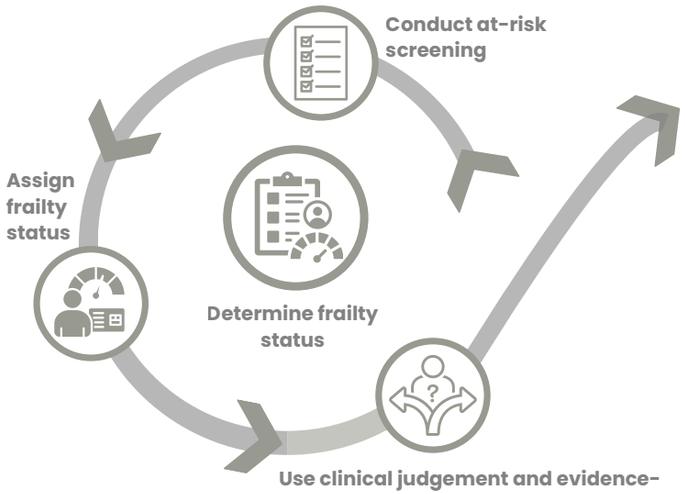
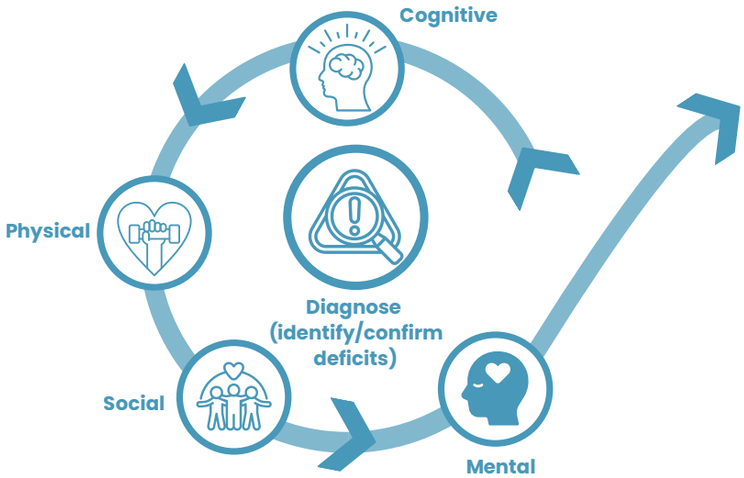
seniors care network

The Geriatric Care Continuum: Screening, Assessment, and Intervention
Exploring key differences and connections

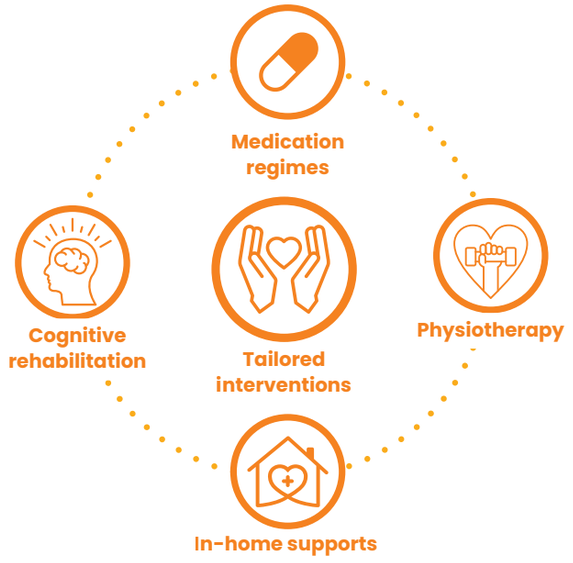
Frailty Screening



Comprehensive Geriatric Assessment



Care Planning



	Frailty Screening	Comprehensive Geriatric Assessment	Care Planning
Purpose	A proactive approach of **identifying** individuals who are living with or at-risk of frailty.	An in-depth **specialized assessment** conducted by geriatric assessors (such as the GAIN interprofessional teams) identifying and/or confirming factors that are leading to deficits and frailty.	A personalized care plan (e.g., medications, in-home supports, physiotherapy, etc.) for **tailored interventions.**
Outputs	Frailty Status using a validated tool such as, Pictorial Fit-Frail Scale (PFFS), Clinical Frailty Scale (CFS), etc.	Diagnosis/multiple diagnoses, staging (e.g., dementia), etc.	Referrals to appropriate community and specialized services
Next Steps	**Further in-depth assessments*** If individuals do not need any further assessments; they will be monitored, connected with services that promote healthy aging, and then **re-screened**	Geriatric specialists/assessors (ideally an interprofessional team) build a **personalized care plan** (e.g., medication changes, physiotherapy, home supports)for tailored interventions.	Continuous monitoring of the **outcomes** of interventions
	Early identification will lead to earlier assessment leading to timely interventions	**Timely CGA would identify and address factors that would contribute to adverse outcomes i.e., the root-causes, and what can be done to manage them through tailored interventions and service connections**	**Enhance patient outcomes, improve quality of life, promote independence, and reduced unnecessary treatments and hospital visits**

***When is further assessment needed?**

In-depth assessments (including CGAs) will be conducted if screened positive for frailty (usually mild and above). These post-screening assessments are based on the frailty status and therefore could be conducted within Primary Care or Specialized Geriatric Services, depending on expertise needed.

References:

- Nalla, N. & Ehsan, S. (2025). Enhancing Comprehensive Geriatric Assessments in Ontario and Canada. Best Practices, Optimization, and the Role of Interprofessional Teams.
- Ehsan, S., & Schwartz, R. (2023). Frailty Screening & Management in Primary Care Guidance Document.

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