

Goal-Based Care Planning in Regional Geriatric Services for Older Persons Living with Frailty



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ABSTRACT

Background

Older adults living with frailty represent a complex group who are increasingly accessing regional geriatric services. Goal-based care planning is the industry standard in the care of older adults, yet few studies illustrate how goal-based care planning is being conducted with this population. Understanding how frailty impacts goal-based care planning in regional geriatric services is key to improving patient care.

Methods

In this “Go-Along” method of data collection, nine observational experiences were conducted, nine responses from the Interprofessional Role Shadowing Tool were obtained, and eight responses to follow-up questions were received. Open coding of the data was performed retrospectively, and indexed themes were identified.

Results

Although the Geriatric Clinicians indicated that goal-based care planning and frailty were central to practice, the observations indicated no clear process to patient-centred goal-setting or frailty identification in practice. The results infer a gap between theoretical knowledge and practical application.

Conclusions

A clear process to goal-based care planning in interprofessional geriatric services is needed. This objective requires practical education that emphasizes the skills necessary to implement goal-setting within unique, interprofessional care environments. Further research is necessary to establish if frailty identification is necessary in goal-based care planning, or if a patient-centred approach is more advantageous in practice.

Key words: frailty, goal-based care planning, older adults, goal-setting, geriatric services, patient-centred care

INTRODUCTION

The frail geriatric population is a high-risk group whose symptoms are both heterogeneous and complex. This vulnerable subset of older adults is not only susceptible to poor health outcomes, but is also more prone to social isolation and the need for institutionalization. Regrettably, the plethora of presenting symptoms of frailty contributes to unpredictability, as even the same co-morbidities of patients can lead to a variety of differing, adverse events. (J. Ingram. *The Recruitment and Retention of Geriatric Medicine Clinicians in the Central East LHIN*. Unpublished document of recommendation presented to the Central East LHIN, Oshawa, Ontario; 2017). In a search to better refine best practice, frailty has become central to the literature on aging and the clinical care of older adults. This research argues that focusing on chronological age alone may be less conducive to successful interventions than emphasizing the spectrum of frailty symptoms that exist within the older cohort.⁽¹⁾ Despite this recognition, the lack of a clear definition of frailty continues to impede effective practice with the geriatric population.⁽²⁾ This lack of knowledge translation from theory to practice requires a more in-depth look at the quality of care being provided for older adults who fit within the spectrum of frailty.

Goal-based care planning has been developed as an industry standard, central to health-care practice and holistic patient-centred care.^(3,4,5) Some literature suggests that identifying frailty can enhance goal-based care planning,⁽⁶⁾ yet little investigation has been conducted on refining a proven method that can be applied in diverse care settings. In response to anticipated growth in the population of older adults living with frailty in the Central East Local Health Integration Network (Central East LHIN)* region—an anticipated growth rate of approximately 12–48% in the next 10 years (J. Ingram. Unpublished document; 2017)—Seniors Care Network†

determined that more research was needed to understand how best to conduct goal-based care planning among this population. In 2017, a collaborative research project in partnership with Trent University, was completed in order to examine how goal-based care planning was being conducted with frail older adults within the Central East LHIN interprofessional geriatric services. This study was reviewed and approved by Trent University Research Ethics Board. It was expected that comparing the study's outcomes to empirical findings in the literature would provide an in-depth knowledge base that could act as a guide to streamline goal-based care planning with the frail older adult population across the region's interprofessional geriatric services.

METHODS

Population, Design & Setting

A total of 10 Geriatric Clinicians[‡] with diverse health professional backgrounds participated in the study, which used the “Go-Along” method of qualitative data collection. The “Go-Along” approach combines the benefits of ethnographic methods of participant observation and semi-structured interviewing by allowing participants to conduct their “natural activities” while the researcher concurrently gathers their interpretations and understandings of these events.⁽⁷⁾ In addition, an Interprofessional Role Shadowing Tool⁽⁸⁾ gathered answers to 10 questions regarding the Geriatric Clinician's practice, during the “Go-Along” experiences. Additional follow-up questions were circulated by email in order to better understand the impact and prevalence of frailty in each geriatric service. By using this extensive approach, a more comprehensive analysis of the events could be conducted and any divergences between the information provided by the participants and their observed interactions could be noted.

The “Go-Along” experiences were conducted over a two-month period and included Geriatric Clinicians with varying professional backgrounds from five different geriatric services. All patients observed were 65 or older, and represented the spectrum of frailty, from Vulnerable to Very Severely Frail (as indicated by the Clinical Frailty Scale⁽⁹⁾). The study aimed to answer the primary research question: How do clinicians with various interprofessional backgrounds conduct goal-based care planning with older patients living with frailty in geriatric services?

Data Coding & Analysis

The data was recorded manually in a field notebook and then transcribed into an electronic document. The data were first divided into two large categories: 1) the data that had been obtained directly from the Geriatric Clinicians in the form of interviews, verbalized comments, and written submissions; and 2) the data that had been observed by the Research Assistants during the “Go-Along” experiences.

Coding of the data was performed retrospectively, once the “Go-Along” experiences were completed. Inductive content analysis was used during the open-coding phase, which allowed for broad-based discovery of codes. The codes were then indexed into themes, and subcategories were identified under each indexed theme to further link related findings. The full research team participated in a discussion of the codes after the open-coding and grouping phases of analysis were completed. These discussions were initiated to ensure a consensus could be reached regarding the findings, and to mitigate any potential bias during the interpretation of the data.

RESULTS

During the research period, nine observational experiences were conducted, nine responses from the Interprofessional Role Shadowing Tool were obtained, and eight responses to the follow-up questions were received.

Goal-Based Care Planning

The themes derived from the analysis of both the interviews and observations were comparable, outlining a patient-centred process that builds the clinician-patient relationship through collaboration, extensive information gathering, and support. From the interviews, the Geriatric Clinicians conveyed a comprehensive knowledge of what goal-based care planning should entail, including a large focus on patient-centred practice, communication, and linking information sources to elicit the patient story. It was clear that the assessment approach the Geriatric Clinicians described played a key role in connecting the information obtained from multiple sources, including the patient, informal caregivers, and both internal and external staff. From the observations, it was evident that this approach yielded both patient-specific and informal caregiver-specific goals. However, the goal-setting methods used by the Geriatric Clinicians varied greatly between the clinicians observed. Interestingly, the word “goal” was rarely used during these clinical interactions.

Some of the observed recommendations made by the Geriatric team could be directly related back to patient-specific goals, whereas other recommendations were based on clinical expertise and derived from information gathered during the patient assessments. For example, a patient may have indicated that they did not know a lot about dementia and therefore the Geriatric Clinician would recommend a referral to the Alzheimer's Society (which specializes in educational programs).

Barriers to Goal-Based Care Planning

There was considerable deviation between the barriers of goal-based care planning identified by the Geriatric Clinicians, compared to those observed during the field research experiences. During the interviews, the Geriatric Clinicians

articulated a broad range of obstacles that impeded goal-based care planning. These included macro health-care system and organization limitations, such as health-care system culture, resource constraints, and needed organizational process improvements. More specific micro barriers were also identified, such as the need for role refinement, as well as improved communication between staff. In particular, organizational culture change represented the largest coded category, with a highlighted need to establish respect for the Geriatric Clinician role as it relates to patient care. Geriatric Clinicians surmised that the differing opinions, perceptions, and personalities of the patient, their family members, and other staff represented the second largest barrier to effective goal-based care planning with patients. Although the need for extra education and training was acknowledged, these identified educational needs related more to other internal and external staff, rather than to the Geriatric Clinicians themselves. Some data demonstrated how a patient's diagnosis or symptoms impacted goal-based care planning; however, this theme was determined to be less significant compared to other factors.

In contrast, the observational data obtained related more specifically to clinical practice. Although some observations of inquiring about patient and caregiver goals was noted, several assessments were conducted without any inquiry into patient goals or the refinement of goals through the use of probing questions. In particular, the Geriatric Clinicians focused more consistently on explaining the purpose and the process of the comprehensive assessment, compared to conferring with the patient about their goals. It was observed that, not inquiring about patient goals or using probing questions to refine goals, impeded patient-centred goal development.

In addition, the observational findings indicated that vague or unrealistic goals were often presented to the Geriatric Clinicians, both from patients and informal caregivers. For example, one immobile, palliative patient indicated that they wanted a magical cure so that they could leave the care setting and walk home. When these types of goals were voiced, the Geriatric Clinicians neither addressed the unrealistic goals and expectations of the patient, nor did they ask any clarifying questions. Furthermore, it was observed that the diverse language used by the Geriatric Clinicians to ask about goals contributed to the identification of vague goals by patients and caregivers.

Observations also revealed that no clear process to goal development could be identified. Geriatric Clinicians were observed to inquire about goals at different points throughout the assessment. These variable approaches to goal-based care planning ranged in effectiveness. It was noted that inquiries made about goals at the beginning of the assessment, prior to holistic information gathering, often resulted in goals that were not feasible due to other factors that were revealed once the patient's assessment was complete. Moreover, no explanation to patients or family members on the process of goal-setting was observed throughout the duration of the study.

Geriatric Clinicians were often observed suggesting goals for patients based on their expertise, rather than positioning

recommendations based on patient input. This approach was particularly evident when the Geriatric Clinicians would provide a suggestion that patients or informal caregivers outwardly disagreed with, as the recommendation did not align with the input they had provided. This discrepancy was also observed during team rounds, where goal formation was conducted without the direct input of either the patient or informal caregivers. The observed use of suggested goals and the exclusion of patients and families from the goal-setting process are findings that directly contrast with the best practice approach to goal-based care planning that was articulated by the Geriatric Clinicians during the research interviews. In addition, clinician-suggested goals, and excluding patients and their family members, were both observed to impede effective goal-setting with older adult patients.

Another barrier to goal-based care planning that was identified was the avoidance of discussing goals that related to services offered by the private sector. This practice often resulted in discussing alternative, publically available services that did not directly relate to the goals identified by the patient. In addition, it was observed that follow-up after the patient assessment was limited to where the particular service was performed, and/or the capacity of the Geriatric Clinician to follow-up. These findings paralleled the interview data that found that resource availability often impeded effective goal-based care planning with patients.

Finally, Geriatric Clinicians were observed to implement safeguards when a patient's goals involved patient assumed risk. This method often contributed to an observable tension between recognizing a patient's choice to live at risk and the safety concerns of the Geriatric Team. This observation had implications on goal-based care planning, such as additional recommendations, monitoring, or follow-up that did not align with patient-identified goals.

Frailty

The three follow-up questions sent to the Geriatric Clinicians after the "Go Along" experiences were aimed at identifying: 1) the prevalence of frail patients being seen by the Geriatric Clinicians; 2) the definitions of frailty used by the Geriatric Clinicians to inform their practice; and 3) the opinions of the Geriatric Clinicians as to whether frailty influenced how they conducted goal-based care planning with patients. The proportion of frail older adults seen by each service varied greatly, from approximately 30 per cent in the Primary Care Initiative to approximately 91 per cent in long-term care settings.

Results indicated a breadth of identifiers to define frailty, such as impaired cognition and compromised activities of daily living (ADLs). All of the Geriatric Clinician responses acknowledged multiple factors of frailty. However, an established, operational definition could not be obtained from the data alone, as there was little unanimity between the answers provided. Many of the Geriatric Clinicians emphasized the use of a frailty scale for frail patient identification. However,

the application of a frailty scale was not observed during any of the patient interactions over the duration of this project. It should also be noted that the word frailty was not observed to be verbalized once during the duration of the study by patients, caregivers, or staff.

Lastly, 75 per cent of the Geriatric Clinicians indicated that frailty informed how they approached goal-setting with patients. For those Geriatric Clinicians who stated that frailty did not inform their practice, they highlighted that their focus was on patient-centred goal-setting, rather than frailty itself. Due to this inconsistency, the results obtained on goal-based care planning may better apply to the broader category of older adults over 65, rather than only the frail older adult population.

DISCUSSION

Goal-Based Care planning

The outcomes from this study align with the substantive amount of literature on older adults that highlight the benefits of a patient-centred approach when conducting goal-based care planning^(4,10) Findings indicate that, when a patient-centred approach is used, the outcomes are favourable, and that this practice often ensures that the recommendations proposed accurately fit the needs of the patient. The Geriatric Clinicians theoretical emphasis on patient-centred goal-based care planning is, therefore, not surprising, given the breadth of literature that supports patient-centred care.

Although the study's findings are consistent with those previously presented on patient-centred goal-based care planning with older adults, the absence of overt goal-based care planning with patients in practice demonstrates a new avenue to explore. This research provides evidence that, when Geriatric Clinicians are conducting goal-based care planning with patients and their caregivers, results may vary in application. The lack of a clear process for goal-based care planning, as witnessed, may explain both the variations in practice and the avoidance of goal-setting all together. It is proposed that, if a best-practice approach to goal-based care planning specific to interprofessional geriatric services could be developed, it would improve the confidence and effectiveness of the Geriatric Clinicians in conducting goal-based care planning with their patients. This approach is supported by scholars who recognize the need to clearly define patient-centred care within the contextual elements of each care setting.⁽¹¹⁾ Refining best practice would not only assist the Geriatric Clinicians to confidently convey to patients the process of goal-based care planning, but would also ensure that goal-based care planning was successfully incorporated into the comprehensive assessment conducted by the Geriatric Clinicians.

Barriers to Goal Planning

This research corroborates previous findings conducted on the application of goal-setting, which found that approaches

are dominated by clinician-centred, population-centred, and system-centred practice, rather than representing patient-centred practice.⁽¹²⁾ From the observations in this study, a prominent clinician-centred and population-centred approach was consistently witnessed. This method of practice was evident from the expert recommendations and the assumed or suggested goals provided by the Geriatric Clinicians that did not align with either the patient's or the caregiver's input. Literary findings correlate a lack of patient-centredness with the divergent knowledge gap between patients and clinicians.⁽¹³⁾ Other scholars also outline how the involvement of caregivers may negatively impact a patient's participation in goal-setting by influencing the direction and length of the assessment.⁽¹⁴⁾ This project, in particular, supports that vague and unrealistic goals presented by patients and their caregivers can act as a barrier to patient-centred goal-based care planning. A lack of patient-centred practice is connected to psychosocial factors, such as a patient's inability to accept their health condition, as well as a patient's lack of desire to participate in goal-setting.⁽¹⁵⁾ These findings of clinician-centred and population-centred practice require further analysis to determine how a clear process for goal-based care planning may help to mitigate these impediments.

In the interviews, the Geriatric Clinicians articulated more system-centred barriers such as the need for health-care system culture change and resource constraints. These findings should not be minimized, as literature specific to patient-centred practice highlight the need for change within the health-care system to better align service provision with the needs of patients. In particular, Pelzang⁽¹¹⁾ indicates that macro issues, such as cost effectiveness and the dominance of the biomedical model in health care, impede the successful implementation of patient-centred care. It is, therefore, essential that the resource barriers identified by the Geriatric Clinicians be further investigated by health-care administrators to ensure the feasibility of goal-based care planning. These findings also raise questions about whether resource barriers particular to older people living with frailty may inhibit goal-based care planning specific to the needs of this population, and whether this might consequently encourage more generic approaches. This project then emphasizes the need for change at the macro, meso, and micro levels in interprofessional geriatric services, in order to better align goal-based care planning with a patient-centred approach.

It is essential to note that outlining a best practice approach to goal-based care planning and identifying resource constraints represents only the first step to ensuring effective practice with older adults. This study highlights a gap between the current knowledge of the Geriatric Clinicians on patient-centred goal-based care planning, and the effective practical application of this approach. This inconsistency suggests the need for reflection on how the distinct professional backgrounds of the interdisciplinary team members inform their execution of goal-based care planning with older adults. Conducting a gap analysis to determine the knowledge, skills, and abilities (i.e.,

competencies) of the Geriatric Clinicians would assist health administrators to seek out or develop education that meets the needs of their employees. For instance, the Regional Geriatric Programs of Ontario has endorsed the *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*,⁽¹⁶⁾ developed by Seniors Care Network and partners, that may provide the basis upon which to evaluate knowledge gaps. Educational interventions to address gaps must extend beyond providing theoretical knowledge to assist Geriatric Clinicians in direct practical application. This would involve not only the practice of goal-setting techniques with patients and caregivers, but also tangible methods to engage patients when barriers to goal-based care planning are presented. This type of education would be particularly beneficial to assist the Geriatric Clinicians with strategies to work with patients who provide vague or unrealistic goals, or to negotiate alternatives when system constraints do not provide interventions that align with patients' needs. Addressing the barriers that inhibit goal-based care planning with clients and establishing how to integrate goal-setting into clinical practice are requisite components to establishing effective interventions with older adults.⁽¹⁷⁾

In addition to practical education, it is suggested that a feedback structure be developed where patients, co-workers, managers and an expert on best practices in goal-based care planning are asked to assess the performance of Geriatric Clinicians. Similar to 360° employee performance evaluations,⁽¹⁸⁾ this specified feedback on patient-centred goal-based care planning would allow the Geriatric Clinicians to refine their practice and ensure that their approach is conducive to meeting patient and caregiver needs. Practical skills development, as well as mechanisms for constructive feedback, is essential to helping health professionals improve patient-centred goal-based care planning with older adults.

Frailty

This study substantiates prior research outlining that the definition of frailty greatly varies in practical application. The clinicians recognized a wide range of factors that contributed to their definition of frailty, which not only influenced their understanding of how frailty impacted their daily practice, but also how this definition influenced their perceptions about persons who they identified as frail. Some researchers suggest that this variation in the definition of frailty is detrimental to the consensus-building needed in the field to ensure best practice.⁽¹⁹⁾ Other authorities note that diverse definitions allow frailty to be tailored to the unique setting in which it is employed.⁽⁸⁾

This study provided evidence that, regardless of the Geriatric Clinician's conceptual definition of frailty, the Geriatric Clinicians were not observed to use frailty identification overtly in their practice. Research conducted by Gobbens *et al.*⁽¹⁾ emphasizes that there is divergence between conceptual and operational definitions of frailty that must be better aligned to ensure that theoretical understandings of frailty can be practically applied in clinical settings.

Interestingly, the findings of those who did not indicate that frailty impacted goal-based care planning leads to a more innovative discovery; specifically, those Geriatric Clinicians unanimously recognized the application of a patient-centred approach. This emphasis of patient-centred care also strongly emerged from both the interview and observational data that were collected on goal-based care planning in general. This emergent theme raises the question as to whether goal-based care planning should be framed through the contextual definition of frailty, or whether goal-based care planning for frail older adults should focus more on the symptoms of frailty that impact each unique patient. More specifically, is the definition of frailty an essential element of goal-based care planning or is it more accurate to utilize a patient-centred lens that focuses on a patient's symptoms (which inherently may indicate frailty)? Although this particular study was unable to establish a direct connection between patient frailty and goal-based care-planning within interprofessional geriatric services, further research should be performed to uncover whether best practice requires a clear definition of frailty or whether a patient-centred approach is a more effective means of conducting goal-based care planning with older adults living with frailty.

Limitations

It is recognized that the findings from this analysis represent a small sample size. In particular, the quantity of the Geriatric Clinicians observed and interviewed in this project were restricted both by the project's duration, as well as by the small number of interprofessional Geriatric Clinicians employed in the Central East LHIN's specialized geriatric services. Despite the small sample size, there was fulsome representation from a variety of clinical contexts (i.e., community, hospital, and long-term care) where Geriatric Clinicians practice. The findings also suggest a need for change in the approach to goal-based care planning in the Central East LHIN, which may also inform research being conducted among other regional interprofessional geriatric services.

In addition, the recommendations posed in this analysis represent mechanisms to bridge the gaps observed in goal-based care planning for older adults in the Central East LHIN geriatric services based on a best practice patient-centred approach. It is acknowledged that these recommendations have not been linked to either direct or indirect funding for goal-based care planning, which greatly impacts the feasibility of these recommendations. A lack of adequate resources highlight one of the primary challenges of quality improvement initiatives in the context of geriatric services, as current health-care funding structures do not align with supporting patient-centred goal-based care planning for older adults. Further analysis that connects goal-based care planning with resource allocation within geriatric services may greatly improve the feasibility of the recommendations provided.

CONCLUSION

Determining a clear process and providing effective training opportunities for Geriatric Clinicians is fundamental to effective goal-based care planning with older adults that reflects a patient-centred approach. Although this particular study was unable to establish a direct connection between patient frailty and goal-based care planning, it did solidify that a broad range of frailty definitions exist, and questions how these conceptual definitions can be leveraged in practical application. For enhanced service, further studies need to examine whether best practice requires a clear definition of frailty or whether a patient-centred approach is a more effective means of conducting goal-based care planning with frail older adults. This process would uncover whether operational definitions of frailty should be utilized to directly influence goal-based care planning, or whether clinicians should focus only on the symptoms and goals specifically related to each patient case. Many questions remain regarding the implementation of goal-based care planning with frail older adults in geriatric services. Despite these unknowns, by utilizing the principles of patient-centred care and ensuring that theoretical models align with frontline application, optimized care of geriatric patients will eventually be realized.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that no conflicts of interest exist.

FOOTNOTES

*A regional health authority in southern Ontario.

†A network of dedicated health professionals that share expertise and support the coordination and integration of health-care services for frail older adults in the Central East LHIN.

‡The term Geriatric Clinician has been used here to denote members of any health discipline who are working in specialized geriatric services and should not be confused with Geriatric Medicine Specialist Physicians.

§Adapted from the Interprofessional Job Shadowing Tool developed by Tomaszewski (2009).

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