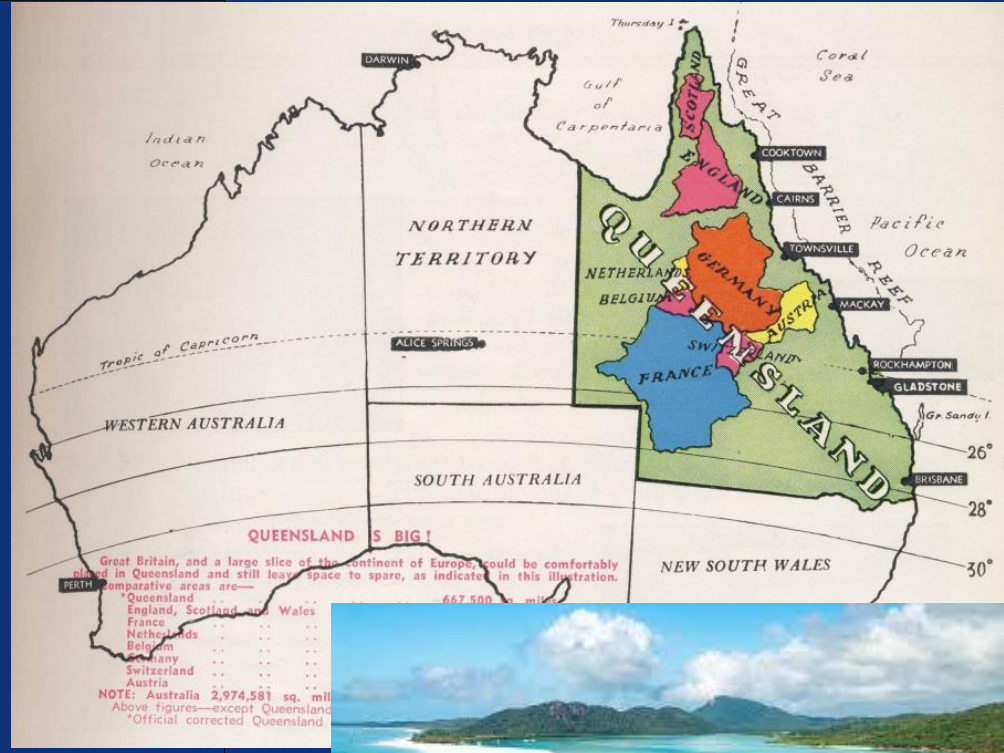
Frailty screening of older people: The journey toward Healthy Ageing



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Presentation to University of the West of Scotland

22 June 2026

Research program

- **Mater Aged Care in An Emergency (MACIAE)** - Older adults from ACFs in ED (2014-2016)
- **Pilot of the FRAIL Scale** in two regions - Sydney North and Brisbane South (2021 – 2023)
- **Implementation of the FRAIL Scale** in Sydney North and Brisbane South with 75+ health assessment (2023 – 2025) PLUS pilot of the **FRAIL Scale in Surat & Augathella** (2024 – 2025)
- **Alliance for Healthy Ageing** (2025-28)

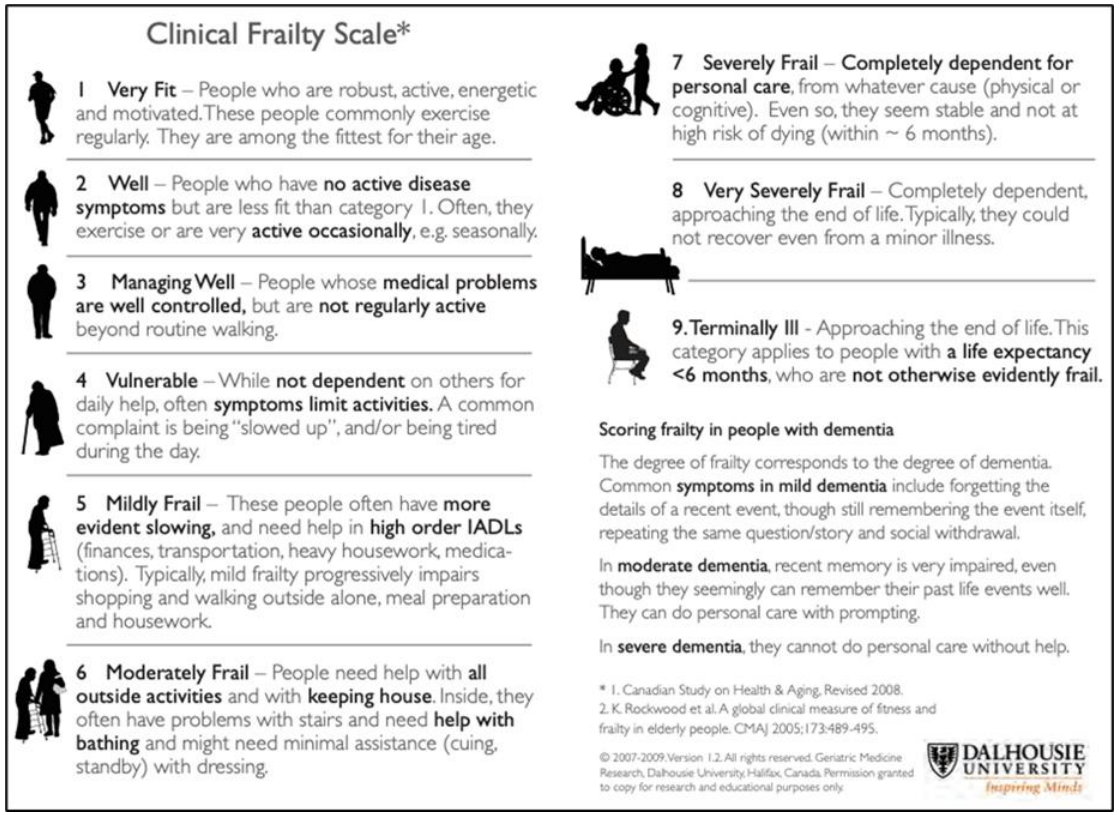
Mater Aged Care in An Emergency

Background

- Hospital Emergency Departments (EDs) experience high presentation rates from older adults residing in Aged Care Facilities (ACFs).
- To designed and implemented a nurse-led model of care for older adults from ACFs and determine its impact on patient outcomes.

Method

- 12-month pre–post intervention study was conducted 2013–2014, with follow-up 2015–2016.
- Frailty status was determined using the Clinical Frailty Scale (CFS).



Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – 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,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – 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 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People 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 **Severely Frail** – **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 **Very Severely Frail** – Completely dependent, approaching the 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 evidently frail.**

Scoring frailty in people with dementia

The degree of frailty 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.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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DALHOUSIE UNIVERSITY Inspiring Minds

*Shrapnel, S., Dent, E. & Nicholson, C. A nurse-led model of care within an emergency department reduces representation rates for frail aged care residents. Aging Clin Exp Res 31, 1695–1698 (2019). https://doi.org/10.1007/s40520-018-1101-z

MACIAE Results

- All participants presenting to ED were frail (n = 1130), 19% severely frail, 55% very-severely frail, and 26% terminally ill.
- All were deemed at risk of hospital representation, 96% had polypharmacy (≥ 5 medications), 74% had impaired cognition, and 85% had vision and/or sight impairment.
- The main reason for ED presentation was falls (37%).
- Reduction in ward admissions by 31.3%.
- Reduction in representation to the ED by 13.2%.
- Decrease in the number of End-of-Life in-patient episodes by 88%.
- Additionally, there was an initiation of over 300 ACPs during the intervention.
- The externally, independently commissioned cost–benefit analysis was determined as 10:1.

Pilot and implementation of FRAIL Scale in general practice

Caroline Nicholson[1], Jenny Job[1], Ruby Strauss[1], Deb Clark[2], Claire Jackson[1]

[1]Centre for Health System Reform & Integration, Mater Research Institute – The University of Queensland

[2]North Sydney Primary Health Network

Background

Frailty:

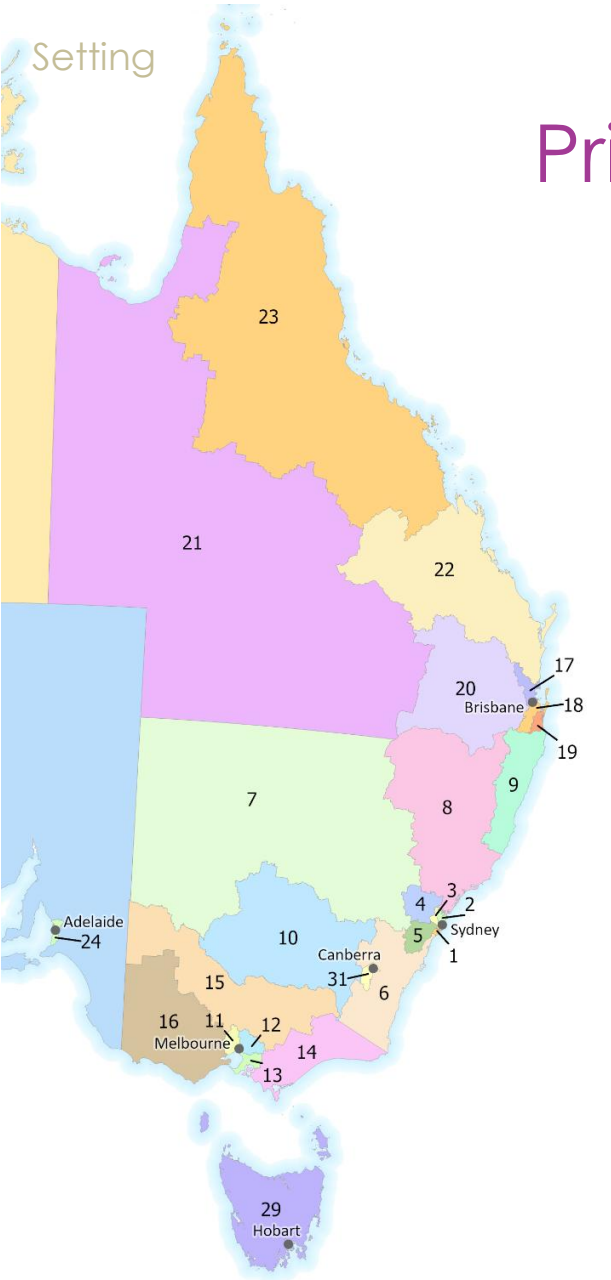
- occurs from existing functional decline and can be exacerbated by acute illness
- is often under recognised
- affects up to 25% of people aged 70 and over.

People with frailty:

- have greater health care utilisation,
- higher morbidity and mortality,
- lower quality of life than their non-frail counterparts.

Importantly, causes of frailty can be managed and, in some cases reversed highlighting the importance of early identification of older people who are living with pre-frailty.

Primary Health Network partners



Brisbane South PHN (#18)

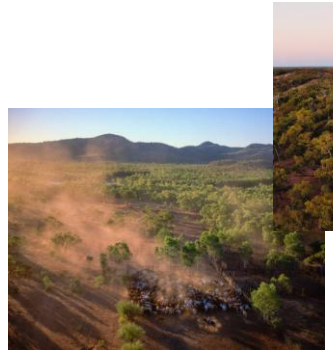
- **includes metropolitan, rural, & remote island locations**
- 20.2% of residents were born in a non-English speaking country
- 13.6% of the population (163,000) aged ≥65 years
- 2.8 % of the population identify as Aboriginal and/or Torres Strait Islander

North Sydney PHN (#2)

- **predominantly metropolitan**
- least socio-economically disadvantaged PHN in Australia
- 17.1% of the population (158,142) aged ≥65 years
- 0.5% of the population identify as Aboriginal and/or Torres Strait Islander

Western Queensland PHN (#21)

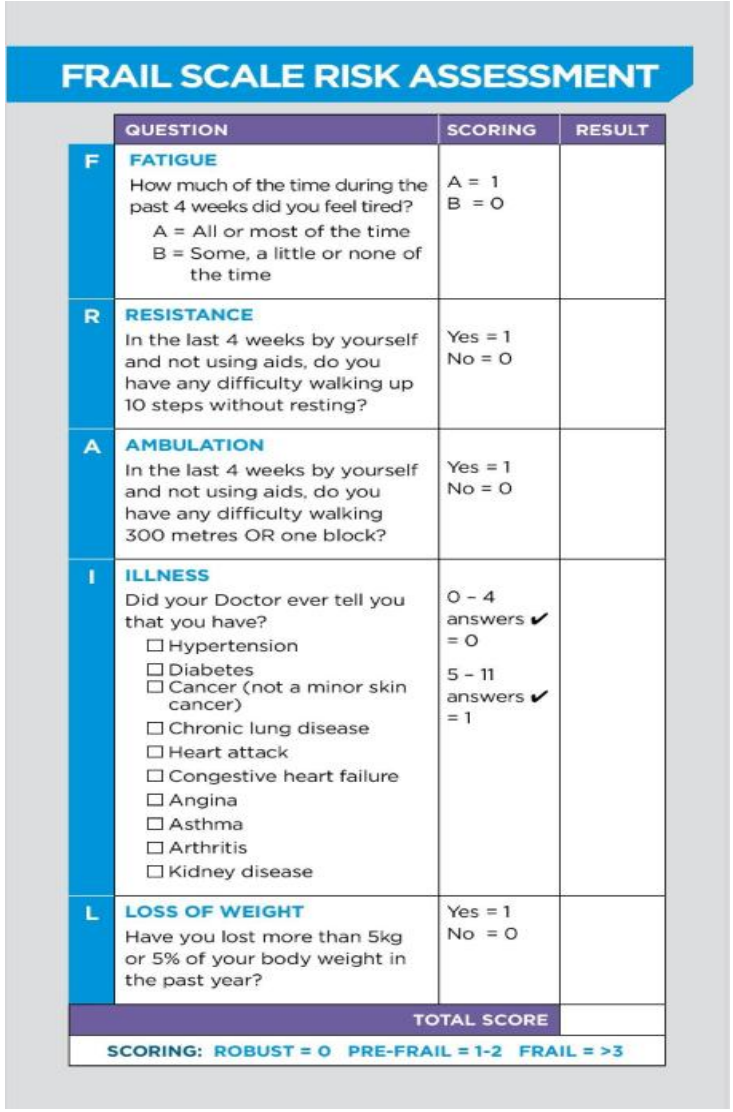
- **rural and remote region, covers >50% of the state**
- 14.0% of the population (~9,000) aged ≥65 years
- 21.2% of the population identify as Aboriginal and/or Torres Strait Islander



The role of primary care

- Standardised assessment of risk of frailty is not routine practice in general practice in Australia
- The yearly 75+/55+ health assessment introduced in general practice in Australia in 1999, conducted by practice nurses and GPs and funded by Medicare does not include frailty assessment
- International guidelines recommend annual frailty assessment using a validated measurement tool built into the workflow of primary care
- In addition, it is important to build the capacity of the primary care team to manage risk of frailty

FRAIL Scale



FRAIL SCALE RISK ASSESSMENT

	QUESTION	SCORING	RESULT
F	**FATIGUE** How much of the time during the past 4 weeks did you feel tired? A = All or most of the time B = Some, a little or none of the time	A = 1 B = 0	
R	**RESISTANCE** In the last 4 weeks by yourself and not using aids, do you have any difficulty walking up 10 steps without resting?	Yes = 1 No = 0	
A	**AMBULATION** In the last 4 weeks by yourself and not using aids, do you have any difficulty walking 300 metres OR one block?	Yes = 1 No = 0	
I	**ILLNESS** Did your Doctor ever tell you that you have? ☐ Hypertension ☐ Diabetes ☐ Cancer (not a minor skin cancer) ☐ Chronic lung disease ☐ Heart attack ☐ Congestive heart failure ☐ Angina ☐ Asthma ☐ Arthritis ☐ Kidney disease	0 – 4 answers ✔ = 0 5 – 11 answers ✔ = 1	
L	**LOSS OF WEIGHT** Have you lost more than 5kg or 5% of your body weight in the past year?	Yes = 1 No = 0	
		TOTAL SCORE	

SCORING: ROBUST = 0 PRE-FRAIL = 1-2 FRAIL = >3

0 = Robust

1-2 = Pre-Frail

3-5 = Frail

Encourage ongoing activity

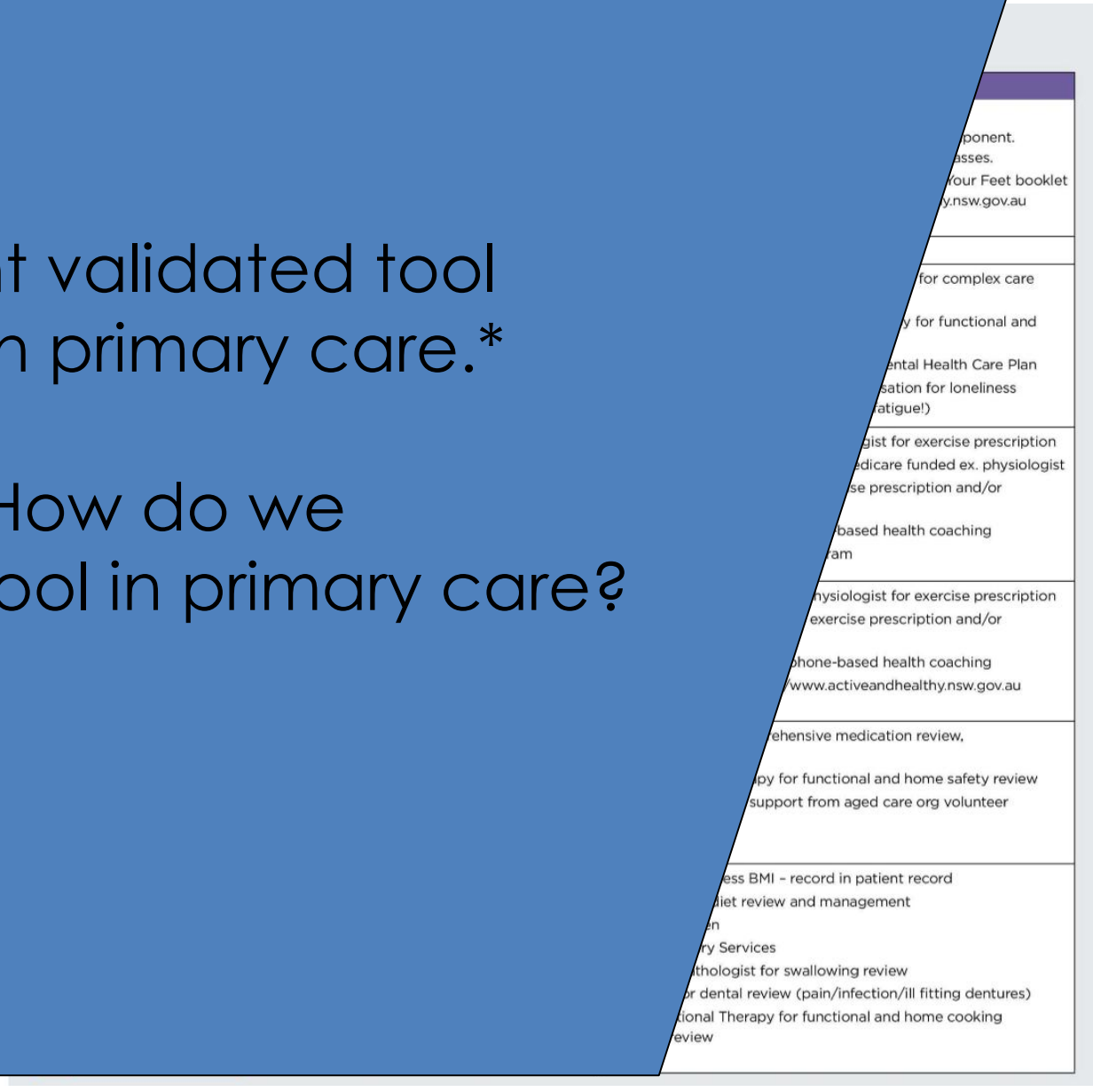
Rescreen in 12 months
Suggest appropriate interventions/ management options to reduce risk of frailty

*Morley et al A simple frailty questionnaire (FRAIL) predicts outcomes in middle aged African Americans. J Nutr Health Aging. 2012;16(7):601-8
*Gardiner et al. Validity and Responsiveness of the FRAIL Scale in a Longitudinal Cohort Study of Older Australian Women. J Am Medical Directors Ass. 2015;16(9):781-3.

FRAIL Scale management/decision tool

A simple, 5- point validated tool suitable for use in primary care.*

Our challenge: How do we implement the tool in primary care?



The crux of implementation science is two-fold:

To identify barriers and enablers across multiple contexts:

- individuals in treatment
- providers
- organisational
- other stakeholder groups
- policy level

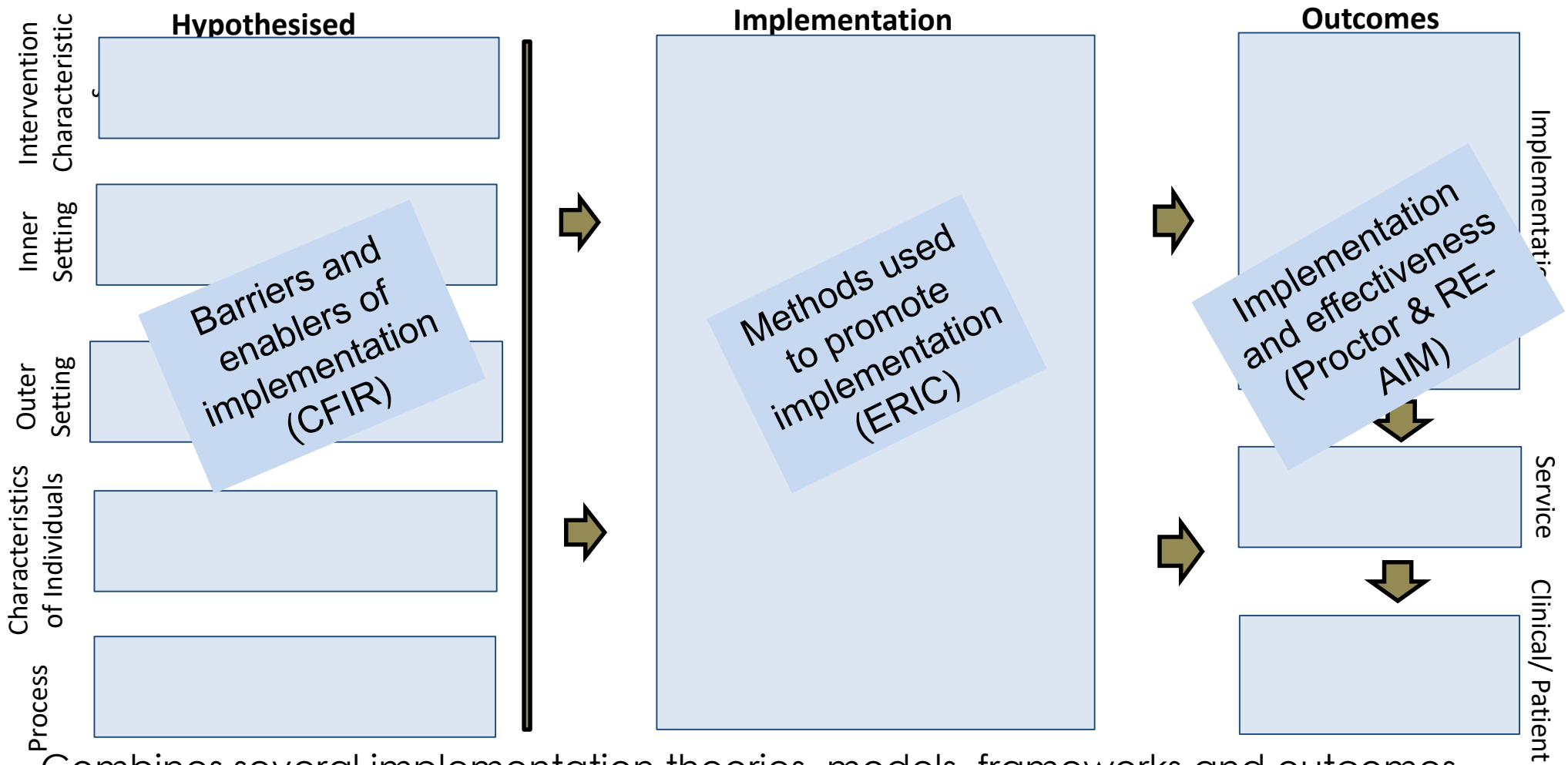
To develop and apply implementation strategies that:

- overcome the barriers &
- enhance the enablers

→ **to increase the uptake of evidence-based clinical innovations**

Bauer MS, Kirchner J. Implementation science: What is it and why should I care? Psychiatry Res. 2020 Jan;283:112376. doi: 10.1016/j.psychres.2019.04.025. Epub 2019 Apr 23. PMID: 31036287.

Implementation Research Logic Model (IRLM)



Combines several implementation theories, models, frameworks and outcomes

Smith JD, Li DH, Rafferty MR. The Implementation Research Logic Model: a method for planning, executing, reporting, and synthesizing implementation projects. Implement Sci. 2020 Sep 25;15(1):84. doi: 10.1186/s13012-020-01041-8. PMID: 32988389; PMCID: PMC7523057.

Methods

Prior to implementation

- Survey stakeholders – which of the CFIR[1] domains are possible determinants of implementation for the FRAIL Scale (barriers and enablers)?
- Used to:
  - develop the qualitative interview guide (https://cfirguide.org/)
  - Inform possible implementation strategies (CFIR-ERIC Matching tool)

Qualitative – during/ post implementation

- Semi-structured interviews with stakeholders, practice staff and patients – to inform feasibility, appropriateness, acceptability, determinants of implementation (barriers and enablers), and implementation strategies (ERIC)[2]

1. Damschroder *et al.* The updated Consolidated Framework for Implementation Research based on user feedback. *Implementation Sci* **17**, 75 (2022).
2. Powell, B.J *et al.* A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project. *Implementation Sci* **10**, 21 (2015)

1 Retrospective **chart audit** of annual 75+ health assessment records: **2021**

- **Frailty domains assessed and recorded** in medical records at annual 75+ health assessment in general practice

2 **Pilot of the FRAIL Scale Tool** in two regions - Sydney North and Brisbane South: **2021 – 2023**

- **Assess impact of FRAIL Scale** for screening older patients
- Identify **resources required to support management**
- **Feasibility, acceptability and appropriateness** of FRAIL Scale tool in general practice and **determinants of implementation**

3 **Broader implementation of the FRAIL Scale Tool** in Sydney North and Brisbane South with 75+ health assessment: **2023 – 2025**

- **Understand barriers & enablers** to implementing management for risk of frailty/frailty
- **Inform strategies** required **to support implementation** (ERIC[1])
- **Likely sustainment** of the **FRAIL Scale Tool** at the time of the **75+ Health Assessment**

4 Implementation of the **FRAIL Scale Tool in Surat & Augathella**: **2024 – 2025**

- **Feasibility** of screening for risk of frailty using the FRAIL Scale tool in WQ general practices
- **Understand barriers & enablers** to implementing management for risk of frailty/frailty in Western Queensland

1

Retrospective **chart audit** of annual 75+ health assessment records (2021) 12 general practices

Chart audit data (patients who had completed the 75+ health assessment in the previous 12 months (n=348)

	12 general practices Number (%) or Mean (SD)
Patient charts asses	n=348
Age (years)	81
Female (%)	57
Assessed for: 1. **F**atigue /exha 2. **R**esistance/ w 3. **A**mbulation/ 4. **I**llness 5. **L**oss of weig	 26 (7.5) 38 (10.9) 61 (17.5) 148 (42.5) 76 (21.8)
Assessed for	7 (2.0)

46.3% had <u>any</u> of the 5 FRAIL Scale indices recorded as assessed

A fraction (2.0%) had <u>all</u> five recorded as assessed.

2 **Pilot of the FRAIL Scale Tool** in two regions - Sydney North and Brisbane South: **2021 – 2023**

Aims

- **Assess impact of FRAIL Scale** for screening older patients
- Identify **resources required to support management**
- **Feasibility, acceptability and appropriateness** of FRAIL Scale tool in general practice and **barriers and enablers to implementation**

Mixed methods:

Quantitative

- **Excel spreadsheets** - patient demographics, FRAIL Scale scores, medication number, hospitalisations/ED attendance, interventions/ resources to manage risk of frailty, barriers to accessing resources

Qualitative

- **Staff interviews (n=13)** (10 practice nurses, 1 chronic disease manager/accredited practicing dietitian, 1 GP, 1 pharmacist) - implementation barriers & enablers (CFIR) and strategies required to support implementation (ERIC) 13 practice staff who had use the Tool

2 **Pilot of the FRAIL Scale Tool** in two regions - Sydney North and Brisbane South: **2021 – 2023**

Frail screening data: 12 SNHN practices - screened opportunistically (2021-2022)
7 BSPHN practices - screened at the time of the 75+ HA (2022-23)

Frail Scale screens

number (%) or mean (SD)

	All (n=1071)	SNHN (n=728)	BSPHN (n=343)
Age (years)	**82.6 (5.8)**	82.6 (5.9)	82.5 (5.4)
Aboriginal or Torres Strait Islander background*	4 (0.6)	0	4 (1.2)
BMI (kg/m^2)*	27.6 (5.1)	27.4 (5.2)	27.8 (4.9)
Medication number*	7.9 (5.2)	7.4 (5.2)	8.0 (5.1)
Frail Score	**1.9 (1.5)**	**2.1 (1.5)**	**1.4 (1.3)**

*Missing data

Findings

Key resources identified to support risk of frailty

- Exercise interventions (classes, physio/exercise physiologists)
- Medication reviews (pharmacy and GP)
- Referrals to geriatrician
- Nutrition support

Primary barriers that patients and their carers identified to accessing the management options

- Cognitive decline
- Mobility, transport and access issues
- Cost
- Issues related to COVID-19 isolation and lockdowns

Qualitative interviews - practice staff

Feasibility, appropriateness and acceptability of screening with the FRAIL Scale Tool

- **Quick and easy to use (takes 2 minutes) -** user friendly, intuitive, doesn't need a lot of training, fits well with 75+ health assessment which funds the nurse time

  "it certainly complements the completeness of the 75+ health assessment"

- **The Tool formalises frailty assessment -**

  "prior to having the formal tool, it was almost a little bit ad hoc"

Staff reported **barriers and enablers** to accessing management options and resources related to:

- **Available resources, knowledge and information**

  "it's sometimes hard to know what services would be good for that patient, or what they kind of need. So yeah, I think just some more information on those services would be good"

- **Resource format** e.g., lengthy brochures & accessing web pages

- **Partnerships and connections**

  "so the main initiative I think we're always looking for is physio"

Qualitative interviews: staff identified implementation strategies

Staff conducting risk of frailty screening identified methods to make it 'business as usual':

- **Linking** risk of frailty screening **with funding i.e. over 75 health assessment**
- **Incorporating** the FRAIL Scale Tool and management options **into the 75+ health assessment template**
- **Screening** for risk of frailty **opportunistically** e.g, with blood pressures, dressings, Mini Mental
- **Supporting access risk of frailty management resources and interventions** e.g., local exercise programs, referrals to allied health professionals with an interest in frailty

Conclusions from the pilot study

1. The **Frail Scale Tool can be readily incorporated into general practice workflow** by **integrating with the 75+ health assessment** (over 600,000 75+ health assessments conducted each year in Australia)
2. The **FRAIL scale tool and management approach** is **appropriate** in general practice and **acceptable** to providers
3. **Resources and services are required in the community to support management** of patients who are at risk of frailty

3 **Broader implementation of the FRAIL Scale Tool** in Sydney North and Brisbane South with 75+ health assessment (HCF research foundation grant - $ 331,340): **2023 – 2025**

Informed by pilot study:

- **Incorporating FRAIL Scale into the 75+ HA fits with the practice workflow**
  - an appropriate method for identifying & tracking risk of frailty in primary care

Aims:

- Assess **risk of frailty in the general practice population** when screened **at the time of the 75+HA**
- **Understand barriers & enablers** to implementing management for risk of frailty and **inform strategies to support implementation**
- **Sustainment** of screening for risk of frailty in general practice
- **Community resources/referral options** required to support identified need
- **Investigate hospital utilisation** (potentially preventable/ED attendance)
- **Change in FRAIL Scale scores** over 12 months

3 **Broader implementation of the FRAIL Scale Tool** in Sydney North and Brisbane South with 75+ health assessment (HCF research foundation grant - $ 331,340): **2023 – 2025**

Mixed methods:

Quantitative

- **REDCap Data collection** - patient demographics, FRAIL Scale scores, medication number, hospitalisations/ED attendance, interventions/ resources to manage risk of frailty, barriers to accessing resources
- **PRESS survey** to measure sustainment reported by general practice staff

Qualitative

- **Staff interviews** - implementation barriers & enablers (CFIR[1]) and strategies required to support implementation (ERIC[2])
- **Patient interviews** - access to resources in the community

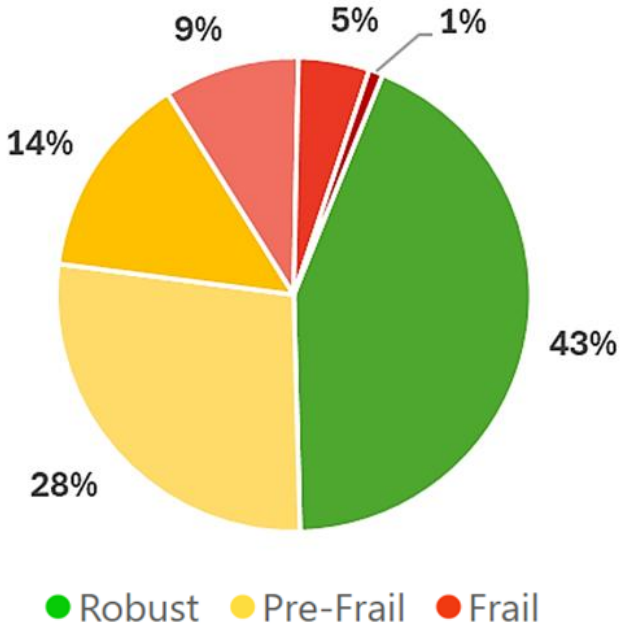
1. Damschroder *et al.* The updated Consolidated Framework for Implementation Research based on user feedback. *Implementation Sci* **17**, 75 (2022).
2. Powell, B.J *et al.* A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project. *Implementation Sci* **10**, 21 (2015)

FRAIL Scale Tool with annual 75+HA: Jul 2023 – Jan 2025

14 **Sydney North** & 10 **Brisbane South** general practices

Median time taken by staff to complete the FRAIL Scale tool was **3.9 minutes**

Patient characteristics (n=1484)	**Robust** Score 0	**Pre-Frail** Score 1-2	**Frail** Score 3-5	**P-value**
N (%)	645 (43.5%)	616 (41.5%)	223 (15%)	-
Age in years, *median (IQR)*	79 (77-83)	80 (77-85)	84 (79-88)	<0.001
BMI in kg/m^2, *median (IQR)*[A]	26.2 (23.5-29.1)	27.3 (24-30.8)	27.1 (23.5-31.2)	<0.001
Prescribed medication count, *median (IQR)*[B]	4 (2-5)	6 (4-9)	8 (5-11)	<0.001
Non-elective hospitalisation in prior 3 months, *n (%)*[C]	5 (0.8)	28 (4.6)	23 (10.6)	0.01
Emergency department in prior 3 months, *n (%)*[D]	20 (3.1)	42 (6.8)	28 (12.6)	0.82
Missing data [A]*n=271,* [B]*n=5;* [C]*n=26;* [D]*n=5*				



Outcomes

Key community resources/referrals required to support patients identified as frail/prefrail:

- Medication reviews
- MyAged Care packages
- Exercise classes (with strength/resistance component)

Change in FRAIL Scale scores over 12 months:

- Subset of patients (n=146) rescreened at 10-38 months to assess change in FRAIL Scale score
- No statistically significant change observed in the frailty score at initial assessment (average 1.51) compared to rescreen (average 1.58)
- Future research will aim to increase sample size for rescreens and narrow follow-up window to 10-14 months

Qualitative Interviews (n=15)

Themes identified guided by Consolidated Framework for Implementation Research (CFIR)

- **Staff interviews (n=5):** 4 practice nurses + 1 general practitioner
- **Patient interviews (n=10):** patients aged 75+ following FRAIL Scale screening at their annual HA

1. **Screening with the FRAIL Scale tool**
   i. Appropriateness & acceptability of the FRAIL Scale Tool
   ii. Barriers & enablers to implementation (CFIR)
   iii. Strategies required to support implementation (ERIC)
2. **Management of frailty risk in primary care**

Implementing the Frail Scale Tool at the time of the 75+ HA

Patients feel the FRAIL Scale provides an opportunity to reflect on their health:

"nobody asks you questions .. like that, usually it's just whatever you're going to the doctor (for) ….the fact that you know at my age 75…I'm still doing well… So ***I was kind of quite happy with my assessment****"* ***Patient***

Patient trust in the medical team facilitates screening:

"[Dr] has been my GP for quite some time and she looks after me and my wife really well. So ***whatever she asks, I'm very happy to discuss with her****."* ***Patient***

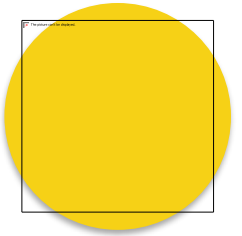
Staff felt the FRAIL Scale screen fit with the workflows for the 75+HA:

"we do .. daily living and then we go through .. risk factors for osteoporosis. And then falls risk and (the) FRAIL Scale tool so ***it works in perfectly****"* ***Nurse***

FRAIL Score can be easily documented in the patient records during the health assessment:

"it's in the patient notes…… this is what the score number was, .. what it meant. And we also ***save… the whole thing with the recommendations and everything into their notes*** *as well into correspondence"* ***Nurse***

Management of frailty/risk of frailty in primary care



Some patients were interested in learning more about health lifestyle behaviours:

"They did suggest maybe that I should … see an Exercise Physiologist which .. ***I've never even heard of before****"* ***Patient***

"it's good learning for me …feeling ***I have to learn more to keep my body healthy****"* ***Patient***

Accessing online resources can be a challenge for some:

"another barrier is because ***we are not IT people****. So sometimes ..the programme .. from* ***online .. is a bit difficult for us to join"*** ***Patient***

Relationships and social connectedness were a facilitator to exercise:

"I walk with my son every weekend. We have coffee and sometimes, if my daughter can, I walk with her. ***I see the family all the time****. I'm in a good place."* ***Patient***

Access to resources can be limited due to health, transport issues, costs or caring duties:

"I've been with the gym for about 15 years…these days I only….go there every once a week … because of my wife, she has dementia... so ***I don't have much time to do that****"* ***Patient***

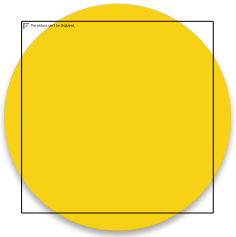
Findings

- **Rates of non-elective hospitalization in prior 3 months are 10x higher and ED attendance 4x greater for older persons screened as frail** compared to those screened as robust
- Embedding the FRAIL Scale into the annual 75+HA provides an opportunity for **early identification of frailty/prefrailty** and a way of documenting/tracking change in score
- Patients use FRAIL Scale **to reflect and learn more** about healthy ageing
- Patient **relationships with primary care providers** facilitate screening & **social connectedness** is an enabler for management

Qualitative interviews: informing implementation strategies

- Incorporate the FRAIL Scale Tool in **funded assessments** e.g. the 75+ health assessment / existing practice workflows
- Management recommendations from the GP to improve **patient motivation**
- **Management resource options in formats** which are easily accessible for practice staff & patients e.g., web hub, Health Pathways, hardcopy education resources
- **Practice and patient support to access risk of frailty management** e.g., health navigators, social prescribing

Sustainment of FRAIL Scale screening (PRESS survey)



Practice staff suggested embedding FRAIL Scale into Practice Software was essential for ongoing sustainment in busy general practice

*"Really should utilise it more. Factors affecting this are **time constraints**, and if it was integrated in the clinical software. It **would be of more use if it was integrated into the practice software**."*

"***Wishing the PMS (practice management software) would allow recording as an observation***"

*"The FRAIL scale is on the desktop, but it meant a few more clicks to open it and I got out of the habit of using it. **Being accessible on BP** (Practice Software) under the 'Clinical' section, where we can easily access percentile charts, mini mental, diabetes risk assessment etc **would make the FRAIL scale more user friendly.**"*

Job J, Nicholson C, Clark D, Arapova J, Jackson C. (2024) The feasibility, acceptability and appropriateness of screening for frailty in Australians aged 75 years and over attending Australian general practice. Australian Journal of Primary Health 30, PY23173. https://doi.org/10.1071/PY23173

Job JR, Nicholson C, Strauss R, Clark D, Pelecanos A, Jackson C. Frailty Screening and Management for Older Australians in General Practice: Mixed Methods Evaluation. Interact J Med Res. 2026 Mar 2;15:e79681. doi: 10.2196/79681. PMID: 41815005; PMCID: PMC12954687.

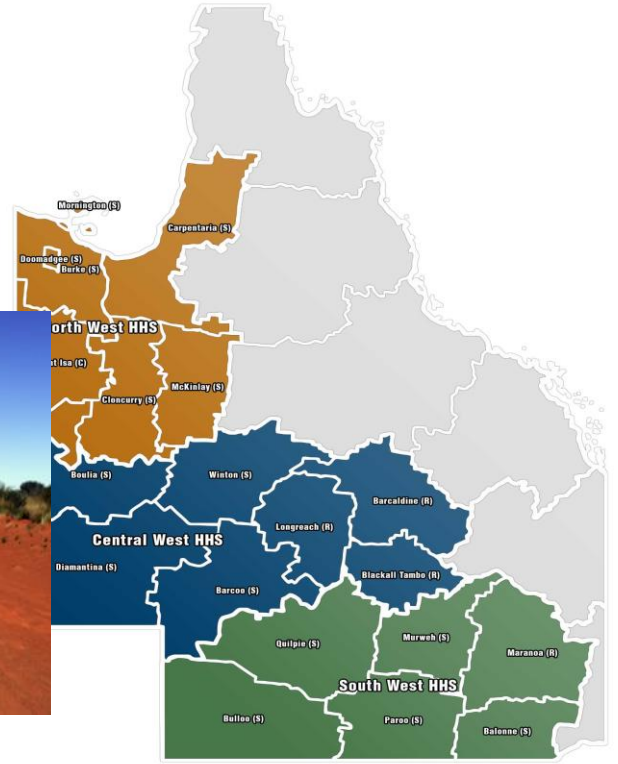
4 Pilot of the **FRAIL Scale Tool in Surat & Augathella**: **2024 – 2025**

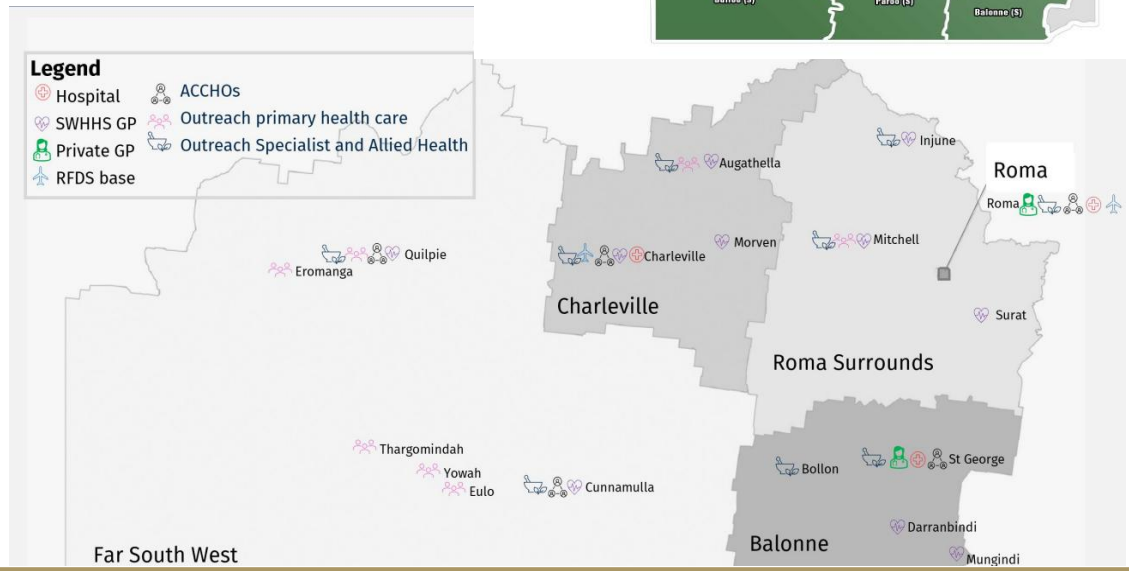
Gap identified:

- Western Queensland Primary Health Network (WQPHN) region has the **highest age-standardised mortality rate in Australia**
- **Aboriginal and Torres Strait Islander people are disproportionately affected**, with a 14.5-year life-expectancy gap

Aims:

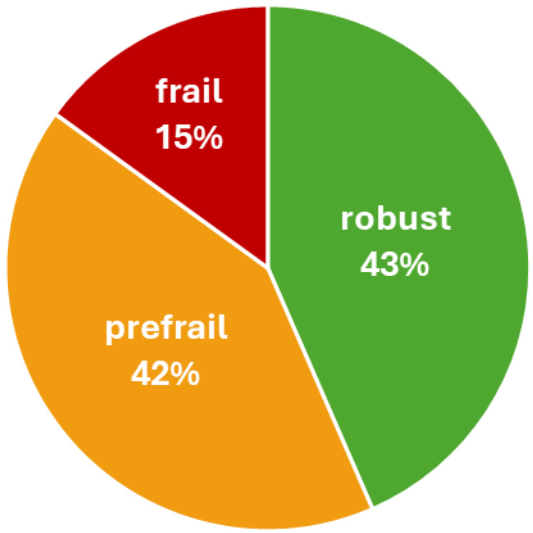
- **Feasibility** of screening for risk of frailty using the FRAIL Scale tool in WQ general practices
- **Assess rates of prefrailty and frailty** in rural and remote general practice
- **Understand barriers & enablers** to implementing management for risk of frailty in Western Queensland





Western Queensland frailty & barriers to management

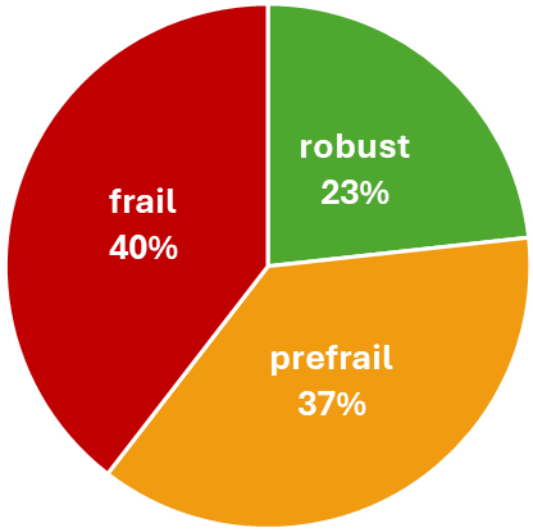
Sydney North & Brisbane South (n=1484)



A **barrier to accessing resources or referrals** required to manage risk of frailty was recorded for **254 out of the 839 patients** (**30.3%**) with a FRAIL Scale score of 1-5 (prefrail or frail).

The two barriers most frequently recorded (**10.5%**) were **health and transport.**

Surat & Augathella (n=43)



A **barrier to accessing resources or referrals** required to manage risk of frailty was recorded **for 32 out of the 33 patients** (**97%**) with a FRAIL Scale score of 1-5 (prefrail or frail).
The two barriers most frequently recorded (**82%**) were **cost and transport.**

Driving license assessments identified as a strategy for implementation

Guidelines for preventive activities in general practice

Miscellaneous

Frailty

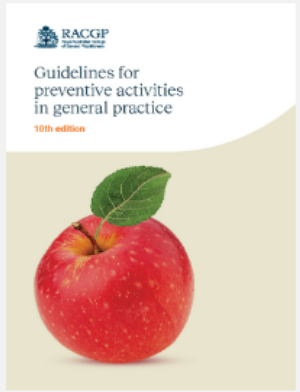


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Table of contents

Table of Abbreviations
About the Red Book

Screening for frailty

A health assessment for people aged ≥75 years provides a good opportunity for GPs to case-find people who are frail or pre-frail.

Screening for frailty helps to identify functional decline. Commonly used frailty scoring tools include the following.[4]

- Frailty indicators – ask about and score:
  - unintentional weight loss (≥4 kg in the past year)
  - self-reported exhaustion
  - weakness (reduced grip strength)
  - slow gait speed
  - low physical activity.

Frailty = ≥3 of the above; pre-frailty = 1–2 of the above; not frail = none of the above.[7]

- Frailty index – based on the accumulation of illnesses, functional deficits, cognitive decline and social circumstances, it involves answering >20 medical and functional questions.[8]
- Clinical Frailty Scale – helpful scale that takes very little time.
- Edmonton Frail Scale – scale that rates frailty from 0 to 17.[9]
- Frail Scale Risk Assessment – scale that assesses fatigue, resistance, ambulation, illness, and loss of weight.
- Other useful simple tests with variable specificity and sensitivity:[10]
  - slow walking speed (>5 seconds to walk 4 metres)
  - Timed Up & Go test (>10 seconds to stand from a chair, walk 3 metres, turn around, walk back to the chair and sit down again).

Translation activities

Management resource options in formats which are easily accessible for practice staff & patients

https://medical-school.uq.edu.au/about/mayne-academies-clinical-disciplines/general-practice/centre-health-system-reform-and-integration/research-and-translation-policy-practice/healthy-ageing

Medical Journal of Australia

MJA
The Medical Journal of Australia

CONSENSUS STATEMENT OPEN ACCESS

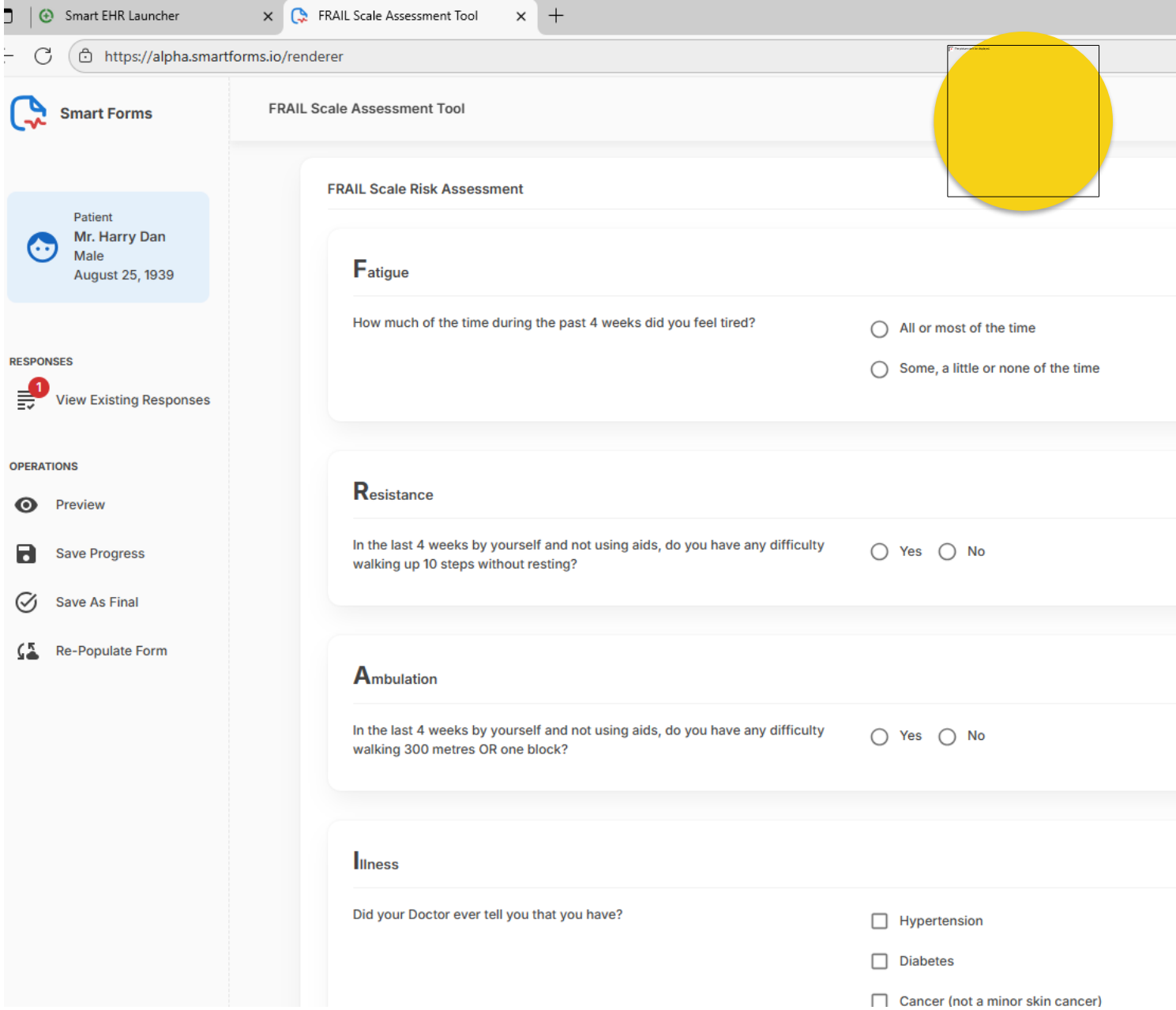
Australian Consensus Statement on the Prevention and Management of Frailty Among Community-Dwelling Older Adults: A Modified Delphi Study

Sakshi Chopra[1] | Ida Tornvall[1] | Natasha Reid[1] | Elizabeth Whiting[2,3] | Sarah N. Hilmer[4] | Jenny Job[5] | Anthony Villani[6] | Andrew J. Maiorana[7] | Mark Morgan[8] | Sarah Fox[1] | Adrienne Young[1] | Caroline Gibson[9] | Donna M. Reidlinger[1] | Elissa Burton[10] | Emily H. Gordon[1] | James Baker[11] | Leila Shafiee Hanjani[1] | Lisa Kouladjian O'Donnell[12] | Marc Sim[13] | Michelle Miller[14] | Peta Dampney[1] | Pazit Levinger[15] | Shannon King[1,16] | Ruth E. Hubbard[1] | on behalf of Australian Frailty Network Working Group

S.Chopra, I.Tornvall, N.Reid, et al., "Australian Consensus Statement on the Prevention and Management of Frailty Among Community-Dwelling Older Adults: A Modified Delphi Study," Medical Journal of Australia224, no. 5 (2026): e70182, https://doi.org/10.5694/mja2.70182 .

Translation activities

- Working with CSIRO and the Australian Digital Health Agency to build into general practice software systems
- Using FHIR technology and SMART Forms



Healthy ageing, frailty screening & digital innovation for multidisciplinary management

Engage patients in planning for healthy ageing at the time ≥75/ ≥ 55 health assessments for Aboriginal and Torres Strait Islander peoples

- practice nurses/ chronic disease managers/ Aboriginal Health Workers/ GPs screen for risk of frailty, using the **FRAIL Scale tool**
- tailor management for patients to address the components of frailty identified by screening with the **FRAIL Scale tool**
- Screening for risk of frailty in **younger populations** e.g., with **chronic disease management plans, indigenous health checks 55+ years, driving licence assessment**

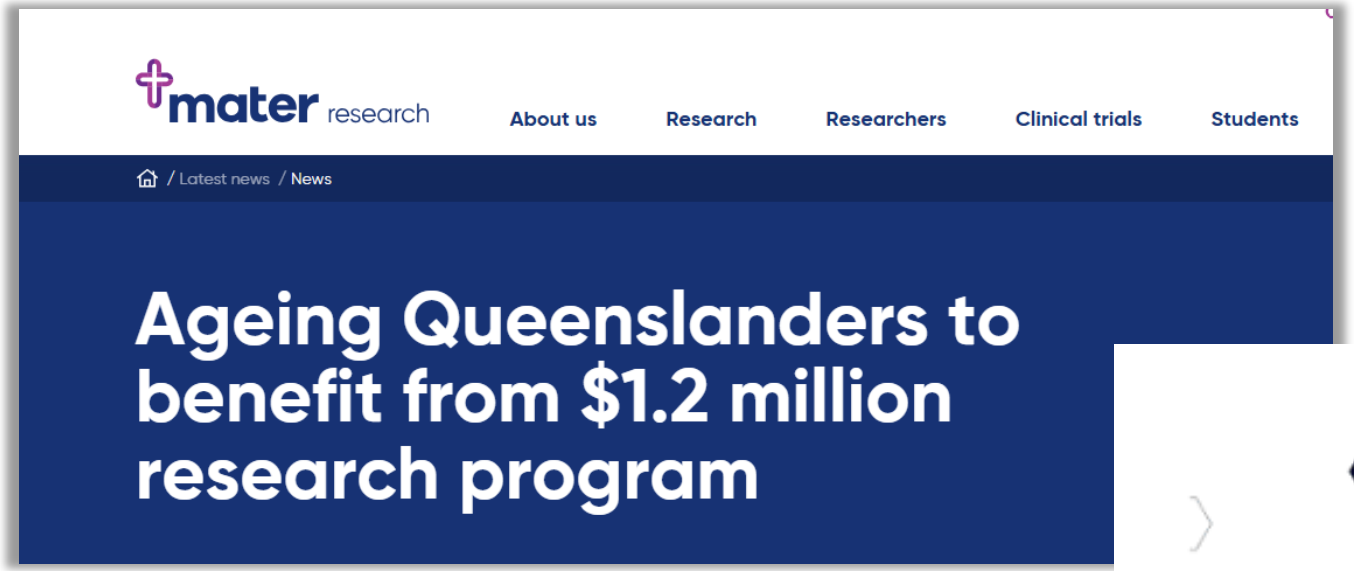
Healthy Ageing resources and promotion for health providers and consumers e.g. via newsletters/ social media & **understand access to resources** for managing risk of frailty in different regions, including rural & remote areas.

Supplement local services with virtual allied health where required: exercise physiology, physiotherapy, pharmacy

Expand Queensland eConsultant advice & guidance service for GPs and NPs to manage older persons to include geriatrician (currently available for Respiratory/sleep, Haematology, Neurology, Nephrology, Cardiology, Dermatology, Endocrinology, Rheumatology, Infectious Disease, Immunology and Obstetric-Medicine)**.**

SUCCESS!

Western Queensland Alliance for Healthy Ageing (AHA)



Medical Research Future Fund

Proposed AHA Governance Members:

phn Western Queensland – An Australian Government Initiative

North West Hospital and Health Service

South West Hospital and Health Service – Building better health in the bush

Central West Health – Central West Hospital and Health Service

Health Workforce Queensland

CHECKUP

Cunnamulla – In unity we walk as one – Aboriginal Corporation for Health

goondir health services

CWAATSICH

Gidgee Healing

Western Qld Private General Practice

Royal Flying Doctor Service

In partnership with:

Consumers

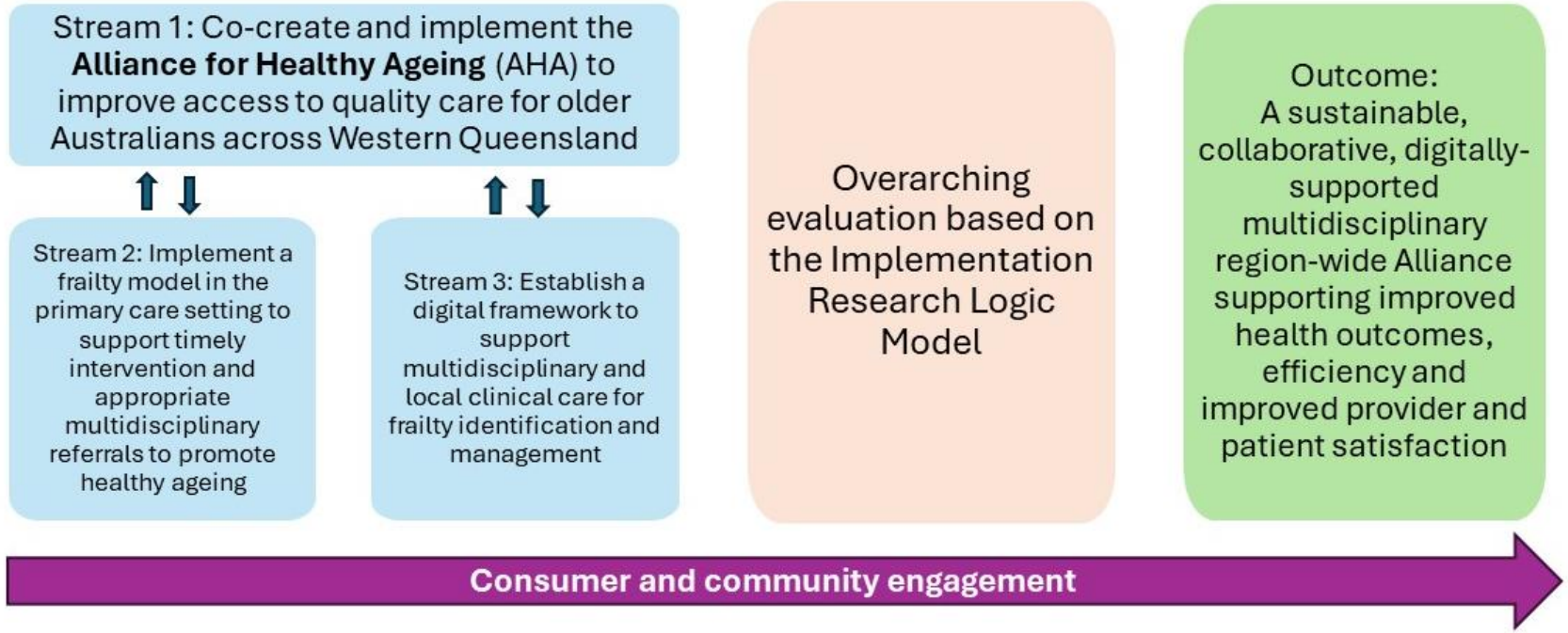
mater research

The University Of Queensland Australia

Background

Aims:

1. Adopt the principles of alliance governance to underpin the development and sustainability of a collaborative regional consortium committed to frailty identification and healthy ageing.
2. ***Determine the key determinants of a regional rural & remote multi-disciplinary service redesign model of care to support frailty identification and healthy ageing***.
3. Develop implementation strategies for frailty management in primary care.
4. ***Implement innovative use of digital linkage and workforce mechanisms to support local care teams to deliver effective regional services***.



Methods

Convergent mixed methods implementation evaluation.

Baseline data collection to understand current frailty screening practices, barriers to screening and allied health service availability and gaps.

Analysis of frailty screening data (baseline & 10-14 months) to assess frail score progression, hospital and health service utilization and healthcare costs

Semi-structured qualitative interviews and surveys at 12-18 months with practice staff and patients to assess acceptability, sustainability and determinants of implementing risk of frailty assessment.

Practice enrolment & screening

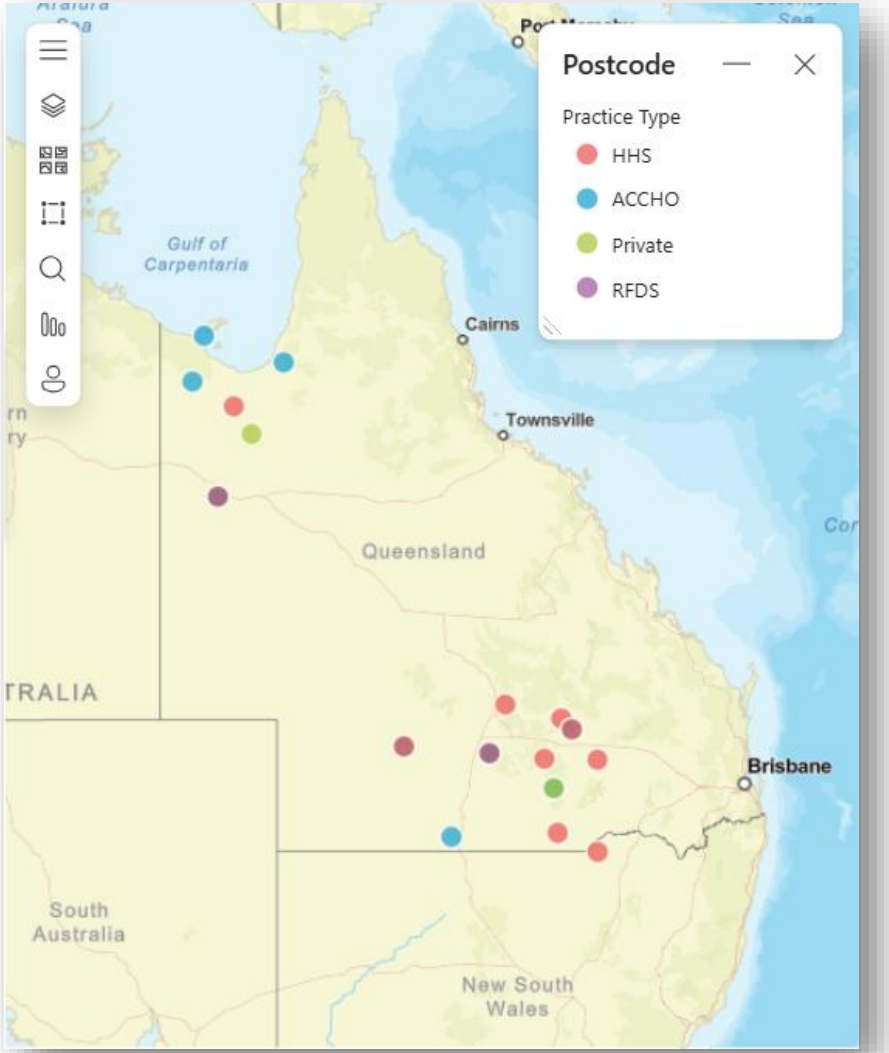
Baseline data received from **18 practices** in SW and NW Queensland

Allied health gaps highlighted – physiotherapy/EP, dietitian, Pharmacy

Frailty screening data received from 10 **practices**

168 patients screened – 37% Robust; 35% pre-frail and 29% frail

QoL & Social Isolation (n=34) – 26.5% Feel Isolated ; 32.4% feel lonely



Findings to date

- **Gaps** in services
  - Allied Health
    - Pharmacy
    - Physiotherapy/EP
    - Geriatrician
- Alliance members **commissioning** additional allied health services (virtual & F2F) to support AHA
- **Management options** to address this:
  - Resistance & Ambulation: Home resistance exercise guide & band
  - Illness: Geriatrician eConsultant for medication review
  - QoL & Social Isolation: Care connectors in local areas

Acacia Country Practice team provided their patients with a "Health pack" as part of the assessment, to encourage healthy ageing practices.

eConsultant Geriatrician

Meet **A/Professor Paul Varghese, Queensland eConsultant Geriatrician.** Paul has vast experience with the complex problems of aging, co-morbidities and polypharmacy. Paul is available for advice to GPs via the Mater Queensland eConsultant Service.

Geriatric eConsult benefits noted in previous research include:

- Reduced need for face-to-face visits – 68% of eConsults avoided a F2F visit.
- Shorter wait times – median response times were less than 2 working days.
- Faster access to specialist advice – 54% of geriatric eConsults provided GPs with advice for a new or additional course of action.

Thank you

If you have any queries or would like to discuss the program, please feel free to contact:

Email : aha@mater.uq.edu.au

For more information see :

- UQ-MRI CHSRI
- https://sydneynorthhealthnetwork.org.au/programs/frailty/
- ACI-Living-with-frailty-clinical-priorities.pdf

Caroline.Nicholson@mater.uq.edu.au

CSIRO PUBLISHING

RESEARCH PAPER

Australian Journal of Primary Health

The feasibility, acceptability and appropriateness of screening for frailty in Australians aged 75 years and over attending Australian general practice

Jennifer Job[A,*], Caroline Nicholson[A], Debra Clark[B], Julia Arapova[C] and Claire Jackson[A,D]

INTERACTIVE JOURNAL OF MEDICAL RESEARCH Job et al

Original Paper

Frailty Screening and Management for Older Australians in General Practice: Mixed Methods Evaluation

Jennifer R Job[1], PhD; Caroline Nicholson[1], PhD; Ruby Strauss[1], MPhil; Debra Clark[2]; Anita Pelecanos[3], BHSc(Hon); Claire Jackson[1,4], MD

JMIR Preprints Job et al

Evaluating the implementation of risk of frailty screening and intervention for older Australians in general practice

Jennifer Rae Job[1]; Caroline Nicholson[1] PhD; Ruby Strauss[1] MPhil; Debra Clark[2]; Anita Pelecanos[3] BHSc(Hon); Claire Jackson[1,4] MD