UBC Division of Geriatric Medicine Position – Frailty and ICU Candidacy

The COVID-19 pandemic has severely disrupted most of the world. The fatalities and morbidity are significantly skewed towards those older than 60, especially those with comorbidities, frailty, and residents of Long Term Care (LTC) (1). The treatment for COVID-19 is supportive, and experience from other centers suggests that frail patients derive little benefit from more aggressive interventions such as critical care.

Many organizations are incorporating the **Clinical Frailty Scale (CFS)** into triage decisions. NICE (National Institute for Health and Care) in the UK uses a CFS score of 5 (mildly frail) or more to distinguish patients that should not be referred immediately to critical care, but rather treated with watchful waiting (3). If felt appropriate, some selected deteriorating frail patients could be referred to ICU if expected benefit is anticipated, but the large remainder would be offered end of life care. **Should our system enter a crisis state with insufficient critical care resources to meet the needs of all acutely ill patients, it is likely that frailty will become an exclusion criteria for ICU candidacy.**

Clinicians need to be ready to discuss goals of care with their patients, including lack of benefit (and probably triage restrictions) to entering critical care. Geriatricians are limited in number. Their skills should be distributed so that the maximum benefit can be gained.

Geriatricians should:

1. Avail themselves to local and regional decision-making bodies to inform their policies.
2. Advocate with LTC and community to provide supportive care, especially to the most frail (CFS $\geq$ 5-6)
3. Give guidance on how to maximize, promote and effectively conduct Goals of Care conversations including providing the best tools to help Family physicians, LTC doctors and hospital physicians, as well as allied health and nursing (4 – COVID Ready Communication Resource).
4. Help with discussing frailty and outcomes for individuals, families and groups of patients. Consultation services, including phone and virtual conferencing should be maximized and made available to as many primary care providers as possible.
5. Support home health & primary care in decreasing unnecessary transfers to acute care and caring for seniors in the community, as well as supporting the ER /GEN-Cs in facilitating early discharge and support. Offering virtual urgent consultation or RACE (Rapid access to Consultative Expertise) telephone line services.
6. Given our patient population's vulnerability, telemedicine should be used as much as feasible, recognizing that this can be difficult in our patient cohort. As a tool, a telephone and a telemedicine version of the Montreal Cognitive Assessment has been made available by its authors (see attachment)

7. Work with Geriatric psychiatry and Palliative care to give coordinated advice and maximize the impact of their specialized skills.

References:

1) Huang, C, Wang Y, Xingwang L et al. Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China. The Lancet. 2000; 395(10223): 497 – 506. DOI: https://doi.org/10.1016/S0140-6736(20)30183-5
2) Rockwood K, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, Mitnitski A. A global clinical measure of fitness and frailty in elderly people. CMAJ. 2005 Aug 30;173(5):489-95
3) NICE COVID-19 rapid guideline: critical care (March 2020)
4) COVID Ready Communication – University of Washington https://docs.google.com/document/d/1uSh0FeYdkGgHsZqem552iC0KmXIgaGKohl7SoeY2UXQ/preview
5) Montreal Cognitive Assessment by telephone and telemedicine at https://mailchi.mp/mocatest/remote-moca-testing?e=bbeb81559c