Using the Clinical Frailty Scale to Rapidly Assay Grades of Fitness and Frailty

The Clinical Frailty Scale (CFS) is an inclusive 9-point scale introduced to summarize the overall level of fitness or frailty of an older adult after they have been evaluated by a health care professional. (Here a health care professional is defined as anyone with a license or registration – e.g. MD, RN, LPN, OT, PT, SW, psychologist.) The CFS is scored so that higher scores mean greater risk. It is not a questionnaire, but a judgement-based tool to screen for frailty and to broadly stratify degrees of fitness and frailty.

Note that the CFS is not designed for people whose disabilities reflect single-system problems (e.g. spinal cord injury) or developmental delay, not a gradual accumulation of health deficits with age.

The CFS focuses on a few items that can be readily observed without special training. The key point is to find out about the person's **baseline health state**. This is especially needed in clinical settings where changes in how healthy someone appears can change quickly. For example, when older people are ill enough to come to the Emergency Department, even people who have been fit can appear frail.

The baseline health state is what the person was like before they were ill (i.e. **two weeks ago**). It is hard for someone to get better than they were two weeks before they became ill. Understanding their baseline is essential in planning for their care. If the person themself cannot tell you about their health over the past two weeks, you must speak with someone who can. The more information you have about someone, the better you are able to score them on the scale. That is why it requires talking to someone who knows what the person is usually like. Scoring the CFS requires you to incorporate this information, with what you observe, and with what you know from experience in dealing with older adults. The CFS requires judgment; it's not a questionnaire in which you write down whatever the patient tells you. If it is not clear to you, ask a colleague whose judgment you trust.

The CFS is introduced by saying something like: "I'd like to know about how you are [your dad is] doing overall." We then ask about four features: *how the person moved, functioned, thought and felt about their health over the last two weeks*. We can ask about which medications the person uses; experienced clinicians can quickly assay which illnesses are likely present from what medications are being prescribed and/or used. We also ask about how active an individual is. This allows the first three levels to be identified. For example, consider a patient who is not impaired in any instrumental or personal activity of daily living (ADL), who is able to move readily, and who is taking an ACE inhibitor. If that person taking the ACE inhibitor for treatment of hypertension, exercises or is otherwise engaged in vigorous activity daily, the CFS score would be **Level 1 – Very Fit**. The same profile, with regular but less frequent or less vigorous activity would be scored as **Level 2 - Well**. Another person who fits the broad description, and who is using the ACE inhibitor as part of post myocardial infarction management, but whose ischemic heart disease has been otherwise asymptomatic, would also be scored based on their degree of physical activity. If their symptoms were mostly controlled, but not entirely so, they would be scored as **Level 3 – Managing Well**. Likewise, a person on an ACE inhibitor as part of symptomatic management of congestive heart failure would be scored as **Level 3 - Managing Well**, as long as their symptoms did not limit activities, in which case they would be scored as **Level 4 - Vulnerable**. People with many chronic conditions often report

incomplete symptom control, feeling slow, or tired A similar complaint is that their health stands in the way of doing as they wish.

For levels 4 to 7, mobility, function and cognition are key. Each reflect high-order aspects of health: they integrate a lot of information. This means that there are many ways to have mobility problems, for example: a sprained ankle, diabetic nerve damage, dehydration, heart failure, kidney damage or pneumonia. In consequence, these key domains are sensitive signs of health but are not very specific. It is the combination of impaired function and impaired mobility, which are commonly accompanied by several illnesses, that make it likely that someone is frail.

Level 4 - Vulnerable is characterized by the person who, although not totally dependent, seems at risk. Incomplete symptom control and a reduction in demanding activities, such as heavy housework, lifting, or climbing more than a flight of stairs are useful signs. Although these activities might still be attempted, commonly they are not done as well or as often. Many people at this stage simply do not feel all that well, and might complain of being "slowed up". When asked, "Compared to others of your own age, how would you rate your health?", they will often rate their health as fair or poor.

Levels 5 to 7 relate to changes in function. Varying degrees of dependence in instrumental ADLs define **Level 5 – Mildly Frail**. At this level, typically, there is no more pretence of doing heavy housework or the like – items that began to be impaired in Level 4. A person doesn't need to be dependent in all demanding activities to quality as Level 4, nor in all aspects of Instrumental ADLs to qualify as Level 5. We are interested in change: someone who never did the banking would not now be scored as dependent in that. With **Level 6 – Moderately Frail**, dependence now extends past instrumental ADLs to intermediate ones, notably including bathing. Often at this level, minimal assistance with personal care might be needed. In **Level 7 – Severely Frail** there is progressive dependence in personal ADLs. People do not need to be dependent in every aspect of personal care to be scored as Level 7. When assessing functional dependence in intermediate (Level 6) and personal (Level 7) ADLs, lifelong habit is a less relevant consideration: most everyone needs to bathe, groom and use the toilet.

Level 8 – Very Severe Frailty is the not uncommon state in which a frail person takes to bed, often for weeks, prior to dying. This is either heralded by an identifiable episode, such as an infection, or the person just slips away, commonly after some days of reduced oral intake. Very severely frail people who die without a single apparent cause typically follow such a trajectory, commonly without much pain or even distress; often with the exception of impaired bowel function, even without opiates.
Level 9 – Terminally Ill is the only level in which the current state trumps the baseline state, in that the terminally ill person might have been operating at various frailty levels at baseline. The person is pictured seated in a chair. Many older adults who are dying with single system illness – notably cancer – have a reasonable level of function until about the very end, and that is why we portray the situation in that way. Even so, if a terminally ill person was bedfast, they would still be scored as Level 9.

Within each level, individuals will vary. About 80% or more of people will fit the description offered for a given level. If they fit two categories equally well, it is best to score the scale at the higher or more dependent level.