Preventive Care for Older People (PCOP) Reminder Tool

The CEP PCOP tool is based on synthesized high-quality guidelines. Click here for the list of evidence sources used.

For use in patients ≥65 years. This form does not have to be completed in one visit.

ⓘ = refer to Additional Information Sheet on pages 3-4 for further information.

Strategies to support culturally safe and patient-centered screening

- Build therapeutic relationships and adopt shared decision-making that considers patient values and preferences.
- Acknowledge the decision to screen does not need to be made on the spot or during one encounter.
- Encourage the involvement of supportive individuals from the patient's network.
- Consider frailty in balancing the benefits and harms of screening. Clinical Frailty Scale is a tool to screen for frailty and to broadly stratify degrees of fitness and frailty.
- Ensure that preventive screening is delivered in an equitable manner, recognizing that disadvantaged or marginalized groups are often under-screened, placing them at a higher risk for developing or exacerbating chronic conditions.

Current concerns

Health behaviours

Update the CPP with relevant information for the following as appropriate for the patient.

Medications 1	Smoking	Advance care planning 5	Calcium and vitamin D 9
Past medical history	Cannabis 4	Social isolation and/or loneliness 6	Notes:
Physical/sedentary activity 2	Alcohol	Elder abuse 7	
Infectious conditions 3	Substance use	Low income 8	

Evidence-based clinical geriatric review

Hearing	Insufficient evidence to recommend for or against routine screening. Use clinical judgement.10
Vision	☐ ***Symptomatic or increased risk for impaired vision*** (lives in long term care, or has dementia, diabetes or vision disorder e.g., glaucoma); refer to optometrist or ophthalmologist if not already receiving their care. ☐ ***Asymptomatic***; insufficient evidence to recommend screening in primary care. Does not apply to patients already under the care of an optometrist/ophthalmologist.
Cognitive impairment	☐ ***Symptomatic*** (cognitive symptoms and/or decline in daily functioning)11; consider screening with either a rapid screen (Mini-Cog, clock) or, if longer appointment, comprehensive screen (MMSE, MoCA or RUDAS) and review for changes in function (ADLs, IADLs). If screen positive, arrange follow-up for appropriate dementia work-up and management. ☐ ***Asymptomatic***; cognitive testing to screen asymptomatic adults for the presence of mild cognitive impairment or dementia, including asymptomatic persons with risk factors is not recommended. Remain vigilant for potential symptoms of cognitive disorders in older or at-risk individuals.
Depression	☐ ***Risk factors*** 12; consider using the PHQ-9 or GDS to screen for depression. Consider using the Cornell Scale in patients with dementia.12 Date: _____ Test: _____ Score: _____ ☐ ***No risk factors***; screening is not recommended.
Anxiety	Insufficient evidence to recommend for or against routine screening. Use clinical judgement particularly in individuals at risk.13
Fall prevention	Ask all patients ≥65 years: "Have you experienced a fall in the last year?"14 ☐ Yes. Date(s): _____; Assess fall severity: ☐Injury ☐≥2 falls ☐Frailty ☐Unable to get up ☐Loss of consciousness ☐None of the above ***If yes to ≥1: Severe fall/high risk***. Offer multidomain interventions informed by a multiprofessional falls risk assessment (i.e., comprehensive geriatric assessment or falls program). Follow-up in 30-90 days. Examples of multidomain interventions include assessing and addressing: - Gait and balance - Medication review - Bone health - Postural (orthostatic) hypotension - Visual impairment - Feet and footwear - Home safety and accessibility (consider an OT home safety assessment) ***If none of the above (non-severe fall):*** assess gait and balance, provide education on fall prevention and exercise (including strength and balance; see **Physical/sedentary activity** section), and consider PT referral. Reassess in one year. ☐ No falls: reassess in one year

Notes:

Physical examination

BP sitting _____ BP supine/standing _____ 15 HR _____ 16 Weight (kg) _____ Height (cm) _____ 17 BMI _____

Notes:

Investigations	65-74 years	≥75 years
Lipids	Date last ordered: _____ Test every 5-10 years, unless risk factors change. Assess using a validated CVD risk calculator. 10-year risk of CVD: _____%	Routine lipid testing and risk assessment is not recommended. [18]
Diabetes	HbA1C: _____ Date: _____ **Screen for type 2 diabetes every 3 years.** Functionally independent (Clinical Frailty Scale score 1-3): target A1C ≤ 7% Functionally dependent (Clinical Frailty Scale score 4-5): target A1C 7.1-8.0% Frail and/or dementia (Clinical Frailty Scale score 6-8): target A1C 7.1-8.5%	Routine screening not recommended if >80. Decision should be made on an individual basis.
Hypertension	**Blood pressure measurement at all appropriate primary care visits.** BP sitting: ***See physical exam section***. [19] Cautions and contraindications to intensive BP lowering include: HF or recent MI, institutionalized individuals, DM, previous CVA, eGFR <20, patient unwilling or unable to adhere to multiple meds, standing BP <110, inability to measure SBP accurately, known secondary cause of HT.	
AAA	Date: _____ One-time screening with ultrasound for abdominal aortic aneurysm for men aged 65 to 80.	
Cervical cancer	Done: _____ Due: _____ Not applicable: _____ Screen every 3 years; stop at age 70, after 3 or more normal tests in the previous 10 years.	Stop screening after age 70 after 3 or more normal tests in the previous 10 years. *
Colorectal cancer	Done: _____ Due: _____ Declined: _____ See Additional Information Sheet for risk-based screening. [20]	For adults >75 years, screening should be individualized based on overall health and life expectancy, prior screening history, risks and benefits, patient values, and preferences. *
Breast cancer	Done: _____ Due: _____ Declined: _____ Screening with mammogram every 2 years.	Same as above. *
Prostate cancer	Screening the general population is not recommended. For patients <70, discuss the risks and benefits of screening and consider individual preferences and circumstances.	Screening the general population is not recommended.
Lung cancer	Refer high-risk patients 55-74 who have smoked cigarettes every day for at least 20 years (not necessarily in a row) for a low-dose CT scan in a centre with expertise in early diagnosis and treatment of lung cancer or through the Ontario Lung Screening Program.	Screening not recommended.
*	**Talking points to explain stopping cancer screening** - *Your other health issues take priority.* - *You are unlikely to benefit from this test.* - *We should focus on quality of life instead of looking for cancer.* - *This test is not recommended for you by medical guidelines.* - *We usually stop doing this test at your age.*	
Fragility fractures	(Risk assessment first screening) to prevent fragility fractures in females ≥ 65. FRAX (without BMD): _____ Use the 10-year absolute risk of major osteoporotic fracture to make a decision about the possible benefits and harms of preventive med. After discussion, if preventive med considered, order BMD using DXA of the femoral neck then recalculate fracture risk. Last BMD: _____ FRAX (with BMD):_____ Refer to "Too fit to fracture" for specific exercise recommendations from Osteoporosis Canada.	
Notes:		

Immunizations	
Tetanus	Tdap once in adulthood. Td booster is recommended every 10 years.
Pneumococcus	Pneu-C-20 is publicly funded for adults ≥ 65 who are pneumococcal vaccine naïve AND individuals at high risk for IPD who have not also received Pneu-C-13. [21]
Shingles (Herpes Zoster)	Recommended for individuals ≥ 50 years of age without contraindications. [22] Adults aged 65-70 are eligible for a publicly funded vaccine. 2-dose series; 2nd dose recommended 2 to 6 months after 1st dose.
Influenza	Recommended every year in the fall. [23]
COVID-19	Consult current guidelines regarding COVID-19.
Respiratory Syncytial Virus (RSV)	Consult current guidelines regarding RSV.

Assessment and plan

Additional Information Sheet

Health behaviours

1. Medications

Conduct a medication reconciliation to create an accurate medication list. Consider polypharmacy and prescribing cascades. Pay attention to CrCl and eGFR. Refer to a pharmacist if patient is on multiple or high-risk medications.

2. Physical/sedentary activity

Refer to "Too fit to fracture" for specific exercise recommendations from Osteoporosis Canada.

Prescribe:

- 150 min/week of moderate to vigorous aerobic activities
- Muscle strengthening and balance exercises at least twice weekly

3. Infectious conditions

Consider TB, STI, Hep C and HIV screening and counselling if at increased risk.

4. Cannabis

Avoid cannabis in patients with substance use disorders, mental health conditions, cognitive impairment, CVD, unstable BP, impaired balance, falls.

- Advise patients on interactions with medications and alcohol.
- Smoking cannabis may exacerbate breathing problems.
- Edible cannabis, liquids, and oils increase the risk of using larger-than-intended doses due to delayed onset of effects.

5. Advance care planning

Document the name and contact information of substitute decision maker (SDM) or POA. Encourage patients to express their values and wishes to this person. Complete a Do Not Resuscitate Confirmation Form when appropriate and advise patient to keep it visibly displayed at home.

6. Social isolation and/or loneliness

Be alert to social isolation, loneliness and social vulnerability. Risk factors include: advanced age, women, racialized and Indigenous groups, living alone, widowed/divorced, low income or education, lack of affordable housing, episodic or chronic physical or mental health issues, poor health behaviours, caregivers, small social network, and 2SLGBTQIA+.

To alleviate social isolation and loneliness, consider referral to social services (211 Ontario). Also see CEP's Social Prescribing Resource.

7. Elder abuse

Be alert to clinical cues of abuse and neglect. Consider referral to social and legal services (211 Ontario).

8. Low income

Do you ever have difficulty making ends meet at the end of the month?" (See Government Programs for Older Adults)

9. Calcium and vitamin D

Calcium

- Males 51-70: 1000 mg; Females > 50 and Males > 70: 1200 mg
- Advise patients to obtain calcium through nutrition (i.e., 2-3 servings of dairy or equivalent per day). If supplementation is needed, add a low-dose calcium supplement (no more than 500-600 mg of elemental calcium at one time).

Vitamin D

- Males 51-70: 600 IU; Females 71 and older: 800 IU
- Given that it is difficult to achieve this level of intake, Health Canada recommends a supplement of 400 IU daily for those 51 or older.

Evidence-based clinical geriatric review

10. Hearing

Perceived hearing loss can be assessed by clinical tests such as the whispered voice test or single question screening (asking "Do you have difficulty with your hearing?"). If there is wax in the ear, this should be removed, and the hearing should be retested. Diagnostic confirmation of a positive screening is performed with audiometry.

11. Cognitive impairment

Features of cognitive impairment may include: reported cognitive symptoms (e.g., memory concerns) by the patient or an informant, decline in instrumental activities of daily living (IADLs), missed appointments or difficulty following instructions or taking medications, decrease in self-care, victimized by financial scams or new onset behavioural changes including new depression or anxiety.

12. Depression

Risk factors include: those experiencing disadvantages, recently bereaved with unusual symptoms, bereaved individuals 3 to 6 months after the loss, social isolation, persistent complaints of memory difficulties, chronic disabling illness, recent major physical illness, persistent sleep difficulties, significant somatic concerns or recent onset anxiety, refusal to eat or neglect of personal care, recurrent or prolonged hospitalization, diagnosis of dementia, Parkinson's disease or stroke, or recent placement in a LTC home.

PHQ-9: Cut off points for minimal (≤4), mild (score 5-9), moderate (score 10-14) and severe depression (score ≥15).
GDS: Score of 5-10 is suggestive of depression. Scores >10 are almost always depression.
Cornell Scale: Cut off points for probably major depressive episode (score >10) and definite major depressive episode (score >18).

13. Anxiety

Risk factors include: cognitive impairment or decline, depression, female sex, functional limitations, insomnia, multimorbidity, pain, polypharmacy, poor health status (objective or subjective), and social isolation or loneliness.

14. Fall prevention

See CEP's Fall Prevention and Management Tool.

Physical examination

15. BP supine/ standing	Do postural vitals in patients who fall or are at risk of falling. Orthostatic hypotension is defined as a decrease in blood pressure of >20 mmHg systolic or >10 mmHg diastolic within 3 minutes of standing from the supine position.
16. HR	Canadian Cardiovascular Society recommends opportunistic screening for atrial fibrillation in individuals aged 65 and older using pulse palpation.
17. Height	A significant loss in height (i.e., prospective loss 2 cm, or 6 cm historical loss) could indicate possible vertebral fracture.

Investigations

18. Lipids >75 years

For adults >75 y in overall good health, it may be reasonable to discuss the benefits and risks of statin therapy for primary prevention. Encourage statin use in patients who have had a CV event. Do not stop statin or reduce dose based on age over 75.

19. Hypertension

BP populations, thresholds and targets.

Patient Population	BP Threshold	BP Target
Low Risk (no target organ damage or cardiovascular risk factors)	SBP ≥ 160 DBP ≥ 100	SBP < 140 DBP < 90
High risk of cardiovascular disease (clinical/subclinical CVD; CKD, est 10 year risk 15%; or age ≥75)	SBP ≥ 130	SBP < 120
Diabetes mellitus	SBP ≥ 130 DBP ≥ 80	SBP < 130 DBP < 80
All others	SBP ≥ 140 DBP ≥ 90	SBP < 140 DBP < 90

20. Colorectal cancer 65-74 years

Risk-based screening:
- Average risk (no family history): FIT, every 2 years, or with flexible sigmoidoscopy every 10 years.
- Increased risk (family history of CRC in first degree relative):

→ Colonoscopy every 5 years if relative diagnosed before age 60
→ Colonoscopy every 10 years if relative diagnosed at age 60 or older

Immunizations

21. Pneumococcus	Pneu-C-20 is not funded if ALL eligible vaccines (Pneu-P-23 +/- Pneu-C-13) have been previously received. When giving Pneu-C-20 to those at high risk of IPD who have 1 dose of Pneu-P-23 or Pneu-C-13, wait at least 1 year after Pneu-P-23 or at least 8 weeks after Pneu-C-13.
22. Shingles (Herpes Zoster)	For individuals previously immunized with a live-attenuated zoster vaccine (Zostavax), immunization with a 2-dose series of RZV should be offered. For individuals with a previous episode of herpes zoster, immunization with a 2-dose series of RZV should be offered. Wait at least one year after an episode of herpes zoster before vaccinating.
23. Influenza	An enhanced vaccine is recommended as it provides better protection in adults ≥ 65 years of age.