority for OHTs
  - Ontario Health Home First Directive (2024) including recommendations from the ALC Leading Practices Guide (2021).

- Extensive evidence suggests that proactive frailty screening & management in hospital Emergency Departments is essential to identify the most vulnerable patients and implement interventions to avoid unnecessary/prolonged stays.[1,2]

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[1]Erhag et. al (2024)
[2]PGLO (2023)

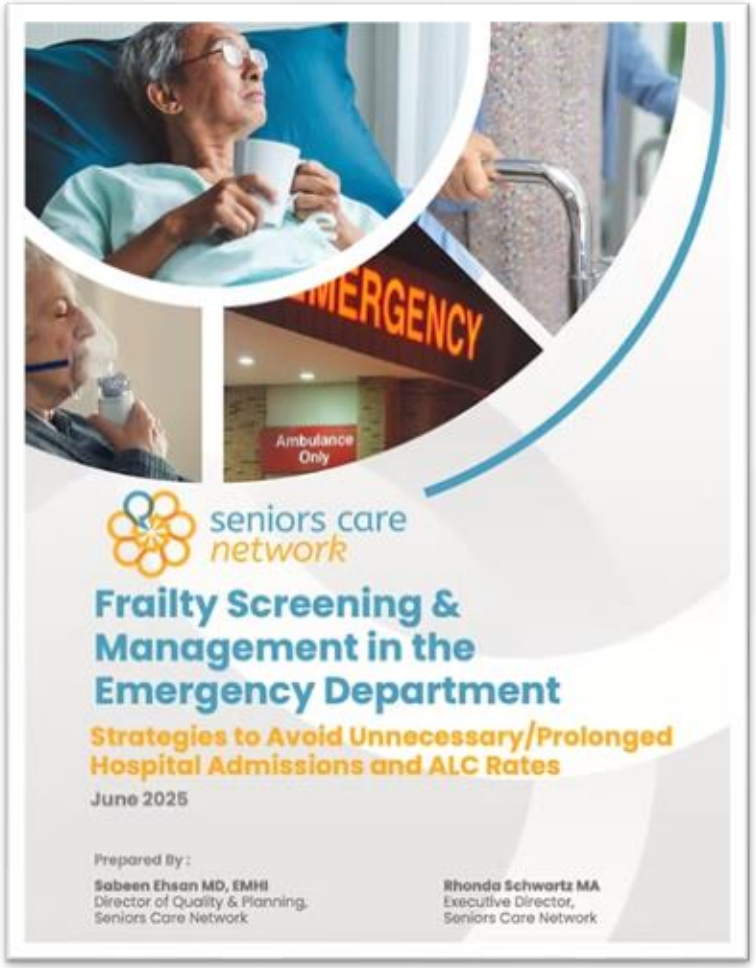
Poll

In your experience, what is the biggest challenge older adults face when accessing emergency care?

1. Long wait times
2. Fragmented transitions between care settings
3. Lack of geriatric expertise
4. Communication barriers
5. Limited community supports after discharge

Frailty Screening & Management in ED

- Addition to and complements SCN sector-specific Frailty Pathways.
- Outlines an evidence-based 4-step approach.
- Including how '**Frailty Status**' can be used as a criterion to inform care, flow and transition decisions (i.e., from the ED to back in the community and/or acute care).



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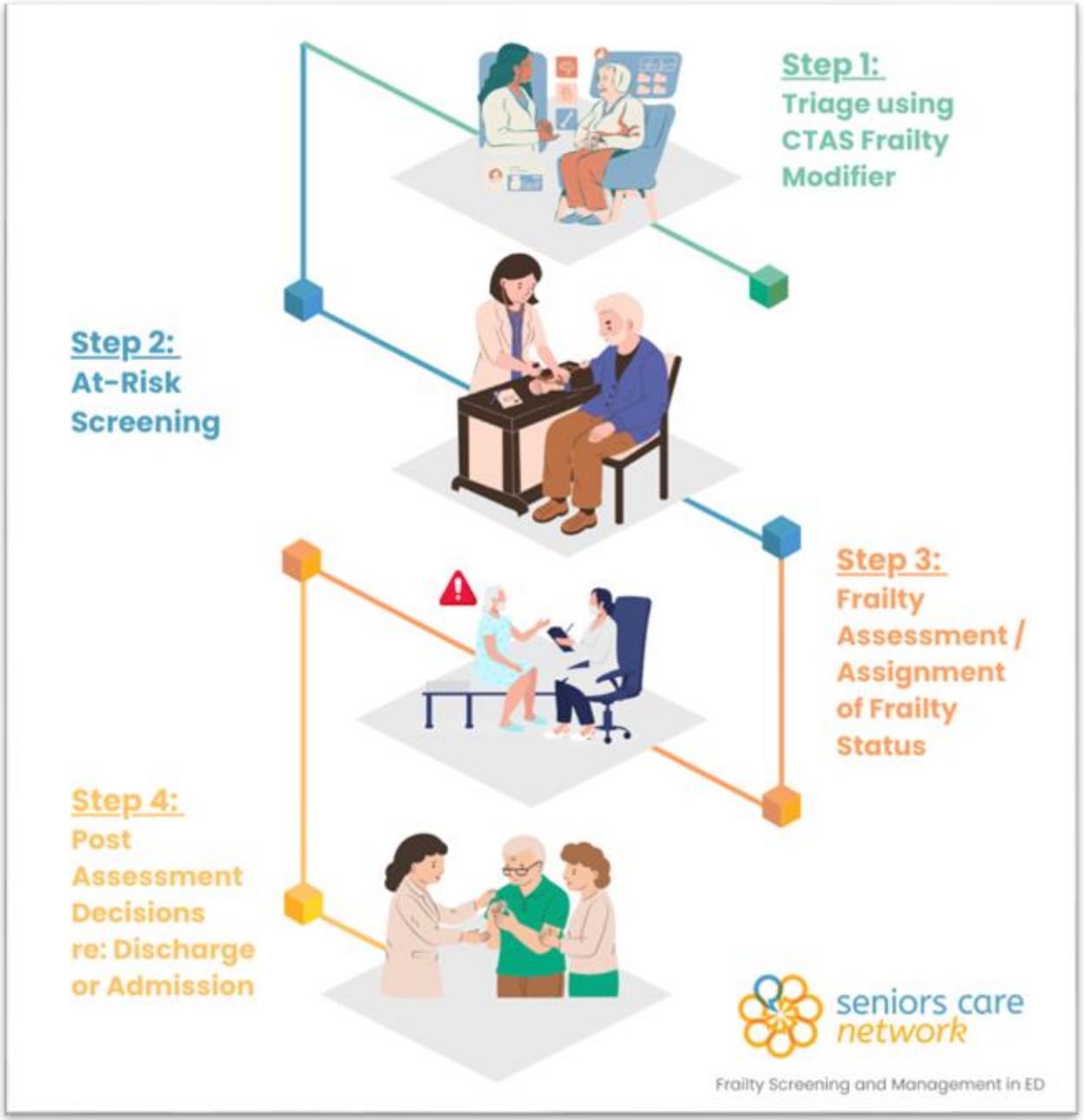
Visit the Frailty Page on our website to access resources

The 4-Step approach



Step 1- Triage using CTAS Frailty modifier to reduce initial assessment wait-times

- A level 3 first-order modifier designed to help identify frail older adults (65 +) presenting to the ED with apparent **non-urgent symptoms** who would otherwise have been assigned a CTAS level of 4 or 5.
  - In CTAS, the lower the number, the higher the urgency; and ideally, the shorter the expected wait time.
- Criteria:
  - completely dependent for personal care
  - wheelchair-bound
  - suffers from cognitive impairment that limits their awareness of their surroundings or ability to appreciate time
  - is in the late course of a terminal illness
  - shows signs of cachexia and general weakness
  - over **80** years of age unless obviously physically and mentally robust.

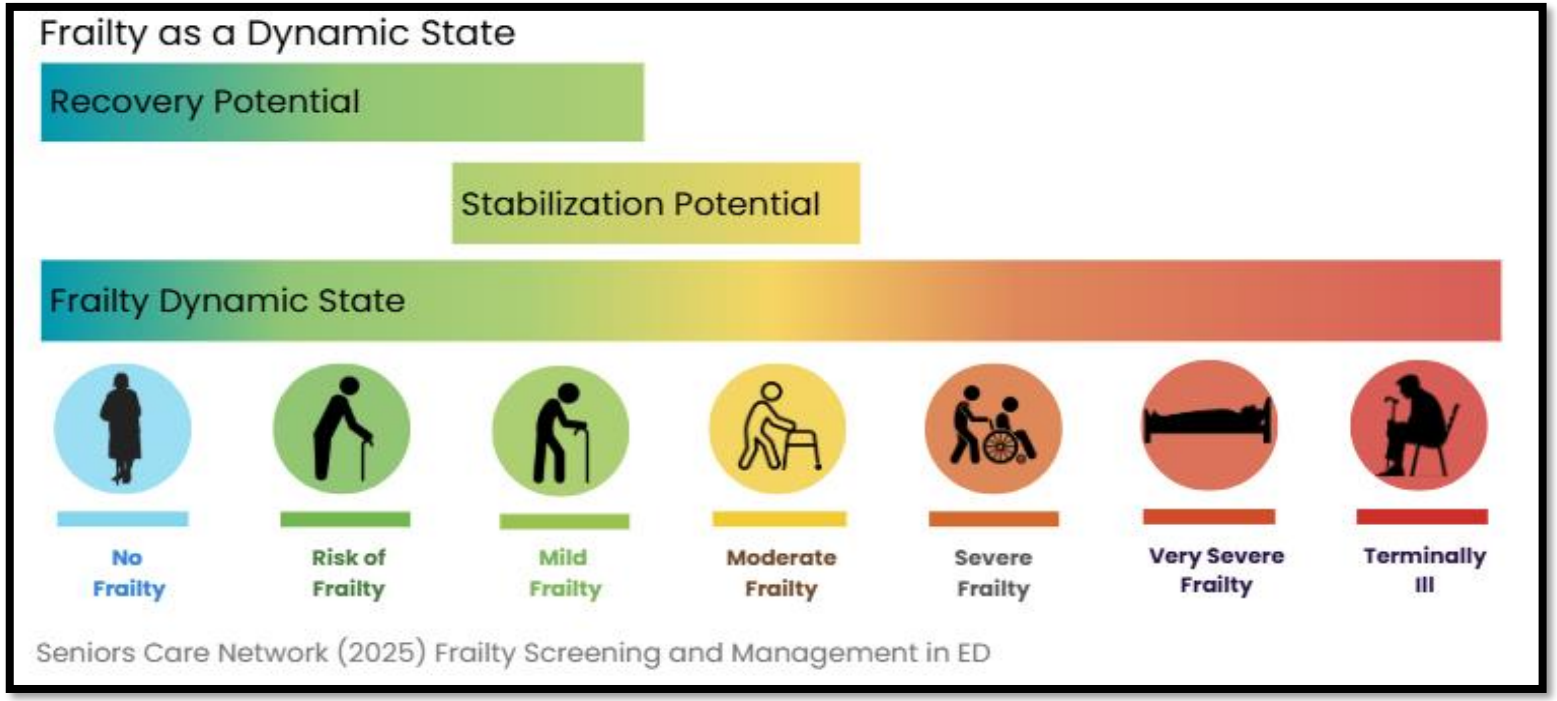
Step 2- Identify risk of adverse outcomes and need for geriatric assessment

- For older adults assigned CTAS levels 3, 4, or 5 implement 'at risk screening' to:
  1. Identify risk of adverse outcomes such as, functional decline, delirium, deterioration, death, high use of community services, etc. **AND**
  2. Prioritize assessment by clinician(s) with geriatric expertise (+screens)
     - Can be completed either by the triage clinician or the Most Responsible Nurse using Identification of Seniors at Risk (ISAR) 2.0, Triage Risk Screening Tool (TRST), Inter RAI-ED
- Recommendation was also made in the OH Home First Directive
- Older adults assigned CTAS levels 1 and 2 are inherently at high risk of adverse outcomes due to acuity/severity and need stabilization.

Step 3- Frailty Assessment to determine root-cause and restorative/stabilization potential

Individuals identified as high-risk in step 2 to be further assessed by clinicians/teams with geriatric expertise i.e., GEM nurses, Assess & Restore teams, Geriatric Activation Teams (OT/PT/SW), etc.

1. conduct a targeted geriatric assessment across 4 frailty domains (physical, cognitive, mental, social)
2. assign a frailty status based on the patient's baseline using a holistic tool that allows broader frailty stratification.

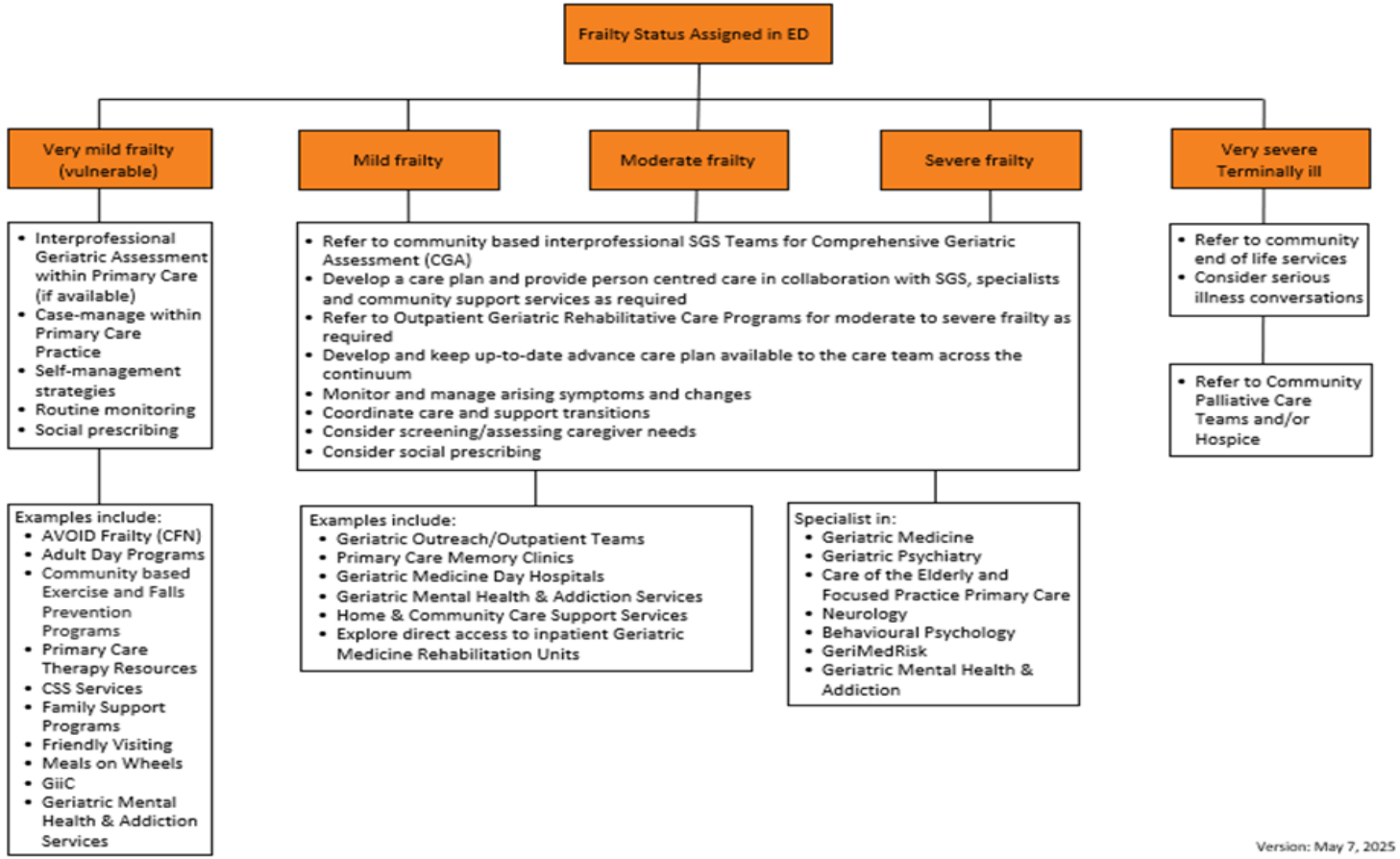


Step 3- Frailty Assessment to determine root-cause and restorative/stabilization potential

- Results of the targeted assessment and frailty status to be communicated to the MRP (MD/NP) and should be among factors guiding discharge and admission decisions.
- If clinicians or teams with geriatric expertise are unavailable, whether due to limited coverage hours or a lack of geriatric specialists in the ED, build capacity in ED clinicians regarding concepts of frailty and frailty screening.

Step 4- Post Assessment Decisions- Discharge

In addition to addressing the acute needs, follow the post ED frailty pathway (decision-tree) to develop a comprehensive discharge plan for **tailored interventions** based on frailty status



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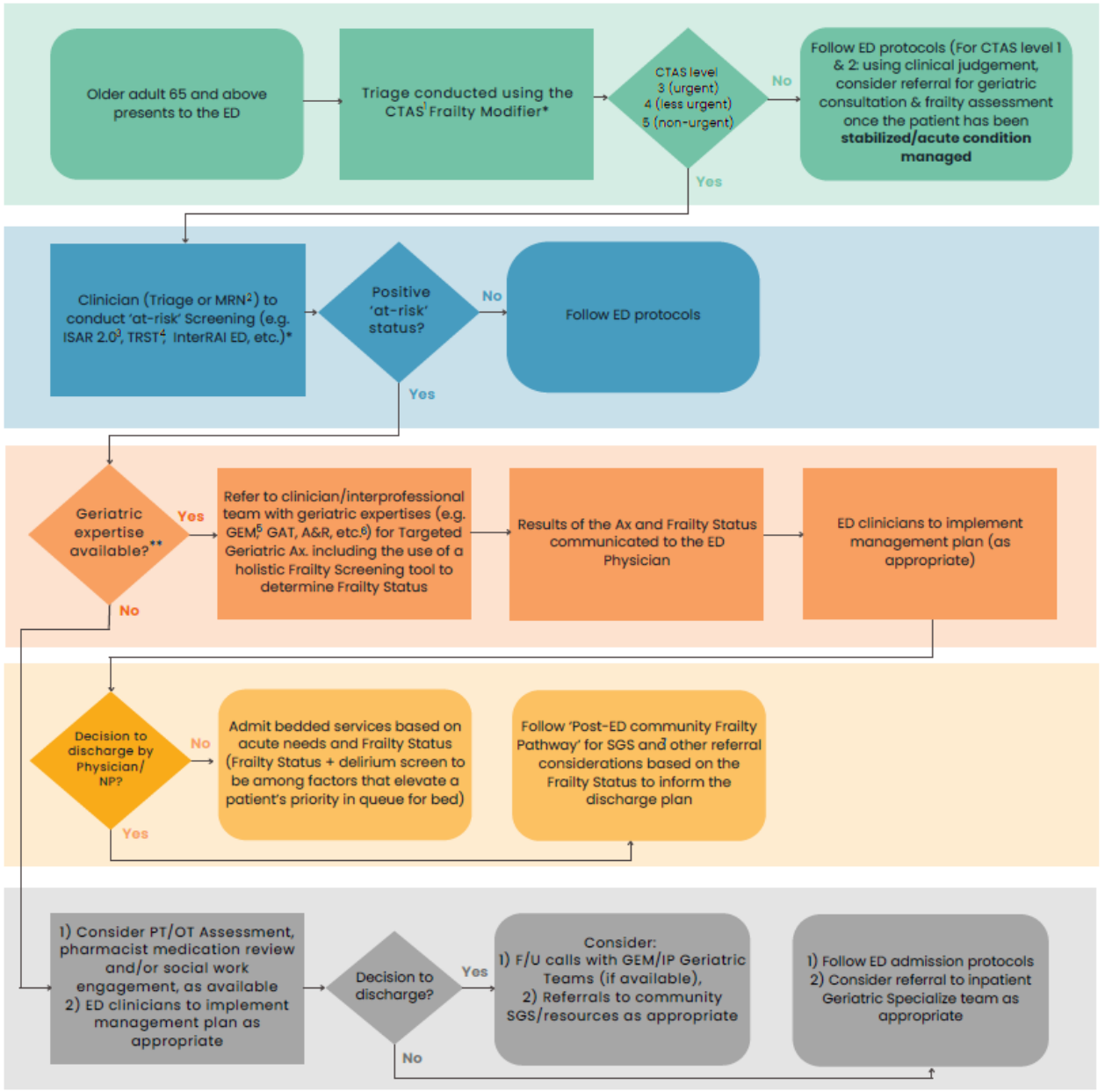
Upstream **Downstream**

Step 4- Post Assessment Decisions- Admission

- ED protocols to be followed while considering frailty status
- **Frailty status should be among the criteria that elevate a patient's priority in queue for a bed and should be communicated during transfer of care**
- Continue monitoring for adverse outcomes such as functional decline, delirium, etc. and reassess frailty status as appropriate during hospital stay.

ED Frailty Pathway - Recommended Best Practices



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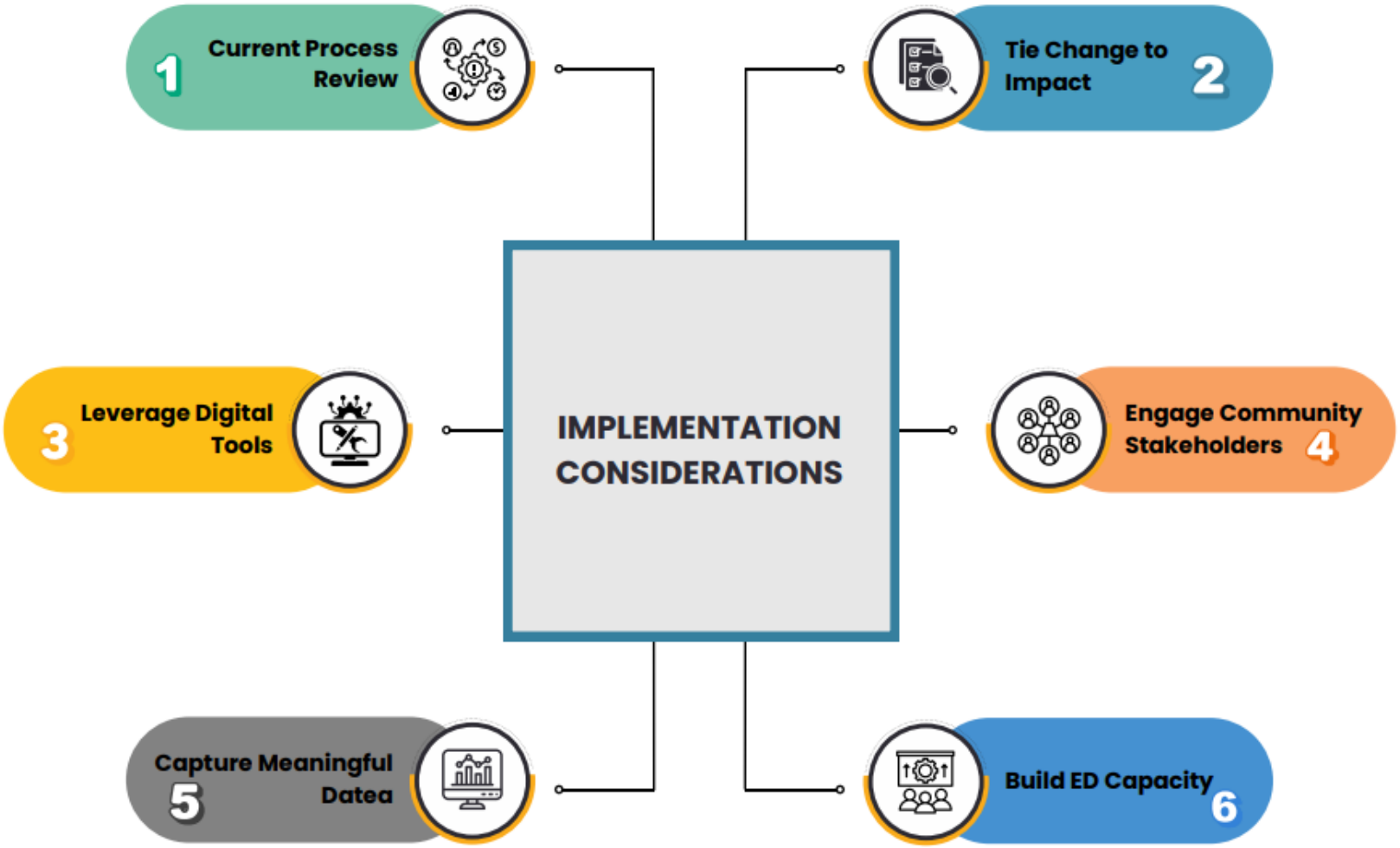
Poll

In your opinion, what is the biggest barrier to implementing frailty pathways in the ED?

1. Time/workload
2. Limited geriatric expertise
3. Workflow integration
4. Training gaps
5. Change Management

Implementation Considerations



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In Summary

- Further strengthen ED processes to support older adults' needs; earlier and targeted interventions

- Prevent adverse outcomes (functional decline, extended length of stay, ALC designation, long term care placement and in-hospital mortality)

- Implement and/or expand cross-sectorial, population level response to Frailty Management; **with frailty status as a common language guiding older adult care during transitions.**

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Poll

If we had to focus our improvement efforts, where would we invest most?

1. Early screening and assessment capacity
2. Community-based alternatives to admission
3. Inpatient frailty-informed care models
4. Transitional care and post-discharge supports
5. Workforce education and training

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