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Original Article

Feasibility evaluation of a stepped procedure to identify community-dwelling frail older people in general practice. A mixed methods study

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KEY MESSAGE:

- A two-step model in identifying frailty is appreciated and time efficient.
- Professionals recognize the advantages of their own appraisal in the decision making.
- Professionals want the identification of frailty and geriatric problem analysis to be part of one integrated approach, in which they found EASYcare-TOS suitable.

ABSTRACT

Background: Implementation of frailty identification methods in general practice has hardly been established. To achieve successful implementation, general practitioners (GPs) should be provided with an identification method that suits their needs. EASYcare-TOS is a new frailty identification method that uses a stepped approach and is specifically developed for use in general practice. The first step consists of the GP's frailty judgment based on his prior information on the patient. If the judgment is 'uncertain' or 'frail,' additional data are collected by a primary care nurse (PCN). The frailty decision is based on clinical reasoning by the GP, without applying predefined cut-offs in a numerical score.

Objective: To evaluate the acceptability of EASYcare-TOS in daily general practice.

Methods A mixed-methods study was conducted. Questionnaires were sent to all professionals ($n = 25$) who participated in the EASYcare-TOS validation study. Subsequently, semi-structured interviews with primary care professionals ($n = 12$) and patients ($n = 9$) were conducted.

Results: Time investment was generally perceived as acceptable. Twenty-two professionals (88%) found a two-step model (very) useful in the identification instrument. Seventeen professionals (68%) valued making the final frailty decision by their own clinical reasoning. Patients appreciated the broad assessment and the advice given based on the assessment. According to 24 (96%) professionals, EASYcare-TOS improved the quality of patient care. GPs stated that implementation will ask for reconsidering allocation of tasks in general practices and adequate reimbursement.

Conclusion: EASYcare-TOS is a new identification method that fits the needs of primary care professionals to a large extent and is acceptable in daily practice.

Keywords: frailty, older patients, identification, general practice

INTRODUCTION

Frailty has become an important and generally accepted concept because it identifies a subgroup of older patients who likely have complex care needs; and it provides new opportunities for prevention, health promotion, and improved healthcare for this group of older persons (1,2). Various methods for identifying frailty in community-

dwelling older patients have been developed and validated for the use in primary care (e.g. the Frailty Index and Groningen Frailty Indicator) (3–6). However, implementation of these methods in general practice has hardly been established (1,6,7).

A major barrier that prevents general practitioners (GPs) from using identification methods for frailty is lack

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of time and resources (8,9). Additionally, consensus on the definition of frailty and its operationalization in a care plan are lacking, which may also contribute to limited use of identification methods (8). To overcome these barriers, the EASYcare two-step older persons screening (EASYcare-TOS) was developed (10). This method gives guidance in evaluating the aspects that can make a patient frail, on physical as well as psychosocial domains. It aims to reduce time constraints by using a two-step approach and facilitating GPs in delegating work to primary care nurses (PCNs) as was recommended in a previous letter by de Lepeleire (9). An overview of the method is given in Box 1 and Figure 1. Validation studies—both into construct and predictive validity—are currently in their final stage. The EASYcare-TOS method applies a slightly adapted version of the original EASYcare instrument for geriatric assessment as the second step (11). This method is extensively studied in The Netherlands (12,13). There are many Dutch primary care professionals who work with this instrument in daily practice.

The aim of this study was to determine whether using EASYcare-TOS is acceptable for frailty identification in daily general practice. Hereby, we aimed to explore in-depth how EASYcare-TOS contributed to overcoming existing barriers.

METHODS

Design

A feasibility study was conducted to investigate the acceptability of EASYcare-TOS with a mixed methods design during a period of three months (April–June 2012), consisting of (a) a quantitative evaluation by a survey among professionals, followed by (b) a qualitative evaluation by means of semi-structured interviews with purposively selected participants (patients and professionals).

The study has been carried out in the Netherlands in accordance with the applicable rules concerning the review

of research ethics committees and informed consent. Owing to the nature of the study, the local ethics committee of the region Arnhem/Nijmegen (The Netherlands) stated that no formal approval was required. Nevertheless, the participants were asked for informed consent.

Quantitative evaluation

Subjects. An overview was made of all professionals who participated in EASYcare-TOS validation study and worked with EASYcare-TOS. All professionals who worked for approximately two years with EASYcare-TOS (12 GPs, 13 PCNs) were asked to fill out a questionnaire. In all, they had applied the method in approximately 1100 persons aged 70 and over. The professionals worked in four different general practices situated in and around the city of Nijmegen (The Netherlands). All GPs worked with a supporting staff (e.g. with medical assistants, primary care nurses).

Data collection and analysis. Two questionnaires, consisting of multiple choice and open-ended questions were designed for this study, one for GPs and one for PCNs. The questionnaires contained 48 questions on demographics, the method's content, implementation, proceeds and use in the future. Data was analysed using descriptive statistics, using SPSS 18.

Qualitative evaluation

Subjects. The sample for qualitative evaluation was selected from the 25 professionals who completed the quantitative questionnaire. It was composed by both stratified and purposive sampling to achieve representativeness of the study population and reflect participants' diversity (14). Hereto, we divided the population into GPs and PCNs; additionally we selected the professionals who appeared to have unique opinions in the quantitative evaluation. The participants' characteristics are shown in Table 1.

The sample of patients was composed by including patients from three different practices. The primary care

Box 1. The EASYcare-TOS.

Step 1. GP's checklist

The method's first step is a short checklist, containing 14 items about physical and psychosocial functioning of the patient that helps the GP to identify blind spots in his prior information on the patients functioning. Subsequently, the GP decides whether the patient is 'frail', 'not frail' or that the existing information is insufficient to make this decision ('unclear') (Figure 1).

Step 2. In-home assessment (primary care nurse)

Patients labelled as 'unclear' or 'frail' continue to the second step in which additional information is collected through an in-home primary care geriatric assessment (EASYcare) by a PCN. In the patients labelled as 'unclear', the second step is aimed at gaining clarity about the presence or absence of frailty. In the patients labelled as 'frail', the aim of the second step is to collect data on all aspects of functioning relevant for providing good care to a frail person.

The final frailty decision

Thereafter, the PCN and GP discuss all information obtained and make judgements on several geriatric domains and a final frailty decision in joint judgment. The frailty decision in both steps is a result of a subjective professionals' judgment and is not a numerical score. The complete EASYcare-TOS instrument (step 1 and 2) is available as web-appendix 1.

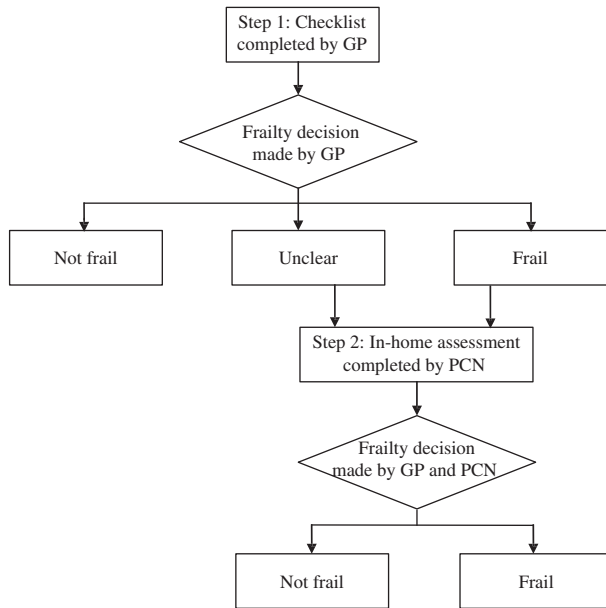


Figure 1. Overview EASYcare two-step older persons screening.

nurses selected the patients. Inclusion criteria for each practice were: one non-frail patient and two frail patients with problems in one or more domains who recently had the in-home assessment. Their characteristics are shown in Table 2.

Data collection and analysis. Three topic lists (for GPs, PCNs and patients, respectively) were developed. The topic lists were adapted during the study based on interim analyses. The final topic lists are shown in Box 2. Data analysis on open-ended questions and the interviews was performed using directed content analysis (15). Coding and analysing was performed (SK) and subsequently reviewed by a second researcher (JvK). Differences in opinion between the researchers were resolved by mutual consensus. Atlas.ti software was used to support the analysis process. When no new topics were introduced, two additional interviews were performed to confirm saturation.

RESULTS

A 100% response rate was obtained for completing the quantitative questionnaire (12 GPs and 13 PCNs). In the

Table 1. Characteristics of interviewed professionals ($n = 12$).

	General practitioners $n = 5$	Primary care nurses $n = 7$
Age in years, mean (range)	57 (48–62)	41 (27–50)
Male, n	3	0
Practice demographics		
Urban, n	3	3
Suburban, n	1	3
Countryside, n	1	1

Table 2. Characteristics of interviewed older patients ($n = 9$).

Age, mean in years (range)	79 (72–89)		
Male, n	5		
Frail according to GP after completing the EASYcare-TOS, n	6		
Level of functioning on the domains reported by general practitioners in EASYcare-TOS	Good	Average	Bad
Physical functioning, n	5	4	0
Medication, n	9	0	0
Cognition, n	8	1	0
Vision and hearing, n	8	1	0
(I) ADL functioning, n	7	2	0
Mobility, n	5	2	2
Mental wellbeing, n	7	2	0
Social context, n	7	2	0

semi-structured interviews, nine patients and 12 professionals (five GPs, seven PCNs) participated. Data analysis of the interviews resulted in five main themes. The results of the quantitative and qualitative analysis are presented by these five main themes.

Time investment

Patients—qualitative data. Patients reported conversation duration of the in-home assessment of 30–45 min; no-one experienced this time span as strenuous or exhausting.

Professionals—quantitative data. The average time needed by the GPs to complete the first step was nine minutes (range: 3–15 min). This time was perceived as ‘little time’ by five GPs (42%), as ‘not a little/not a lot of time’ by six GPs (50%) and as ‘a lot of time’ by one GP (8%). For the second step, PCNs needed 65 min (range: 45–90 min) in frail patients and 48 min (range: 30–75 min) in non-frail patients. This time was perceived as ‘not a little/not a lot of time’ by seven PCNs (54%) and as ‘a lot of time’ by five PCNs (38%). Discussing the received information and making the final frailty judgment on average required nine minutes (range 3–15 min).

Professionals—qualitative data. Several GPs (step one) could fit the work in the normal working hours, without conflicting too much with other tasks. Other GPs stated that frailty identification is at the expense of other patient care and thus implementation of frailty identification needs to be accompanied by reconsidering division of tasks and practice priorities.

GP2: Well, because uh, it is all extra work. (...) But at a certain moment you can't reduce your consulting hours anymore. Because, otherwise you have too little time for your patients. They start pounding when the assistants can't plan patients with us.

Box 2. Final topic lists.

Topics discussed with GPs and PCNs

1. EASYcare-TOS
 - What are your experiences? What are your preferences?
2. Proceeds
 - How does using EASYcare-TOS affect patient care?
3. Two-step approach
 - Experiences with two-step approach? Who should be assessed in the second step? ('frail'—'unclear'—'non frail' according to the first step—other)
4. Domains
 - What is your opinion on the domains used in EASYcare-TOS? Should specific domains be added? Should specific domains be deleted?
5. Frailty decision
 - Experiences with making the frailty decision? Preferences? (judgment-score)
6. Acceptability in daily practice
 - How acceptable is EASYcare-TOS in daily practice? Which barriers did you experience? Which facilitators?
7. Organization
 - Where should identification of frailty be placed in healthcare? (primary care—hospital—other) Who should organize the identification process? How should the tasks be distributed?
8. Use of EASYcare-TOS in the future
 - Would you like to work with EASYcare-TOS? Why/why not? What are your terms for using EASYcare-TOS?
9. Time spent
 - How much time did you spent on EASYcare-TOS? (in total—step 1 (GPs)—step 2 (PCNs)—the final discussion? How do you rate this time spent? What should be adjusted?

Topics discussed with PCNs only

10. Burden patients

- How did the patients experience the conversation? (Exhausting?)

Topics discussed with patients

11. Opinion on EASYcare-TOS assessment

- What is your opinion on the conversation with the primary care nurse? What are qualities of the conversation? What are weaknesses? Which adjustments do you prefer?

12. Topics

- What is your opinion on the topics that were discussed? Which topics did you miss? Which topics were superfluous? Were any discussed topics uncomfortable or embarrassing to talk about?

13. Time spent

- How much time was spent on the conversation? How do you rate this time spent? Which time span do you prefer for the conversation?

14. Preferred location for assessment

- (At home—in the general practice office.)

15. Burden experienced

- How did you experience the conversation? (Exhausting?)

16. Proceeds

- Did the conversation have effect on the care you receive? (Change—effect on relationship with GP) Was the conversation useful?

17. Future

- Would you like to participate in the future? Why/why not? In how much time do you prefer the next conversation take place? (One year—two years—other.)

List of topics discussed with GPs, PCNs and patients sorted by main topics, followed by additional questions.

One GP argued that completing the first step for all older patients provides few advantages in relation to the amount of work and suggested this step should be optional. Practices with many older patients experienced most time constraints in completing the complete EASYcare-TOS, however, GPs recognized that follow-up is less time consuming.

GP3: Now we have everyone in the picture. (...) So for us it isn't, not such a big job anymore to keep it up to date.

GP1: In my opinion it was a pretty quick instrument to work with and I think that's useful.

PCNs (step two) explained that they needed time for a good conversation, to gain trust, test the patient's memory, observe how the patient functions at home and get a general impression of the living situation. One PCN stated that time constraints were still an important barrier.

PCN7: But it is a quality improvement, which takes time.

Application of the stepwise method

Professionals—quantitative data. Of the professionals, 22 (88%) found a stepwise model (very) useful in an identification instrument. Seven professionals (28%)

(6 PCNs, one GP) considered performing both steps also useful in non-frail patients. Fourteen professionals (56%) (nine GPs, five PCNs) stated that the second step should be reserved for the 'unclear' cases and the 'frail' of the first step.

Professionals—qualitative data. According to some professionals, completing both first steps in non-frail patients is useful because it confirms prior information (GP) or they receive new information on patients (PCNs).

PCN3: Step two is in my opinion always useful, frail or not frail. A home visit by a primary care nurse is always of value. It always provides more, different and new information.

Others did not think that this was useful because enough information is known about the 'non-frail' whereas in 'unclear' cases, new sometimes surprising information can be collected. One GP argued that the extensive assessment should be optional for frail patients.

GP6: Step two provides lots of useful information to make a treatment plan that can reduce frailty. This adds less in elderly who appear to be frail after step one, but are well known. (It is) perhaps an option to make step two optional or complete only the unknown domains.

Frailty judgement

Professionals—quantitative data. All professionals ($n = 25$) found evaluating all geriatric domains separately a useful step prior to the final frailty judgment, the questions in the EASYcare assessment were helpful in exploring and rating persons' functioning in the different domains. Seventeen professionals (68%) preferred making the final frailty decision by their own clinical reasoning, five professionals (20%) preferred a score, and two professionals (8%) were neutral on this point (one missing value). Six professionals (24%) (four GPs, two PCNs) experienced difficulties in making the frailty judgment. Three professionals (all GPs) preferred a score.

Professionals—qualitative data. Some professionals thought a numerical score could give some further guidance in making the final decision, although the professionals' opinion was most important for them.

GP3: I think that it (score) gives a kind of false security. More important is the picture that you have of someone and the interpretation of that.

A GP stated the following on the difficulty of making the frailty decision:

GP6: It remains difficult to take stock, to weigh the factors that make someone vulnerable against the countervailing factors.

Effects of EASYcare-TOS on patient care

Patients—qualitative data. Patients' most important argument for participation in the assessment was personal health improvement. They were pleased with the personal attention and some patients said that the broad assessment caused valuable discussion of sensitive topics. Patients appreciated advice given based on the assessment.

P3: At the end of the day, I walk bent over because of the back pain. And I don't know when to stop, so you just keep on going in the garden. And (the nurse) gave me the advice to rest in between.

Professionals—quantitative data. After two years using EASYcare-TOS, 11 GPs (92%) felt they knew the older patients better, whereas one GP did not experience this feeling. Furthermore, 24 (96%) professionals thought that EASYcare-TOS improved the quality of patient care.

Professionals—qualitative data. The GP who did not feel by using EASYcare-TOS he knew his older patients better explained that he already felt he knew his patients very well. A PCN said that patients who received EASYcare-TOS were less reserved in contacting her and patients who usually avoided care were more willing to accept help. Several professionals stated that identification stimulated a more proactive approach, which could prevent or delay functional decline. A GP stated that EASYcare-TOS enabled him to provide better patient-centred care.

GP2: In this way you are able to provide tailor made care. You can spend your time on the potentially frail or on the complex care situations and anticipate on this.

PCNs reported that the second step of EASYcare-TOS stimulated them to explore and analyse patients' problems and perform immediate in-depth analysis with additional questions and tests. This was confirmed by GP observations.

PCN7: That, that if you notice that that the memory is poor, you immediately complete a MMSE. Otherwise, you have to go back to the patient to do this next step.

GP4: (Reflection on assessment by PCN) Are we dealing with a behavioural problem? Is dementia the cause or is it just old age?

EASYcare-TOS's future

Patients—qualitative data. Most patients would appreciate follow-up screening. Some patients preferred a yearly home visit; others mentioned that GPs should determine the visits' frequency.

Professionals—quantitative data. Of the professionals 19 (76%) definitely would and five (20%) might like to work with EASYcare-TOS in the future.

Professionals—qualitative data. Some professionals would like the opportunity to use EASYcare-TOS in a more flexible way, focussing on domains that are specifically relevant for a particular individual.

P7: This is too time consuming. (...) I think that we, that we should focus on subjects that are relevant for the patient.

GPs stated that to implement EASYcare-TOS in everyday practice, they need to hire practice nurses, preferably who specialized in care of the older patients to organize the identification process. Furthermore, registration must be integrated in the GPs' electronic medical records. Reimbursement for identification should be adequate, otherwise broad implementation in general practice is unlikely.

GP4: So, it should be financed by the healthcare insurance. Yes, otherwise it depends on the idealism of the general practitioner.

DISCUSSION

Main findings

This study showed that EASYcare-TOS is a well-accepted method for identification of frail elderly in general practice. Although time investment was generally perceived as acceptable, some professionals stated that frailty identification was at the expense of other patient care. Implementation thus will ask for reconsidering allocation of tasks in general practices and adequate reimbursement.

The stepwise approach facilitates GPs in delegating work to PCNs, which was appreciated and provided an efficient use of time.

EASYcare-TOS was judged to cover all relevant geriatric domains and professionals recognized the advantages of their own appraisal as a decisive part of the frailty identification, although some found it difficult.

Patients appreciated advice given based on the assessment. According to 24 (96%) professionals, EASYcare-TOS improved the quality of patient care. Patients were less reserved in seeking and accepting help. Furthermore, it stimulated a more proactive approach and exploration of patients' problems by immediate in-depth analysis.

Primary care professionals felt that the frailty identification procedure and subsequent geriatric problem analysis are best served when both are part of one integrated approach, in which they found EASYcare-TOS suitable.

Strengths and limitations

To our knowledge, this study is the first to explore the opinions and experiences of both primary care professionals and patients on the use of a method to identify frailty in community-dwelling elderly.

A methodological strength of this study is that we supplemented quantitative with qualitative data to deepen the results. Although the sample was small, we fulfilled important quality criteria of qualitative research, such as purposive sampling and saturation.

A limitation, which may prevent implementation of the instrument, was that some professionals experienced difficulties in weighing the frailty factors against the protective factors when making the frailty judgment. Experiencing these difficulties did not mean that they did not want to work with this method in the future. It is likely that most GPs experience fewer difficulties after getting more experienced in making the frailty decision.

Another important limitation is the potential bias in participant selection because the most enthusiastic professionals may have agreed to participate in this validation study. Nevertheless, diverse opinions were given, positive as well as more critical opinions. Furthermore, for the patients' interview sample, patients from three general practices were selected. Patients from one of the four general practices were excluded because the time between the assessment in the second step and the interview was too long. If we compare this practice to the other three, we do not expect this to have strongly affected the generalizability of the results.

Another potential threat to the generalizability of this study is the fact that the number of participants in this study is small, although all professionals who participated in the validation study were included. Nevertheless, even if minor differences occur, the method can still be appreciated and accepted.

A probably more important limitation for generalizability is the difference in the functioning of GPs in diverse healthcare systems in Europe. However, the original EASYcare instrument is accepted by an international network, which pleads that an instrument like EASYcare should become an integral part of health assessment (16).

Strengths of EASYcare-TOS

EASYcare-TOS is innovative because it introduces several new assets in frailty identification: (a) the frailty

judgment is made by the GP's clinical judgment; (b) it uses a two-step model with a simple 'case-finding' tool as the first step and a more complex assessment as the second step; and (c) because of its broad and elaborate assessment of those persons for whom this is indicated, EASYcare-TOS appeared to be solid ground to further problem analysis and individualized care.

Most important for optimally using EASYcare-TOS is that this method needs a GP working in a structured practice with supporting staff. In that way, EASYcare-TOS can be embedded in clinical practice most efficient, and it will reduce the GPs high workload when identifying frail older persons.

Future implications

EASYcare-TOS is suitable for use by PCNs and supports further problem analysis and individualized care planning. Other short methods, like the Groningen Frailty Indicator and the Frailty Index, are not suitable for this purpose (3,6). The needs and preferences of professionals and patients found in this study and the on-going validation studies will enable further development of EASYcare-TOS, like integration in GPs' electronic medical records and integration with geriatric problem analysis. To ensure broad implementation, reimbursement for frailty identification by health insurance companies is needed. The translation and use of EASYcare-TOS in other countries than the Netherlands will cost relatively little effort, as the original EASYcare instrument is already available in 25 languages (17).

Conclusion

EASYcare-TOS is a new identification method for frailty that suits the needs of primary care professionals to a large extent and is acceptable for use in daily practice. Furthermore, the method supports professionals in providing proactive and individualized care. For the implementation of EASYcare-TOS in clinical practice, a supporting staff (PCN) and adequate reimbursement should be available to the GP.

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REFERENCES

1. Crome P, Lally F. Frailty: Joining the giants. *Can Med Assoc J*. 2011;183:889–90.
2. Bergman H, Ferrucci L, Guralnik J, Hogan DB, Hummel S, Karunanathan S, et al. Frailty: An emerging research and clinical paradigm—issues and controversies. *J Gerontol A Biol Sci Med Sci*. 2007;62:731–7.
3. Metzelthin SF, Daniels R, van Rossum E, de Witte LP, van den Heuvel WJ, Kempen GI. The psychometric properties of three self-report screening instruments for identifying frail older people in the community. *Tijdschr Gerontol Geriatr*. 2011;42:120–30. In Dutch.
4. Steverink N, Slaets JP, Schuurmans H, van Lis M. Measuring frailty: Development and testing the GFI (Groningen Frailty Indicator). *Gerontologist* 2001;41:236–7.
5. Lacas A, Rockwood K. Frailty in primary care: A review of its conceptualization and implications for practice. *BMC Med*. 2012;10:4.
6. Drubbel I, de Wit NJ, Bleijenberg N, Eijkemans RJ, Schuurmans MJ, Numans ME. Prediction of adverse health outcomes in older people using a frailty index based on routine primary care data. *J Gerontol A Biol Sci Med Sci*. 2013;68:301–8.
7. Ravaglia G, Forti P, Lucicesare A, Pisacane N, Rietti E, Patterson C. Development of an easy prognostic score for frailty outcomes in the aged. *Age Ageing* 2008;37:161–6.
8. Pialoux T, Goyard J, Lesourd B. Screening tools for frailty in primary health care: A systematic review. *Geriatr Gerontol Int*. 2012;12:189–97.
9. de Lepelire J, Degryse J, Illiffe S, Mann E, Buntinx F. Family physicians need easy instruments for frailty. *Age Ageing* 2008; 37:484.
10. van Kempen JA, Schers HJ, Jacobs A, Zuidema SU, Ruikes F, Robben SH, et al. Development of an instrument for the identification of frail elderly as a target population for integrated care. *Br J Gen Pract*. 2013;63:225–31.
11. Easycare: A new world for older people (Internet). Instruments; (4 screens). Available at: <http://www.easycare.org.uk/instruments> (accessed 27 May 2013).
12. Perry M, Melis RJ, Teerenstra S, Draskovic I, van Achterberg T, van Eijken MI, et al. An in-home geriatric programme for vulnerable community-dwelling older people improves the detection of dementia in primary care. *Int J Geriatr Psychiatry* 2008; 23:1312–9.
13. Olde Rikkert MG, Long JF, Philp I. Development and evidence base of a new efficient assessment instrument for international use by nurses in community settings with older people. *Int J Nurs Studi*. 2013;50:1180–3.
14. Teddlie C, Yu F. Mixed methods sampling: A typology with examples. *J Mixed Methods Res*. 2007;1:77–100.
15. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res*. 2005;15:1277–88.
16. Easycare: A new world for older people (Internet). About. (2 screens). Available at: <http://www.easycare.org.uk/about/> (accessed 8 May 2013).
17. Easycare: A new world for older people (Internet). International. (1 screen). Available at: <http://www.easycare.org.uk/international> (accessed 8 May 2013).