The Vincent Fairfax Churchill Fellowship to study physical ageing in community dwelling older adults – USA & Canada

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Signed

Natalie de Morton

Dated 7th March 2011
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>3</td>
</tr>
<tr>
<td>Executive summary</td>
<td>4</td>
</tr>
<tr>
<td>Program</td>
<td>5</td>
</tr>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>Project background and aims</td>
<td>6</td>
</tr>
<tr>
<td>How will this project benefit the Australian community?</td>
<td>8</td>
</tr>
<tr>
<td>Physical Activity and Public Health Course (PAPH), Utah USA</td>
<td>9</td>
</tr>
<tr>
<td>University of South Carolina, Columbia, South Carolina, USA</td>
<td>11</td>
</tr>
<tr>
<td>Centre for Hip Health &amp; Mobility, University of British Columbia Canada</td>
<td>14</td>
</tr>
<tr>
<td>Methods</td>
<td>16</td>
</tr>
<tr>
<td>Results</td>
<td>17</td>
</tr>
<tr>
<td>Conclusion</td>
<td>21</td>
</tr>
<tr>
<td>Recommendations</td>
<td>23</td>
</tr>
<tr>
<td>References</td>
<td>24</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

The physical health of older people is an important indicator of their health status. In Australia, the average age of the population is increasing and unlike other important health indicators such as blood pressure, we currently do not have a standardised approach to measuring and assessing the physical health of older adults. The Vincent Fairfax Churchill Fellowship provided the opportunity for me to work with two of the worlds leading researchers in ageing and their teams, explore methods that are used in the USA and Canada to assess the physical health of older adults, attend an internationally recognised post graduate course in Physical Activity and Public Health (PAPH) and to lead a research project in ageing using advanced technology that is available only at the University of British Columbia, Centre for Hip Health and Mobility, Vancouver, Canada.

I am enormously grateful to the Winston Churchill Memorial Trust and the Vincent Fairfax Foundation for the opportunity to learn, collaborate with and observe international experts in ageing and their teams. I hope that the contents of this report will provide the Australian community with information that advances our management of the physical health of older adults.

To my referees, Professor Karim Khan and Professor Stephen Lord, I am very grateful for your support with my Churchill Fellowship application. The Churchill Fellowship has been a privilege and would not have been possible without your kind and supportive words.

During my fellowship, I met many wonderful and inspiring people and I am very grateful for their generosity and hospitality. I would particularly like to thank Professor Stephen Blair and Professor Karim Khan for the research opportunities and mentoring that they provided and their sophisticated, ethical and mature leadership. Many thanks also to the wonderful staff at the School of Public Health, University of South Carolina and the Centre for Hip Health and Mobility, University of British Columbia, in particular Erin Macri and Douglas Race.

I am also grateful to my visitors during my Churchill Fellowship, in particular, my husband Simon Muller. I would like to dedicate this report to my wonderful family and friends who, for many years now, have supported me and my research and clinical interests in geriatrics and ageing.
EXECUTIVE SUMMARY

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Position held during Churchill Fellowship period:
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The Vincent Fairfax Churchill Fellowship to study physical ageing in community dwelling older adults – USA & Canada

Highlights:
- Attendance at the Physical Activity & Public Health (PAPH) post graduate course in Utah with leading researchers from the USA
- Visiting the Palmetto Health-University of South Carolina Mobility and Research Clinic (“The Mobility Clinic”)
- Leadership and mentoring from Professor Stephen Blair (University of South Carolina, School of Public Health, USA) and Professor Karim Khan (University of British Columbia, Centre for Hip Health and Mobility (CHHM), Canada)
- Leading ageing research projects in Canada with sophisticated technology from the CHHM mobile research laboratory

Recommendations:
- Promoting and supporting the dissemination of the World Health Organisation Global Recommendations on Physical Activity for Health and the Australian Physical Activity Guidelines to Australian healthcare professionals and older adults.
- Developing rehabilitation units for community dwelling older adults with a philosophy and funding model that facilitates an outcome of successful healthy ageing rather than usual ageing or returning to premorbid status only.
- Implementation of a standardised and recommended approach to screening physical health in community dwelling older adults
- Influencing policy makers regarding introduction of a standardised physical health assessment into Medicare rebated health assessments for community dwelling older adults

Implementation and dissemination:
- Disseminate this report to the Victorian Department of Human Services and Department of Veterans Affairs
- Disseminate information via conference presentations and scientific publication(s)
- Disseminate via the soon to be launched DEMMI® website (www.demmi.org.au)
PROGRAM

14th – 22nd September 2010
Salt Lake City, Utah, USA
- Physical Activity & Public Health (PAPH): A postgraduate course in research directions and strategies

27th September – 2nd October 2010
Columbia, South Carolina, USA
- School of Public Health, University of South Carolina

4th October – 19th November 2010
Vancouver, Canada
- Centre for Hip Health and Mobility, University of British Columbia
INTRODUCTION

Project background and aims

In Australia, people aged 65 years and older comprise 13% of the population [1]. In 2004-05, this subgroup accounted for approximately 50% of hospital bed days [2] and this figure is likely to increase as the average population age increases [2]. Healthcare costs, carer costs, demands on families and pressure on the health care system are expected to escalate. Interventions that improve the health status of older adults and reduce dependence on carers and limited healthcare resources warrant research attention.

Physical inactivity is a major public health issue and is associated with loss of independence and increased risk of falls, fracture and mortality [3]. Maintaining physical health in older age is an important predictor of their health outcomes and quality of life. Just as measurement tools are used to measure other important domains of health, an instrument that accurately measures and monitors the physical health of all older adults in any health care setting would have important health benefits. Blood pressure is considered one of 5 vital signs and thus a blood pressure cuff is used to monitor blood pressure across healthcare settings and prevent serious health conditions such as stroke or heart attack. A blood pressure reading of 120/80 is considered a healthy normal reading. However, in Australia, there is currently not a standardised approach to assessing, monitoring and screening the physical health of older adults and therefore we do not have data that indicates whether an older person is above or below healthy norms for their age and gender.
Prior to the recent development of the DEMMI® [4], no measurement tool had the properties required to accurately measure the mobility of all older people [5-7]. The advantages of such an instrument are that it can be applied across older populations regardless of the clinical setting and health status. It is quick and easy to use, freely available, has minimal equipment requirements, provides interval level measurement (rather than ordinal) and can measure from bed bound up to very high levels of independent mobility without floor or ceiling effects.

The DEMMI® can be applied to identify early signs of decline and prompt early intervention, facilitate goal setting during rehabilitation and accurately assess the physical health outcomes of older people in clinical trials. The DEMMI® is unique and Australian developed. It consists of 15 hierarchical items with interval-level scoring from 0-100 (where 0 represents lowest level of mobility and 100 represents highest level). The DEMMI® was developed to overcome the limitations of existing mobility instruments. It is the first mobility instrument that accurately measures the mobility of all older adults across clinical settings. Establishing normative data estimates is an important step in high quality health instrument development. It provides essential benchmarks for comparing the mobility status of older people and can facilitate goal setting for therapeutic intervention.

Most older people in Australia live independently in the community. For health care workers, it is important to understand normal ageing and to have data on the expected physical ability of older people as a benchmark to guide assessment and treatment of older people with health conditions.
The aims of this project were:
- to attend an internationally recognised course in physical activity and public health
- to collect, using a mobile research laboratory in Canada, a large sample of mobility assessment data using the DEMMI® in order to establish the normal mobility profile of older people
- to gain international research experience with 2 world leading researchers in ageing and their teams, Professors Blair (USA) and Khan (Canada).

How will this project benefit the Australian community?
Ageing is an important issue facing healthcare systems around the world. This project will benefit the older Australian community, their carers and families by providing normative data for the first mobility instrument that can accurately measure all older adults. This project will assist in developing a large normative dataset for the DEMMI® that will facilitate clinicians and researchers with identifying the mobility levels required for community participation, identifying early signs of decline, goal setting for therapeutic intervention and interpreting the results of public health research in older populations. Large normative datasets are an important part of the development of high quality outcome measures (i.e. as per the development of other measures such as the SF-36) and this project will facilitate the progression of this Australian research.
PHYSICAL ACTIVITY AND PUBLIC HEALTH COURSE (PAPH), UTAH, USA

The PAPH course was an 8-day intensive course led by leading researchers in physical activity from the USA. The goal of the course is to: “enhance public health by expanding the nation’s capacity for conducting research on the health implications of physical activity and on the promotion of physical activity in populations.” (PAPH course manual, 2010).

The attendees (approximately 30) were predominantly from the USA but included some international researchers. The structure of the course was 3 sessions per day that included a morning of lectures, one-on-one discussion sessions with the course leaders in the afternoon and an evening lecture. The content of the lectures addressed key issues relating to research in physical activity and public health, developing grant writing skills for nationally and internationally competitive funding sources and informal discussions with course leaders and participants facilitated development of project ideas and design. On the final day of the course, each PAPH Fellow presented their research proposal to the group.

Lectures on healthy/successful ageing provided the latest research in this field and emphasised the well-documented importance of optimising physical health during the ageing process. Key points from ageing specific lectures were:

- The trajectory of decline in older age is significantly improved in older adults who are physically active. The studies discussed compared masters athletes, successfully ageing older adults, usual ageing and usual ageing with chronic disease.
- Physical Activity has important preventative and therapeutic effects late in life
- Physical Activity has important benefits for the musculoskeletal system, in particular, on physical function, lean muscle mass and insulin resistance and glycaemic control.
- Physical Activity has beneficial effects on physical and cognitive function
- Small increases in physical activity can result in clinically important gains for older adults
- Physical Activity is a key component of successful ageing

The senior researchers who presented at the course and with whom I had discussions were:
Professor Russell Pate
Professor Stephen Blair
Professor David Buchner
Professor William Haskell
Dr Loretta DiPietro
Professor Wendy Korht
Dr Michael Pratt
Dr Janet Fulton
Dr Stewart Trost

Lectures and discussions with senior researchers and fellow attendees clearly identified that a standardised approach to assessing the physical health of older adults does not yet exist in the USA. A broad range of measures are currently used in clinical and research settings.
UNIVERSITY OF SOUTH CAROLINA, SCHOOL OF PUBLIC HEALTH, COLUMBIA, SOUTH CAROLINA, USA

The University of South Carolina is located in Columbia, South Carolina, USA. The Arnold School of Public Health, located within the University, is one of 40 Schools of Public Health in the United States. It has 6 departments and the Department of Exercise Science is where Professor Stephen Blair and his team are based.

During my week at the School of Public Health at South Carolina, I had one-on-one meetings with more than 15 staff and doctoral students and learned of the techniques, projects, designs and technology that were being implemented into a broad range of Physical Activity and Public Health projects in older adult and paediatric populations. Projects ranged from the micro level (e.g. genetics and exercise) to macro level public health promotion projects. These discussions also provided great insight into how a world leading research unit operates and functions and provided a platform for future collaboration.

A question that I raised in most discussions was regarding methods for measuring physical health in the US in older adult and paediatric populations. Based on these discussions it was clear that a standardised approach to mobility assessment and screening has not been implemented for older adults in the USA at this stage. A broad range of outcome measures are currently selected for use by individual researchers and clinicians.

During my visit to the University of South Carolina, I had a meeting arranged with Associate Professor Victor Hirth, University of South Carolina and Internal Medicine and Medical Director, Columbia. Dr
Hirth was instrumental in the development of SENIOR SMART, a pioneering service available to older adults in South Carolina. SENIOR SMART is a research and economic centre of excellence. It consists of:

SMART HOME – use of technology and community support services to allow older adults to stay at home longer and more safely
SMART WHEELS – use of technology to improve transportation for older adults – crash avoidance systems, “smart” cars and technology, driver evaluation and rehabilitation after stroke – safer, more secure systems for seniors.
SHARP BRAINS – prevention, rehabilitation, brain development to promote healthy ageing brains. Preventing (eg. Alzheimer’s disease, stroke) and treating (e.g. Parkinson’s Disease) brain disease. Integrating body and mind to promote brain health.

SENIOR SMART is funded by a mixture of private and public sources. It was an impressive display of the integration of academic and clinical expertise translated into clinical practice to optimise health outcomes for older adults.

During my visit with Dr Hirth he also took me on a guided tour of the Palmetto Health-University of South Carolina Mobility and Research Clinic which is affiliated with SENIOR SMART. “The Mobility Clinic” as it is abbreviated contains the latest technology in rehabilitation available and provides intensive one-on-one therapy for community dwelling older adults. It aims to return older adults to a higher level of functioning than their premorbid status. The unit is Medicare-funded. Since muscle strengthening typically takes 6-8 weeks, therapy programs usually need to be 12 to 18 weeks but some of this program may be
completed as a home exercise program. All patients are community
dwelling and are referred to the program by their local doctor. A broad
range of outcome measures were available for clinical staff to measure
the efficacy of the program. Consistent with other discussions in the US,
clinicians could select the outcome measure(s) for application.

“The Mobility Clinic” was an impressive service that aimed to return
older adults not only to their premorbid function but to the successful
healthy ageing curve.
CENTRE FOR HIP HEALTH AND MOBILITY, UNIVERSITY OF
BRITISH COLUMBIA, CANADA

The Centre for Hip Health and Mobility (CHHM), University of British Columbia is located in Vancouver, Canada. Professor Karim Khan is a world leading researcher in older adults and CHHM is where he and his team are located. My primary reason for wishing to spend an extended period of time at CHHM was to work with and learn from Professor Khan and to lead a research project using the CHHM mobile research laboratory to obtain normative data for the DEMMI®.

CHHM has a mobile research unit (see photos below) that was launched in 2009 and enables data collection in communities of choice. The unit was developed to facilitate data collection within the Canadian community. It includes equipment such as a Hologic 4500 DXA scanner to measure bone density, a SCANCO peripheral QCT to estimate bone strength from cross-sectional images, the Physiological Profile Assessment (PPA) instrument to quantify falls risk, as well as satellite connectivity for data downloads. Since its development, it has been used to collect data in a range of studies in Vancouver and the Lower Mainland area of British Columbia and other major centres in the rest of the province. The mobile research laboratory provided the opportunity for the DEMMI® assessment procedure to be conducted in healthy community dwelling older adults in their community, to concurrently collect other measures of health and to efficiently obtain normative data for the DEMMI®.
Figure 1. Photograph of the CHHM Mobile research Laboratory (from the side of the lab)

![Image of CHHM Mobile research Laboratory from the side](image1.jpg)

Figure 2. Photograph of the CHHM Mobile Research Laboratory (from the rear of the lab)

![Image of CHHM Mobile research Laboratory from the rear](image2.jpg)
Methods

Recruitment
Data was collected at a range of community sites between October and December 2010 from older persons in the Vancouver region. Participants were recruited using a range of possible recruitment strategies. These included advertising in local newspapers, Retirement villages, sporting groups, and seniors groups. Participants were asked in the advertisement to make contact/phone a nominated contact person if they were interested in participating in the study. Assessments were conducted either at a location in the community with the mobile research laboratory, local centre or at the Centre for Hip Health and Mobility.

Participants
All healthy community dwelling adults 60 years or older residing in the community were eligible to participate in this study. Healthy community dwelling adults did not include any individuals who were hospital inpatients, were attending outpatient rehabilitation clinics, were living in an institution and required assistance with Activities of Daily Living or lived in the community with a diagnosed clinical condition that affected their mobility (e.g. stroke, fracture). Participants were only included if able to read and write English. Those with any cognitive limitations that affected their ability to provide informed consent were also excluded.

Test Procedure
On the day of data collection, written and informed consent was obtained and study inclusion and exclusion criteria were applied by a researcher. Demographic information was obtained and a battery of questionnaires was then completed that included:
- Charlson Co-morbidity Index [8]
- FROP-COM [9]
- Falls Efficacy Scale-International (FES-I) [10]
- Barthel Index [11]
- Instrumental Activities of Daily Living [12]
- Friendship Scale [13]
- The Lower Extremity Functional Scale [14]
- The Late Life Functional Disability Instrument [15]

The Charlson Co-morbidity Index and FROP-COM were completed by participant interview by a researcher and the remaining questionnaires were completed by the participant and assistance was provided if necessary. The DEMMI® assessment procedure was completed by a physiotherapist. At sites where the mobile research laboratory was used, participants were also able to have a full body bone density scan conducted.

Ethics approval for this study was obtained from the University of British Columbia and Vancouver Coastal Health (the local regional health authority).

Results
Data were collected from 8 sites. These were:
• Elim Village, Surrey, British Columbia
• Silver Harbour Seniors' Activity Centre, North Vancouver, British Columbia
• McKee House, Delta, British Columbia
• North Shore Neighbourhood House / John Braithwaite Community Centre, North Vancouver, British Columbia
• West Vancouver Seniors Activity Centre, West Vancouver, British Columbia
• Kennedy Seniors Centre, North Delta, British Columbia
• White Rock Community Centre, White Rock, British Columbia
• Centre for Hip Health and Mobility, Vancouver, British Columbia

There were 123 participants who provided written and informed consent and were screened for study inclusion. See flow diagram below (Figure 3).

Figure 3. Flow diagram of included participants
The results of this study are shown in Tables 1 and 2 and Figure 4 below. Table 1 shows the characteristics of included participants. Figure 4 and Table 2 show normative DEMMI® mobility scores significantly declined with increasing age in healthy community dwelling older adults.

Table 1. Demographics of included participants

<table>
<thead>
<tr>
<th></th>
<th>60-69 years (n = 33)</th>
<th>70-79 years (n = 51)</th>
<th>80+ years (n = 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (sd)</strong></td>
<td>65.7 (2.5)</td>
<td>73.5 (2.7)</td>
<td>83.6 (2.5)</td>
</tr>
<tr>
<td><strong>% female</strong></td>
<td>81.8%</td>
<td>84.3%</td>
<td>73.7%</td>
</tr>
<tr>
<td><strong>Use walking aids (%yes)</strong></td>
<td>3.0%</td>
<td>3.9%</td>
<td>5.3%</td>
</tr>
<tr>
<td><strong>Place of residence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House</td>
<td>57.6%</td>
<td>60.8%</td>
<td>31.6%</td>
</tr>
<tr>
<td>Unit</td>
<td>36.4%</td>
<td>31.4%</td>
<td>52.6%</td>
</tr>
<tr>
<td>Retirement Village</td>
<td>3.0%</td>
<td>7.8%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Other</td>
<td>3.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Live alone</strong></td>
<td>39.4%</td>
<td>49.0%</td>
<td>73.7%</td>
</tr>
<tr>
<td><strong>Fallen past 12 months (%yes)</strong></td>
<td>15.2%</td>
<td>13.7%</td>
<td>21.1%</td>
</tr>
<tr>
<td><strong>Charlson Index</strong></td>
<td>0.30 (0.68)</td>
<td>0.55 (0.99)</td>
<td>0.53 (1.12)</td>
</tr>
<tr>
<td><strong>FROP-COM</strong></td>
<td>5.12 (3.36)</td>
<td>5.20 (3.12)</td>
<td>5.78 (2.10)</td>
</tr>
<tr>
<td><strong>FES-I</strong></td>
<td>8.6 (2.92)</td>
<td>8.31 (1.68)</td>
<td>9.26 (3.31)</td>
</tr>
<tr>
<td><strong>Barthel Index</strong></td>
<td>99.70 (1.21)</td>
<td>99.31 (2.65)</td>
<td>96.05 (6.36)</td>
</tr>
<tr>
<td><strong>IADL</strong></td>
<td>8.0 (0)</td>
<td>7.98 (0.14)</td>
<td>7.95 (0.22)</td>
</tr>
<tr>
<td><strong>Friendship Scale</strong></td>
<td>22.09 (3.36)</td>
<td>22.24 (2.38)</td>
<td>22.10 (1.97)</td>
</tr>
<tr>
<td><strong>LEFS</strong></td>
<td>70.97 (9.61)</td>
<td>71.04 (8.70)</td>
<td>65.05 (11.32)</td>
</tr>
<tr>
<td><strong>Late Life Disability Index</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 1: How often limited?</td>
<td>66.88 (6.28)</td>
<td>67.56 (7.84)</td>
<td>65.26 (5.46)</td>
</tr>
<tr>
<td>Section 2: To what extent limited?</td>
<td>76.90 (5.09)</td>
<td>70.67 (18.69)</td>
<td>74.47 (6.50)</td>
</tr>
</tbody>
</table>
Figure 4. DEMMI® scores by age in healthy community dwelling Canadians

Table 2. DEMMI® scores by age

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>Mean (sd)</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-69</td>
<td>33</td>
<td>87.1 (10.5)*</td>
</tr>
<tr>
<td>70-79</td>
<td>51</td>
<td>85.5 (9.4)</td>
</tr>
<tr>
<td>80+</td>
<td>19</td>
<td>80.6 (10.2)**</td>
</tr>
</tbody>
</table>

*group 60-69 compared 80+: p=0.02 (1 tailed t test)
** group 70-79 compared 80+: p=0.04 (1 tailed t test)
CONCLUSION

Based on research conducted in Australia, prior to my Churchill fellowship, it was identified that prior to the development of the DEMMI®, a mobility instrument did not exist that could accurately measure mobility across the full mobility spectrum in older adults in community and hospital settings. The DEMMI® normative data collected during my Churchill Fellowship will facilitate health care professionals for assisting goal setting for therapeutic intervention, planning service requirements for after hospital discharge and provide norms to facilitate identifying early signs of decline in community dwelling older adults.

Discussion with health authorities, academics and a range of other healthcare providers indicated that mobility assessment, as is currently the case in Australia, is not routinely conducted for older adults in the USA or Canada. Also, the choice of assessment procedure is left to the individual clinician or researcher to determine.

Based on the existing scientific literature, the most recent information presented at the PAPH course and discussions at the University of South Carolina, the health and economic benefits of maintaining physical independence in older age, to both the individual and the broader healthcare system, are enormous. Given the indisputable evidence that supports physical activity as a key factor in healthy ageing, regular mobility assessment/screening for community dwelling older adults would provide a platform for not only monitoring the physical health of older adults but also facilitating discussion and advice regarding physical activity patterns and, where necessary, instigate referral for exercise prescription or other appropriate intervention.
The physical health of older adults is becoming increasingly recognised as the “6th vital sign.” The World Health Organisation has recently endorsed that “Physical inactivity is the fourth leading risk factor for all global deaths, with 31% of the world's population not physically active [16].” Given the ageing population and the benefits that individuals and society stand to gain by maximising the physical health of our older adults, regular mobility screening and assessment in healthy community dwelling older adults would be a preventative healthcare strategy with benefits for older Australians, their families, the broader Australian community and the Australian healthcare system. Just as other vital signs are regularly assessed in primary care, the implementation of routine mobility screening with the DEMMI® would facilitate accurate screening of mobility.

Currently, standardised mobility screening has not been implemented at the policy level in the USA or Canada and Australia now has the opportunity to lead the way.
RECOMMENDATIONS

The outcome of this Churchill Fellowship is important to the Australian community because we have both an aged and an ageing population. The Federal government has articulated the challenge that we face through the greying of the nation in the recent Intergenerational Report. There can be absolutely no doubt that research that ultimately promotes older adults maintaining mobility is critical to Australia’s successful future.

My recommendations for enhancing current practices in Australia are based on observations and discussions overseas, results of the study conducted using the mobile research laboratory in Canada and the existing scientific evidence base:

• promoting physical activity in older age with older adults and healthcare providers by actively supporting the dissemination of the World Health Organisation Global Recommendations on Physical Activity for Health and the Australian Physical Activity Guidelines
• implementation of a standardised and accurate mobility assessment procedure that can be applied to all older adults in any health care setting
• promoting the importance of assessing and recording physical health of older adults and appropriate exercise prescription, particularly in primary care
• influencing policy makers to include a standardised mobility assessment in Medicare-rebated health schemes for older adult health assessments
• considering future centres of clinical rehabilitation excellence, that is, intensive outpatient rehabilitation units such as the one observed in South Carolina; changing the philosophy from rehabilitation to pre-morbid state for older adults in the community to rehabilitation that places older adults on the successful physical ageing curve rather than the usual ageing curve.
REFERENCES


7. de Morton, NA., Berlowitz DJ, and Keating J, A systematic review of mobility instruments and their measurement properties for older acute medical patients. BMC Health and Quality of Life Outcomes, 2008. 6(44).


