seniors care network

Frailty Screening & Management in the Community

GUIDANCE DOCUMENT

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Acknowledgments

This guidance document is based on the ongoing efforts of the members of the **Ontario Collaborative for Aging Well (OCAW)**; a grass-roots group of local, regional, and provincial partners who work with older adults living with or at risk of frailty. OCAW brings together more than 25 organizations representing: age friendly communities; caregivers; dementia experts; francophone planners; mental health and addictions experts; older adults; rehabilitative experts; research and academic institutes; Ontario Health Teams (OHTs inclusive of primary care); and specialized geriatric services.

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Intended Audience

The guidance document is intended to guide the implementation of frailty screening and management in **community**-settings i.e., organizations providing community-based support(s) and services to older adults.

An accompanying document titled 'Customizable Templates for Frailty Screening and Management in the Community' has been developed to help community organizations tailor the recommended practices in accordance to their preferences and service availability in their local area/region.

What is frailty and its various domains

Across the Ontario health care system, there is developing interest in designing care approaches that better address the needs of older adults (individuals aged 65+) living with multiple, and often interacting, complex and chronic health conditions.[1]

According to the Canadian Frailty Network, frailty is defined as a state of increased vulnerability, with reduced physical reserve and loss of function across multiple body systems.[2] It predicts death, heightened vulnerability, institutionalization, and a reduced quality of life.[1]

OCAW takes a more comprehensive approach in describing the concept of frailty and therefore recommends that the concepts such as complexity and frailty, must include the physical, cognitive, mental, and social health of older adults and their care partners, and the interaction and integration of these domains.[1]
See **Figure 1** below:

FIGURE 1: Domains of Frailty

SOURCE: PGLO, 2022

[1] Provincial Geriatric Leadership Ontario (2022). **Consensus Statement: Care for the Older Adult with Complex Health Conditions—Reframing 'Frailty' in an Ontario Contex—Provincial Geriatrics Leadership Ontario**

[2] Canadian Frailty Network (2023). Backgrounder: The Concept of "Frailty" and How it Can Help Reform our Health System

Considered this way, an older adult may simultaneously demonstrate some or all of:

- a change or reduction in function or decline from relatively minor illness (physical)[3]
- changes in thinking or memory that may also impact function (cognition)[4,5,6]
- changes in mood (e.g., depression[7,8,9]) or psychological well-being (mental health[10]) and/or
- a limited or inconsistent support network[4], loneliness and social isolation, housing precarity, or food insecurity among other concerns, as well as the impacts of structural ageism, institutional racism and other forms of discrimination (social health).[1]

Holistic approaches to Frailty Prevention and Management (Frailty Pathways)

Supporting older adults with complex needs requires holistic, coordinated, and integrated approaches to promote independence and quality of life, and prevent adverse events (e.g., falls, institutionalization)[11] also sometimes referred to as frailty pathways. Frailty pathways are standardized approaches to prevention, identification, assessment, and management (treatment and interventions) to support older adults with living in the community, and/or maintaining their function and independence. These holistic population-level and/or collaborative approaches have been successfully implemented in various international (e.g., **National Health Services, UK**) and Canadian jurisdictions (e.g., **Seniors Community Hub, Alberta**, **CARES Program, BC**).

A thorough review of literature (including the models specified above), and consultations with geriatric experts further heightened the importance of implementing these holistic yet standardized approaches to frailty prevention and management across Ontario. Considering that an older adult interacts and receives services from various health care sectors (primary care, acute care, community and social supports, etc.), each sector can play a pivotal role in the prevention and timely management of frailty.

[1] Provincial Geriatric Leadership Ontario (2022). Consensus Statement: Care for the Older Adult with Complex Health Conditions—Reframing 'Frailty' in an Ontario Contex—Provincial Geriatrics Leadership Ontario
[3] Canadian Frailty Network https://www.cfn-nce.ca/frailty-matters/what-is-frailty/
[4] Rivan et al. (2021). https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-021-02525-y
[5] Ellwood et al. (2021). https://doi.org/10.1177/01640275211045603
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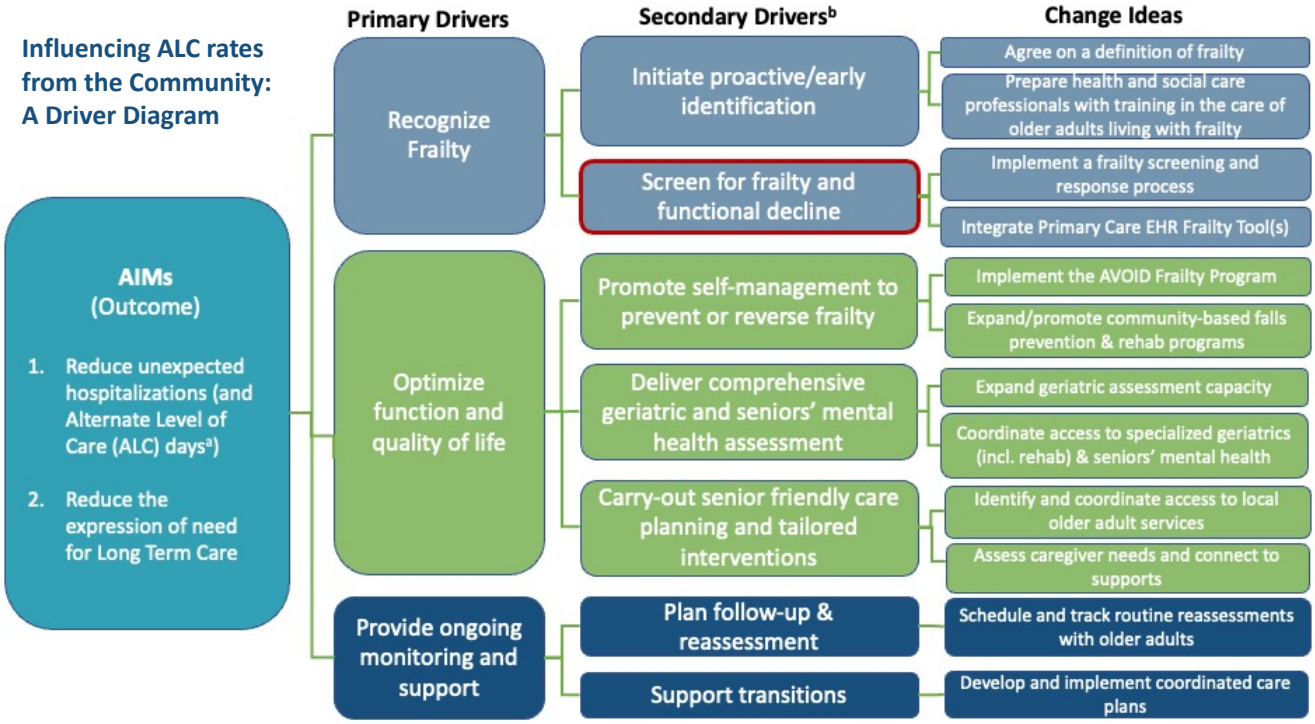
[10] WHO (2018). https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response
[11] PGLO 2022.

Additionally, as elaborated in **Figure 2**, avoidance, and early recognition and management of frailty can drive reductions in early and/or repeat institutionalizations (both in hospital and long-term care), hence directly impacting Alternate Level of Care (ALC) rates and long-term-care waitlists. Additional recommendations on ALC prevention and management are further elaborated in ALC Leading Practices.

FIGURE 2: Influencing ALC Rates from the Community: A Driver Diagram

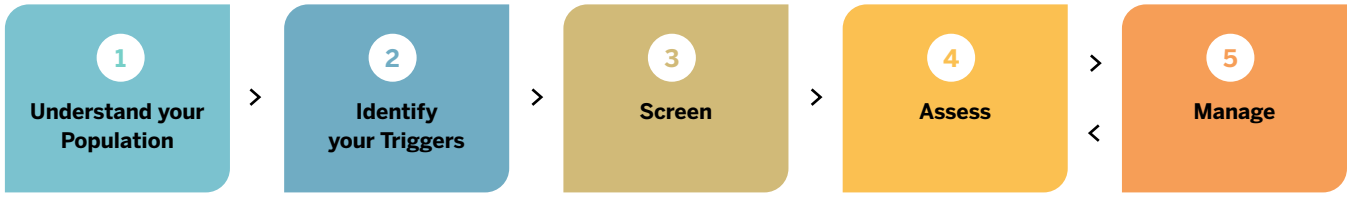
SOURCE: PGLO, 2023.



[a]Required cQIP Indicator
[b]ALC Leading Practices (Community)

Based on the above evidence, OCAW recommends an evidence-informed 5-step (See **Figure 3**) approach to frailty management in primary care and community settings.

FIGURE 3: Holistic Approach to Frailty Management



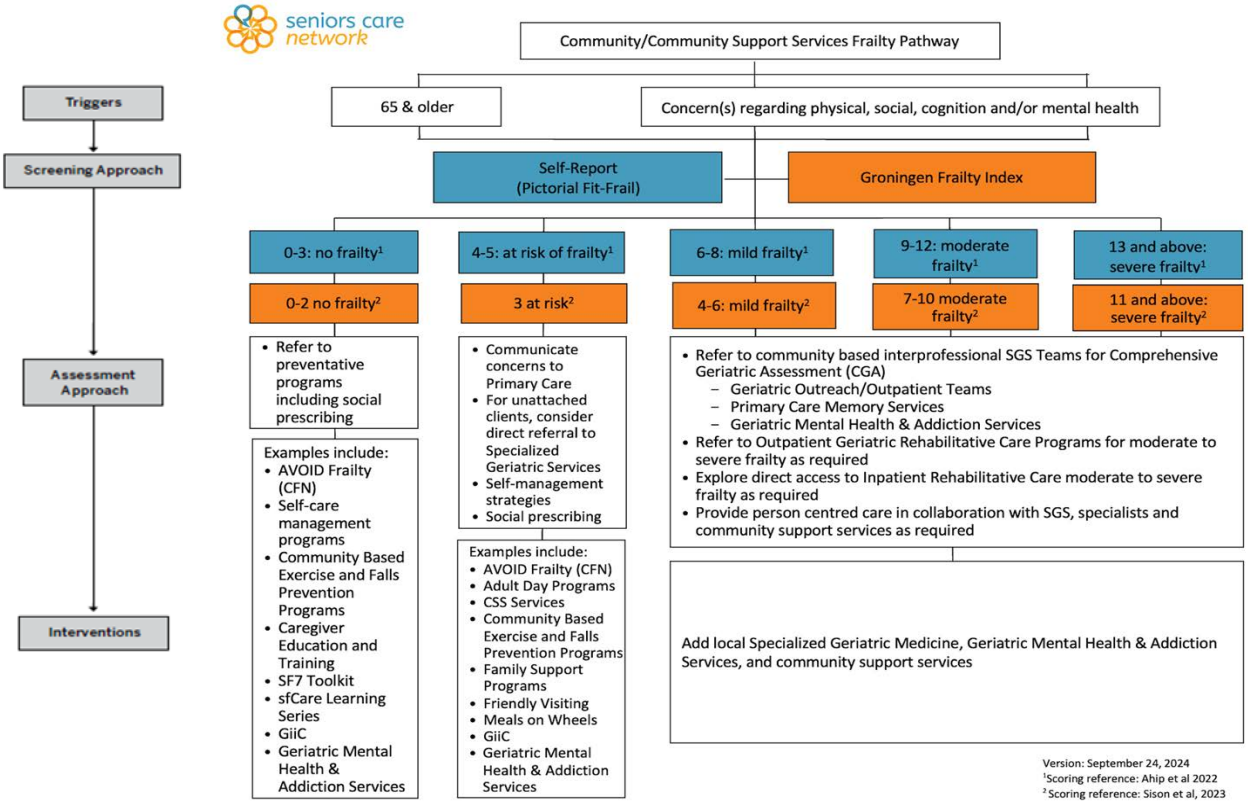
STEP 1—UNDERSTAND YOUR POPULATION

There are different methods that can be used to understand your population and trends.

- **Population-level:** Review of administrative data sources such as the PGLO Frailty Estimates is recommended to understand the prevalence of frailty in your population and identify trends. Review **Appendix 1** for tips regarding the interpretation of administrative data.
- **Practice-level:** Consider conducting chart-reviews using the sample chart review tool.

Refer to the **Figure 4** as a guide for the remaining 4 steps:

FIGURE 4: Community/Community Support Services Frailty Pathway



STEP 2—IDENTIFY YOUR TRIGGERS

The following triggers can be used to identify individuals that should be screened for the presence of frailty:

- Age 65 & older
- Presence of concerns regarding physical, social, cognition and/or mental health

STEP 3—SCREENING APPROACH

A rapid review of literature and reference resources was conducted to identify validated frailty screening tools for community settings. Each tool was examined in the following 8 areas:

- Implementation setting
- Expertise required
- Screening process
- Domains screened (physical, cognitive, mental and social aspects)
- Classification/scoring
- Time of administration
- Pros (ease of access)
- Cons (costs)

"Supporting older adults with complex needs requires holistic, coordinated, and integrated approaches to promote independence and quality of life."

Based on the findings of the review (See **Appendix 2**), the following two tools are recommended: Pictorial Fit-Frail Scale, and the Groningen Frailty Index. These two tools can be completed by the client/care partner, are comprehensive and cover all four domains of frailty. The one tool that best meets the needs and preferences of the organization should be selected.

If the use of a screening tool other than the ones recommended above is being considered, it is advised to review the tool in light of the above-stated 8 criteria. The criterion of 'domains covered' is important, as it determines the comprehensiveness of a screening tool. If your shortlisted/selected tool does not cover all four domains of frailty, we recommend adding additional questions or parameters to the screening process.

STEP 4—ASSESSMENT APPROACH

Follow the Frailty Pathway **(Figure 4)** for assessment approaches based on the presence and/or level of frailty leveraging primary care and specialized services partners.

STEP 5—INTERVENTIONS

Refer to the interventions section of the Frailty Pathway (**Figure 4**) as an example to appropriately manage clients across the frailty spectrum. However, these interventions should be modified and refined based on the availability of local and sub-regional community and SGS resources in your jurisdiction.

The bottom rectangle on left most side highlights some upstream approaches for individuals who are not frail or at risk for frailty. These include leveraging the AVOID Frailty framework such as, preventative/self-management resources and coaching programs, and community support services.

The right side depicts more downstream approaches with the explicit role of Specialized Geriatric Services (SGS) and Geriatric Mental Health and Addictions Services for individuals that are more advanced on their frailty journey. **Appendix 3** refers to some examples of Social Prescribing that should be considered across the frailty spectrum. These interventions should be modified and refined based on the availability of local and sub-regional community and specialized resources in your jurisdiction.

Refer to the accompanying document titled 'Customizable Templates for Frailty Screening and Management in the Community' to design the pathway based on your preferences and the available interventions in your local area/region.

"Interventions should be modified and refined based on the availability of local and sub-regional community and specialized resources in your jurisdiction."

Interpreting Administrative Data and Identifying Limitations

SOURCE: PGLO, 2022.

- Ask "Who entered this data and what do they know about older adults"? What is the purpose of the data (evaluation or learning)?
- Administrative data may underestimate the population living with frailty. Plan for more demand than the data suggests.
- High multimorbidity suggests single diagnosis pathways will be less effective and geriatric approaches are called for. Partner with local geriatric services to support implementation.
- High numbers of visits to primary care are an important signal of the need for interprofessional team-based care and proactive appointment scheduling.
- Patients who visit primary care frequently may not be the same group visiting the emergency department.
- High emergency department utilization signals the need for ED based geriatric care (in addition to other care) to support discharge or admission with a plan.
- If the CTAS frailty modifier is not being used in your ED, be suspicious of CTAS scores 4 & 5 in people with frailty—the very definition of frailty is that minor stressors cause major effects.
- Low rates of Ambulatory Care Sensitive Conditions (ACSC) related hospitalizations (e.g., 3.4%) means people with frailty are not using the hospital inappropriately.
- High 30-day readmission (e.g., 26%) means more attention is required for rehabilitative care.

"High numbers of visits to primary care are an important signal of the need for interprofessional team-based care and proactive appointment scheduling."

Rapid Review of Frailty Screening Tools

TABLE 1—Tools covering all 4 domains of Frailty as defined by OCAW

SOURCE: SENIORS CARE NETWORK, 2022.

TOOLS	OVERVIEW	EXPERTISE REQUIRED	TIME OF ADMIN	DOMAINS COVERED	COMMENTS
Groningen Frailty Index Click here to download Groningen Frailty Index	15-item self-completion questionnaire	• Filled by general public • Interpretation by clinician	++	Physical, psycho-logical, social, cognition	• Can be mailed/posted • Score of 4 or higher indicates frailty
The Pictorial Fit-Frail Scale Click here to download the Pictorial Fit-Frail Scale (dal.ca)	• Used for self- or proxy-assessment of a person's usual state of fitness-frailty • Evaluates a person's ability in 14 different domains	• Filled by general public • Interpretation by clinician	+	Physical, psycho-logical, social, cognition	• 0 (no frailty; very fit) to 43 (severe frailty) • The Pictorial Fit-Frail Scale (PFFS)—YouTube video • Various versions available • Copyrighted

TABLE 2—Other tools for consideration

TOOLS	OVERVIEW	EXPERTISE REQUIRED	TIME OF ADMIN	DOMAINS COVERED	COMMENTS
Frailty Assessment for Care Planning (FACT Tool) accessible through PATH app https://pathclinic.ca/app/	• FACT uses the descriptors within the Clinical Frailty Scale • **Collateral** reported questions; can also be completed by HCP • Objective cognitive testing by HCP	• Filled by general public • Interpretation by clinician	++	Physical, social, cognition	• The tool provides information on frailty level, the drivers of frailty and produces a mini CGA style printable report and links to care guidelines • Screening for frailty with the FACT (Frailty Assessment Care planning Tool)—YouTube
Assessment Urgency Algorithm (AUA)	• Identifies the need for comprehensive assessment • Used to prioritize the need and urgency for follow-up/additional assessments.	• Filled by general public • Interpretation by clinician	+	Physical, psycho-logical, cognition	• Higher score associated with a higher risk for loss of indepen-dence and indicates the need for a more comprehensive geriatric-focuses assessment. • An older adult scoring 5 or 6 would benefit from referral to a physician for further comprehensive clinical assessment in addition to other services identified.
PRISMA 7 https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/frailty-prisma7.pdf	• 7 item self-completion questionnaire	• Filled by general public • Interpretation by clinician	+	Physical, social	• Can be mailed/posted • **less effective at discriminating the non-frail from the pre-frail or frail populations**
FRAIL Scale https://ihub.scot/media/6732/20170131-frailty-tools-table-v50.pdf (ihub.scot)	• Five yes/no questions covering five physical domains. • It can be administered by health professionals and care givers. • 0: robust health status • 1-2: Pre-frail • 3-5: Frail	• Filled by general public • Interpretation by clinician	+	Physical	• Not widely used • Broad classification

Social Prescribing Examples & Considerations

Community Health Centres of Northumberland-Social Prescription embedded in EMR.

SOCIAL PRESCRIPTION DESCRIPTIONS

Access to Info and Support	Help with finding services in the community (i.e. income taxes, house cleaning, transportation,)
Exercise programs Internal/External	Any physcial activity. i.e. yoga, chair based classes, walking. Also assistance to connect to external agencies (i.e. Ruth Clarke, YMCA etc)
Outdoor Activities (garden, trails etc)	Assistance connecting to Garden programs, walking groups, Ganaraska Trails, Tree Top Trekking, Fishing etc
Social/Cultural Programs	Assitance connecting to social groups internally and externally. (i.e. teas, book club, cards, art, woodworking etc)
Wellness Programs	Assistance connecting to support grps, friendly callers, mental health workshops, mindfulness etc
Food Support/ Food Literacy	Assistance connecting to a food bank, community meals, cooking programs etc
Digital Equity	Loaning of an iPad, assistance with device, assistance connecting to a virtual program or appointment
Volunteering	For clients interested in volunteering at our Centre, or curious about volunteer opportunities in the community

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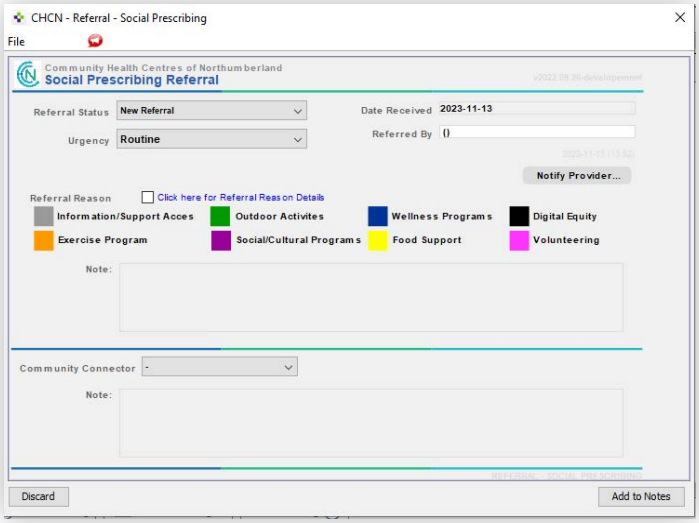

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