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Enhancing Comprehensive Geriatric Assessments (CGAs) in Ontario and Canada- Best Practices, Optimization, and the Role of Interprofessional Teams

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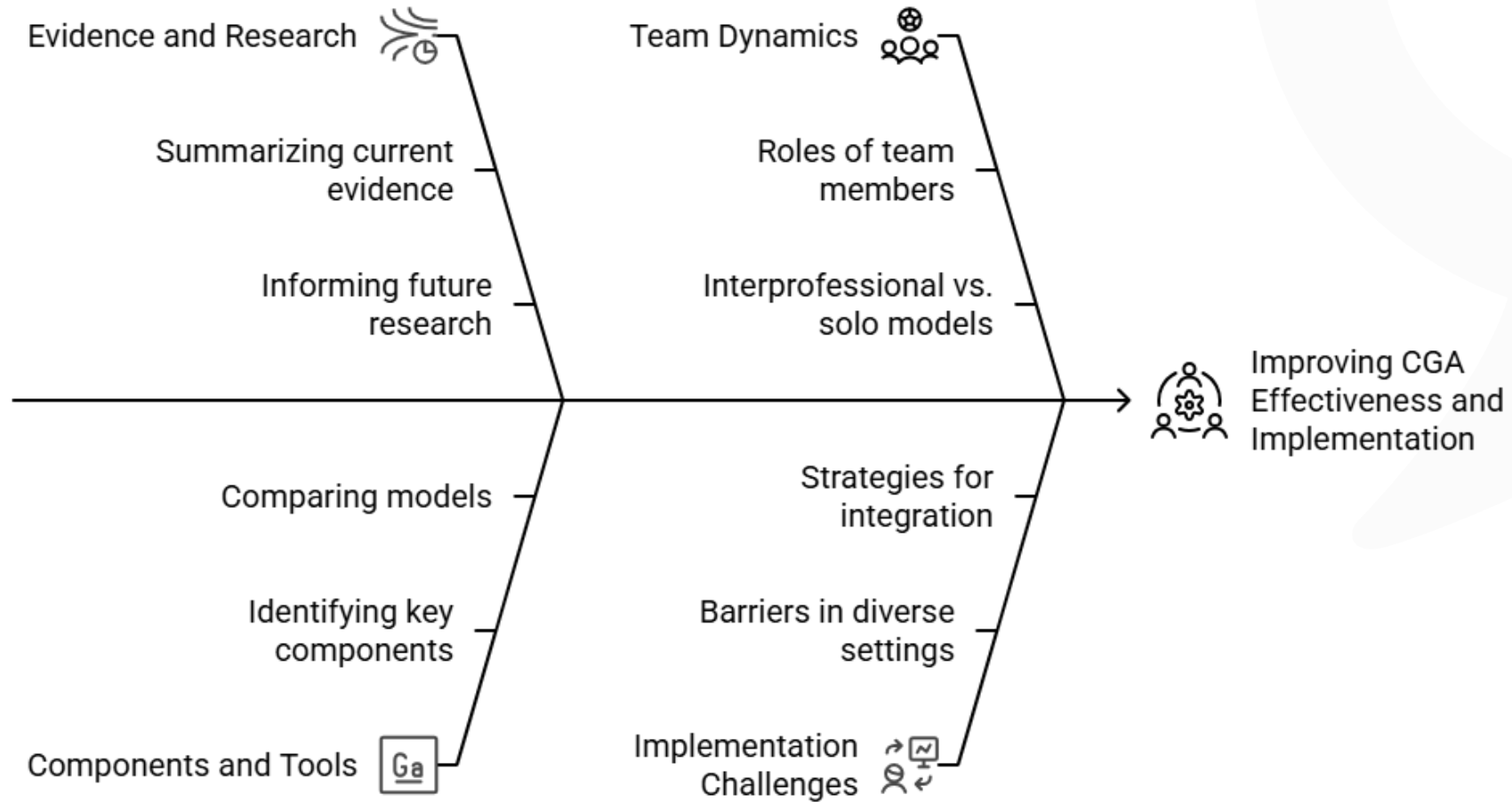
Background

- By 2036, **one in four** Canadians will be over the age of 65, placing significant pressure on the healthcare system (Saripella et al., 2021; Flores-Sandoval et al., 2021).

- Comprehensive Geriatric Assessments (CGAs) are considered the gold standard for evaluating the medical, functional, and psychosocial needs of older adults (St. John & Hogan, 2014).

- While CGAs have traditionally been led by physicians or nurse practitioners, there is increasing recognition of the value interprofessional teams bring in enhancing assessment quality and improving patient outcomes (Soobiah et al., 2017; Wong et al., 2025).

- Evidence from Ontario shows that interprofessional CGA models such as Integrated Care Teams and Geriatric Oncology Clinics have been piloted and implemented, **though their effectiveness and scalability remain under-examined** (Heckman et al., 2025; Menjak et al., 2025).
  - Although not identified in the literature review, other SGS Programs have also implemented interprofessional CGAs in Ontario.

- A comprehensive review is needed to evaluate the effectiveness of these models (assessment perspectives), identify best practices, and inform future healthcare planning.

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Objectives

- To examine:
    - The foundational elements of CGA
    - The effectiveness and outcomes of CGA
    - Implementation and optimization strategies
    - How interprofessional teams enhance the delivery and outcomes of CGAs; unique roles and value-add

- The scope is limited to publicly available, peer-reviewed literature relevant to the Canadian context.

Approach

Enhancing Comprehensive Geriatric Assessments

Evidence and Research

Summarizing current evidence

Informing future research

Comparing models

Identifying key components

Components and Tools

Team Dynamics

Roles of team members

Interprofessional vs. solo models

Strategies for integration

Barriers in diverse settings

Implementation Challenges

Improving CGA Effectiveness and Implementation

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Review Methodology

A SPIDER framework was employed to guide the search strategy, inclusion criteria, and data synthesis. SPIDER is a qualitative evidence synthesis tool that is particularly useful for reviews focusing on practice-based and experiential research, making it well suited for evaluating Comprehensive Geriatric Assessment (CGA) practices and interprofessional teams versus solo providers in Ontario and Canada.

SPIDER FRAMEWORK

SPIDER Element	FOCUS – Effectiveness of CGA	FOCUS - Interprofessional teams versus solo providers
S – Sample	Older adults (≥60 years) in Ontario and Canada	Older adults in Canada/Ontario receiving CGAs; healthcare providers (physicians, NPs, SWs, RNs, OTs, PTs, pharmacists).
PI – Phenomenon of Interest	Effectiveness of Comprehensive Geriatric Assessments (CGAs)	Use of interprofessional teams vs. solo providers in conducting CGAs.
D – Design	Literature reviews, systematic reviews, clinical guidelines	Qualitative, mixed-methods, observational, and comparative studies.
E – Evaluation	Best practices, time efficiency, comprehensiveness, diagnostic accuracy, care planning	Thoroughness, quality, provider roles, patient outcomes, and system barriers.
R – Research Type	Empirical studies, systematic reviews, meta-analyses, policy documents, clinical frameworks	Qualitative, quantitative, mixed-methods, opinion pieces, and editorials in Canada/Ontario.

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Article Screening

Search Strategy for Effectiveness of CGA

Inclusion Criteria

Comprehensive Geriatric Assessment (CGA) in Canadian (especially Ontario) context must be a central focus. Papers must address best practices, time efficiency, diagnostic accuracy, care planning, or quality indicators.

Information must be relevant for older adults (60+)

Exclusion Criteria

Exclude: Book, chapters, editorials, letters, and papers that are not peer – reviewed.

In addition, a manual check on the reference lists in the articles and reviews identified was also conducted to seek any additional sources of information. Nine articles were selected for inclusion based on the above criteria. The selection process emphasized diversity in care settings (hospital, community, home care) and relevance to the Ontario and Canadian healthcare systems.

Data Base	Search Strategy
PubMed	("Comprehensive Geriatric Assessment"[Mesh] OR "Comprehensive Geriatric Assessment" OR "geriatric assessment" OR "geriatric evaluation" OR "geriatric care") AND ("best practices" OR guidelines OR standards OR optimization OR efficiency OR "diagnostic accuracy" OR "care plan" OR comprehensiveness OR "time efficiency") AND (Canada OR Ontario OR Canadian)
EBSCO	MH "Geriatric Assessment" AND (MH "Canada" OR TX Ontario OR TX Canada) AND TX ("best practices" OR "time efficiency" OR optimization OR accuracy OR "care planning" OR comprehensiveness OR indicators OR outcomes OR quality)
Google Scholar	"Comprehensive Geriatric Assessment" AND (Canada OR Ontario OR Canadian) AND (guidelines OR "care plan" OR efficiency OR standards OR optimization)

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Article Screening

Inclusion Criteria

Comprehensive Geriatric Assessment (CGA) in the Canadian (especially Ontario) context must be a central focus. Papers must compare interprofessional team-based versus solo-provider CGAs in older adults (≥60), examining effectiveness, comprehensiveness, team roles, or implementation barriers.

Exclusion Criteria

Exclude: Studies not addressing interprofessional CGA models or lacking comparison with solo-provider CGA

In addition, a manual search of reference lists within the selected articles and reviews was conducted to identify further relevant studies. Nine studies were selected for inclusion based on the above criteria which are evaluation studies of interprofessional CGA models in primary care, oncology, and home-based settings addressing CGA implementation and interprofessional education.

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Search Strategy for IP teams versus Solo Providers

Data Base	Search Strategy
PubMed	("Comprehensive Geriatric Assessment"[Mesh] OR "Comprehensive Geriatric Assessment" OR CGA) AND ("Interprofessional Relations"[Mesh] OR interprofessional OR multidisciplinary OR team-based OR collaborative) AND ("Canada"[Mesh] OR Canada OR Ontario) AND ("Health Services Accessibility"[Mesh] OR "Delivery of Health Care"[Mesh] OR effectiveness OR implementation OR barriers OR outcomes) AND (physician* OR "nurse practitioner*" OR "health personnel"[Mesh] OR "Allied Health Personnel"[Mesh])
Google Scholar	"Comprehensive Geriatric Assessment" OR CGA OR "geriatric assessment" OR "multidimensional assessment" AND "interprofessional team" OR "multidisciplinary team" OR "collaborative care" OR "team-based care" OR "integrated care" OR "allied health professional" OR "health professional" OR "healthcare professional" AND physician OR "nurse practitioner" OR NP OR "primary care provider" OR "family physician" OR "solo provider" OR "single provider" OR "most responsible provider" OR MRP OR geriatrician AND effectiveness OR comprehensiveness OR quality OR outcomes OR performance OR impact OR benefits AND "social worker" OR pharmacist OR "occupational therapist" OR OT OR "physical therapist" OR PT OR "registered nurse" OR RN OR "team member" OR "provider perspective" OR role OR "scope of practice" AND barrier OR challenge OR obstacle OR "implementation issue" OR "system-level barrier" OR "resource constraint" OR "funding issue" OR "staffing limitation" AND Canada OR Ontario OR "Canadian healthcare" OR "Ontario healthcare" OR "Canadian context"

What is a Comprehensive Geriatric Assessment- Hx and modern context
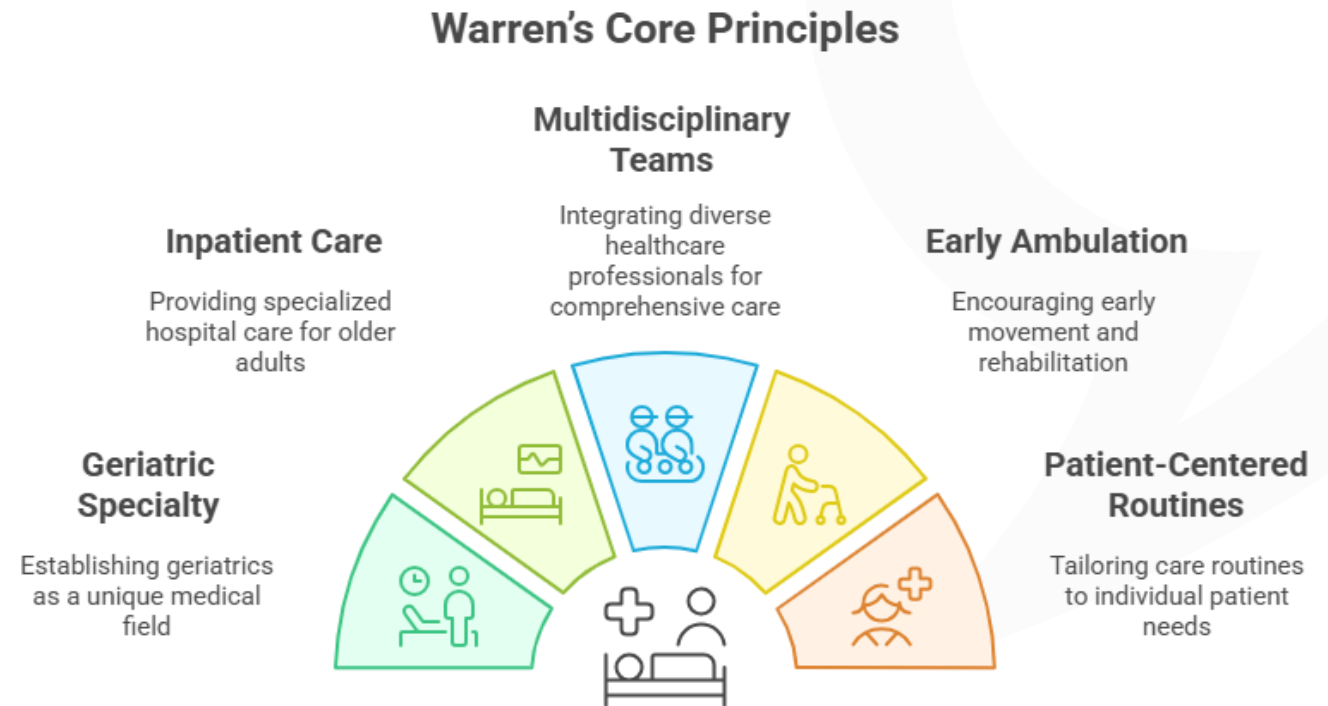
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Origins of CGA

- **Dr. Marjory Warren** is recognized as the founder of modern geriatric medicine.

- Her work in the 1940s laid the foundation for Comprehensive Geriatric Assessment

- In 1935, she led care for 874 elderly residents in a UK workhouse.

- She introduced structured assessments, rehabilitation, and multidisciplinary team-based care.

- These principles are still central to CGA today.

(St. John & Hogan, 2014)

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Warren's Core Principles- the foundations of CGA

- Geriatrics as a distinct medical specialty

- Specialized inpatient care tailored to older adults

- Multidisciplinary teams (physicians, nurses, OTs, PTs, social workers)

- Early ambulation and rehabilitation
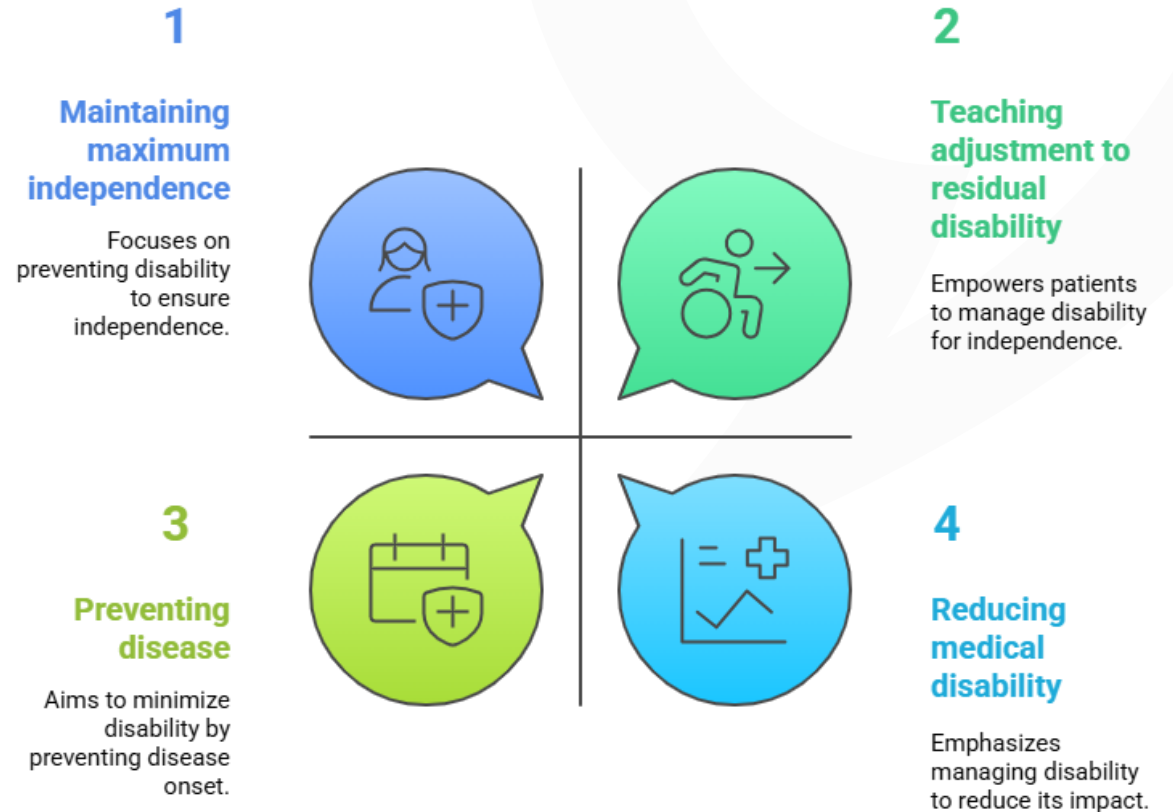
- Patient-centered routines and environments

Warren's Core Principles

Inpatient Care
Providing specialized hospital care for older adults

Multidisciplinary Teams
Integrating diverse healthcare professionals for comprehensive care

Early Ambulation
Encouraging early movement and rehabilitation

Geriatric Specialty
Establishing geriatrics as a unique medical field

Patient-Centered Routines
Tailoring care routines to individual patient needs

(St. John & Hogan, 2014)

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Warren's Care Goals for Geriatric Patients

Warren's broad goals for health care of older adults highlighted her interest in the prevention and management of disability:

- To obtain and maintain maximum independence.

- To teach the patient to adjust himself intelligently to his residual disability.

- To prevent disease whenever possible.

- To teach the patient to manage disability to reduce its impact.

Warren's Goals for Older Adults' Health Care

1
Maintaining maximum independence

Focuses on preventing disability to ensure independence.

2
Teaching adjustment to residual disability

Empowers patients to manage disability for independence.

3
Preventing disease

Aims to minimize disability by preventing disease onset.

4
Reducing medical disability

Emphasizes managing disability to reduce its impact.

(St. John & Hogan, 2014)

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Modern Validation

- Marjory Warren's model anticipated the structure and principles of modern geriatric care units, such as:
    - **Acute Care for the Elderly (ACE) units**
    - **Hospital Elder Life Program (HELP)**

- Randomized controlled trials (RCTs) and systematic reviews have validated the effectiveness of CGA:
    - **Ellis et al. (2011)**: CGA improves discharge outcomes and reduces institutionalization
    - **Van Craen et al. (2010)**: Meta-analysis supports the effectiveness of inpatient geriatric units
    - **Rubenstein et al. (1984)**: CGA enhances functional outcomes and reduces mortality.
    - **Landefeld et al. (1995):** ACE units improve functional outcomes in acutely ill older adults.
    - **Inouye et al. (1993, 2000):** HELP reduces delirium and functional decline.
    - **Rubenstein et al. (1984):** Geriatric evaluation units outperform usual care in multiple domains.

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(St. John & Hogan, 2014)

Key Findings and Value-Added Insights on CGA Practice, Delivery, and Impact in Ontario and Canada

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CGA Settings and Target Populations

CGA Settings and Target Populations

Characteristic	Hospital	Community/Home	Oncology	Ontario Initiatives
Target Population	Adults aged ≥60/65	Frail older adults	Older adults (≥65)	Older adults in Ontario
Focus	Surgery or trauma care	Preventive and supportive care	Cancer-specific geriatric needs	Regional CGA implementation
References	Saripella et al., 2021; Debra et al., 2021; Ellis et al., 2017	Briggs et al., 2022; Giosa et al., 2021	Cook et al., 2023	Giosa et al., 2021; McLeod & DiMillo, 2018

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Key Indicators of High-Quality CGA
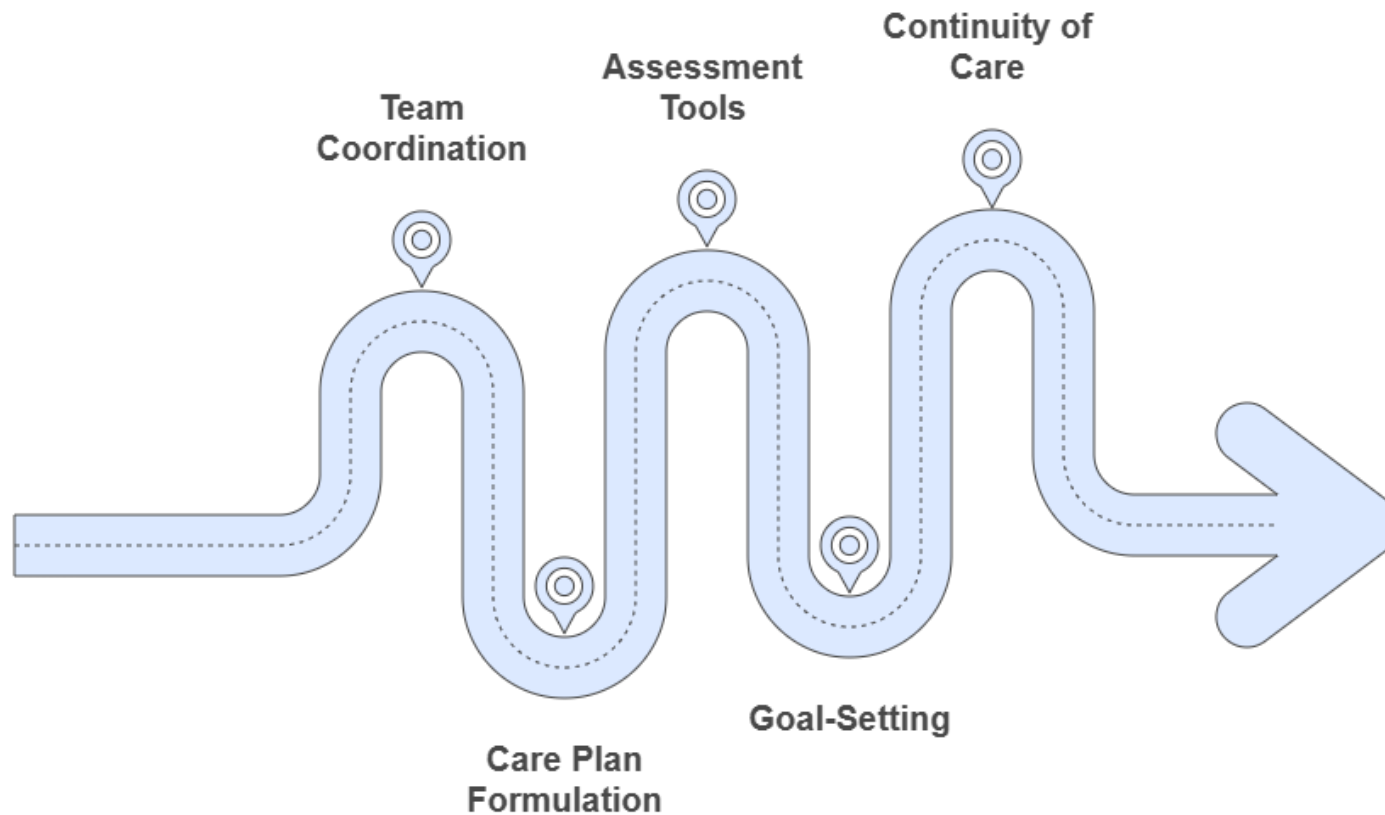
- **Multidisciplinary Team Coordination**
  A collaborative approach involving physicians, nurses, social workers, and therapists ensures holistic care tailored to the older adult's needs.

- **Care Plan Formulation + Direct Implementation**
  Individualized care plans are not only developed but also actively executed by the team to address medical, functional, and psychosocial issues

- **Use of Validated Assessment Tools (e.g., Barthel, MMSE)**
  Standardized tools provide objective data to guide diagnosis, monitor progress, and evaluate outcomes.

- **Patient-centred Goal-Setting**
  Goals are aligned with the older adult's values, preferences, and life context, promoting autonomy and engagement in care.

- **Follow-up and Continuity of Care**
  Ongoing monitoring and coordination across settings help maintain health gains and prevent readmissions or deterioration.

(Eamer et al., 2017, Saripella et al., 2021, McLeod & DiMillo, 2018)

Professionals Involved in different CGA care delivery models
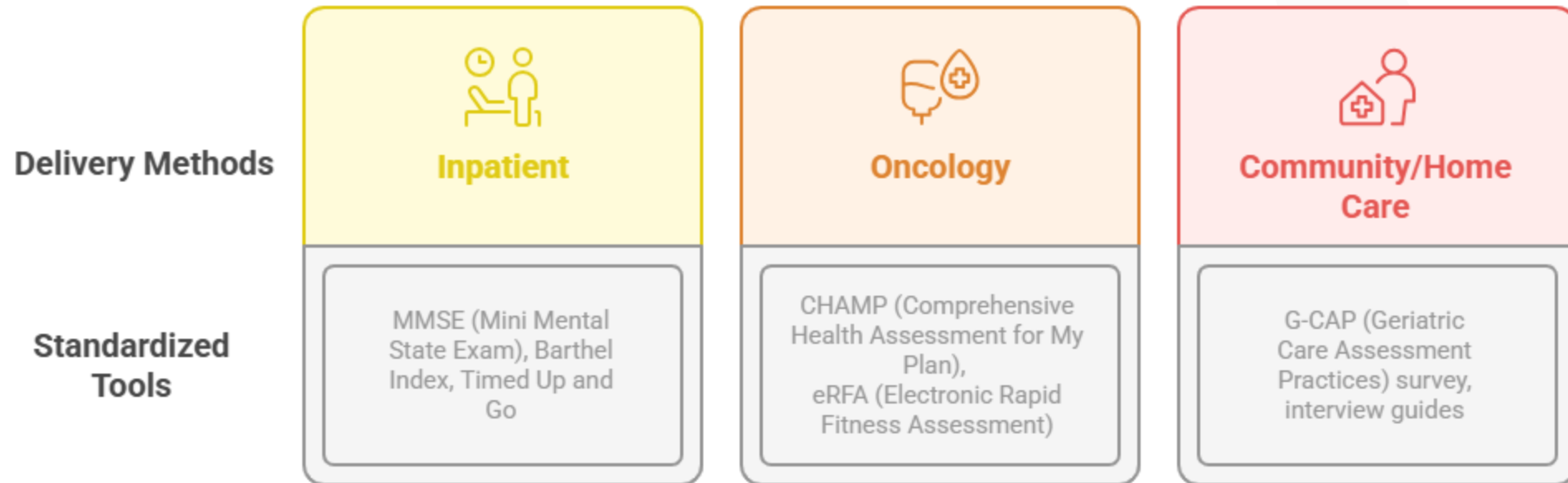
Delivery Model	Professionals Involved
Hospital Based	Geriatricians, Nurses, Anesthesiologists and Surgeons
Oncology Focused	Oncologists and oncology nurses
Community Based	Physiotherapists, Occupational therapists, dieticians and social workers
Ontario's Regional Model	Interprofessional collaborations among community-based assessors

CGA models vary from specialized to broadly collaborative teams.

Hospital-based — Combines medical and surgical expertise

Ontario's regional — Integrates diverse community assessors

Specialized

Collaborative

Oncology-focused — Focuses on cancer patient needs

Community-based — Provides therapy and social support

(Saripella et al., 2021; Ellis et al., 2017, Briggs et al., 2022, Giosa et al., 2021, Cook et al., 2023, McLeod & DiMillo, 2018)

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Tools & Methods

Comparison of CGA Delivery Methods and Tools Across Settings

	Inpatient	Oncology	Community/Home Care
Delivery Methods			
Standardized Tools	MMSE (Mini Mental State Exam), Barthel Index, Timed Up and Go	CHAMP (Comprehensive Health Assessment for My Plan), eRFA (Electronic Rapid Fitness Assessment)	G-CAP (Geriatric Care Assessment Practices) survey, interview guides

(Saripella et al., 2021; Ellis et al., 2017, Briggs et al., 2022, Giosa et al., 2021, Cook et al., 2023, McLeod & DiMillo, 2018)

Outcomes and Impact

Area	Summary
Clinical	Mixed results: some improvements in length of hospital stay, functional return; minimal impact on mortality
Cost	CGA was found to be cost-effective in surgical and trauma settings, especially for elderly orthopedic patients by improving outcomes like mortality and function while reducing hospitals stays and overall healthcare costs.
Patient-Centeredness	High in models emphasizing shared goal-setting and interdisciplinary planning
System Relevance	Ontario-based studies reflect local applicability, implementation interest, and system alignment needs

(Briggs et al., 2022, Saripella et al., 2021, Debra et al., 2021, Eamer et al., 2017, Giosa et al., 2021, Parker et al., 2018, McLeod & DiMillo, 2018, Cook et al., 2023)

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CGA Implementation Barriers & Facilitators

Barriers:

- Lack of standardized tools

- Clinician workload concerns (adoption of new digital tool)

- Limited RCTs / evidence gaps

Facilitators:

- Efficient Clinical Decision Algorithms

- High usability and acceptance (CHAMP, G-CAP - user friendly and easy navigation)

- Strong stakeholder engagement and interdisciplinary collaboration

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(Briggs et al., 2022, Saripella et al., 2021, Debra et al., 2021, Eamer et al., 2017, Giosa et al., 2021, Parker et al., 2018, McLeod & DiMillo, 2018, Cook et al., 2023)

Value of Interprofessional Teams

Examples of Interprofessional CGA Models in Ontario

Integrated Care Teams (ICT) (Heckman et al., 2025)

- ☐ 49.5% reduction in ED visits.
- ☐ Improved medication optimization.

Geriatric Oncology Clinics (GO) (Menjak et al., 2025)

- ☐ Faster assessments (3 weeks vs. 11 weeks).
- ☐ Better treatment decisions and allied health referrals

Home-Based Primary Care (HBPC) (Smith-Carrier et al., 2015)

- ☐ Holistic, in-home assessments.
- ☐ Enhanced identification of functional and environmental risks.

Unique Contributions of Team Members

Pharmacists

Medication experts who reduce polypharmacy. They identify adverse drug interactions.

(Heckman et al., 2025; Menjak et al., 2025; Smith-Carrier et al., 2015)

Social Workers

Experts who address mental health. They also address social determinants of health.

(Menjak et al.,2025; Smith-Carrier et al., 2015)

OTs/PTs

Assess mobility, fall risk, and home safety. They ensure patient well-being.

(Smith-Carrier et al., 2015)

RNs/NPs

Coordinate care and ensure responsiveness. They maintain continuity of care.

(Goldman et al., 2010; Heckman et al., 2025; Menjak et al., 2025)

Geriatricians

Provide input on complex cases including input on the need for geriatrician consultation

(Heckman et al., 2025)

*Note that in various NP-led models including GAIN, NPs provide key assessment, diagnostic and care playing expertise (within scope of practice)

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Benefits of Interprofessional CGAs

Interprofessional CGAs offer superior patient care benefits.

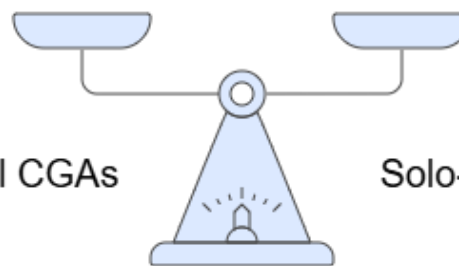|	
Comprehensive Patient Care	Individualized Care Focus
Improved Care Coordination	Independent Care Delivery
Enhanced Diagnostic Accuracy	Limited Diagnostic Scope
Increased Satisfaction Levels	Moderate Satisfaction Levels

Interprofessional CGAs — Solo-Provider Models

(Heckman et al., 2025, Menjak et al., 2025, Smith-Carrier et al., 2015, Goldman et al., 2010, Flores-Sandoval et al., 2021)

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Barriers to Implementation

Barrier	Description	References
Role Ambiguity	Unclear scopes of practice can cause confusion and inefficiencies in care delivery.	Goldman et al., 2010; Smith-Carrier et al., 2015
Hierarchical Dynamics	Resistance from some physicians due to traditional power structures can impede collaboration.	Goldman et al., 2010; Smith-Carrier et al., 2015
Funding Models	Fee-for-service models disincentivize collaboration, while salaried or capitation models better support interprofessional approaches.	Grant et al., 2023
Training Gaps	Limited interprofessional education in geriatrics restricts team effectiveness.	Flores-Sandoval et al., 2021
Logistical Constraints	Time, space, and scheduling challenges hinder coordination and joint care planning.	Goldman et al., 2010; Smith-Carrier et al., 2015
System Fragmentation	Poor integration across care sectors leads to disjointed service delivery and communication failures.	Wong et al., 2025; Grant et al., 2023

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Interprofessional Education (IPE)

Challenges and Opportunities in IPE Implementation

- **Essential for CGA delivery**
  Prepares healthcare teams to collaborate effectively in geriatric care.

- **Current gaps in training**
  Many programs lack structured team-building components.
  Limited focus on practicing professionals. (Flores-Sandoval et al., 2021)

- **Evidence from successful models**
  Memory clinics show improved team communication and provider confidence (Soobiah et al., 2017; Flores-Sandoval et al., 2021).

- **Need for standardization**
  Calls for widespread, consistent IPE initiatives across healthcare systems.

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Policy and Practice Implications

Scaling Interprofessional CGAs: Strategic Enablers

- **Supports patient-centered care and system sustainability:** Aligns with goals of improved outcomes and efficient resource use. (Heckman et al., 2025; Wong et al., 2025)

- **Requires strategic investments in:**
    - **Funding reform** – Shift toward models that incentivize collaboration.
    - **Education** – Expand interprofessional training across career stages.
    - **Infrastructure** – Improve access to shared tools and spaces.
    - **Leadership development** – Cultivate collaborative leadership. (Grant et al., 2023; Flores-Sandoval et al., 2021)

- **Operational supports are critical:**
    - Enhanced electronic medical records (EMRs) for shared documentation.
    - Protected time for team meetings and care planning. (Goldman et al., 2010; Smith-Carrier et al., 2015)

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Recommendations

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Recommendations

- **Develop and Validate Digital Tools:** Support the integration of user-friendly electronic CGA platforms (e.g., CHAMP) into clinical workflows.

- **Demonstrate value:** Invest in research to evaluate CGA's impact on mortality, quality of life, and cost-effectiveness.

- **Promote Patient-Centered Care Planning** : Encourage shared goal-setting and interdisciplinary collaboration to align care with patient values.

- **Strengthen Interprofessional Training:** Provide ongoing education for healthcare teams on CGA tools, roles, and collaborative practices.

- **Expand CGA in Community Settings:** Scale successful practices/tools like Eastern Ontario's decision algorithms to improve consistency in home and community care.

- **Align with Health System Priorities:** Integrate CGA into broader aging, digital health, and primary care strategies at the policy level.

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Recommendations

- **Expand Interprofessional CGA Models**
  - Scale up successful models like ICTs and GO clinics.
  - Focus on rural and underserved areas.

- **Integrate Interprofessional Education (IPE)**
  - Embed IPE in health professional training at all levels.
  - Emphasize team-based learning, communication, and role clarity.

- **Reform Funding and Remuneration:** Shift to (advocate for) blended or capitation models that support team-based care.

- **Strengthen Collaboration Infrastructure:**
  - Invest in shared EMRs, co-located workspaces, and virtual platforms.
  - Ensure protected time for interprofessional collaboration.

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Recommendations

- **Clarify Roles and Promote Leadership:**
  - Standardize role definitions to reduce ambiguity.
  - Encourage shared leadership and mutual respect across disciplines.

- **Address System-Level Barriers:**
  - Develop provincial and national frameworks for CGA implementation.
  - Improve integration across primary, home, and community care.

- **Evaluate and Monitor Outcomes:**
  - Use robust evaluation frameworks to track patient, provider, and system outcomes.
  - Support continuous quality improvement and learning.

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In Summary

- CGA is a multidimensional, interdisciplinary process used to evaluate the medical, functional, psychological, and social needs of older adults. It aims to develop a coordinated care plan tailored to the individual[1]

- Interprofessional CGAs call superior patient and provider benefits[2]

- **Beneficiaries:**
  - **Patients:** Receive more holistic, personalized, and coordinated care
  - **Caregivers:** Gain support in managing complex needs and navigating services
  - **Healthcare Providers:** Collaborate more effectively, reducing duplication and improving outcomes
  - **Health Systems:** Experience reduced emergency visits and better resource utilization

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[1](Eamer et al., 2017; Giosa et al., 2021, Saripella et al., 2021; McLeod & DiMillo, 2018, Ellis et al. Cochrane Review)

[2](Heckman et al., 2025, Menjak et al., 2025, Smith-Carrier et al., 2015, Goldman et al., 2010, Flores-Sandoval et al., 2021)

Section B.
Policy Implications

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Current evidence on the impact of CGA in care settings in Ontario

- Since 2011, Ontario Health Quality has published 42 quality standards to guide the care of people experiencing complex health conditions.
- Comprehensive assessment is recommended in almost all of Ontario Health's Quality Standards, either as a specifically named activity or inferred in specific standards statements.
- Comprehensive assessment is typically identified a first step to identifying and diagnosing a condition and establishing goals of care and an individualized care plan with people living complex health conditions.
- **Of 11 current quality standards that are highly relevant to the care of older adults, 10 include a recommended indicator related to comprehensive assessment**:
  - **% of people with [condition] who received a comprehensive assessment for [purpose].**

- **There are currently no indicators recommended in Ontario Health's quality standards that directly link the activity of comprehensive assessment to system impact!**

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Provincial Geriatrics Leadership Ontario

- **Clinical effectiveness of CGA:**
  - Outputs: Diagnosis (including diagnostic clarification, staging), identification of risk, root-cause and restorative potential, comprehensive care planning (considering deficits across multiple systems/domains), tailored interventions.
  - Outcomes: evident in literature but not directly/consistently tracked or reported by programs and at system level.

- **Policy recommendation:**
  - SGS/program level: meaningful metrics and outcomes focused evaluations
  - System level: Standards to include metrics/indicators linking practice change (Comprehensive Ax, CGA implementation) to system performance (including resource use and cost).

Frailty Screening vs. CGA

Both are integral components of the Frailty Pathways

1	2	3	4	5
Understand your Population	Identify your Triggers	Screen	Assess	Manage
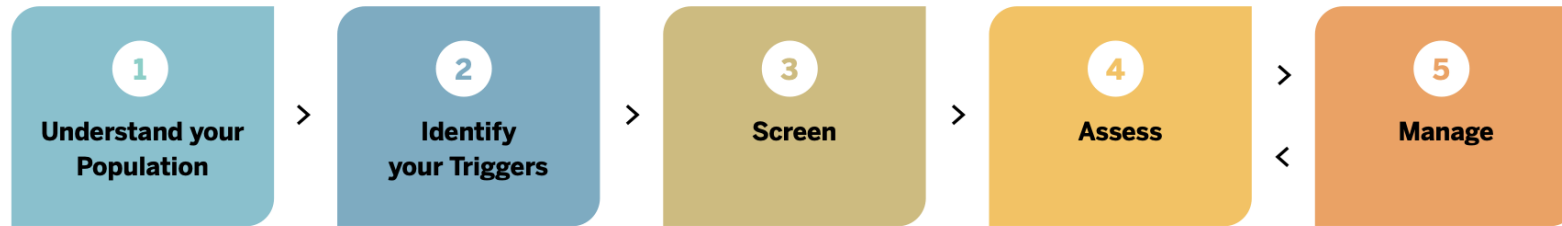
Source: Frailty Screening & Management in Primary Care and Community

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Frailty Screening vs. CGA

Frailty Screening	CGA (assessment)
• A proactive approach of **identifying** individuals who are living with or at-risk of frailty. • Early identification will lead to earlier assessment leading to timely interventions. • Delayed identification misses opportunity for frailty reversal	• An in-depth **specialized assessment** for older adults identifying/confirming factors that are leading to deficits and frailty. • The output is a diagnosis/multiple diagnoses, staging (e.g., dementia), comprehensive care plan, and tailored interventions based on the findings.

• Using clinical judgement and evidence-informed decision trees, screened individuals are connected to appropriate clinicians/services to conduct in-depth assessments (including CGAs)
    • These **post-screening** assessments are based on the frailty status and therefore could be conducted within Primary Care or Specialized SGS (depending on expertise needed)
        • Some individuals may not need any further assessments; they should be monitored, connected with services that promote healthy aging, and the **re-screened**.
	• CGAs are specialized assessments conducted by geriatric assessors.
	• Timely CGA would identify and address factors that would contribute to adverse outcomes. What is the root-case, what can be done to manage it (tailored interventions, service connections, etc.)

Screening vs. Assessment vs. Care/Intervention Planning

Screening	Assessment	Care/Intervention Planning
Frailty screening (e.g., PFFS, CFS) detects **frailty**	A positive frailty screen* leads to a **Comprehensive Geriatric Assessment (CGA)**—an in-depth review of medical, functional, cognitive, and social needs	The interprofessional team builds a **personalized care plan** (e.g., medication changes, physiotherapy, home supports) for tailored interventions
A mammogram or colonoscopy detects **possible cancer**	A positive screen leads to **biopsy, imaging, diagnosis, and staging** to understand the type and extent of cancer	Oncologists create a **personalized treatment plan** (e.g., surgery, chemo, radiation)
PHQ screening for depression	Psychiatric evaluation for diagnosis	Individualized therapy and supports

There is a problem! If missed, dire consequences

The whole story!

*usually mild and above

Recommendations:

- **Address the knowledge gap:** Frailty conferences, Frailty focused sessions, leverage social media to post byte-sized information, etc.
  - Seniors Care Network to develop some key infographics regarding CGA and difference between frailty screening and CGA; share with PGLO, post on social media, and use in conferences/webinars.

- **System-level:** contribute to future Frailty-focused Policy/Standards/Model design etc.

Appendix 1

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THANK YOU

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References: Appendix1

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