CHCA Project ECHO
Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in
Home and Primary Health Care

Assessing Frailty in Medically Complex Older Adults: Integrated Approaches to Care Across Home, Community, and Primary Care Settings

Presenters:

Dr. Kenneth Rockwood OC MD, FRCPC, FRCP, Professor, Dalhousie University; Geriatrician, Nova Scotia Health

Dr. Sabeen Ehsan, MD, EMHI, Director, System Planning & Quality, Seniors Care Network

Host: Jennifer Campagnolo, CHCA

January 21, 2026

Canadian Home Care Association

Land Acknowledgement

Artist Credit: Patrick Hunter

We recognize with humility and gratitude that Canada is located in the traditional, historical and ceded and unceded Lands of First Nation, Inuit and Metis Peoples. On behalf of us all, we acknowledge and pay respect to the Indigenous peoples past, present and future who continue to work, educate and contribute to the strength of this country.

Canadian Home Care Association

Project ECHO

Integrated Seniors Care

Introductions

Dr. Kenneth Rockwood OC MD, FRCPC, FRCP
Professor, Dalhousie University; Geriatrician, Nova Scotia Health

Dr. Sabeen Ehsan, MD, EMHI
Director, System Planning & Quality, Seniors Care Network

Assessing Frailty in Medically Complex Older Adults: Integrated Approaches to Care Across Home, Community, and Primary Care Settings

Kenneth Rockwood OC, MD, FRCPC, FRCP
Senior Medical Director, Frailty & Elder Care Network; Staff Physician, Nova Scotia Health
Clinical Research Professor of Frailty & Aging; Professor of Geriatric Medicine
Dalhousie University
Halifax, Nova Scotia, Canada

Webinar ECHO Integrated Seniors Care; January 21, 2026

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- Committee Member: Dr. Aamir Haq
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  - Non-Financial Relationships: College of Family Physicians of Canada.
- Committee Member: Jean Johnston-McKitterick
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- Committee Member: Lara de Sousa
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DISCLOSURE OF COMMERCIAL SUPPORT

- This program has received financial support from the Canadian Medical Association in the form of an educational grant.

- This program has NOT received in-kind support.

- Potential for conflict(s) of interest:

  None to be disclosed.

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MITIGATING POTENTIAL BIAS

- The information presented in this CME program is based on recent information that is explicitly "evidence-based”.

- This CME Program and its material is peer reviewed and all the recommendations involving clinical medicine are based on evidence that is accepted within the profession; and all scientific research referred to, reported, or used in the CME/CPD activity in support or justification of patient care recommendations conforms to the generally accepted standards

PRESENTER DISCLOSURES

Through Dal's Industry Liaison Office, to stop unauthorized commercialization, I have asserted copyright of the **Clinical Frailty Scale**, a standardized **Comprehensive Geriatric Assessment**, and the **Hierarchic Assessment of Mobility and Balance**. Each is **free for use.** Authorized users agree not to *change*, *commercialize*, or *charge* for them.

I co-founded Ardea Outcomes, Inc. It contracts with industry, academics, and charities for individualized outcome measurement, but not in frailty.

I edit *Brocklehurst's Textbook of Geriatric Medicine & Gerontology*, now in its 9th edition, Release date: February 2026

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OBJECTIVES

By the end of this session, participants will be able to:

Understand the purpose and application of the Pictorial Fit-Frail Scale (PFFS), including when and how it can be used to support care planning.

Recognize the value of frailty assessment in tailoring individualized care for older adults living with complex conditions.

Describe how clinical judgment and structured tools like the PFFS can work together to identify risk and inform care strategies.

Reflect on how respectful conversations about risk can reduce stigma and support person-centred decision-making.

SESSION OVERVIEW

Frailty is more than a score, it's a lens through which to understand risk, resilience, and priorities in complex care. This teleECHO clinic will explore how tools like the Pictorial Fit-Frail Scale (PFFS) support meaningful assessment while creating opportunities for proactive, person-centred care planning.

Participants will examine how clinical judgment complements structured tools and how *dignity of risk* frameworks can reshape how we talk about vulnerability. The session will highlight the importance of understanding how older adults perceive risk and how to engage them in respectful, values-based conversations that inform care decisions.

It will also explore how early frailty identification can reduce stigma, improve collaboration between home and primary care teams, and strengthen person-centred pathways for individuals with complex conditions, including dementia.

CASE STUDY Background
Occupation & Finances

Mr. André, Francophone and widowed, completed high school and is retired, having worked for more than 35 years as a maintenance supervisor at a local manufacturing plant.

He lives on a fixed income through the Canadian Pension Plan (CPP) Old Age Security (OAS) and a modest workplace pension.

While financially stable, he has limited flexibility for private services, home modifications, or transportation costs.

CASE STUDY Background

Family & Social Network

Two adult children live several hours away and provide emotional support, help in placing online grocery orders for delivery, assistance with paperwork and are involved in his overall health care matters and service coordination by phone, but not in his day-to-day care.

Otherwise, one close friend in his building; occasional participation in a local seniors' centre. This he attends less, due to fatigue and mobility limitations.

CASE STUDY Background
Health & Social Services Availability

Mr. André is rostered to a family physician at a primary care clinic.

Until about 12–18 months ago, Mr. André managed his own shopping, light housekeeping, and medications independently, pacing himself around symptoms.

He receives home and community care services for personal care and meal support.

Transportation to appointments is challenging, particularly during winter, and he has declined some referrals due to travel demands.

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CASE STUDY Background
Location & Living Situation

Small city in central-western Manitoba (population <75,000 residents).

Lives alone in a one-bedroom rental apartment in an older low-rise building with elevator access. The apartment has narrow hallways and a standard bathtub without grab bars. Snow and ice in winter limit outdoor mobility and access to services.

CASE STUDY Background
Medical History

- Chronic obstructive pulmonary disease (mild-moderate)
- Atrial fibrillation (rate controlled)
- Chronic kidney disease (Stage 3)
- Chronic low back pain related to a previous injury and osteoarthritis
- Hearing impairment
- Two reported falls in the past year
- Unintentional weight loss of 15lbs/6.58kg in past year

CASE STUDY Background
Medical History

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Atrial fibrillation (rate controlled)

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Chronic low back pain related to a previous injury and osteoarthritis

Hearing impairment

Two reported falls in the past year

Unintentional weight loss of 15lbs/6.58kg in past year

CASE STUDY Background
Functional Status

ADLs: Independent with basic self-care.

Note however, ADLs now done more slowly and needs to rest.

IADLs: Requires help with meals, transportation, and appointment coordination.

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Functional Status

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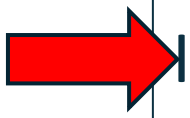

IADLs: Requires help with meals, transportation, and appointment coordination.

CASE STUDY Background
Functional Status

ADLs: Independent with basic self-care.

Note however, ADLs now done more slowly and needs to rest.

IADLs: Requires help with meals, transportation, and appointment coordination.

(Should he be doing his own meds?)

CASE STUDY Background
Mental & Emotional Wellbeing

Mr. André's increased fear of falling has caused him to limit his activities leading to social isolation, and an increase in loneliness

He has expressed sadness and loss of confidence in his mobility and threats to his independence

His shrinking social interaction has affected his social network whom he has relied on for emotional support and connection

CASE STUDY Background
Mental & Emotional Wellbeing

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CASE STUDY Background
Current Challenges & Concerns

- Home care providers report a gradual decline in Mr. André's endurance, shortness of breath with exertion
- Mr. André describes occasional dizziness when standing
- Chronic pain limits Mr. André's mobility

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Current Challenges & Concerns

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Chronic pain limits Mr. André's mobility

CASE STUDY Background
Current Challenges & Concerns

Mr. André did not seek emergency or medical care following either fall and minimized their significance, stating he “just lost his balance”

Home care staff have noted increased caution with walking and reduced activity since these events

He remains clear that staying in his own home is his priority, even if it involves accepting some risk

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- Home care staff have noted increased caution with walking and reduced activity since these events
- He remains clear that staying in his own home is his priority, even if it involves accepting some risk

The Pictorial Fit-Frail Scale: Developing a Visual Scale to Assess Frailty

Olga Theou, PhD[1,2,3], Melissa Andrew, MD[1,2], Sally Suriani Ahip, MMed[4], Emma Squires, BA[2], Lisa McGarrigle, PhD[1], Joanna M. Blodgett, MSc[5], Judah Goldstein, PhD[6,7], Kathryn Hominick, MSW[2], Judith Godin, PhD[2], Glen Hougan, MDes[8], Joshua J. Armstrong, PhD[9], Lindsay Wallace, MSc[1], Shariff Ghazali Sazlina, PhD[10], Paige Moorhouse, MD[1,2], Sherri Fay, MA[2], Renuka Visvanathan, PhD[3,11], Kenneth Rockwood, MD[1,2]

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DOI:https://doi.org/10.5770/cgj.22.357

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Theou O et al. *Can Geriatr J.* 2019

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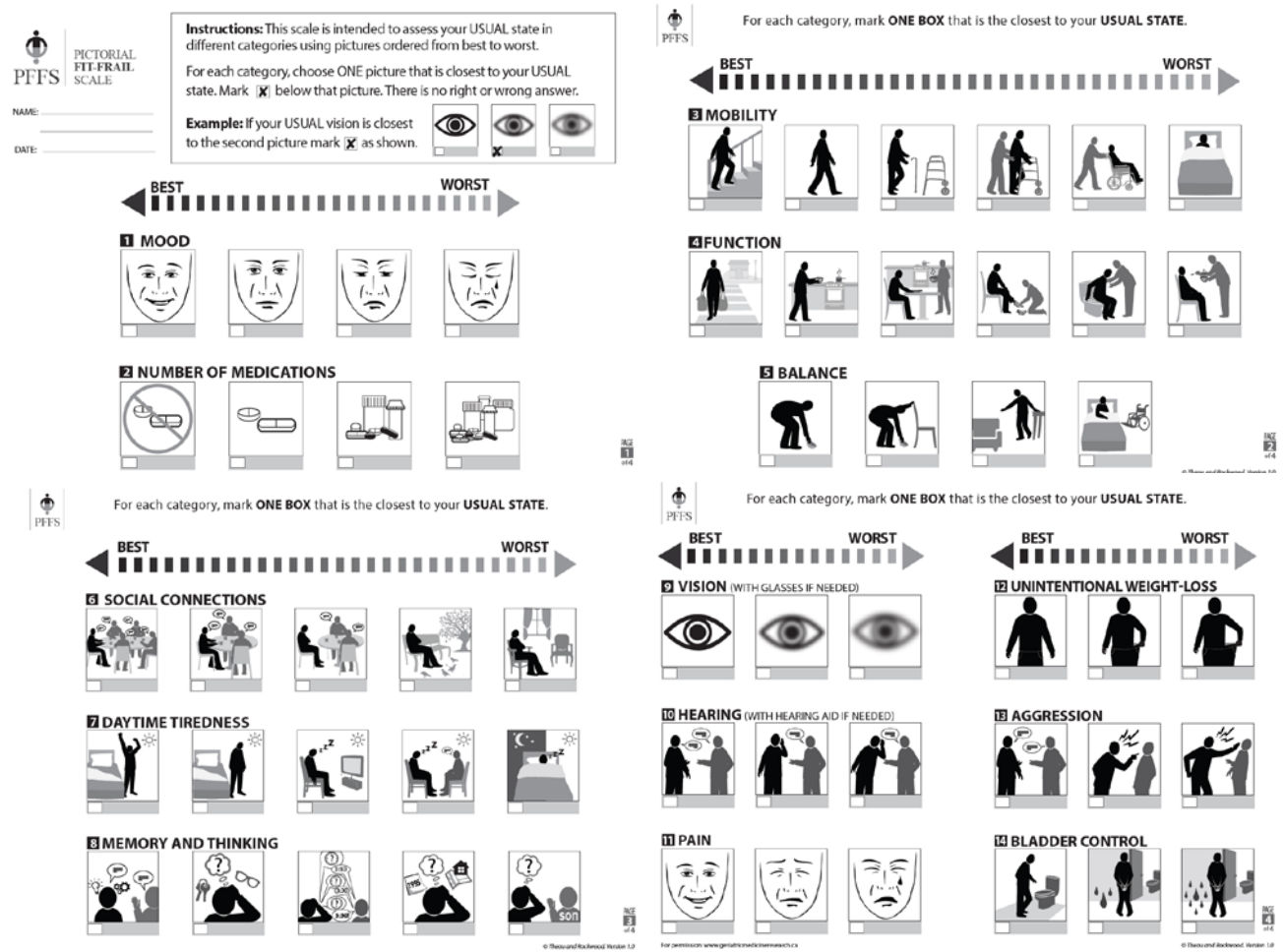
Pictorial Fit-Frail Scale



https://www.dal.ca/sites/gmr/our-tools/pictorial-fit-frail-scale.html

Pictorial Fit-Frail Scale

Visual images to assess a person's level of fitness-frailty; scale accessible across literacy levels, languages, and cultures

Evaluates a person's ability in 14 different domains; 3 to 6 levels/domain

Final score range from 0 to 43

<2 min when assessed by a clinician and <5 min for self and proxy assessment

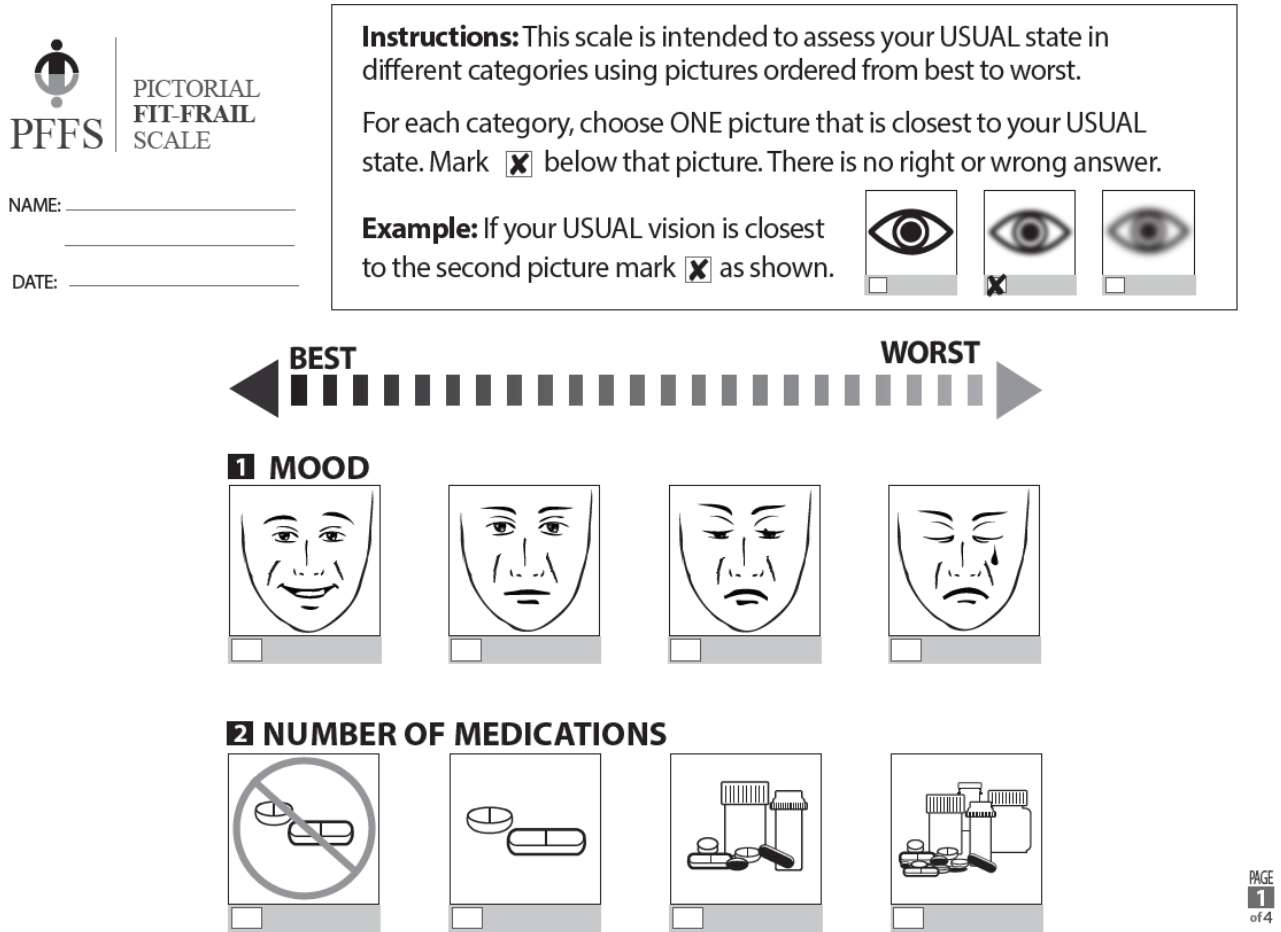
Test-retest reliability good for patients (ICC = 0.78) and nurses (ICC = 0.88)

Inter-rater reliability between HCPs was good (ICC = 0.75)

It is valid (association with other frailty tools and outcomes)

Theou O et al., *Can Geriatr J*. 2019; McGarrigle L et al. *Age Ageing*. 2019

Pictorial Fit-Frail Scale



PFFS PICTORIAL FIT-FRAIL SCALE

NAME: _____

_____

DATE: _____

Instructions: This scale is intended to assess your USUAL state in different categories using pictures ordered from best to worst.

For each category, choose ONE picture that is closest to your USUAL state. Mark ☒ below that picture. There is no right or wrong answer.

Example: If your USUAL vision is closest to the second picture mark ☒ as shown.

BEST WORST

1 MOOD

2 NUMBER OF MEDICATIONS

PAGE 1 of 4

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https://www.dal.ca/sites/gmr/our-tools/pictorial-fit-frail-scale.html

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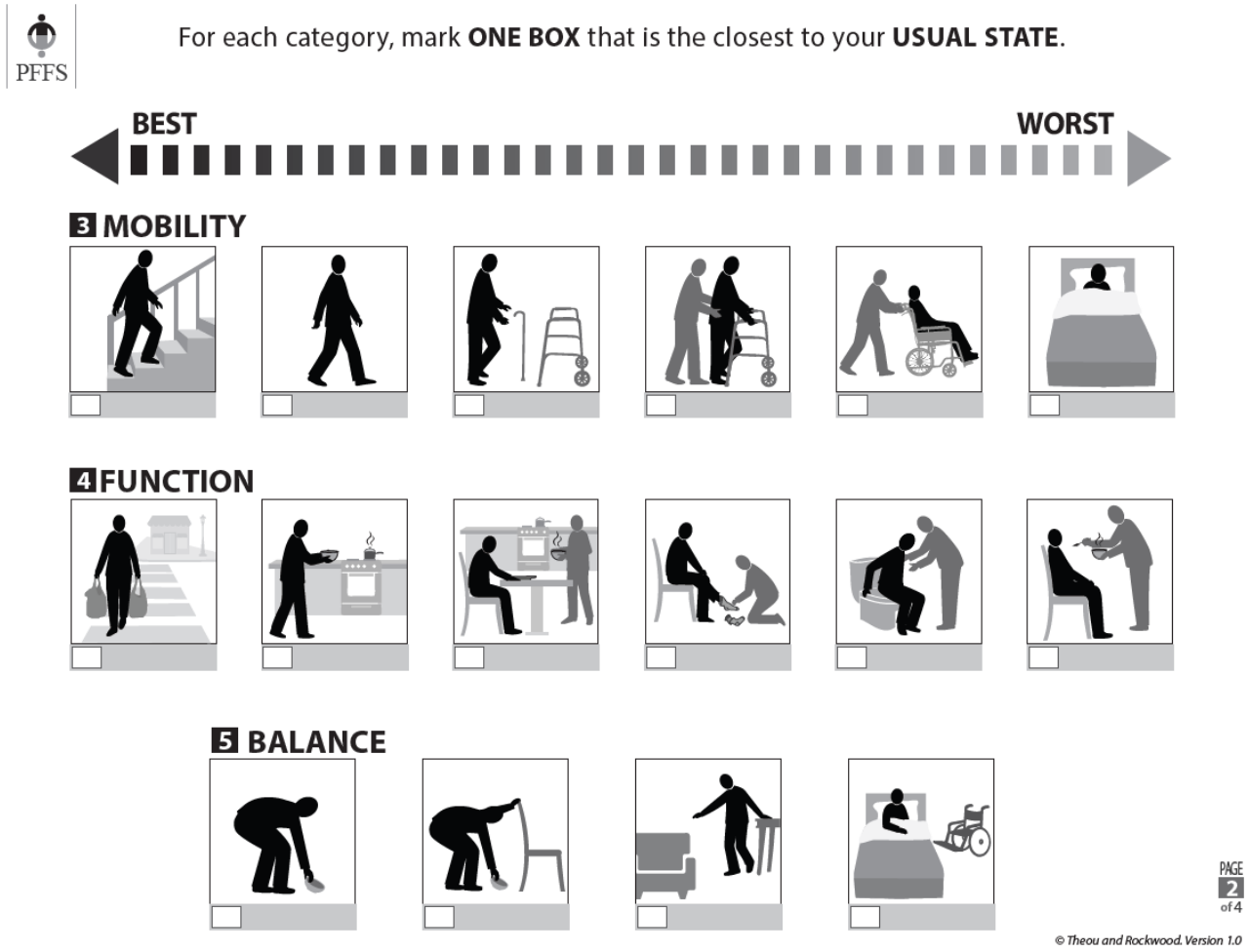
Pictorial Fit-Frail Scale



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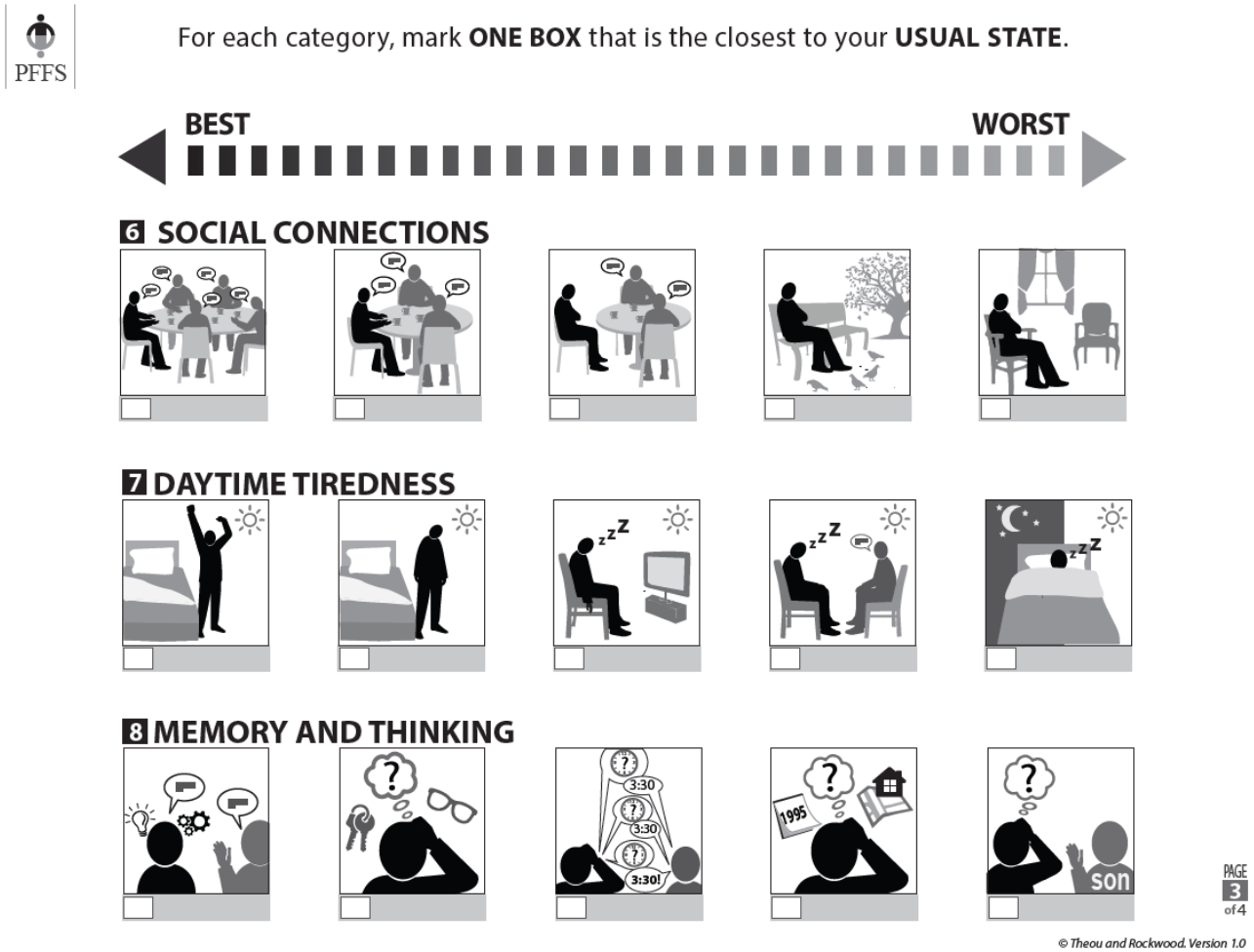
Pictorial Fit-Frail Scale



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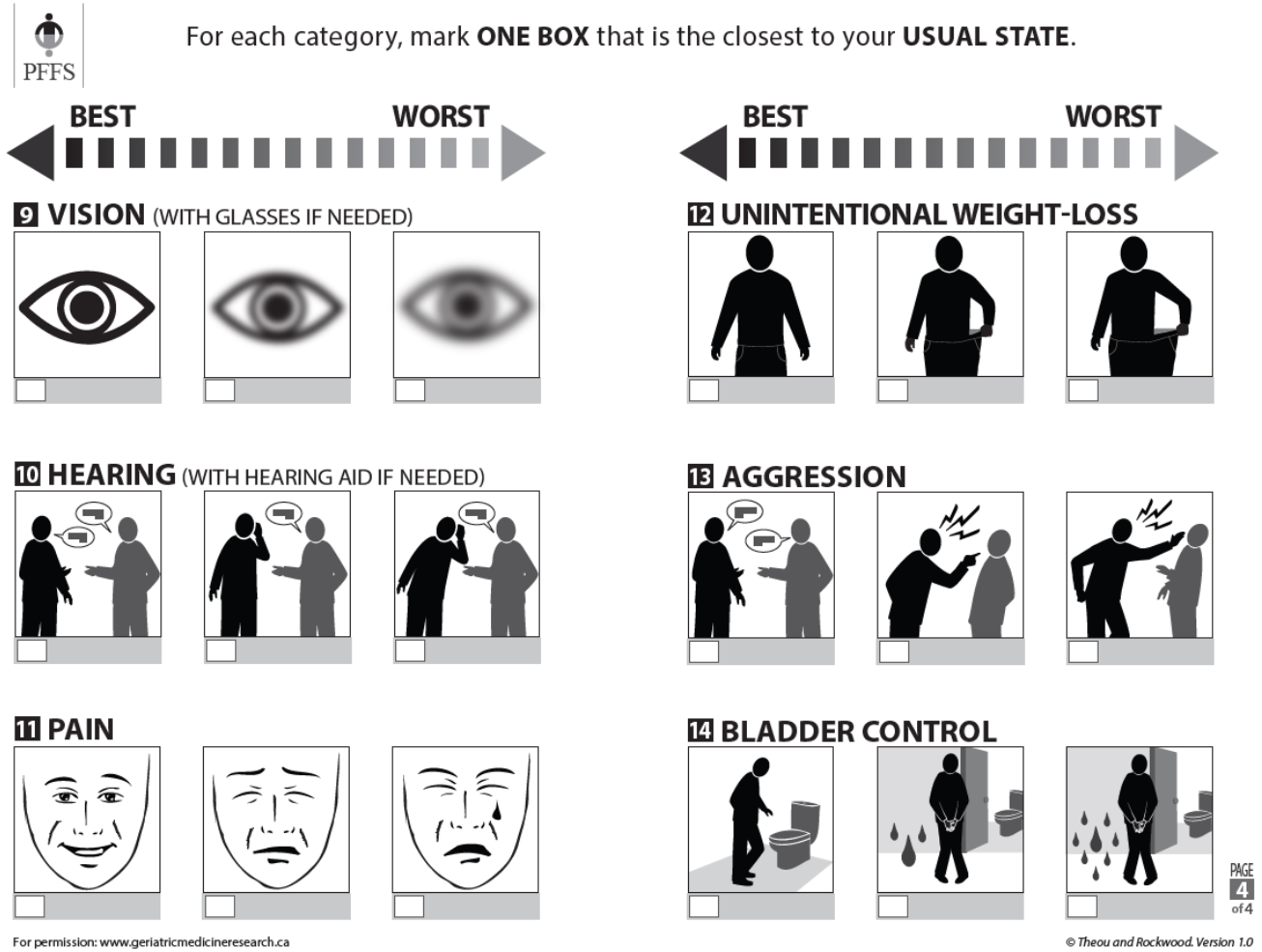

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Dignity of Risk

Barriers to Dignity of Risk:

Ageism

Believing older adults can't or shouldn't do something, e.g., living at home with risk.

Paternalistic Attitudes

Protecting older adults in a way that removes their independence and choice, e.g., bubble wrapping.

Safety Focus

Thinking older adults are "unsafe", or removing meaningful activities due to safety concerns, rather than risk management, e.g., mobilizing

Personal Values

Your risk and liability concerns may conflict with the older adults', but *it's not your choice, it's not your life.*

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DignityofRisk@nshealth.ca

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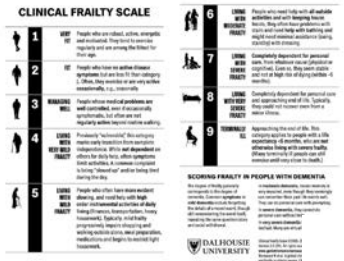
How frailty manifests clinically changes as the *degree of frailty* increases.

The Clinical Frailty Scale lets us grade the degree of frailty at baseline



DALHOUSIE UNIVERSITY Rockwood K, et al., CMAJ 2005;489-495; updated to person-first language, 2019.

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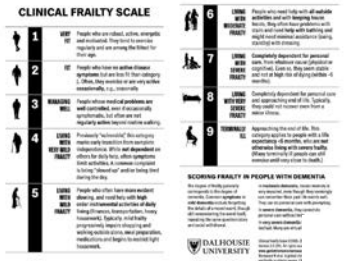
SUMMARY: The continuum of fitness and frailty can get (wrongly) compressed with acute illness.

The Clinical Frailty Scale lets us grade the degree of frailty at baseline



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4 LIVING WITH VERY MILD FRAILTY

Marks **early transition from complete independence**. While not depending on others for daily help, **often symptoms limit activities**. A common complaint is being "**slowed up**" and/or being **tired** during the day.

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Rockwood K, Theou O. *Can Geriatr J.* 2020;23:210-215. doi: 10.5770/cgj.23.463

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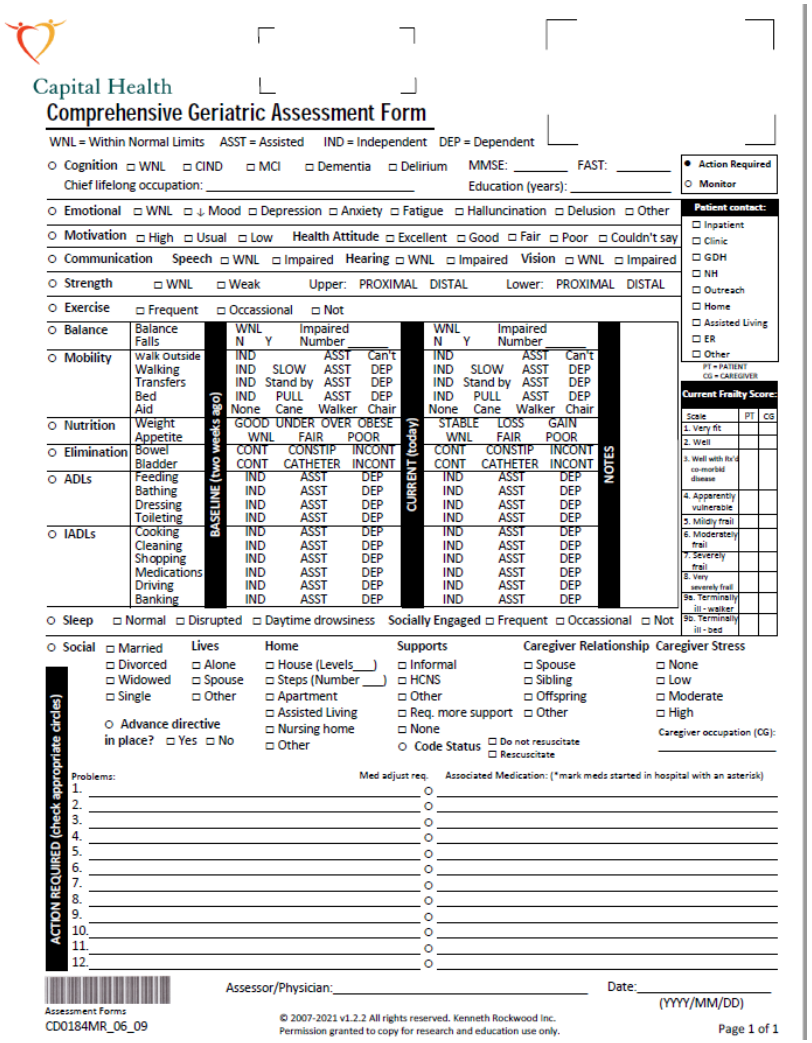
8 LIVING WITH VERY SEVERE FRAILTY

Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.

At baseline.

Rockwood K, Theou O. *Can Geriatr J.* 2020;23:210-215. doi: 10.5770/cgj.23.463

A standard Comprehensive Geriatric Assessment: can we help others see what we see?



Capital Health

Comprehensive Geriatric Assessment Form

WNL = Within Normal Limits ASST = Assisted IND = Independent DEP = Dependent

○ Cognition ☐ WNL ☐ CIND ☐ MCI ☐ Dementia ☐ Delirium MMSE: _____ FAST: _____
Chief lifelong occupation: _____ Education (years): _____

● Action Required ○ Monitor

○ Emotional ☐ WNL ☐ ↓ Mood ☐ Depression ☐ Anxiety ☐ Fatigue ☐ Hallucination ☐ Delusion ☐ Other

○ Motivation ☐ High ☐ Usual ☐ Low Health Attitude ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Couldn't say

○ Communication Speech ☐ WNL ☐ Impaired Hearing ☐ WNL ☐ Impaired Vision ☐ WNL ☐ Impaired

○ Strength ☐ WNL ☐ Weak Upper: PROXIMAL DISTAL Lower: PROXIMAL DISTAL

○ Exercise ☐ Frequent ☐ Occassional ☐ Not

Patient contact: ☐ Inpatient ☐ Clinic ☐ GDH ☐ NH ☐ Outreach ☐ Home ☐ Assisted Living ☐ ER ☐ Other

PT = PATIENT CG = CAREGIVER

		BASELINE (two weeks ago)	CURRENT (today)	NOTES
○ Balance	Balance Falls	WNL N Y Impaired Number ____	WNL N Y Impaired Number ____	
○ Mobility	Walk Outside	IND ASST Can't	IND ASST Can't	
	Walking	IND SLOW ASST DEP	IND SLOW ASST DEP	
	Transfers	IND Stand by ASST DEP	IND Stand by ASST DEP	
	Bed	IND PULL ASST DEP	IND PULL ASST DEP	
	Aid	None Cane Walker Chair	None Cane Walker Chair	
○ Nutrition	Weight	GOOD UNDER OVER OBESE	STABLE LOSS GAIN	
	Appetite	WNL FAIR POOR	WNL FAIR POOR	
○ Elimination	Bowel	CONT CONSTIP INCONT	CONT CONSTIP INCONT	
	Bladder	CONT CATHETER INCONT	CONT CATHETER INCONT	
○ ADLs	Feeding	IND ASST DEP	IND ASST DEP	
	Bathing	IND ASST DEP	IND ASST DEP	
	Dressing	IND ASST DEP	IND ASST DEP	
	Toileting	IND ASST DEP	IND ASST DEP	
○ IADLs	Cooking	IND ASST DEP	IND ASST DEP	
	Cleaning	IND ASST DEP	IND ASST DEP	
	Shopping	IND ASST DEP	IND ASST DEP	
	Medications	IND ASST DEP	IND ASST DEP	
	Driving	IND ASST DEP	IND ASST DEP	
	Banking	IND ASST DEP	IND ASST DEP	

Current Frailty Score:

Scale	PT	CG
1. Very fit		
2. Well		
3. Well with Rx'd co-morbid disease		
4. Apparently vulnerable		
5. Mildly frail		
6. Moderately frail		
7. Severely frail		
8. Very severely frail		
9a. Terminally ill - walker		
9b. Terminally ill - bed		

○ Sleep ☐ Normal ☐ Disrupted ☐ Daytime drowsiness Socially Engaged ☐ Frequent ☐ Occassional ☐ Not

○ Social ☐ Married ☐ Divorced ☐ Widowed ☐ Single
Lives ☐ Alone ☐ Spouse ☐ Other
Home ☐ House (Levels___) ☐ Steps (Number ___) ☐ Apartment ☐ Assisted Living ☐ Nursing home ☐ Other
Supports ☐ Informal ☐ HCNS ☐ Other ☐ Req. more support ☐ None
Caregiver Relationship ☐ Spouse ☐ Sibling ☐ Offspring ☐ Other
Caregiver Stress ☐ None ☐ Low ☐ Moderate ☐ High

○ Advance directive in place? ☐ Yes ☐ No
○ Code Status ☐ Do not resuscitate ☐ Rescuscitate
Caregiver occupation (CG): _____

ACTION REQUIRED (check appropriate circles)

Problems: Med adjust req. Associated Medication: (*mark meds started in hospital with an asterisk)
1. _____ ○ _____
2. _____ ○ _____
3. _____ ○ _____
4. _____ ○ _____
5. _____ ○ _____
6. _____ ○ _____
7. _____ ○ _____
8. _____ ○ _____
9. _____ ○ _____
10. _____ ○ _____
11. _____ ○ _____
12. _____ ○ _____

Assessor/Physician: _____ Date: _____ (YYYY/MM/DD)

Assessment Forms
CD0184MR_06_09

Community Comprehensive Geriatric Assessment Form

● Action Required ○ No Action Required

WNL = Within Normal Limits ASST = Assisted IND = Independent DEP = Dependent Y=Yes N=No
Chief lifelong occupation: _____ Education (years): _____

○ CrCl (Creatine Clearance)

○ Cognition ☐WNL ☐CIND/MCI ☐Dementia Delirium ☐Y ☐N MOCA: _____ Mini-Cog: _____ FAST: _____

○ Emotional ↓Mood ☐Y ☐N Depression ☐Y ☐N Anxiety ☐Y ☐N Fatigue ☐Y ☐N Hallucination ☐Y ☐N Delusion ☐Y ☐N Other ☐Y ☐N

○ Motivation ☐High ☐Usual ☐Low Health Attitude ☐Excellent ☐Good ☐Fair ☐Poor ☐Couldn't Say

○ Communication Speech ☐WNL ☐Impaired Hearing ☐WNL ☐Impaired Vision ☐WNL ☐Impaired

○ Sleep ☐WNL ☐Disrupted Daytime Drowsiness ☐Y ☐N ○ Pain ☐None ☐Moderate ☐Extreme

○ Immunizations Zoster ☐Y ☐N Influenza ☐Y ☐N Pneumococcal ☐Y ☐N Tetanus and Diphtheria ☐Y ☐N Hep A ☐Y ☐N Hep B ☐Y ☐N

○ Advance directive in place ☐Y ☐N ○ Code Status ☐Do not resuscitate ☐Resuscitate

○ Control of Life Events ☐Y ☐N ○ Usual Activities ☐No Problem ☐Some Problem ☐Unable

○ Exercise ☐Frequent ☐Occasional ☐Not ○ Smoker ☐Current ☐Ever ☐Never

○ Strength ☐WNL ☐Weak UPPER: ☐Proximal ☐Distal LOWER: ☐Proximal ☐Distal

○ Balance	Balance	☐WNL	☐Impaired	Falls	☐Y	☐N	Number _____
○ Mobility	Walk Outside	☐IND	☐ASST	☐Can't	Walking	☐IND	☐SLOW ☐ASST ☐DEP
	Transfers	☐IND	☐Stand by ☐ASST	☐DEP	Bed	☐IND	☐PULL ☐ASST ☐DEP
	Aid	☐None	☐Cane ☐Walker	☐Chair	5 Sit to Stand	Time _____	Crossed Arms: ☐Y ☐N
○ Nutrition	Weight	☐Good	☐Under ☐Over	☐Obese	Appetite	☐WNL	☐FAIR ☐POOR
○ Elimination	Bowel	☐CONT	☐INCONT	Constip	☐Y ☐N	Bladder	☐CONT ☐INCONT
						Catheter	☐Y ☐N
○ ADLs	Feeding	☐IND	☐ASST	☐DEP	Bathing	☐IND	☐ASST ☐DEP
	Dressing	☐IND	☐ASST	☐DEP	Toileting	☐IND	☐ASST ☐DEP
○ IADLs	Cooking	☐IND	☐ASST	☐DEP	Cleaning	☐IND	☐ASST ☐DEP
	Shopping	☐IND	☐ASST	☐DEP	Meds	☐IND	☐ASST ☐DEP
	Driving	☐IND	☐ASST	☐DEP	Banking	☐IND	☐ASST ☐DEP

○ Enough Income? ☐Yes ☐No ○ Socially Engaged ☐Frequent ☐Occasional ☐Not

○ Marital ☐Married ☐Divorced ☐Widowed ☐Single ○ Lives ☐Alone ☐Spouse ☐Other

○ Home ☐House ☐Apartment ☐Assisted Living ☐Nursing home ☐Other Steps ☐Y ☐N

○ Supports ☐None needed ☐Informal ☐HCNS ☐Other Requires more support ☐Y ☐N

○ Caregiver Relationship ☐Spouse ☐Sibling ☐Offspring ☐Other

○ Caregiver Stress ☐None ☐Low ☐Moderate ☐High Caregiver Occupation: _____

Clinical Frailty Score

Scale	Pt.	CG
1. Very fit		
2. Fit		
3. Managing Well		
4. Very Mild Frailty		
5. Mild Frailty		
6. Moderate Frailty		
7. Severe Frailty		
8. Very Severe Frailty		
9. Terminally ill		

Problems: Med adjust req. Associated Medication:
1. _____ ○ _____
2. _____ ○ _____
3. _____ ○ _____
4. _____ ○ _____
5. _____ ○ _____
6. _____ ○ _____
7. _____ ○ _____
8. _____ ○ _____

Assessor: _____ Date (YYYY/MM/DD): _____

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Frailty Pathways
An integrated model for older adult care

Sabeen Ehsan MD, EMHI

Director System Planning & Quality

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- Relationships with commercial interests:
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  - Speakers Bureau/Honoraria: none
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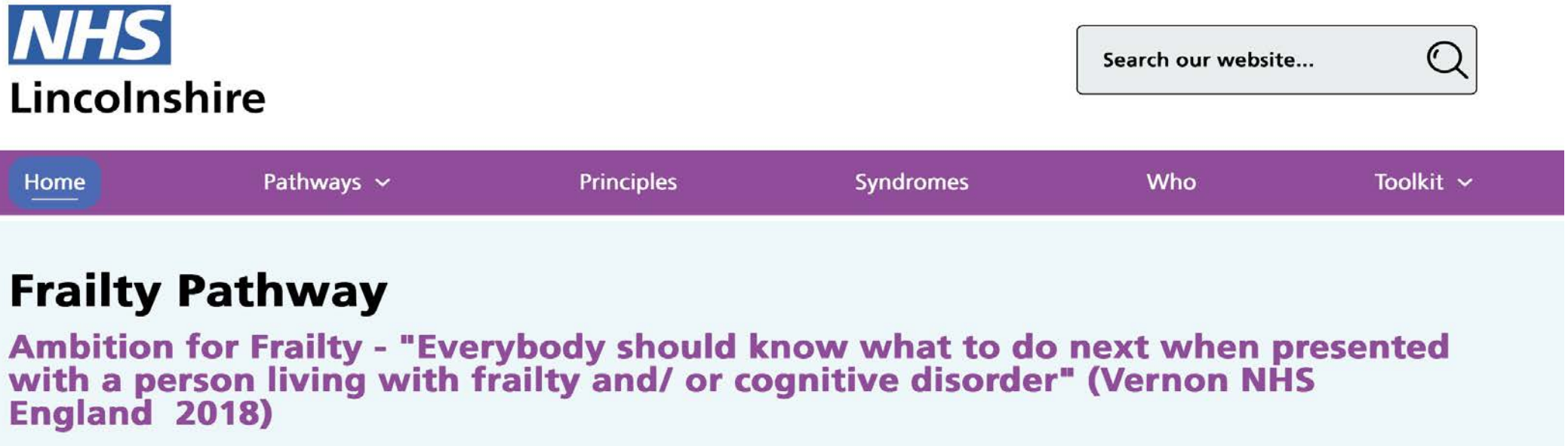
- Potential for conflict(s) of interest:

  - None to be disclosed.

MITIGATING POTENTIAL BIAS

- The information presented in this CME program is based on recent information that is explicitly "evidence-based".

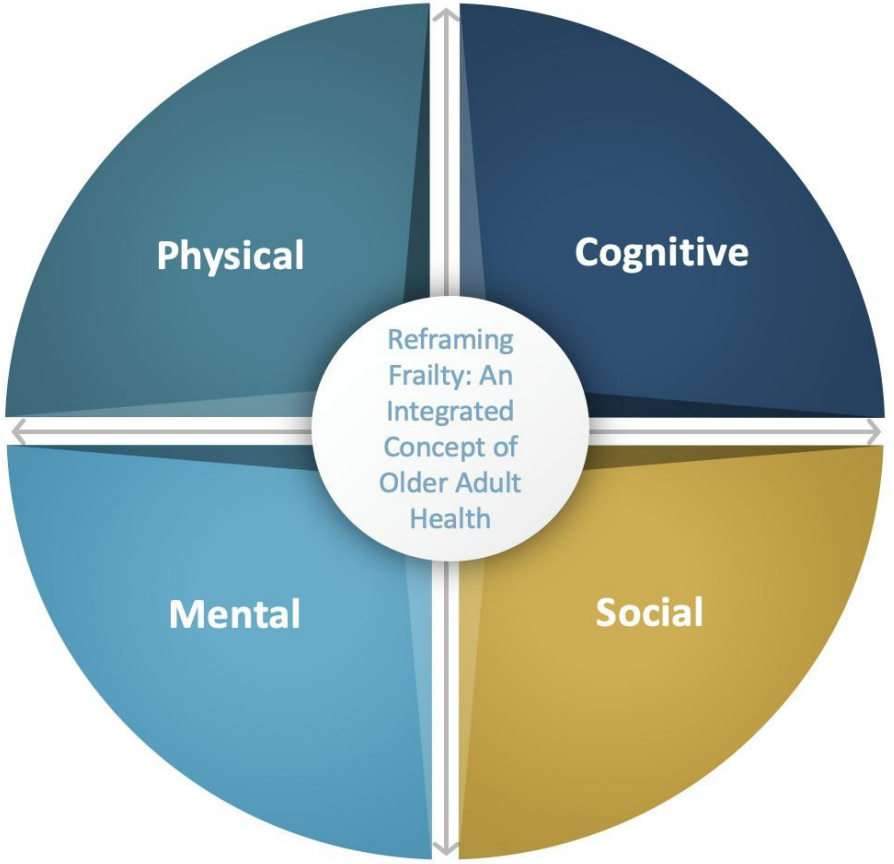
- This CME Program and its material is peer reviewed and all the recommendations involving clinical medicine are based on evidence that is accepted within the profession; and all scientific research referred to, reported, or used in the CME/CPD activity in support or justification of patient care recommendations conforms to the generally accepted standards



Source: https://www.frailtypath.co.uk/home

Frailty- a multidimensional concept

- The concepts of frailty must include the physical, cognitive, mental, and social health of older adults and their care partners, and the interaction and integration of these **four** domains[1]
  - As exemplified by the **case study** just presented
- An adequate response to frailty should also include the intersection of services that support all these domains
  - coordinated integration of medical care with social and community-based services.



Source: PGLO 2023

Provincial Geriatrics Leadership Ontario

[1] Ontario Collaborative for Aging Well, 2023

Seniors Care Network

- Based in Ontario, Seniors Care Network is responsible for the organization, coordination and governance of specialized geriatric services (SGS) in Central East Ontario.
- Key services include the planning, design, implementation, evaluation, quality improvement and performance monitoring of clinical SGS. Applied health research is a key component of our mandate.
- SGS in Central East are offered across the continuum of care:

Seniors Care Network Frailty Pathways

- 2019 led to the inception of Ontario Health Teams (OHTs) in the Province. All CE OHTs identified older adults living with complexity/multiple co-morbidities among the populations of focus

- Highlighting the need for an actionable **Population-level Health Management Strategy** for
- older adults living with frailty
  - What processes/practices can be put in place to support early identification and management of frailty thereby contributing to **healthy aging and ALC reduction**?
  - How can Frailty status be used as the common language to inform service access, flow and transition decisions across the continuum?

- Conceptualization and development of sector-specific Frailty

Our Frailty Journey

2021

Involvement with all local OHTs

2021-22

OCAW Membership

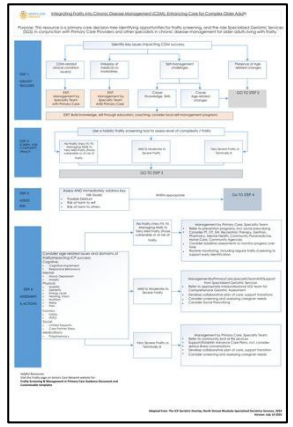
Led the Frailty Working Group: Thorough review of literatures (NHS frailty pathways) and broad consultation with local and national experts

2023

Primary Care and Community Frailty Pathways

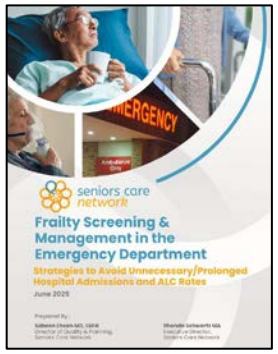
2024

Frailty and Chronic Disease Management



2025

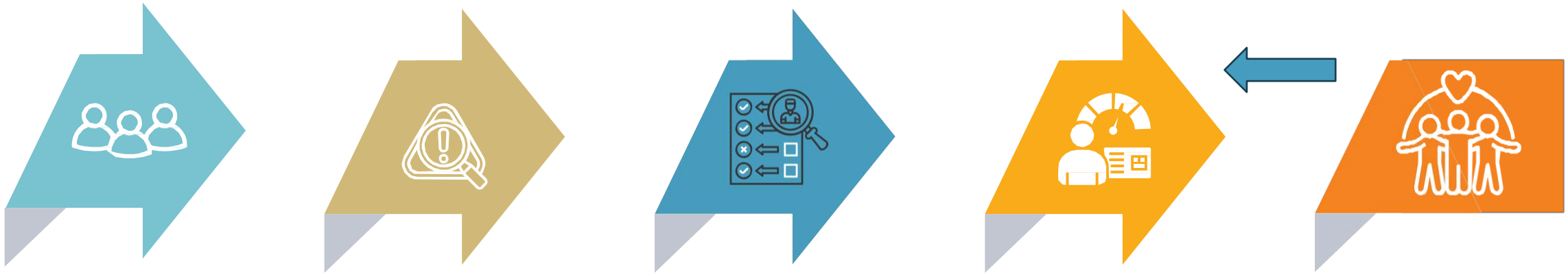
ED Frailty Pathway



Visit the Frailty Page on our website to access these Guidance Documents and resources

Frailty Management

A step-wise evidence-informed approach



1
Understand Your Population

2
Identify your Triggers

3
Screen

4
Assess

5
Manage

Reference: Ehsan, S., & Schwartz, R. (2023). Frailty Screening & Management in the Community Guidance Document.

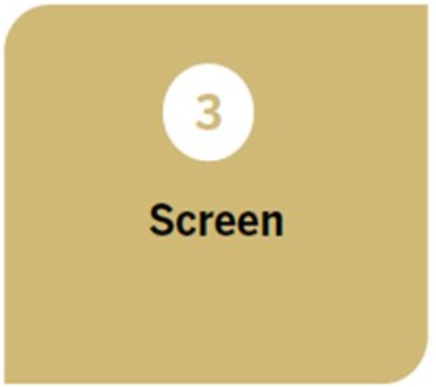
- Administrative data sources to understand population-level trends
- Review of charts or client profiles to better understand the characteristics/needs at organization level

- Examples (one or more):
- Age 65 & older
  - Can be further stratified
- Presence of Geriatric Syndrome(s)
- Multi-morbidity
- Psycho-social concerns, etc.

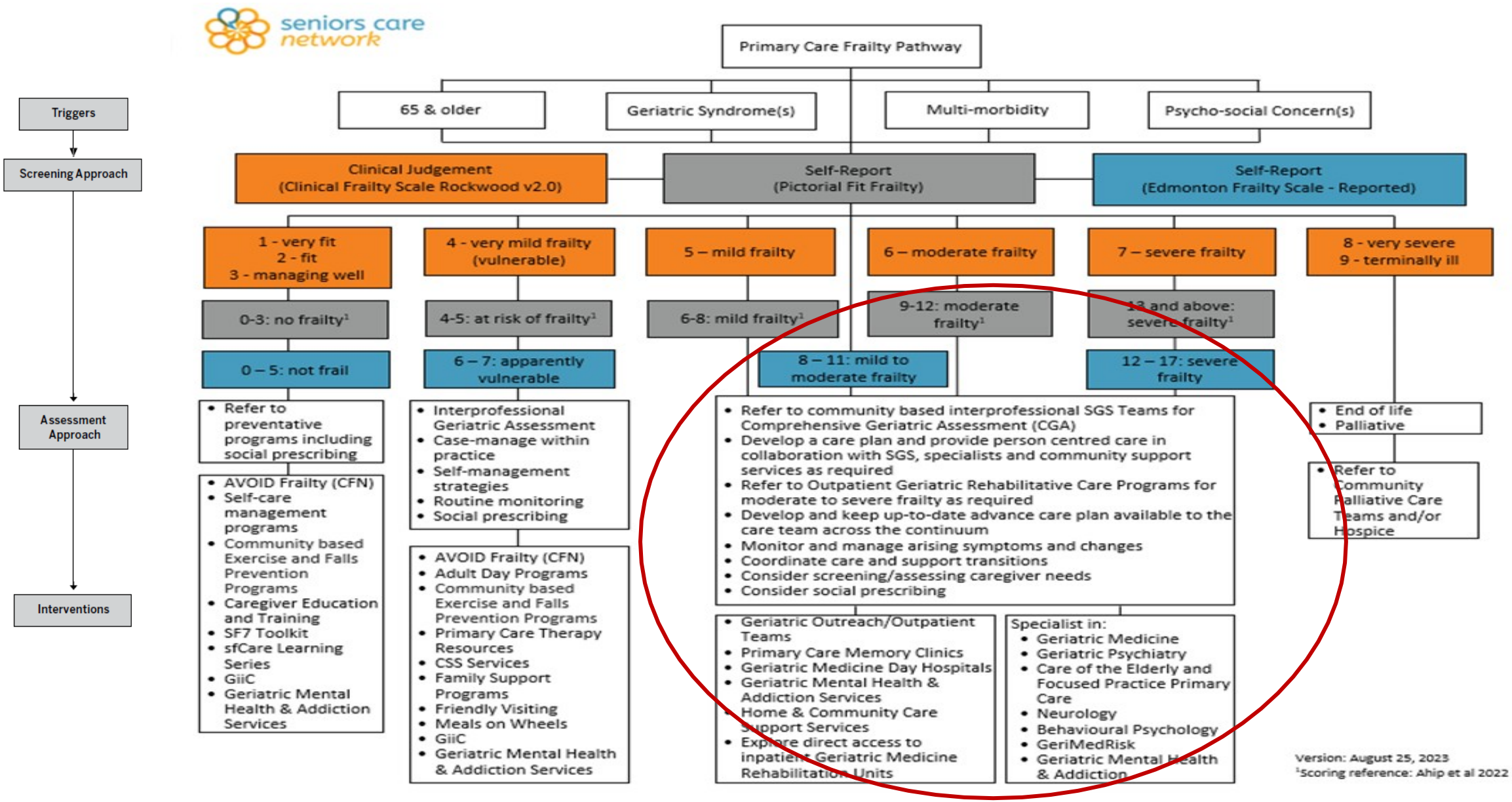
Frailty Screening

- A proactive approach of **identifying** individuals who are living with or at-risk of frailty
- Early identification will lead to earlier/further fulsome assessments (e.g., CGAs) leading to timely diagnoses and interventions.
  - Delayed identification misses opportunity for frailty reversal
  - Usually a quick process
  - Frailty status is an explicit output

- Clinical judgement, further assessments and diagnostics identify the root cause



Reference: Nalla, N. & Ehsan, S. (2025). Enhancing Comprehensive Geriatric Assessments in Ontario and Canada. Best Practices, Optimization, and the Role of Interprofessional Teams.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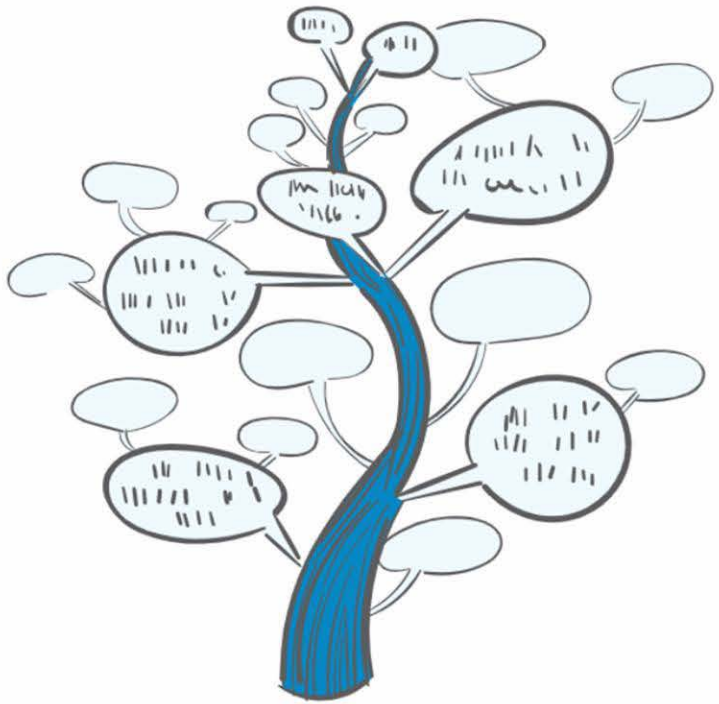
Primary Care Frailty Pathway
Triggers
65 & older
Geriatric Syndrome(s)
Multi-morbidity
Psycho-social Concern(s)
Screening Approach
Clinical Judgement (Clinical Frailty Scale Rockwood v2.0)
Self-Report (Pictorial Fit Frailty)
Self-Report (Edmonton Frailty Scale - Reported)
1 - very fit
2 - fit
3 - managing well
4 - very mild frailty (vulnerable)
5 – mild frailty
6 – moderate frailty
7 – severe frailty
8 - very severe
9 - terminally ill
0-3: no frailty[1]
4-5: at risk of frailty[1]
6-8: mild frailty[1]
9-12: moderate frailty[1]
13 and above: severe frailty[1]
Assessment Approach
0 – 5: not frail
6 – 7: apparently vulnerable
8 – 11: mild to moderate frailty
12 – 17: severe frailty
Refer to preventative programs including social prescribing
Interprofessional Geriatric Assessment
Case-manage within practice
Self-management strategies
Routine monitoring
Social prescribing
Refer to community based interprofessional SGS Teams for Comprehensive Geriatric Assessment (CGA)
Develop a care plan and provide person centred care in collaboration with SGS, specialists and community support services as required
Refer to Outpatient Geriatric Rehabilitative Care Programs for moderate to severe frailty as required
Develop and keep up-to-date advance care plan available to the care team across the continuum
Monitor and manage arising symptoms and changes
Coordinate care and support transitions
Consider screening/assessing caregiver needs
Consider social prescribing
End of life
Palliative
Refer to Community Palliative Care Teams and/or Hospice
Interventions
AVOID Frailty (CFN)
Self-care management programs
Community based Exercise and Falls Prevention Programs
Caregiver Education and Training
SF7 Toolkit
sfCare Learning Series
GiiC
Geriatric Mental Health & Addiction Services
AVOID Frailty (CFN)
Adult Day Programs
Community based Exercise and Falls Prevention Programs
Primary Care Therapy Resources
CSS Services
Family Support Programs
Friendly Visiting
Meals on Wheels
GiiC
Geriatric Mental Health & Addiction Services
Geriatric Outreach/Outpatient Teams
Primary Care Memory Clinics
Geriatric Medicine Day Hospitals
Geriatric Mental Health & Addiction Services
Home & Community Care Support Services
Explore direct access to inpatient Geriatric Medicine Rehabilitation Units
Specialist in:
Geriatric Medicine
Geriatric Psychiatry
Care of the Elderly and Focused Practice Primary Care
Neurology
Behavioural Psychology
GeriMedRisk
Geriatric Mental Health & Addiction
Version: August 25, 2023
[1]Scoring reference: Ahip et al 2022

KAWARTHA LAKES HALIBURTON
PRIMARY CARE NETWORK

Home About Practice Supports KLHOHT Contact



Care Pathways Decision Tree

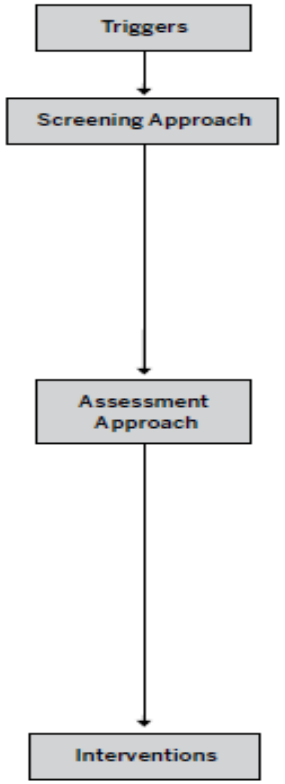
Select the most appropriate decision tree based on where the patient resides. If you have any questions about the Frailty Pathway or would like help setting up the referral destinations in Ocean, reach out to info@klhpcn.ca

Download (Microsoft Word):

Kawartha Lakes

Haliburton County

Community Frailty Pathway



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Community/Community Support Services Frailty Pathway

65 & older

Concern(s) regarding physical, social, cognition and/or mental health

Self-Report (Pictorial Fit-Frail)

Groningen Frailty Index

0-3: no frailty[1]	4-5: at risk of frailty[1]	6-8: mild frailty[1]	9-12: moderate frailty[1]	13 and above: severe frailty[1]
0-2 no frailty[2]	3 at risk[2]	4-6: mild frailty[2]	7-10 moderate frailty[2]	11 and above: severe frailty[2]

- Refer to preventative programs including social prescribing

Examples include:
- AVOID Frailty (CFN)
- Self-care management programs
- Community Based Exercise and Falls Prevention Programs
- Caregiver Education and Training
- SF7 Toolkit
- sfCare Learning Series
- GiiC
- Geriatric Mental Health & Addiction Services

- Communicate concerns to Primary Care
- For unattached clients, consider direct referral to Specialized Geriatric Services
- Self-management strategies
- Social prescribing

Examples include:
- AVOID Frailty (CFN)
- Adult Day Programs
- CSS Services
- Community Based Exercise and Falls Prevention Programs
- Family Support Programs
- Friendly Visiting
- Meals on Wheels
- GiiC
- Geriatric Mental Health & Addiction Services

- Refer to community based interprofessional SGS Teams for Comprehensive Geriatric Assessment (CGA)
  - Geriatric Outreach/Outpatient Teams
  - Primary Care Memory Services
  - Geriatric Mental Health & Addiction Services
- Refer to Outpatient Geriatric Rehabilitative Care Programs for moderate to severe frailty as required
- Explore direct access to Inpatient Rehabilitative Care moderate to severe frailty as required
- Provide person centred care in collaboration with SGS, specialists and community support services as required

Add local Specialized Geriatric Medicine, Geriatric Mental Health & Addiction Services, and community support services

Version: September 24, 2024

[1] Scoring reference: Ahip et al 2022

[2] Scoring reference: Sison et al, 2023

Why timely connections matter ?

As evident by the Return on Investment Report of one of our biggest SGS programs, GAIN, comprehensive assessments & coordinated interventions improve client outcomes.

Frailty Status
stabilized or improved in **66%** of the clients.

Dementia Staging
scores stabilized or improved in **68%** of the clients

Falls/falls-risk
reduced in **69%** of the clients for whom it was identified a concern at initial CGA

ED utilization
reduced in **1 in 3** clients

Read full report

Reach and Uptake

~3500

Frailty-specific Page Views

>600

Resources Downloads

Presentations at over a dozen multi-stakeholder tables: OH-West Knowledge Exchange, OH-West CSS group, Alzheimer Societies in Ontario (ASiO), etc.

Examples of uptake:

- **OHTs:** Kawartha Lakes Haliburton OHT, Brantford Brant Norfolk OHT
- **Organizations, collaboratives & SGS programs:** East Region ADP Collaborative, Northumberland Hills Hospital (ED Frailty Pathway), etc.

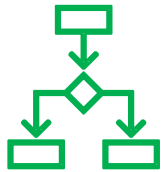
" Having a "common language" between different specialized geriatric programs has been incredibly helpful for triage and waitlist management.....we look forward to continuing to implement frailty pathways across different programs."
Location: organization in **OH East**.

"I have been using these documents widely at a pre-implementation phase in a NSM SGS early identification project. The documents are exceptionally well laid out in terms of conceptualizing how to implement the project thoughtfully."
Location: organization in **OH Central.**

Perceived Benefits – Goal(s) for implementation for early adopters

Proactive service connections home and community services

Individualized care planning



Outcomes Monitoring

Objective measure of the complexity of the clientele served in Adult Day Programs

Referral distribution among SGS

Central East Cognition Referral Pathway

Discharge and transitions

Example- Cross-sectoral frailty response at KLH OHT

Community

HHHS-CSS Central Intake

Telephone-based Frailty tool (GFI) implemented as a part of the intake: Facilitates in-house service connections, establishment of a base-line, identifying clients suitable for Wellness Connections Program

CCCKL- Social Prescribing Program

Telephone-based Frailty tool (GFI) implemented as a part of the intake: Facilitates connections to community services impacting social determinants of health; staff reported great feedback from PCPs

Primary Care

Haliburton Highlands FHT

PFFS implemented across select specialized programs (Memory Clinic). Facilitates personalized care planning, service connections and establishment of a baseline; Custom tool bars developed within the EMR, and efforts made to digitize outbound referrals

Expansion efforts across other Primary Care Practices

Planning efforts to implement PFFS and GFI in a partner FHT and another partner memory clinic

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Kawartha Lakes Haliburton Ontario Health Team

Success Stories- KLH OHT

Supporting individuals with self-management:

Client connected to *Bounce Back Ontario* and *Anxiety Canada* online programs. Client used structured CBT therapy virtually; was able to recognize major sources of anxiety and develop a plan to address it with ongoing support from WP coordinator.

Timely SGS connections:

Unintentional weight loss of >25 lbs. in 2 months identified through PFFS; guided by the frailty decision-tree, connection with interprofessional geriatric team was successfully made.

Provider Experience:

Decision-tree is great!

We have further modified it to our local setting!

Clients are inquisitive!

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Kawartha Lakes Haliburton Ontario Health Team

In Summary

- All system partners can play a pivotal role both individually and collectively in optimizing outcomes for individuals living with or at risk for frailty

- Frailty management requires integration of primary, specialized, & social and community support service

- We need mechanisms to **share** frailty status across internal and external providers to facilitate a coordinated community response where frailty status is used as a common language

- Collective frailty data will provide overview of the clientele served
  - May further inform priorities for cross-partner collaboration.
  - Overtime, frailty status can be tracked as an outcome measure

Read full ROI report

Contact:

Sabeen Ehsan: sehsan@seniorscarenetwork.ca

Access Frailty Pathway Guidance Documents:
https://www.seniorscarenetwork.ca/frailty

Want to join Frailty Pathway Community of Practice?

Complete the form or contact Sabeen Ehsan

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Canadian Home Care Association | Project ECHO

Integrated Seniors Care

Discussion / Q&A

Dr. Kenneth Rockwood OC MD, FRCPC, FRCP
Professor, Dalhousie University; Geriatrician, Nova Scotia Health

Dr. Sabeen Ehsan, MD, EMHI
Director, System Planning & Quality, Seniors Care Network

Upcoming TeleECHO Clinics

Canadian Home Care Association
Project ECHO
Integrated Seniors Care

cdnhomecare.ca/chca-project-echo-integrated-seniors-care

CHCA Project ECHO Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in Home and Primary Health Care

Canadian Home Care Association ECHO

Respecting Spiritual and Cultural Needs in Decision-Making
March 4 2026, 1 – 2 pm Eastern

Recognizing and Responding to Caregiver Burden in Home and Community Care Clients
April 1, 2026 12 – 1 pm Eastern

Applying the Comprehensive Geriatric Assessment (CGA) in Team-Based Care
April 29, 2026 12 – 1pm Eastern

Thank you for taking a moment to complete the survey!