Assessing and Connecting Frail Older Adults using the Clinical Frailty Score (CFS) in 3 Easy Steps!

Step 1: Use the CFS to determine your patients frailty score

CLINICAL FRAILTY SCALE

1	**VERY FIT**	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
2	**FIT**	People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.
3	**MANAGING WELL**	People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.
4	**LIVING WITH VERY MILD FRAILTY**	Previously "vulnerable," this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up" and/or being tired during the day.
5	**LIVING WITH MILD FRAILTY**	People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
6	**LIVING WITH MODERATE FRAILTY**	People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.
7	**LIVING WITH SEVERE FRAILTY**	**Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
8	**LIVING WITH VERY SEVERE FRAILTY**	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
9	**TERMINALLY ILL**	Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY

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Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

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Step 2: Review resources based on your patients CFS

Resources for Clinical Frailty 1-3

Programs

- Older Adults Activity Calendar
- Community programs for CFS 1-3
- Dementia Supports

Resources

- Brain Health Tip Sheet

Referrals

- eReferral to 211 for social prescribing, social isolation, social determinants of health
- Alzheimer Society of Simcoe
- FHT Cardiovascular rehab
- FHT Pulmonary Rehab

Resources for Clinical Frailty 4-6

Programs

- Community programs for CFS 4-6
- Dementia Supports

Resources

- Brain Health Tip Sheet

Referrals

- eReferral to 211 for social prescribing, social isolation, social determinants of health
- Alzheimer Society of Simcoe
- SGB NSM HA referral (including CARE) – referral goes to FHT, no need to send referral to NSM
- FHT Cardiovascular rehab
- FHT Pulmonary Rehab

Resources for Clinical Frailty 7-9

Programs

- Dementia Supports

Referrals

- Hospice GT
- Ontario Health@Home
- Alzheimer Society of Simcoe

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Step 3: Refer your client to Community Connection 211 for continued support

Who is Community Connection 211?

They are an information and referral organization that help individuals, families, and communities identify, understand, and effectively use the programs that are part of the human service delivery system.

What happens when a referral is made?

A highly trained Community Navigator will contact your client to support them in overcoming barriers to accessing community resources by:

- Completing a needs assessment
- Offering advocacy and empowerment
- Providing Information and Referral
- Following up with patient until needs are met

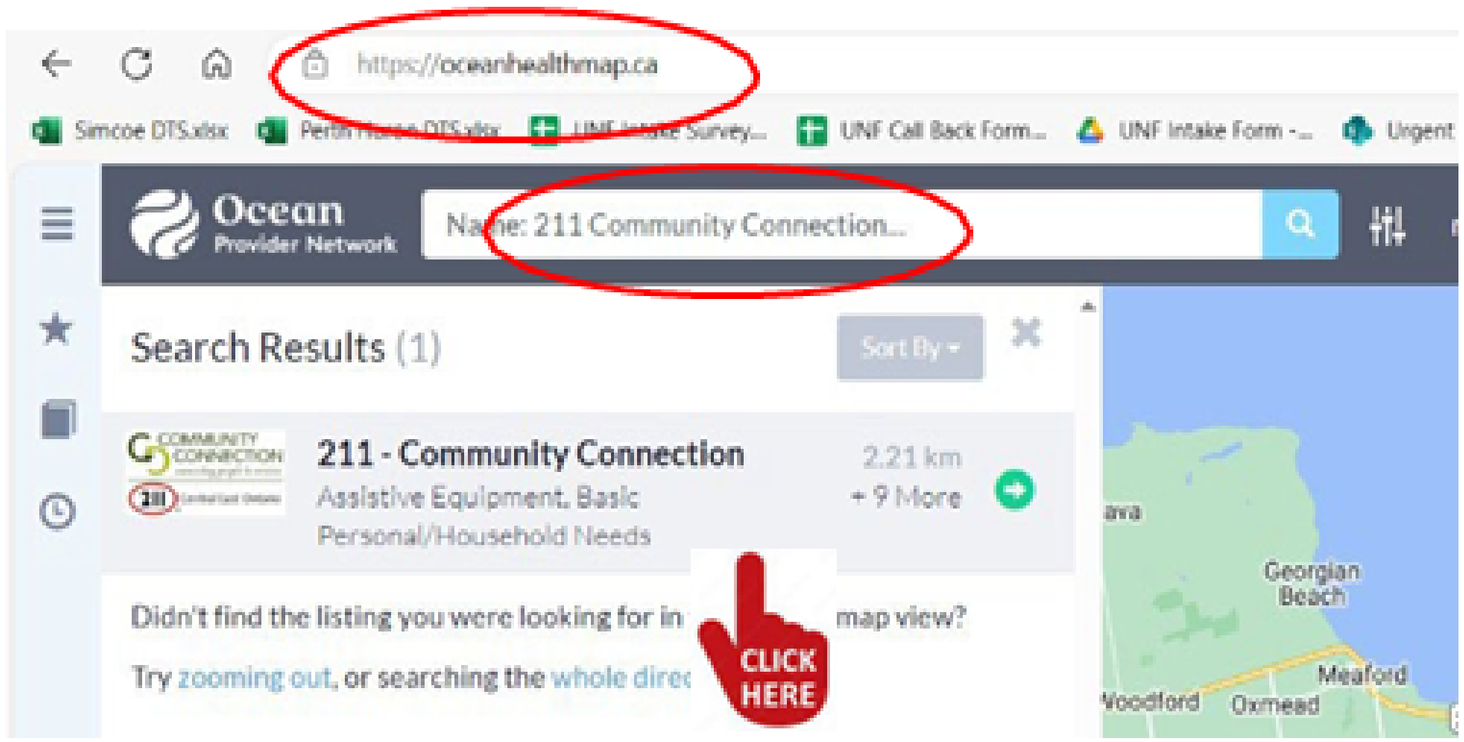
Who can be referred? **Clients requiring support with:**

- Financial Assistance (e.g. Bills/utilities/budgeting)
- Food (e.g. food banks, church dinners, Meals on Wheels)
- Housing (e.g. regional housing support, affordable housing resources)
- Transportation
- Caregiver Support
- Mental Health/Substance Use
- Community Support (e.g. tax clinics, technology, Legal help)
- Social Connection (e.g. friendly visiting, social activities)
- Obtaining Assistive Devices (e.g. personal care/household needs)
- Activities of Daily Living (e.g. personal care/household needs)

How to make a referral:

For Organizations WITHOUT an Ocean account:

Open the Public 211 eReferral Form by visiting: www.communityconnection.ca/referral-partners

For Organizations WITH an Ocean account (2 options):

1. Search '211 Community Connection' on www.oceanhealthmap.ca and fill out referral form
2. Launch Ocean from patient's chart in EMR and search '211 Community Connection' on the Ocean HealthMap and fill out referral form