



Australian Society for Geriatric Medicine

Position Statement No. 8

Geriatric Assessment and Community Practice

1. Geriatric assessment can be defined as a multi-dimensional, interdisciplinary, diagnostic process used to quantify an older individual's medical, psychosocial and functional capabilities and problems, with the intention of arriving at a comprehensive plan for therapy and long-term follow-up. It is part of the core skills and knowledge base of specialists in geriatric medicine.
2. Geriatric assessment has proven efficacy in affecting optimal living location, reducing hospital readmission, maintaining optimal cognitive and physical function and possibly reducing mortality. Geriatric assessment is useful in guiding therapeutic and prognostic decisions about older persons.
3. The patient is the focus of geriatric assessment and his/her consent must be sought if possible. The assessment process should always be multifactorial. It should involve carers and include consideration of the person's living environment and physical, mental and social status. The aim is to keep the person in his/her chosen living environment as long as possible but, if necessary, to organise residential accommodation appropriate to the needs of the person.
4. Geriatric assessment should not be applied indiscriminately to all older people. Those with moderate amounts of disability benefit the most. Patients at risk for functional decline need to be assessed when they contact the health system either during hospital admission or in the primary care setting.
5. Geriatric assessment is delivered on a referral basis by specialist geriatric medical services as part of a regional geriatric service. Specialists in geriatric medicine are fundamental to the delivery of effective geriatric assessment. Aged Care Assessment Services (ACAS) are one modality that delivers this assessment and are therefore best integrated into the regional geriatric service. This provides seamless care with specialist geriatricians as well as an array of other programs that regional geriatric services may operate, including rehabilitation services, specialist clinics and home care and support services.
6. ACASs should be based on a multidisciplinary team model with physiotherapy, occupational therapy, social work, nursing and geriatric medicine being the core elements. In addition the assessment teams should have optimal communication with general practitioners and local community services.
7. Objective assessment of cognition and function should be part of every assessment. There are validated instruments which should be used for this purpose. The use of such measures of function may not always be appropriate for every setting where geriatric assessment is undertaken. In particular when an ACAS sees someone at home it may be more appropriate to collect information on a minimum number of domains of function (Table 1) rather than use an instrument validated in a rehabilitation setting.
8. Given that home is the preferred living location for most older people it is also the best place for most assessments to be carried out. This is particularly so for people who require a low level of care. Aged care services must have the resources to provide adequate staff, including specialist geriatrician, nursing and allied health staff, to provide a prompt assessment service in the person's home.
9. An essential part of geriatric medical practice involves home visits and community consultations because older persons often experience difficulty in attending outpatient clinics. All geriatricians must have some degree of training in home visits. Home visits require different skills compared to outpatient clinic visits. A broader range of information is sought in the home visit with particular regard to the

person's social and physical function. Routine physical examination can often not be as detailed in the home setting while performance based examination such as assessment of gait, cognition and function is ideally performed at home

10. Often older people are assessed in inpatient settings, especially during an acute crisis. This is frequently associated with a request for a high level of care. Geriatric assessment services need to be based in acute hospitals in order to provide the rapid response needed in that environment, therefore allowing those patients in need of rehabilitation or specialised subacute care to be transferred expeditiously. This also facilitates the education and training of acute hospital staff (medical, nursing, allied health and administrative) in the needs of older people.
11. Some clinical conditions common in older people need access to multidisciplinary teams with particular clinical and investigative skills and knowledge. Such teams include, but are not restricted to, those in dementia (memory), falls, continence, sensory impairments (visual and hearing), pain and wound clinics. These clinics should also be integrated into the regional geriatric service.
12. Assessment services for older persons need to cater for rural, non-English speaking and Aboriginal groups, as well as those with psychiatric illness. This may involve the hiring of staff with particular backgrounds to ensure cultural sensitivity. Assessment services need to be adequately resourced to provide for geriatricians to visit rural and isolated areas if required.
13. As tertiary health care shifts into the community more geriatricians will need to be involved in other forms of community practice including rehabilitation and hospital outreach services.

This Position Statement represents the views of the Australian Society for Geriatric Medicine. This Statement was approved by the Federal Council of the ASGM in June 2000.

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BACKGROUND PAPER

Definition

Assessment can be defined as: "a multidimensional, usually interdisciplinary, diagnostic process used to quantify an elderly individual's medical, psychosocial and functional capabilities and problems with the intention of arriving at a comprehensive plan for therapy and long-term follow-up"[1]. It has two essential components: the process of evaluation coupled to an appropriate management plan. Comprehensive geriatric assessment (CGA) is a fundamental part of a specialist geriatrician's practice.

Evidence of Efficacy

CGA had its beginnings in the UK during the 1930s, when Drs Marjory Warren, Lionel Cosin and Sir Ferguson Anderson identified a high prevalence of unrecognised yet remediable disorders in frail older people, many of whom were residing in long-term assessment process the patient's wishes must have care institutions [2]. A variety of models of practice have evolved for the assessment of older patients' care needs. The assessment process has been carried out as an inpatient service, as a community based service and as a purely liaison service to other physicians. While there have been conflicting results from individual trials evaluating the effectiveness of these different models of CGA, a meta-analysis [3] of controlled trials indicated that CGA has significant benefits on mortality, living location, physical and cognitive function and hospital readmission. Those programs where control over medical recommendations and extended ambulatory follow-up were provided were more likely to be effective. In addition, CGA may also be beneficial in providing preventive care for older people living in the community [4].

In Australia the drop in nursing home admissions which has occurred since 1985 is related to the introduction of geriatric assessment prior to nursing home admission. This has had undoubted economic benefit by delaying or prioritising the need for expensive long-term care [5].

Guiding Principles

Although there is considerable variation in the way geriatric assessment services are organised, there are a number of guiding principles which are central to the entire process. The assessment process needs to be multidimensional and often multidisciplinary, identifying all impairments and so ameliorating the

resultant disability and handicap. Most problems faced by older people are multifactorial and functional impairment is usually due to multiple medical and psychological antecedents. The experiences of the caregiver also need to be assessed as caregiver burden is a better predictor of service use than any measure of the older person's health or functional capabilities [6]. In addition carers may also be old, often with significant health problems of their own.

The assessment process has at its centre the older person's needs and wishes. The process should only be initiated with the consent of the person when he/she is competent to give it. Indeed geriatric assessment should educate patients and relatives about the system of accessing aged care services. Although caregivers and relatives are important in the assessment process the patients' wishes must have ascendancy should conflict arise. This issue becomes clouded when an older person's testamentary capacity is called into question because of cognitive impairment.

Part of geriatric assessment is acting as an advocate for an older person's rights and trying to ensure that the person is able to make informed choices about future care. In addition, if there is a suspicion of abuse of that person's rights (elder abuse) then intervention is necessary.

Geriatric assessment is not effective if applied indiscriminately to the older population nor could such services be provided in an environment of limited resources. The target population for geriatric assessment, those at risk for institutionalisation or functional decline, is not clearly defined in the literature. Those most at risk include the oldest old (age >85) [7], those who live alone [8], those whose carers can no longer give support [9], those with preceding functional impairments such as incontinence [8] and impaired mobility and balance [10] and those with cognitive impairments [8]. In general those patients with a moderate amount of disability are most likely to benefit, compared to the severely disabled and the relatively fit.

Older patients are currently assessed in an opportunistic fashion when they enter hospital or are referred by their GPs, families or other community services. It is not clear how at risk patients can be identified within the community. Attempts to screen for and prevent functional decline have not been well studied [11] nor proven successful [12].

It is a widely held belief that the environment in which an assessment occurs influences the process, however it has not been well studied. The few well designed studies available do suggest that functional performance in a familiar environment is better than in a clinic or hospital environment. This may be particularly so for patients with dementia [13]. For example, the demented patient may become incontinent because of unfamiliarity with the hospital's toilet facilities, but would manage in more familiar surroundings. Any decision about future care and accommodation must therefore involve consideration of that person's preferred living environment.

Geriatric Assessment in the Australian Health Care System

In Australia CGA is delivered by a variety of mechanisms and funded from different sources. This pattern of care is seen in inpatient rehabilitation units, multidisciplinary outpatient clinics (eg. memory, falls and balance clinics) specific geriatric and evaluation and management units, and is supported by the community Aged Care and Assessment Services (ACAS). In addition CGA may be provided to patients who are acutely unwell in hospital, often under the care of a specialist geriatric service, or who are referred to such a service.

Assessment by an ACAS is mandatory prior to entering residential care. ACASs are funded and given the delegated authority by the Federal Government to approve entry to residential care. The ACAS operates under the principles of CGA in that a multidimensional assessment of a patient's needs is undertaken with subsequent referral to social services, rehabilitation and other therapeutic options. Thus the ACAS plays a vital role in the delivery of social services and the screening for patients who may need a more detailed assessment, as well as approving entry into residential care.

This role is successfully carried out when the ACAS is integrated into the regional geriatric service, which provides the therapeutic arm of geriatric assessment. Indeed many Home and Community Care (HACC) funded programs are also successfully integrated into this regional service. This integration allows the best clinical assessment for patients and the tailoring of services to their needs.

It is axiomatic that the best outcome for the patient involves the linking of a medical, psychological and functional needs assessment to the delivery of

appropriate services, treatment and, if appropriate, residential care. The view that ACAS assessment purely provides a 'gatekeeper role' to residential care belies the complexity and utility of this form of assessment. The push towards the separation of ACAS services from the therapeutic arm of the regional geriatric services should be avoided as the available evidence would suggest CGA can only be delivered by an integrated unit. Similarly the belief that social and home care services can be delivered and administered independent of any medical assessment or involvement ignores the important medical contribution to a multidisciplinary assessment.

Method of Assessment

For community dwelling older persons, geriatric assessment should and does occur in that person's own home. This could range from a home visit by a geriatrician, to interventions by a physiotherapist or occupational therapist to provide equipment to make the home environment safer, to a comprehensive assessment which co-ordinates a whole range of services to enable a person to remain at home. The process of geriatric assessment involves several considerations including the site where assessment is conducted, which disciplines could best assess and what information should be collected. Geriatric assessment in an inpatient setting has been discussed in another position paper [14], consequently emphasis here has been given to assessment occurring in community settings. Where discussion is relevant only to the practice of ACASs this distinction has been made.

Location of Assessment

Community geriatric assessment, in particular an ACAS assessment, occurs in a client's own home, after admission to hospital following some crisis or when already in a residential care facility such as a hostel or nursing home. Each of these areas has individual requirements as well as issues common to all.

Home. Home is the most appropriate location for assessment for most older persons who are not acutely unwell. Although there is little research outlining the advantages of domiciliary assessment, clinical experience dictates that a greater wealth of information is often obtained. It allows direct assessment of the person's function in his/her own environment, of how meals and food are prepared, of the older person's carer network and medication management. In direct comparison of geriatric home

assessment and a clinic visit in a general practice setting the home assessment is more likely to yield problems with social support which are rarely mentioned in the medical record [15]. Assessment at home may also influence the decision to move to care, with those assessed at home four times less likely to be recommended for low care (hostel) rather than community services as compared to assessment in hospital [16]. In addition, in this study there was little association between health status and recommendation for low care placement, suggesting that this effect is not simply explained by the sicker inpatient population. ACAS assessment for low care accommodation should almost always occur in the patient's home environment.

Hospital. Older people are also assessed by ACASs as hospital inpatients, often after an acute medical crisis and often when in need of 24 hour nursing care. ACASs are most frequently called upon to assess for entry into high care (nursing home). The functional criteria for entry into high care are such that, almost by definition, it is impossible for a person to remain in the community safely for any length of time even with full supports. This is particularly so for older patients who live alone. Hospitals have filled the gap in providing the 24 hour nursing care needed for these patients while in crisis and until suitable accommodation has been found. Because of financial and bed pressures there is increasing impetus to assess these patients earlier and quicker, possibly when the patient is not medically stable. The projected lack of high care beds for the Australian population age structure compounds this problem [17]. These pressures make the need to integrate regional geriatric services into acute hospitals all the more important to provide the rapid response services that acute hospitals are demanding.

Residential care facilities. ACAS assessments also occur in residential care facilities, usually where a transition to a higher level of care is required. This may require relocation to another facility, which may be a difficult decision for the resident. Occasionally an older person, who carers feel is no longer able to be managed in a hostel, may refuse to leave. This is a difficult situation which requires sensitive handling by the assessment team.

Special Needs Groups

Older people who have a psychiatric illness or a non-English speaking background, are of Aboriginal descent, or who live in rural communities, may have

difficulty in accessing the full range of assessment services. This is particularly true when accessing the skills of a geriatrician. Assessment services need to develop strategies for dealing with these groups, such as use of interpreters and the hiring of staff from appropriate cultural backgrounds. Specialist geriatricians have to be prepared to visit country areas so that assessment teams can have access to their services. Consideration of the use of telemedicine links are important in this context. Assessment teams need to develop culturally sensitive ways of dealing with Aboriginal and other groups.

Assessment Team Composition

At the heart of geriatric assessment is a multidisciplinary team made up typically of medical practitioners, nursing staff, physiotherapists, occupational therapists and social workers. Other allied health practitioners in areas such as speech pathology, podiatry and dietetics may also be needed occasionally. The team should meet regularly to discuss the patients under its care and set goals and plans for its patients. Input from general practitioners is also relevant.

Although by its nature assessment is a team process, it may not be practical for the entire team to review every case. In inpatient settings, review by multiple team members usually occurs, particularly as these patients are often in an acute health crisis and have complex problems and circumstances. In ACAS assessments, given the large workloads and the need to visit people in their own homes across a large geographic area, it is not practical for multiple therapists to see each patient. In this instance a single team member, or a limited number of team members, can review the case with the ability to consult the rest of the team should the need arise. However care must be exercised not to overlook areas to which another professional may clearly contribute.

Geriatrician's role. Geriatric assessment is core business for specialist geriatricians. Functional impairment usually has as its basis multiple medical and physical problems which require accurate diagnosis. Geriatricians, through their training, provide these skills as well as a broad knowledge base for the management of problems and indications as to prognosis in the older patient. Referral for geriatric assessment is therefore referral for specialist geriatric medical input as part of a comprehensive multidisciplinary assessment. All

inpatient settings, especially acute hospitals, need access to these skills.

Assessments occurring in the community as part of an ACAS visit obviously cannot all involve a geriatrician, particularly as in many cases there may be few diagnostic dilemmas which require direct contact with a geriatrician. Geriatricians often have great experience in difficult or unusual circumstances and these are the cases that should be referred by other team members to them. When issues of the patient's competency arise then the geriatrician has a role in this assessment.

General practitioner's role. Although general practitioners (GPs) are not formally part of the ACAS, nor do they have direct involvement in many inpatient settings, the importance of their role in the process must be recognised.

A recent survey in Australia on community ACAS assessments concluded that GPs were largely satisfied with the process but often excluded from the assessment process, received little feedback and wished for greater involvement [18]. When the general practitioner can be present during the assessment process there is a higher degree of satisfaction for both the team and the GP [19]. The general practitioner will have often initiated the referral to ACAS or hospital, but if this is not so, should be contacted to provide an input. It is important that, when the patient is to be referred to a geriatrician, the patient's general practitioner be consulted and informed.

Role of community services. Domiciliary care and district nursing organisations may also initiate referrals and their input is also of great value. A close liaison between regional geriatric services / ACASs and community services is vital to the successful coordination of many cases. In some states the regional geriatric service/ACAS and the domiciliary care services are part of the one organisation and this could be the preferred model of delivery assuming that this does not interfere with the structural integrity of any party.

Information Gathering

Role of the carer. Unlike the traditional medical consultation, geriatric assessment typically needs to involve carers and relatives as well as the patient. This is particularly the case when the older person has cognitive impairment. It is advisable that, when an older person with cognitive impairment is assessed at home, he/she be seen by two people, with one interviewing the family/carers and the other

interviewing the person being assessed. At the very least there should be a separate interview for the carer. For older patients in hospital, communication channels need to be established for relatives to the involved staff because too often carers are frustrated by this process.

Assessment instruments. It is impossible to prescribe an exact data set that needs to be collected for each person and most clinical information is collected from an 'unstructured' history. However there is a danger in not structuring and quantifying some parts of the assessment. Measurements of cognition and function allow for a more accurate description of a person's abilities, ensure that significant cognitive impairment does not go undetected and enable easier communication between staff at team meetings. These measurements are limited in that they will not give a diagnosis as to the underlying cause of a person's cognitive and functional impairments. Diagnoses such as dementia or depression need a full clinical evaluation, although an appropriate score on a measurement scale will help inform the diagnostic process.

At least two objective measurements should be taken, one of cognition and one of a person's functional status. In certain settings, screening tools for depression may be useful, particularly in isolated areas where there is limited availability of psychogeriatric assessment. The Mini-Mental State Examination [20] has wide acceptability and is a valid and reliable tool in both community and inpatient settings [21]. Simpler screening tools such as the Short Portable Mental Status Questionnaire (a 10 point scale) [22] and clockface drawing [23] are also useful. There are a number of tools used for screening for depression with the Geriatric Depression Scale being the most common validated scale used with older people [24]. There are many scores available for the measurement of function including the Functional Independence Measure [25] and the Barthel Index [26]. These two scores are reliable and well validated in rehabilitation settings and serve a useful purpose to monitor the progress of a patient while undergoing rehabilitation which may be part of an inpatient geriatric assessment [27-28]. However for the issues of purposes of ACAS assessment where the shopping, cooking and other instrumental ADLs are important to determine future care, these scales have less utility. Indeed no specific valid instrument exists for the purposes of this form of assessment. However it is still crucial to perform a structured and comprehensive assessment of function

with every older person. The domains which should be assessed are listed on Table 1.

Table 1: Domains that should be covered in a functional assessment

Personal Activities of Daily living
<ul style="list-style-type: none"> ▪ Mobility ▪ Transfers ▪ Washing/bathing, including personal grooming ▪ Dressing, including shoes and socks ▪ Toileting and continence
Instrumental Activities of Daily Living
<ul style="list-style-type: none"> ▪ Meal preparation ▪ Housework ▪ Shopping ▪ Financial management ▪ Transport ▪ Medication

Community Practice

An integral part of geriatric medical practice is the domiciliary assessment. Because of their many comorbidities, older patients can find it difficult to attend the traditional outpatient setting and a home visit is often more informative than the traditional outpatient consultation. The home visit has usually been seen as the domain of the general practitioner but it should also be seen as a vital part of the specialist geriatrician's practice. However this style of practice is often not encouraged by the remuneration and employment conditions of many geriatricians. In order for older people to receive the appropriate attention of a specialist geriatrician, these structural elements of the health care system need to be addressed. This is particularly so for rural older people, where access can be even more difficult.

The method of clinical examination is also different for home assessment and requires a separate set of skills. Some aspects of clinical examination, for example detailed physical examination including rectal and vaginal examinations, may be difficult to perform. Functional based assessments such as observation of gait, arising from a chair and other simple daily activities are easier and better performed at home where the environmental hazards can be directly observed. Standardised clinical examinations of gait are good predictors of falls in both community [29],

institutional settings [30] and populations including the very old [31]. Cognitive testing is also reliably and easily carried out at home. It is vital that practitioners who see older patients at home are capable of performing these assessments.

Visiting patients in residential care is also an important aspect of community work. Specialist geriatricians can provide important input into the management of behavioural and medical problems that nursing home residents have, in particular the rationalisation of medication and use of psychotropic drugs.

Increasingly geriatricians are also being involved in other innovative ways to deliver health care at home. Rehabilitation programs can work effectively in the home environment and produce significant improvements in function [32]. In Australia, a randomised trial of stroke rehabilitation at home is nearing completion (the ESPRIT trial) and others involving the care of orthopaedic patients are planned. Given the strong traditions of community based care, such programs will increasingly involve geriatricians. Indeed given the cost of hospital admissions, it is likely that more and more care will be delivered in the community and geriatricians are well placed to be involved in the development of these services.

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