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POSTER ABSTRACT

Frailty Pathways: A Population Health Management strategy for Older Adults.

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Sabeen Ehsan[1], Rhonda Schwartz[1], Stacey Hawkins[1], Xin Yi Dong[1]

1: Seniors Care Network, Canada

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). Comprising of health and community sector providers, OHTs organize and deliver services in local communities. Evidence suggests that proactive frailty screening and identification, and promotion of self management strategies contribute towards reducing hospitalizations 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.

These five-step pathways offer a standardized approach to preventing, identifying, assessing, and managing frailty. 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 i.e, Primary Care, community programs, community paramedicine, ED, Acute Care, etc. In Central East Region, Kawartha Lakes Haliburton Ontario Health Team (KLH-OHT) is an early adopter of the pathways.

The implementation begins with understanding the characteristics of the older adult clientele, which allows identification of 'triggers' (age cut-offs, geriatric syndromes, psycho-social concerns, etc.) to initiate frailty screening among high-risk groups. Frailty screening is conducted using a holistic tool that covers the physical, cognitive, mental and social domains of frailty .
The resulting frailty status (absence, risk or severity of frailty) is used to identify immediate and long-term assessment and management needs. A customized 'decision-tree' facilitates care planning, which includes referrals to local self-management programs, specialized geriatric services, and community supports, 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 measure3. Unexpected progression prompts reassessment to address modifiable factors.

Results: To-date ~300 frailty screens have been completed across 4 settings in the KLH-OHT. Clients are connected with appropriate programs & services to support identified needs. Health and community care providers are trained on the use of appropriate frailty screening tools and the communication of frailty status to the client. 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 partners to prevent screening fatigue and support integrated care planning.

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.

References: Ontario Health. Ontario Health; 2025.
Provincial Geriatrics Leadership Ontario. Influencing ALC Rates from the Community. Provincial Geriatrics Leadership Ontario; 2023.
Ehsan, S., & Schwartz, R. Frailty Screening & Management in Primary Care Guidance Document. Seniors Care Network; 2023.
Provincial Geriatric Leadership Ontario. Consensus Statement. Provincial Geriatrics Leadership Ontario; 2022.