Frailty Pathways: A Population Health Management Strategy for Older Adults

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Background

In Ontario Canada, community-dwelling older adults living with frailty and/or impacted by social determinants of health are a priority population for various Ontario Health Teams (OHTs). Composed of health and community sector providers, OHTs organize and deliver services in local communities.[1] Evidence[2] suggests that proactive frailty screening and identification, and promotion of self-management strategies improve function and independence, and contribute towards reduced acute care utilization and permanent institutionalization among older adults living with complexity.

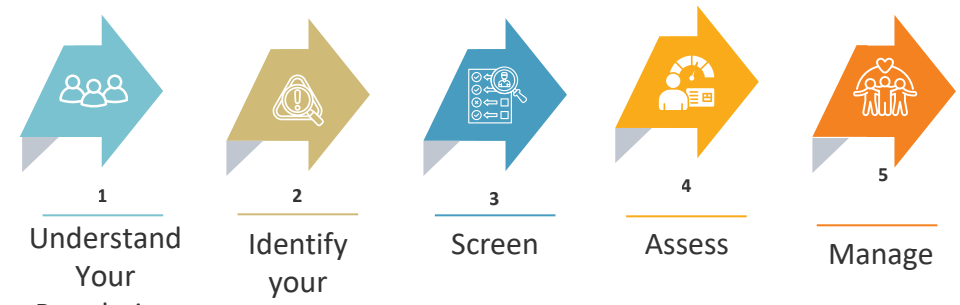
Approach

Seniors Care Network leads the organization, coordination, and governance of specialized geriatric services across Central East Ontario. This Region hosts four OHTs and is home to ~51,000 older adults living with frailty. In response to the growing needs of this population, the Network took a strategic approach by designing **sector-specific Frailty Pathways** tailored to Ontario's healthcare context.

Figure 1. Sector-Specific Frailty Pathways

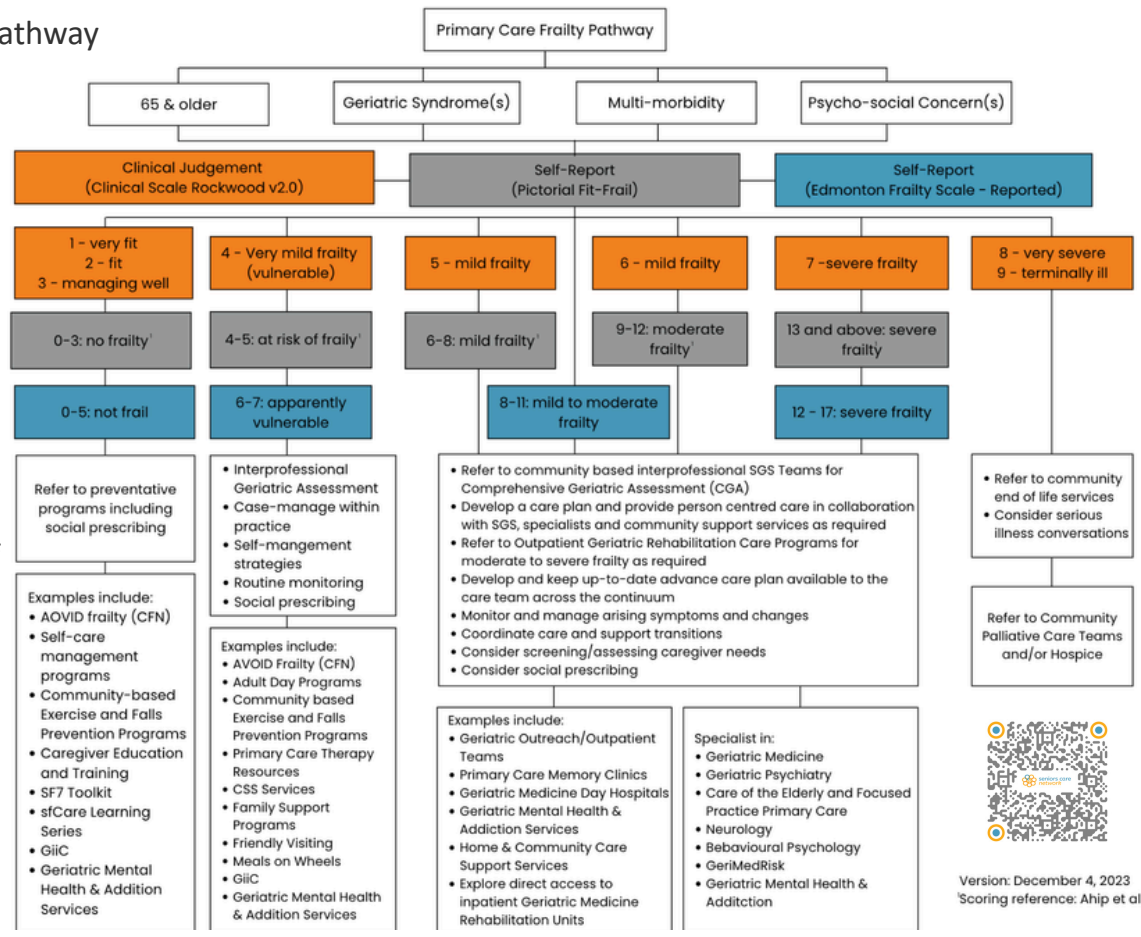
Primary Care and Community Frailty Pathways | **Frailty and Chronic Disease Management** | **ED Frailty Pathway**

Figure 2. Step-wise Approach



These pathways offer a step-wise, standardized approach to preventing, identifying, assessing, and managing frailty.[3] They position frailty status as a **common language** to guide service access and transitions across the continuum of care. Entry into a pathway can occur through any setting (e.g., primary care, community programs, emergency services, acute care, etc.). See Figure 3 as an example. Multiple organizations in Central East Ontario and beyond, have implemented Seniors Care Network frailty pathways across the aforementioned settings.

Figure 3. Primary Care Frailty Pathway



1 Understand Your Population

The implementation starts with understanding the characteristics of the older adult clientele served, which allows identification of triggers to initiate screening among high-risk groups.

2 Identify Triggers

Triggers can be used to identify individuals that should be screened for the risk/presence of frailty. These may include: age cut-offs, geriatric syndromes, psycho-social concerns, etc.

3 Screen

Frailty screening is conducted using a holistic tool that covers the physical, cognitive, mental and social domains of frailty.

4 Assess

The resulting frailty status (absence, risk or severity of frailty) is used to identify immediate and long-term assessment and management needs.

5 Manage

A customized 'decision-tree' facilitates care planning, which includes referrals to local self-management programs, specialized geriatric, seniors' mental health, and community services, particularly those addressing social determinants of health.

Using clinical judgement, re-screening at regular intervals is recommended to monitor changes in frailty status as both a clinical indicator and outcome measure.[3] Unexpected progression prompts reassessment to address root cause/contributing factors.

Results

To date, hundreds of frailty screens have been completed across various settings. Consequently, clients are connected with appropriate programs and services to support their assessment and management needs. Health and community care providers are trained on the use of setting-appropriate frailty screening tools. Coaching is provided to support effective communication of the frailty status to the client and care partners. To reduce administrative burden, digital tools (e-screening forms, referral platforms, etc.) are used to streamline workflows. Processes have been built to share frailty status among providers to prevent screening fatigue and support collaborative care planning. Providers find customized decision-trees easy to use as they help answer the 'so-what?', thereby relieving post-screening decision-fatigue. Clients are inquisitive and want to learn more about frailty and the ability to manage their own health.

Implications

Frailty pathways demonstrate an integrated, cross-sectoral response to frailty management in Ontario. They strengthen geriatric expertise across the circle-of-care and facilitate older adults to age well in their communities.

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Citations
[1]Ontario Health. Ontario Health; 2025.
[2]Provincial Geriatrics Leadership Ontario. Influencing ALC Rates from the Community. Provincial Geriatrics Leadership Ontario; 2023.
[3]Ehsan, S., & Schwartz, R. Frailty Screening & Management in Primary Care Guidance Document. Seniors Care Network; 2023.
[4]Provincial Geriatric Leadership Ontario. Consensus Statement. Provincial Geriatrics Leadership Ontario; 2022.