



Fall Prevention: Implementing what works

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Evidence to support decisions

- Effectiveness across continuum
- Assessments that signal the need for action
- Information on all persons – beyond the limitations of Randomized Clinical Trials
- Computerized information that can be aggregated to answer other questions
- Data to support resource allocation decisions and policy decisions



Overview

- Important public health problem: 25-35% of elderly people fall each year in the community
- Falls are the leading cause of severe non-fatal injuries and impact on health care expenditures in terms of hospitalizations and other service use
- Impact on psychosocial well-being: fear of falling, decreased social interactions, depression
- Inter-relationship between falls, functional decline and physical activity



What is the best single predictor of falls?

- history of a fall
- Highest risk group: multiple falls in the past 3 months



- Do you routinely ask about falls?
- When treating for consequence of falls eg wrist fracture- do you investigate balance, osteoporosis risk or other risk factors?



Multi-factorial risk

Conceptual Framework

- Physical capacity (e.g. balance, strength)
- Opportunity to fall (e.g. environment, activity level)
- Judgment (e.g. risky behaviors, sedation)

Potentially Modifiable Risk Factors

- **Physical ability** e.g. balance, mobility, strength
- **Low physical activity**
- **Fear of falling**
- **Pain**
- **Medical status**
- **Medication use** eg psychotropic medications
- **Vision**
- **Cognitive Status, Mood**
- **Environment**



Shared responsibilities

- Public health
- Community
- Hospital, Emergency, home care, rehabilitation, seniors' residences, nursing home
- Health professionals

- Screening
- Assessment
- Interventions



Integrated health information

- Client centered not site specific
- Computerized
- Multidimensional assessment
- Interactive, guiding service/care planning
- Common core of items across continuum
- Used for multiple purposes
- Reflects essential information needed across settings



interRAI

- Who
 - International, not-for-profit network of 50+ researchers and health/social service professionals
- What?
 - Comprehensive assessment of strengths, preferences, and needs
 - Application of evidence to improve quality of life in vulnerable populations

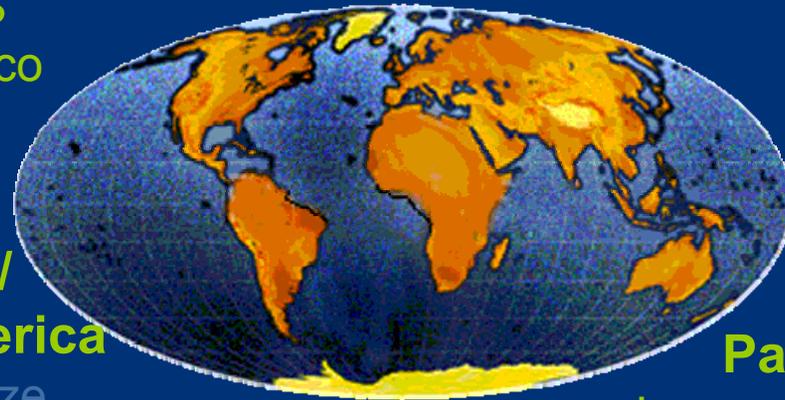
interRAI Countries

North America

Canada
US
Mexico

Central/ South America

Chile, Belize,
Cuba, Brazil,
Peru



Middle East

Israel

Europe

Iceland, Norway, Sweden, Denmark, Finland,
Netherlands, France, Germany, Switzerland,
UK, Italy, Spain, Czech Republic, Poland,
Estonia, Belgium, Austria,
Portugal, Lithuania

Pacific Rim

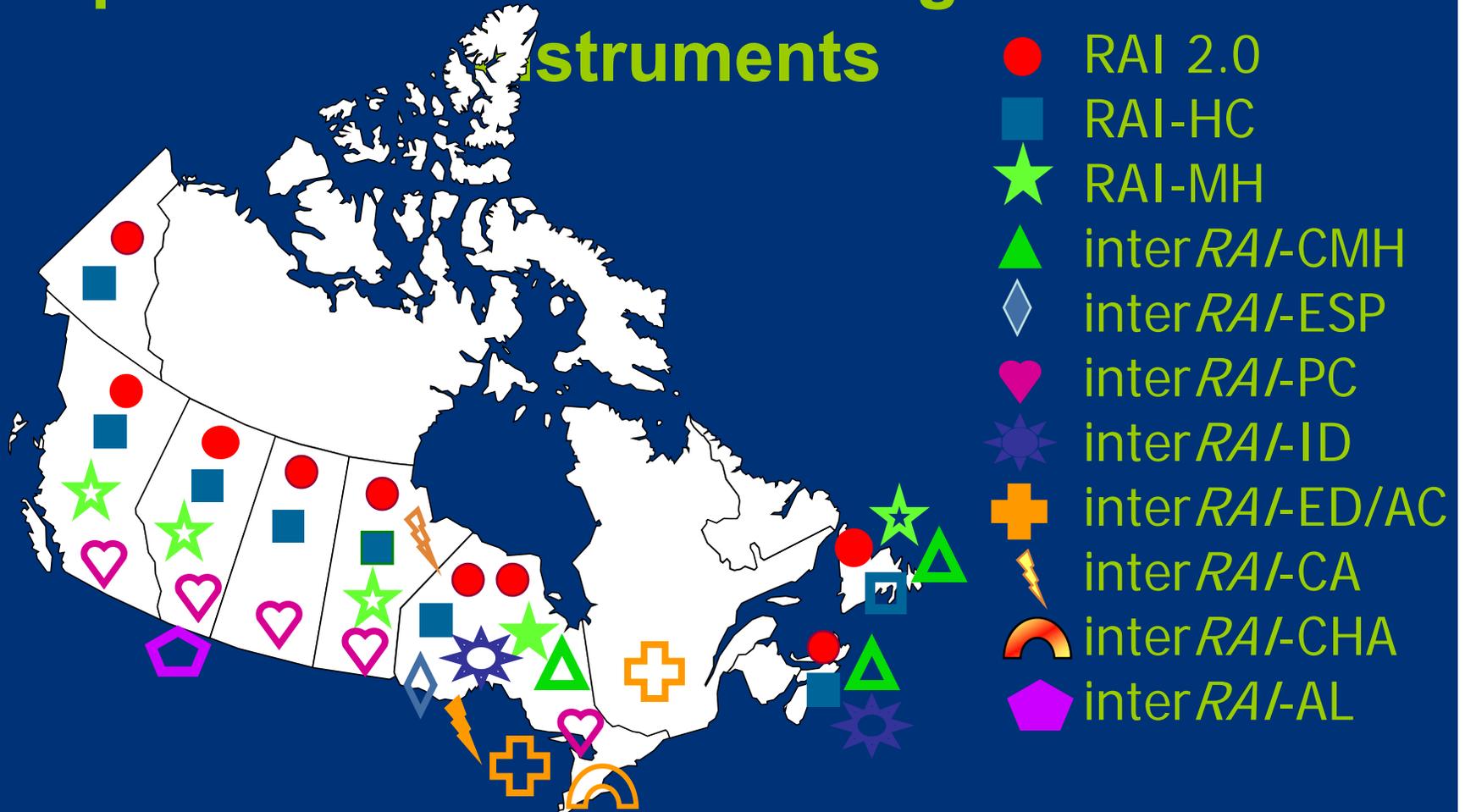
Japan, China, Taiwan,
Hong Kong, South Korea,
Australia, New Zealand,
India



The interRAI Family of Instruments

- Long Term Care
- Home Care
 - Contact assessment
- Community Health Assessment
- Mental Health
 - Inpatient
 - community
- Intellectual Disability
- Acute Care
 - + ER Screener
- Post-Acute Care-Rehabilitation
- Palliative Care
- Assisted Living

Implementation and Testing of interRAI Instruments





Applications of the interRAI Instruments



Rationale for items

- Cover dimensions needed for multiple purposes
- Clinical content validity
- Utility for care planning (strong risk factors or predictors of problems)
- Observable behaviours
- Common elements with existing measures in other settings

Dimensions of Assessment

- Admission information
- Cognitive patterns
- Communication /Vision
- Mood/behaviour
- Functional status
- Physical Activity
- Premorbid function
- Skin condition
- Pain
- Infections
- Medical complexity
- Health conditions
- Oral/nutrition
- Procedures/services
- Psycho-social
- Environment
- Resources for discharge
- Medications

Characteristics of assessment

- Multiple assessment methods (interview with client, family and staff and appropriate, observation of behavior and medical record review).
- No prescribed sequence and no set questions
- Responses are standardized
- All items must be completed
- Items or sets of items signal potential problems
- Evidence from Italian RCT suggests benefit in terms of delaying hospitalization when interRai used by case managers vs usual geriatric test battery



Personal Health Profiles and Educational Brochures: Enhancing health promotion by home care & primary care



Personal Health Profiles

- RAI-HC
 - Comprehensive assessment designed to support care planning and outcome measurement for home care professionals
 - About 300 items covering broad range of functional, medical, social, psychological and environmental issues



Personal Health Profiles (PHPs)

- Short summary of key findings from RAI-HC assessment
- Abstract of subset information that will be of particular interest to specific target audience from external agencies
 - Primary care
 - Home care provider agencies
 - Long term care
- Aim is to improve communication, reduce assessment burden, and increase continuity of care



Personal Health Profile for Primary Care Clinicians

Personal Health Profile for Primary Care Clinicians

See PHP key for information on scoring; terms in square brackets refer to MDS-HC assessment items.

Name: Jane Doe
 Assessment Reference Date: January 26, 2005
 Age: 92
 Lives alone (CC6): Alone

Health Card Number: xxxxxxxxxx
 Date PHP Printed: June 13, 2007
 Sex: Female

Health Profile	
Medical Conditions	
CHES Score (medical complexity).....	2 out of 5
Cognitive Performance Scale (CPS).....	3 out of 6 / moderate impairment
Depression Rating Scale (DRS).....	6 out of 14/ possible depression
Diarrhea or vomiting [K2a or K2e].....	no
Difficulty urinating, or urinating 3+ times a night [K2b].....	no
Chest pain/pressure at rest or on exertion [K3a].....	no
Constipation (No bowel movement in 3 days) [K3b].....	no
Dizziness or light-headedness [K3c].....	no
Edema [K3d].....	no
Shortness of breath [K3e].....	no
Experiences hallucinations or delusions [K3f or K3g].....	no
Preventive Health Measures	
Potential problem related to emotional well-being.....	no
Potential problem related to falls.....	yes
Falls frequency [K5].....	3 falls in the last 90 days
Flu shot in last 2 years [K1b].....	no
Breast health screening in last 2 years (if female) [K1d].....	yes
Medication review in last 6 months [K3].....	yes
Physical Functioning (Physical and Mental Status / Health Status)	
Pain Scale.....	3 out of 3 / excruciating pain
ADL long form scale.....	9 out of 26
Potential for improvement in ADLs.....	yes
Potential problem related to alcohol dependence.....	no
Potential problem with skin or foot conditions.....	no
Cognitive decline [B2b].....	yes
Sudden or new onset/change in mental function [B3a].....	yes
Severe agitation or disorientation [B3b].....	no
Vision [D1].....	impaired
Hearing [C1].....	minimal difficulty
Concern with caregiver distress [G2a or G2b or G2c].....	yes
ADL decline [H3].....	yes
Bladder Continence [I1].....	usually continent
Bowel Continence [I3].....	usually continent
Smoked or chewed tobacco daily [K7c].....	no
Unintended weight loss [L1a].....	no
Noticeable decrease in amount of food or fluids consumed [L2b].....	yes
Pressure or stasis ulcer present [N2a or N2b].....	no
Emergency Care (in last 90 days)	
Emergency Room (without overnight stay) [P4b].....	1 visit(s)
Emergency Care [P4c].....	3 visit(s)
Medications	
Managing medications [H1da].....	some help
Compliance with medications [Q4].....	less than 80% compliant
Receipt of psychotropic medication [Q2a or Q2b or Q2c or Q2d].....	yes
Medications list: Verapamil, Slow-K, Oxycocet, Clonazepam, Baclofen, Zestril, Prednisone, Tenormin, plaquenil, lasix, VitD	

Personal Health Profile Key for Primary Care Clinicians

CHES Score: Changes in Health, End-stage disease and Signs and Symptoms

Scores range from 0 to 5. CHES measures medical complexity and health instability, based on: vomiting, dehydration, leaving food uneaten, weight loss, shortness of breath, edema, end-stage disease, and decline in cognition and ADL. Higher scores indicate higher levels of medical complexity.

Cognitive Performance Scale (CPS)

Scores range from 0 to 6. Scores are based on skills for daily decision-making, making self understood, and short-term memory recall. "Eating impairment" differentiates a score of 5 or 6. Higher scores indicate a greater degree of cognitive impairment.

Score	Description	Equivalent Average MMSE
0	Intact	25
1	Borderline intact	22
2	Mild impairment	19
3	Moderate impairment	15
4	Moderate/severe impairment	7
5	Severe impairment	5
6	Very severe impairment	1

Depression Rating Scale (DRS)

Scores range from 0 to 14. The DRS is based on 7 MDS-HC items: negative statements, persistent anger, expressions of unrealistic fears, repetitive health complaints, repetitive anxious complaints, sad or worried facial expression, and tearfulness. A score of 3 or greater suggests possible depression.

Potential problem related to Emotional Well-Being: Identifies community dwelling people who may suffer from the symptoms of anxiety or depression.

Potential problem related to Falls: Identifies those for whom falls have occurred recently and if there is a risk of falling. Potential problem based on: history of falls, dementia, Parkinsonism, unsteady gait, does not limit going outdoors, change in mental function.

Pain Scale

Scores range from 0 to 3. Scores are based on two pain questions: pain frequency and pain intensity

Score	Description
0	No pain
1	Mild pain – pain less than daily
2	Moderate pain – daily pain that is mild or moderate
3	Excruciating pain – daily pain that is severe or horrible

ADL Long Form Scale

Scores range from 0 to 28. The Activities of Daily Living (ADL) Long Form is a summative scale capturing 7 of the activities of daily living items: bed mobility, transfer, locomotion, eating, toilet use, personal hygiene, and the more dependent of dressing upper and lower body. Each item is given a value from 0 "Independent" or "Setup help only" to 4 "Total dependence" or "Activity did not occur". Higher scores indicate a more dependent individual.

Potential for Improvement in ADLs: Identifies potential for either greater independence in self-care or prolonged periods in which the risk of decline is lessened. Potential problem based on: ADL deficit is present, the client can understand others, and either a decline has occurred or a belief is present that improvement is possible.

Potential problem related to Alcohol Dependence: Identifies alcohol abuse or dependence. Potential problem based on: one or both of the alcohol-related items.

Potential problem related to Skin or Foot Conditions: Identifies those with, or at risk of developing skin or foot problems. Potential problem based on: any troubling skin conditions or changes, corns/calluses, structural problems, infections, fungi on feet, open lesions.



PHPs – Falls content

Preventive Health Measures

Potential problem related to emotional well-being	no
Potential problem related to falls	yes
Falls frequency [K5]	3 falls in the last 90 days
Flu shot in last 2 years [K1b].....	no
Breast health screening in last 2 years (if female) [K1d]	yes
Medication review in last 6 months [Q3]	yes

Potential problem related to Falls: Identifies those for whom falls have occurred recently and if there is a risk of falling. Potential problem based on: history of falls, dementia, Parkinsonism, unsteady gait, does not limit going outdoors, change in mental function.

Use of Educational Health Promotion





Study Design

- 8 participating Community Care Access Centres (CCACs → single point entry agencies)
- PHPs used with first ~250 HC assessments
 - Provider PHP sent to all provider agencies
 - 1,643 clients
 - Primary Care PHP sent to clients family physician
 - 1,569 clients
 - Ministry of Health provided software to pilot sites
- Educational pamphlets given to client based on decision rules for five target areas

EXPERT OPINION on fall prevention

“Falling represents one of the few health conditions meeting all the criteria for prevention – high frequency, evidence of preventability, and heavy burden of morbidity.”

— *Mary Tinetti, PhD and
Christianna Williams, MPH*

“You can be safe from falling in your home. By working with your doctor and other health professionals, such as physiotherapists, occupational therapists and pharmacists, many falls can be prevented.”

— *Katherine Berg, PhD*

Where can you get more information?

For more information contact:

- ▶ Your family doctor or nurse practitioner
- ▶ Other health care practitioner, such as a nurse or physical therapist

And use the Internet:

- ▶ Active Independent Aging: A Community Guide for Falls Prevention and Active Living: www.falls-chutes.com
- ▶ Government of Canada’s Public Safety Branch: www.safecanada.ca/seniors_e.asp
- ▶ Health Canada’s Division of Aging and Seniors: www.hc-sc.gc.ca/seniors-aines OR www.phac-aspc.gc.ca/seniors-aines
- ▶ Ministry of Health and Long Term Care: Assistive Devices Program: www.health.gov.on.ca/english/public/public_mn.html

 **ideas** for health
innovations in data,
evidence & applications

health information series

- Primary Health Care Transition Fund
- Homewood Research Institute, Guelph, ON
- Department of Health Studies and Gerontology
University of Waterloo, Waterloo, ON
www.ideas.uwaterloo.ca/interRAI

Stay on Your Feet

Don't Fall Head
Over Heels



health information series



At the time of the home visit

- Case Manager completes the RAI-HC Assessment as per normal practice
- Using the Educational Pamphlet Guide, review RAI-HC to determine if a trigger for one or more of the pamphlets has been cued
- If a pamphlet is given:
 - Provide the client the opportunity to discuss any concerns or questions
 - Reassure the client
 - Provide relevant educational information, including resources
 - Discuss with informal care providers, if necessary



Follow-up data

- For clients who remain on service & received brochure
 - Link baseline HC to follow-up to determine rate of change in triggers
 - Compare with other cohorts & clients in other agencies to determine whether brochures associated with change
- Focus groups
 - Provider agencies
 - Teleconference with physicians
 - CCACs



Age and gender distribution of PHP Clients, by CCAC

CCAC	Female %(n)	Age Mean (SD)
HM	65.1 (2229)	74.4 (151.)
HN	67.0 (474)	77.2 (13.9)
HP	68.7 (617)	77.7 (13.5)
NY	70.8 (1391)	80.1 (11.1)
OX	68.8 (471)	77.3 (12.7)
TB	67.2 (617)	77.0 (13.6)
WA	69.1 (1092)	77.4 (13.6)
YR	66.6 (1422)	76.5 (13.8)



How many unique physicians received PHPs?

CCAC	Number of physicians sent PHPs
HM	244
HN	428
HP	129
NY	128
OX	174
TB	140
WA	147
YR	323



Percentage of Clients Who Would Trigger Brochure by Topic, Ontario

	Clients Triggering Brochure % (n)
Falls	45.3 (5576)
Breast Screening	48.1 (5916)
Influenza vaccination	24.8 (3056)
Emotional Well-being	25.0 (3083)
Medication Management	38.7 (4760)



	Not triggered & Not provided	Triggered & Provided	Triggered But Not provided	Not triggered But Provided	Triggered But Refused
Falls	56.3	32.2	4.2	5.9	1.4
Breast Screening	62.7	22.3	9.2	2.2	3.6
Influenza vaccination	67.5	17.7	8.9	3.3	2.6
Emotional Well-being	65.4	23.7	3.7	5.6	1.5
Medication Management	62.0	24.5	6.7	4.9	2.0

- Quasi experimental design
 - 8 CCACs where large majority of clients who met criteria received brochure
 - n=2770
 - Matched to other CCAC clients in regions not using brochure
 - n=5863
 - Compared subsequent outcomes using provincial RAI-HC data repository



Ontario Provincial RAI-HC Database (as of June 2006)

- RAI-HC Assessments

- 1st 232,885
- 2nd 107,911
- 3rd 57,282
- 4th 28,753
- 5th 12,253
- 6+ 3,994

- Assessments by year

- 2003 68,376
- 2004 160,727
- 2005 193,406
- 2006 20,569 (Partial)

- Assessments by region

- Central East 66,312
- Central South 56,384
- Central West 57,171
- Eastern 48,456
- North 48,092
- South West 83,697
- Toronto 82,963

Outcomes of PHP and Brochure Pilot

- Falls intervention
 - Overall trigger rate – 46.0%
 - Experimental CCACs – 45.8%
 - Control CCACs – 47.1%
- Unadjusted rates of *not* triggering Falls CAP at follow-up among those who triggered it at baseline
 - Experimental CCACs – 30.3%
 - Control CCACs – 25.3%



Outcomes of PHP and Brochure Pilot

- Risk of any falls among those who triggered Falls CAP *and* had 1+ falls at baseline
 - After adjusting for sex, cognitive impairment and time between assessments ...

... the odds of falling at follow-up for clients who received the brochures and PHP was *0.82* that of those with conventional care



Potential benefits

- Improved communication of case manager with
 - Physicians & other primary care clinicians
 - Provider agencies
 - Client
- Enhances health promotion aspect of RAI-HC
- Further embeds RAI-HC in health care system by making it an information source for multiple organizations/professionals
- Reduced assessment burden



Potential benefits

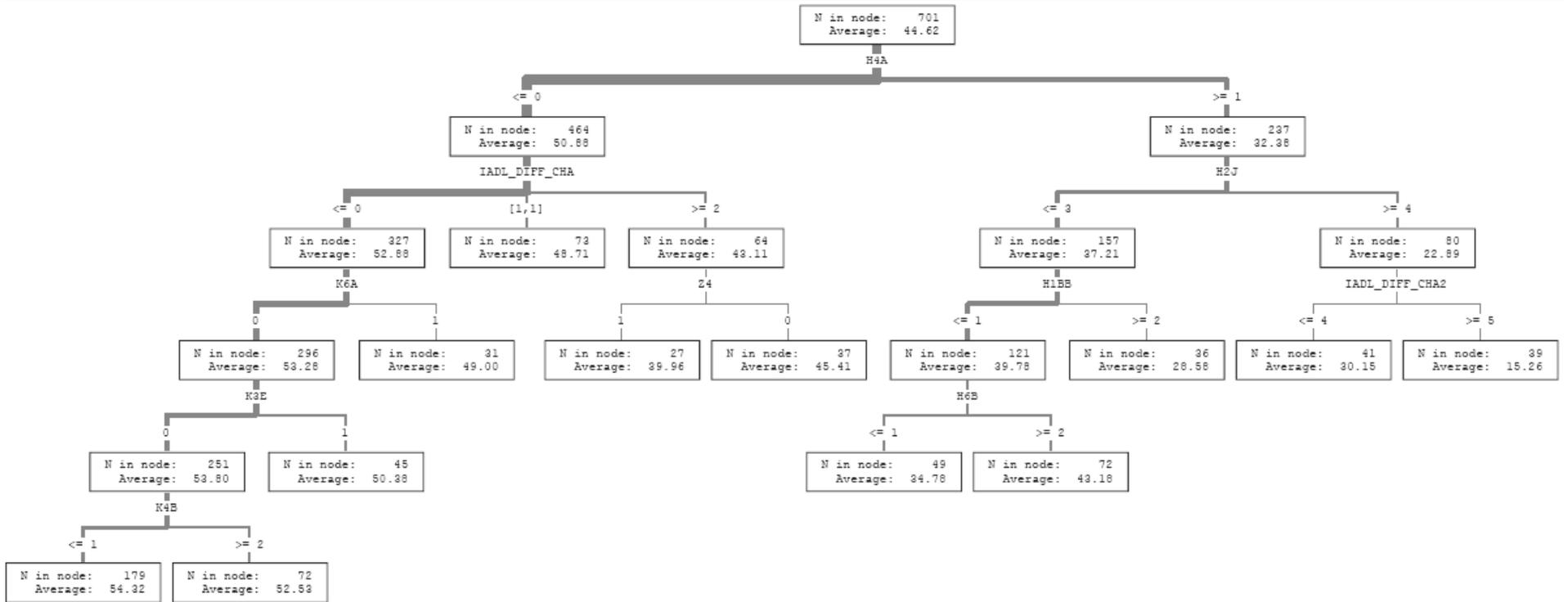
- Dual intervention strategy
 - Provide information to physician to identify needs not previously recognized or responded to
 - Empower client & family by giving them relevant information and encouraging them to speak to their physician



interRAI BBS approximation

- Multiple Fall Prevention Projects funded by Health Canada
- Common use of measures: BBS scale and preliminary version of interRAI CHA Community Health Assessment

713 assessments used to approximate Balance Scale scores using interRAI items





Variables used to derive 6 levels

- Mobility aids
- IADL difficulty scale
- Unsteady gait
- Bathing level of assistance
- Hours of physical activity
- SOB
- Pain



interRAI BBS Approximation

level	N	Mean (95% CI)
0	179	54.3 (53.9, 54.8)
1	72	52.7 (51.7, 53.7)
2	145	49.6 (48.6, 50.5)
3	110	43.9 (42.4, 45.4)
4	85	36.3 (34.0, 38.7)
5	89	27.5 (24.8, 30.1)
6	33	17.9 (13.6, 22.1)



Validity

- Related to fall risk in original sample independent of ADL, cognition and mood.
- Next step to assess performance of index in Ontario Home Care database



Any Fall reported (one year prevalence from Ontario)

scale	N Obs	Mean	Lower 95% CL for Mean	Upper 95% CL for Mean
0	3830	0.08	0.07	0.09
1	1399	0.10	0.08	0.11
2	10810	0.18	0.17	0.18
3	34855	0.20	0.20	0.21
4	29622	0.33	0.32	0.34
5	44941	0.36	0.35	0.36
6	34967	0.41	0.41	0.42



Functional decline in 6 months

scale	N Obs	Mean	Lower 95% CL for Mean	Upper 95% CL for Mean
0	6100	0.41	0.35	0.47
1	2558	0.38	0.30	0.46
2	28299	0.44	0.42	0.47
3	88453	0.95	0.93	0.98
4	82210	0.85	0.82	0.87
5	127308	1.04	1.02	1.07
6	78259	0.61	0.58	0.64



Home Care database

- Cross sectional relationship with falls, ADL, mood
- Longitudinal relationship with functional decline and falls
- Fall History is a stronger predictor

Persons who did not fall in previous period

Scale	New faller		Non faller	
	n	%	n	%
0	661	11.9	4877	88.1
1	277	12.1	2004	87.9
2	3579	15.4	19611	84.6
3	11816	16.5	59662	83.5
4	11032	19.1	46612	80.9
5	17185	20.0	68842	80.0
6	8486	16.3	43437	83.7

Index shows promise

- Possible to approximate balance scores from interRAI assessments
- Validation of the content of interRAI instruments
- Facilitate sharing of information across professionals



Fit Project

- building evidence for sustainability
- clients being assessed and discharged from **Emergency Room** post a fall
 - clients referred from **Falls Clinics**
 - clients living in **Supportive Housing Units**
 - testing of a sustainability strategy for the clients by providing weekly follow-up friendly phone calls



instrumentation

- RAI HC
- Community Health Assessment
interRAI CHA

Database development



Falls prevention for frail seniors: Falls Intervention Team (FIT) project

Angela Chan MHS Sc BPT, Baycrest

Pat Thomas RN, MScN, MEd, Toronto Public Health

Loretta Bernard RN, BScN, MEd (cand), York Region
Health Services

Jennifer Churchill BSW, York Region Health Services

Financial support: Population and Public Health Branch – Ontario Region, Health Canada

The intervention consisted of 6 in-home visits:

Visit	Health professional(s)	Activities
V1	PHN and PT	Comprehensive assessment, Identification of modifiable risk factors, Instruction- Home Support Exercise Program (HSEP)
V2	PT	Monitor and follow-up on recommendations from V1 Complete instructions to all 10 exercises on HSEP Reinforce calendar completion and monthly return.
V3	PHN	Reassessment for changes in modifiable risk factors Reinforce calendar completion and monthly return
V4	PHN	Reinforce recommendations and calendar review
V5	PHN telephone visit	Telephone reinforcement of above
V6	PHN	Review recommendations and discharge

PHN = Public Health Nurse

PT = physiotherapist

Measurement Times

Performed by designated assessors Public Health Nurses

T1	Before the start of the program	Collect baseline data	Pre measurement
T2	3 month post T1	At the conclusion of the intervention period	Post measurement
T3	9 month post T1	6 month after completion of the intervention	6 month follow-up

Age

Range	65-99
Mean	84
	91% are \geq 75

Gender

Female	86.4%
Male	13.6%

Number of participants (6 month intake period):

Self referral	133
T1	81
T2	67
T3	61

Baseline frailty score & mean number of falls per person (previous 90 days)

Frailty score	# of clients	% of total clients	Mean Falls
0	23	28.0	0.0
1	14	17.1	1.0
2	21	25.6	1.0
3	24	29.3	2.0

Change in mean number of modifiable risk factors from V1 to V6

Number	V1	V6	Difference	p value
67	7.51	6.43	-1.08	< .0001

Exercise Adherence

Time	Number of clients	% of adherence to exercise
V1 to T2	67	94.03%
From V1 to T3	65	73.85%
T2 to T3	65	58.46%

Mean change in the number of falls per participant per month
 At Baseline, average number of falls per client per month = .38

Time	Number of clients	Change in values	P value
Baseline to T2	66	-.27	<.0001
T2 to T3	58	-.06	<.05
Baseline to T3	58	-.35	<.0001

Of the 81 who started the in-home intervention program

- 82.7% were able to complete the 3 month program
- 75.35% were able to complete the 9 month follow-up visit

Changes in measurements over time:

Falls:

- significant ↓ in the average number of falls
- significant ↓ in average numbers of falls between baseline and 9 month post (T3)

Number of modifiable fall risk factors:

- significant ↓ at program completion



This 12 week self referral program delivered in the client's home resulted in:

- decreased number of modifiable falls risk factors,
- increased social participation,
- improved balance and balance confidence,
- reduced number of falls.

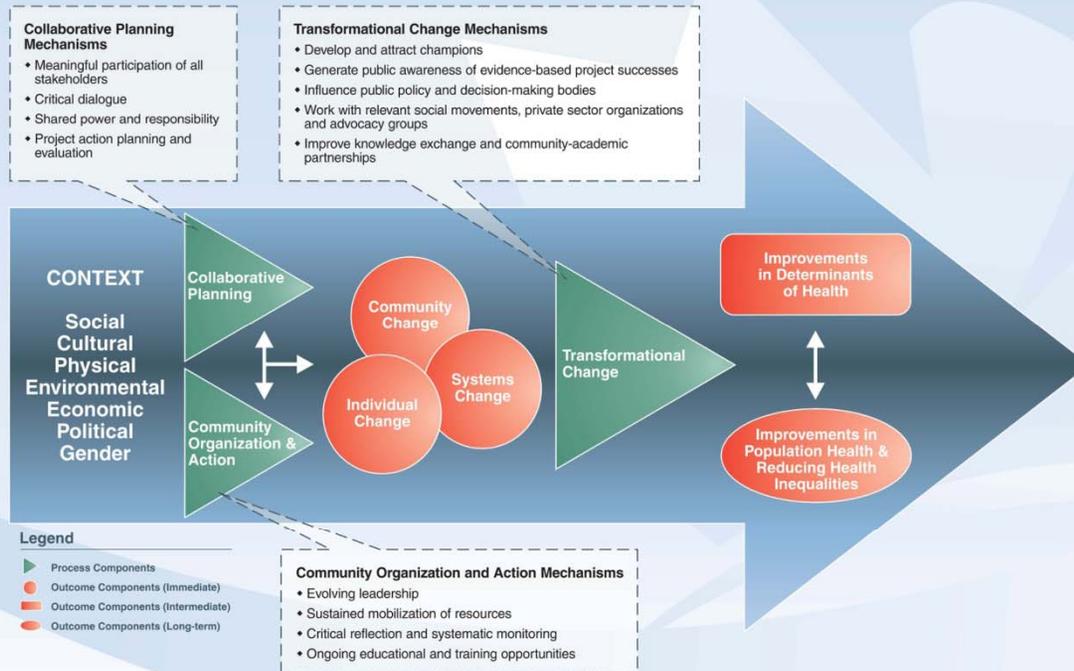


interRAI

PHAC – Best Practice Model

Effectiveness of Community Interventions Project (ECIP): Framework for Assessing the Effectiveness of Community Interventions that Promote Health

Contact: ecip-peic@phac-aspc.gc.ca
Public Health Agency of Canada
(Project funded by the Public Health Agency of Canada and Health Canada)



Public Health
Agency of Canada

Agence de santé
publique du Canada

Canada



Implementing what works

- Need evidence to support clinical, administrative and policy decisions
- Optimal for assessments to signal need for actions – not to miss the opportunity
- Evidence to get the resources and programs in place
- Common information across programs, sites and countries helps build the evidence and improve the quality of services



Many thanks to my collaborators

- John P. Hirdes, Ph.D.
- Jeff Poss PhD
- Paula Fletcher, Ph.D.
- Angela Chan and the FIT team



For additional information

- www.ideas.uwaterloo.ca/interrai
- www.interrai.org





BBS interRAI crosswalk

0: absence of walking aids, IADL difficulty, unsteady gait, SOB, Pain

1: absence of walking aids, IADL difficulty, unsteady gait, SOB but moderate or greater pain intensity

2: absence of walking aids, IADL difficulty score of 1 or IADL difficulty of zero with SOB or with unsteady gait



- 3: absence of mobility aid, and iadl difficulty scale => 2 and fear of falling, OR use of walking aid and independent to limited assistance in bathing and difficulty with ordinary housework and reports more than 2 hours of physical activity.
- 4: absence of mobility aid and IADL difficulty => 2 and fear of falling OR uses walking aid and independent to limited assistance in bathing and independent and physical activity less than 2 hours.
- 5. use of mobility aid and extensive assistance or greater in bathing and IADL difficulty scale less than 5 OR bathing limited assistance or less and independent or some difficulty in ordinary housework.
- 6 use of mobility aid and extensive assistance in bathing and IADL difficulty scale score of 5 or 6



Screening for individuals in need of exercise counseling

- 96 seniors living in senior housing
- Question: What is the relationship between indicators from Rai-HC and performance tests of gait speed, balance and chair stands?



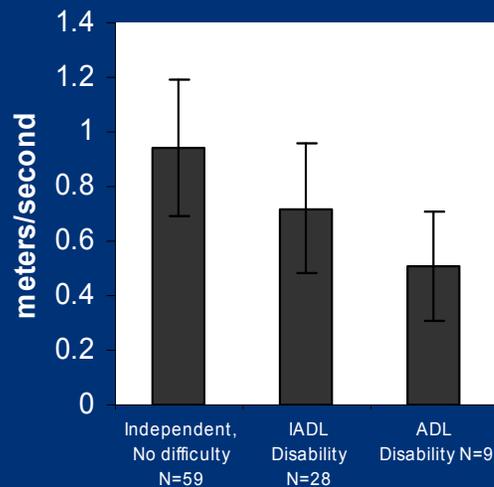
Triggers for Health Promotion Cap: Physical Activity Aspect

Factors suggesting need for physical activity counseling:

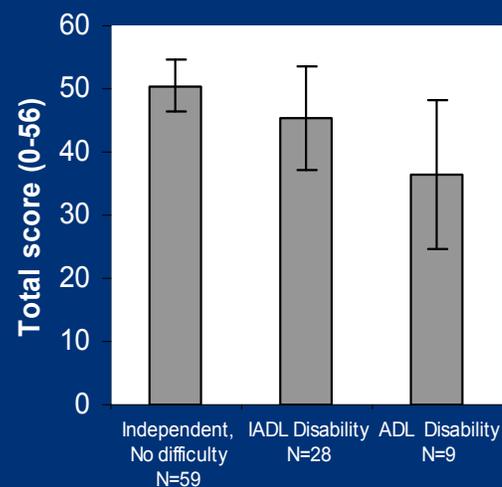
- Hours of exercise
- Days going outdoors
- Stair climbing

Performance Test Scores by Functional Status (n=96)

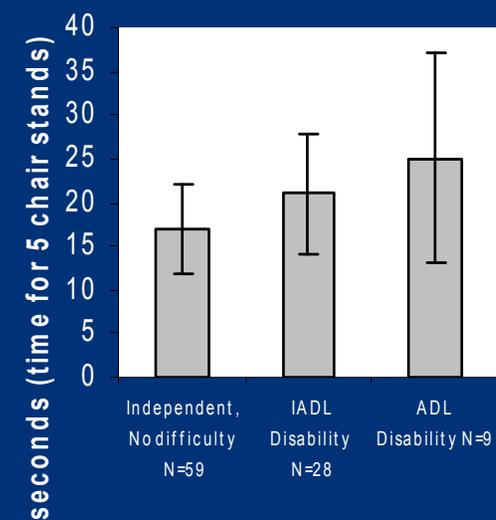
Gait Speed



Balance Scale



Chair Stands





Screening for low exercise among independent elders

	Gait speed (m/s)	Balance Scale (0-56)	Chair stands (seconds)
Not triggered	1.02 (.21)**	51.6 (3.1)**	16.2 (4.0)*
Triggered for activity counseling	0.67 (.17)	47.2 (4.9)	20.5 (8.5)



Screening for exercise counseling among older adults with IADL Disability/Difficulty

	Gait speed (m/s)	Balance Scale (0-56)	Chair stands (seconds)
Not triggered	0.86 (.20)*	50.2 (3.5)**	19.4 (7.0)
Triggered for Exercise Counseling	0.63 (.23)	42.1 (8.6)	22.1 (6.9)



Conclusion

- Health promotion CAP items did identify individuals with lower physical function
- Validating the need for health promotion/exercise counseling
- Suggests alternate quick method of screening
- Potential quick screen for out-patients