

**UNIVERSITY OF SOUTH FLORIDA
GERIATRIC WORKFORCE
ENHANCEMENT PROGRAM
(GWEP)
FACULTY
DEVELOPMENT
MASTERWORKS
SERIES**



Kathryn Hyer, PhD, MPP
Principal Investigator



Providers of
Continuing Education

For additional information about this and other USF GWEP offerings, email amaynard@health.usf.edu

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health & Human Services (HHS), under grant #U1QHP28739, **USF Geriatric Workforce Enhancement Program** for \$2.24 M. This information or content and conclusions are those of the presenter and should not be construed as the official position or policy of, nor should any endorsements be inferred by, HRSA, HHS or the U.S. Government.

Evaluation of the Older Patient

BRUCE E. ROBINSON MD MPH

CHIEF OF GERIATRICS,

SARASOTA MEMORIAL HOSPITAL

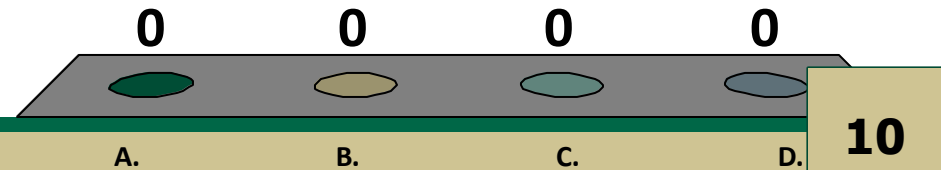


Objectives:

1. Describe the opportunities for improving efficiency in the comprehensive evaluation of older persons
2. Discuss the role of comprehensive assessment in developing clinical expectations
3. Understand the role of the clinician in facilitating good choices for care

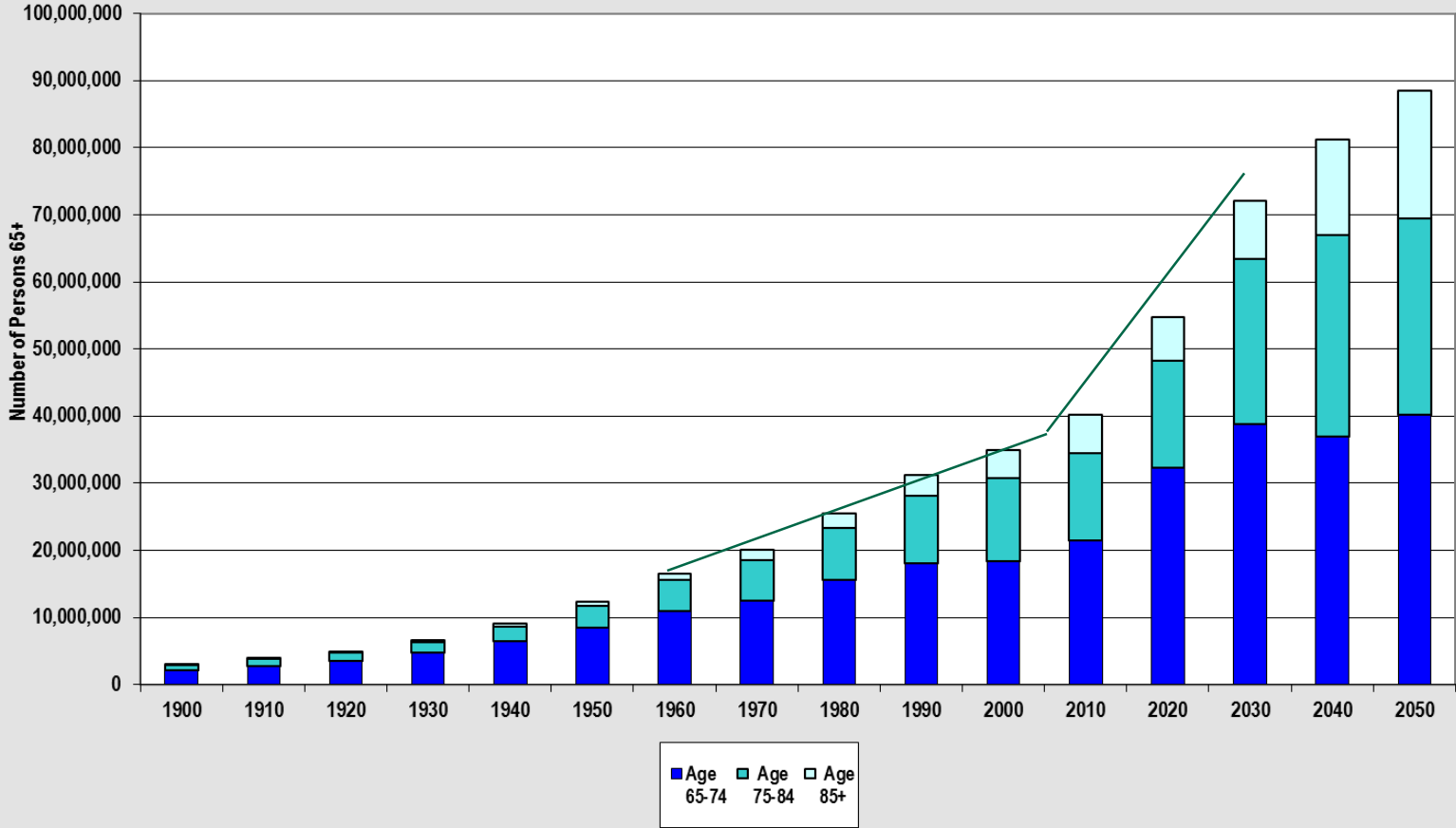
Why do Irishmen put nails in coffins?

- A. For necessary structural reinforcement
- B. For exercise
- C. They are cheaper than other fasteners
- D. To keep doctors out



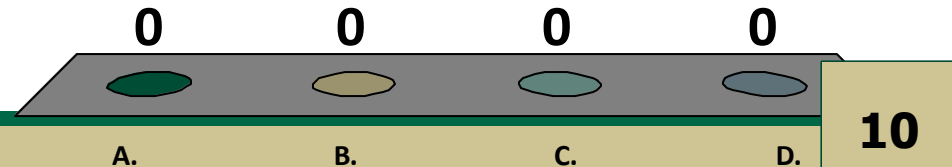
Population 65+ by Age: 1900-2050

Source: U.S. Bureau of the Census

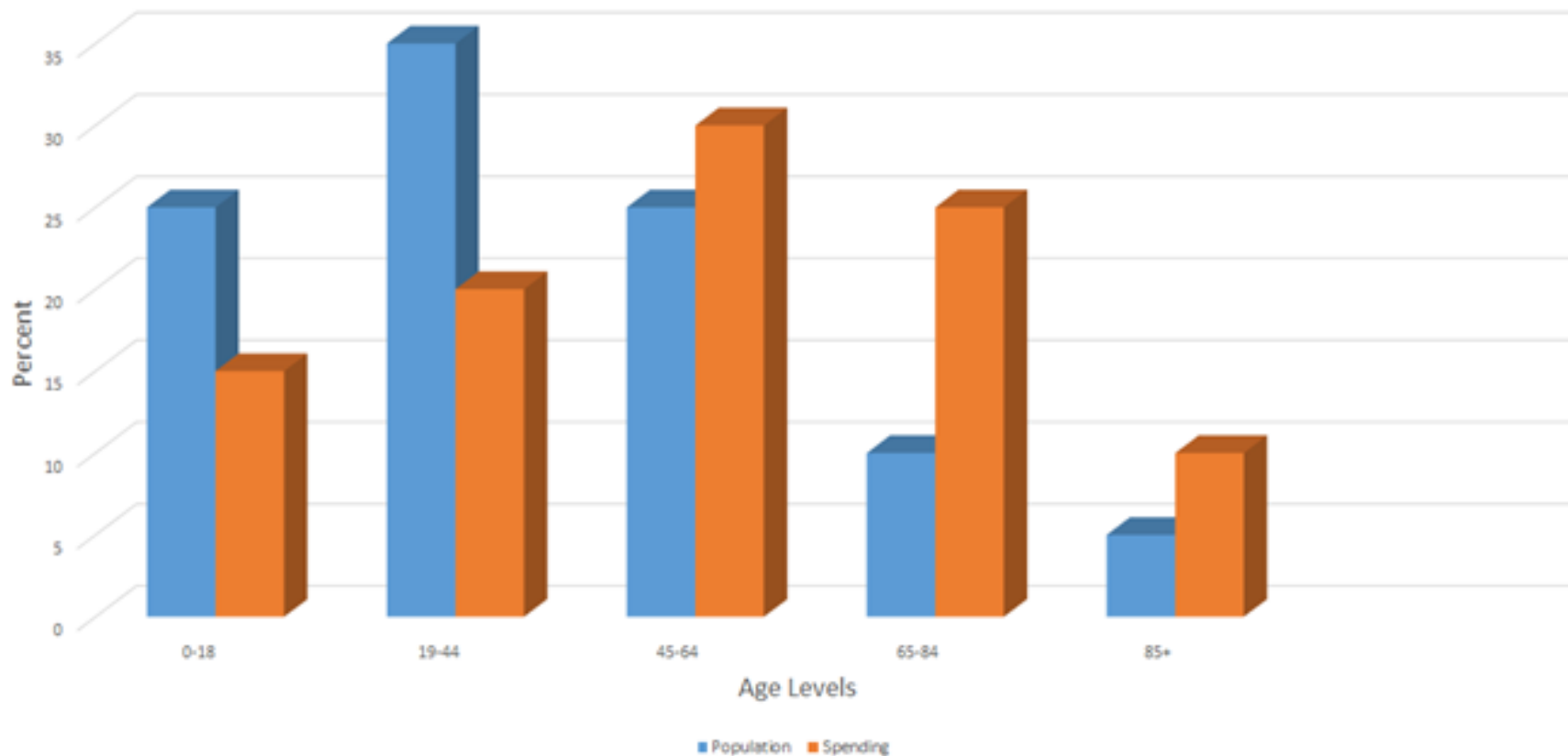


The major reason for the change in the growth slope of the aging population is:

- A. Decreased death rate from cardiac disease
- B. Advances in public health with reduced deaths from infectious disease
- C. Increased birth rate in the late 1940's and 50's
- D. Increased birth rate in the late 1960's and 70's

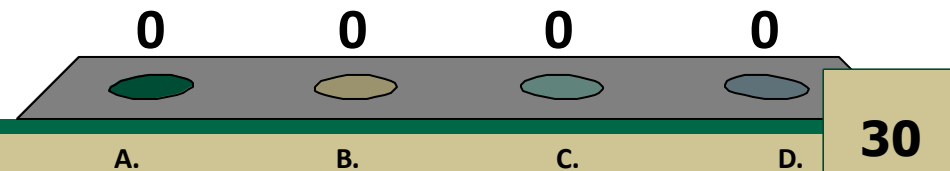


Shares Of The US Population And Personal Health Care Spending, By Age Group, 2010



Over the next thirty years, if no dramatic changes in utilization occur, which statement best describes projected healthcare costs:

- A. Gradual increase in spending across all age groups
- B. Dramatic increase in spending for those over 65
- C. Slow reduction in spending for those over 65
- D. Gradual decrease in overall healthcare costs



Characteristics of Older Patients in health care settings

Older

- Chronic
- Multiple
- Illness
- Self-care
- Care
- Lost the book
- Life enhancing

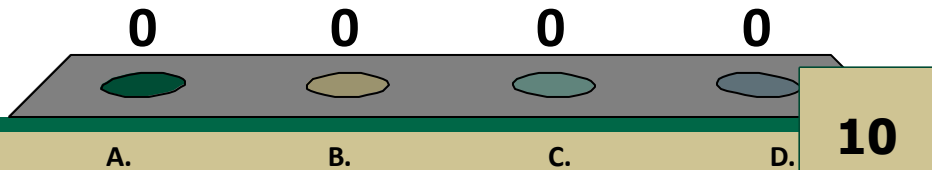
Younger

- Acute
- Single
- Disease
- Prof care
- Cure
- Wrote the book
- Life prolonging

Any correct decision for a frail older person requires understanding that person in multiple specific dimensions, with the depth of understanding determined by the clinical question

In your most common practice setting, how much face time do you have to evaluate a new older patient?

- A. Less than 20 min.
- B. 20-39 minutes
- C. 40-59 minutes
- D. Over 60 minutes



Bedside Geriatric Assessment

An 88 yo woman (Mrs. M) is hospitalized following a trip over a pet with a non-displaced multi-part fracture of the left femoral neck. She has a history of hypertension, borderline diabetes and osteoporosis. Her daughter at the bedside states that her medicines are lisinopril, calcium with vitamin D, and hydrochlorothiazide.

Bedside Geriatric Assessment



- **Can you outline the major areas of assessment you should include in your evaluation?**
- **Do you have a repertoire of “moves” for obtaining the necessary information for effective care?**
- **(Can you do all that is needed in 20 minutes or less?)**

Comprehensive Geriatric Assessment the gold standard

Multidisciplinary clinical process

Identifies opportunities and expectations for interventions

- Medical
- Psychological
- Social
- Functional

Develops a plan

Goal of optimal health

CGA: Targeting

Advanced age

Functional impairment

Geriatric Syndromes: confusion, falls, immobility, incontinence, depression, wt. loss, weakness

Hi utilization: CHF, Cancer

At time of transition

CGA: Gold Standard

Domain

General physical

Drug regimen

Oral health

Nutrition

C-P reserves

Cognition

Affect

Social resources/goals

Function

Criterion

Physician H&P, specialists

Physician/pharmacy

Dentist

Dietician, anthropometrics, labs

Exercise testing

Neuropsychologist

Psychiatrist

Social worker

PT/OT/SLP

Choosing an Assessment Method

- Domains
- Goals
- Accuracy and precision
- Setting (time, personnel)
- Population
- Examiner

Assessment Techniques

Clinical (usual care)

- Advantages: flexible, efficient, superior in expert hands
- Disadvantages: variable quality/examiner dependent

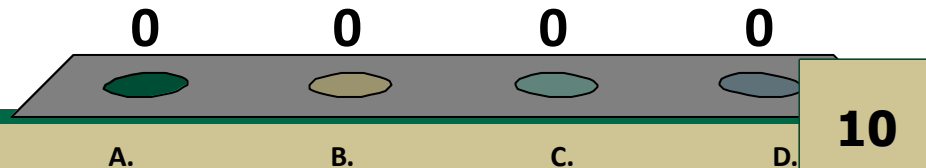
Assessment Tools

- Advantages: reliable, valid, consistent, less examiner dependent
- Disadvantages: less efficient

Performance vs. report

Which of the following is **NOT** a performance measure?

- A. Katz ADL scale
- B. Folstein Mini-mental Status Examination
- C. Timed up and go
- D. Gait speed



Obstacles to Effectiveness

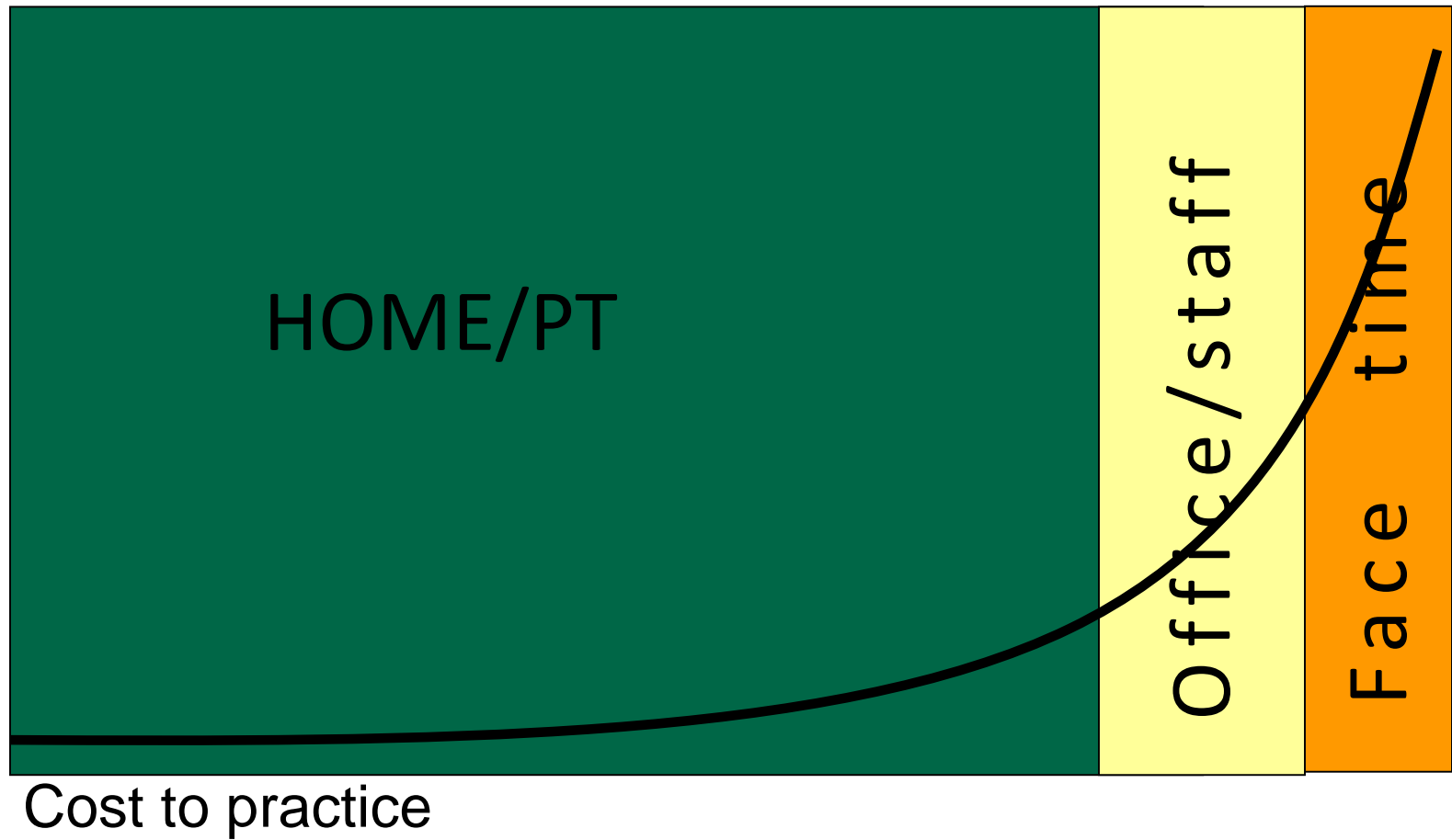
TIME

TIME

TIME



Time and Money



Ex. Cognition and the MMSE

MMSE offers good sensitivity/specificity to Alzheimer's dementia with a 15 minute investment in time

Widespread understanding of score

Performs poorly in non-Alzheimer's dementia

Insensitive to MCI

Inefficient compared to clinical eval by expert

Multidimensional Assessment

Physical health: problems, diseases, treatments, endurance, pain, organ function, sensory, dental, nutrition

Mental health: cognitive, affective, behaviors

Social resources/satisfactions: caregivers, money, philosophy/goals

Functional abilities: gait (falls?), ADL, IADL, continence

Finding your right questions

Excellent assessment tools for every issue can be found on-line with validated questions

You can choose tools/questions to fill gaps, improve efficiency

Google “Geriatric Assessment” and explore the libraries, web sites and individual tools for use, or for questions to include in your personal clinical toolbox

www.pogoe.org holds many and varied tools

Portal of Geriatrics Online Education

RAPID ASSESSMENT OF OLDER PATIENTS IN THE EMERGENCY DEPARTMENT

A Manual for Emergency Medicine Residents

**The Stealth Geriatrician: How to find out
what you need to know from your
patients**



**CHAMP (Curriculum for the Hospitalized
Aging Medical Patient) Evaluation
Instruments For Residents**



IOWA GERIATRIC EDUCATION CENTER

IOWA GERIATRIC EDUCATION CENTER

Geriatric Assessment Tools are a standardized means of obtaining information as part of a comprehensive assessment visit. Assessment tools enable the practitioner to efficiently evaluate a person's current level of function, cognition, and safety. Examples of tools are organized into the following categories. Click on the appropriate category for a menu of tools.

The assessment tools can be viewed and printed. Viewing and printing require Acrobat Reader, a free download from Adobe Systems. Click on the logo if you do not already have Acrobat Reader.

Assessment Tool Categories

[Caregivers](#)

[Dementia and Delirium](#)

[Depression](#)

[Functional Assessment / ADLs](#)

[Gait and Immobility / Fall Risk](#)

[Nutrition / Weight Loss](#)

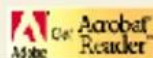
[Oral Health](#)

[Pain](#)

[Pressure Ulcers](#)

[Sensory Perception](#)

[Urinary Incontinence](#)



Our intent is to provide education about tools that our colleagues in geriatrics have developed. Comments and feedback may be directed to geriatric-education@uiowa.edu. Full citation information is provided with each tool. Requests for specific uses/specific tools should be directed to the author(s) listed within the tool.

The Warning Signs of poor nutritional health are often overlooked. Use this Checklist to find out if you or someone you know is at nutritional risk.

DETERMINE YOUR NUTRITIONAL HEALTH

Read the statements below. Circle the number in the "yes" column for those that apply to you or someone you know. For each "yes" answer, score the number in the box. Total your nutritional score.

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Total Your Nutritional Score. If it's –

- 0-2 Good! Recheck your nutritional score in 6 months.
- 3-5 You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.
- 6 or more You are at high nutritional risk. Bring this Checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition. Turn the page to learn more about the Warnings Signs of poor nutritional health.

These materials are developed and distributed by the Nutrition Screening Initiative, a project of:



AMERICAN ACADEMY
OF FAMILY PHYSICIANS
THE AMERICAN
DIETETIC ASSOCIATION
THE NATIONAL COUNCIL
ON THE AGING, INC.



The Nutrition Screening Initiative • 1010 Wisconsin Avenue, NW • Suite 800 • Washington, DC 20007
The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.

MORPHING

YOUR

MOVES

Physical Health Assessment

The History & Physical Plus!

- Endurance/exercise capacity (stairs, shopping)
- Vision/hearing (performance)
- Oral health (hard to eat?)
- Nutrition (wt. loss or gain)
- Continence
- Pain
- Medications- include supplements, OTC

Mental Health Assessment

Cognitive function

- Screen- CDT, temporal orientation, 3 item recall
- Tools- MoCA, MMSE, FAQ
- Criterion- neuropsychological assessment

Affect

- Screen- “Sad or depressed”, “do for fun?”
- Tools- GDS, PHQ
- Criterion- psychiatric interview

Social Resources and Satisfaction

Social resources

- Caregivers- “who can help you when you’re sick”
- Money- “enough for the little things that make life worth living”

Social satisfactions

- Advance directives?
- Goals for care
- Context specific- target choices on the table

Functional Abilities

Domains- mobility, ADL, IADL, continence

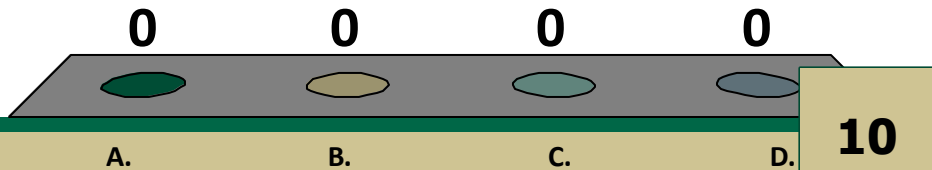
Performance screen- evaluate elements: cognition, gait, hand/arm ROM and strength, coordination (grip, writing, hands behind head)

Self-report scales: Katz ADL, PSMS, IADL

Criterion- formal PT/OT evaluation

When you walk in the room, which area should be first assessed in a previously unknown older patient?

- A. Cognition and senses
- B. Heart and lung sounds
- C. Area of primary pathology
- D. Gait



Mrs. M: Where to Start

Use questionnaire/team to gather background information (before you enter) Family can help

Brief Cognitive Screen- tool vs clinical

- How old are you?
- Can you tell me what month it is now?
- 3 item register/serial 3's/recall

Consider cognition, hearing, vision and communication early

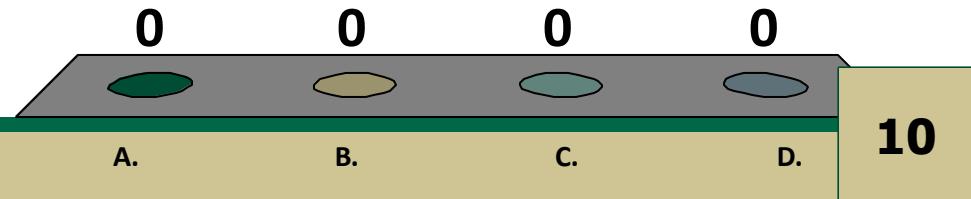
You ask staff to get her daughter. Mrs. M reads your name/title off of your nametag

Mrs. M states that her age is 89 (its 88), correctly identifies the year but misses the day of the week. She registers 3 objects on two tries, but quickly runs into trouble subtracting 3's- she loses her place twice, and stops. She recalls none of the items registered. She then drifts off to sleep

She received 4 mg. of IV morphine on arrival at the ER 30 minutes ago.

This patient's mental status exam best supports a diagnosis of:

- A. Dementia
- B. Mild cognitive impairment
- C. Delirium
- D. Depression



Delirium and Dementia

Delirium: acute change, inattention, one of disorganized thinking or altered LOC

- 3D CAM: 3 minute interview, rating for delirium presence and severity

Dementia (Major Neurocognitive Disorder): impairment in one major cognitive domain in pt. **not** delirious

- FAQ: informant screen for dementia using cognitively demanding IADL's for rating

Confusion Assessment Method (CAM)

1. Acute change/fluctuating course

- Report, or disorientation, fluctuations in LOC

2. Inattention

- Digits backwards, DOW backwards, serial 3's

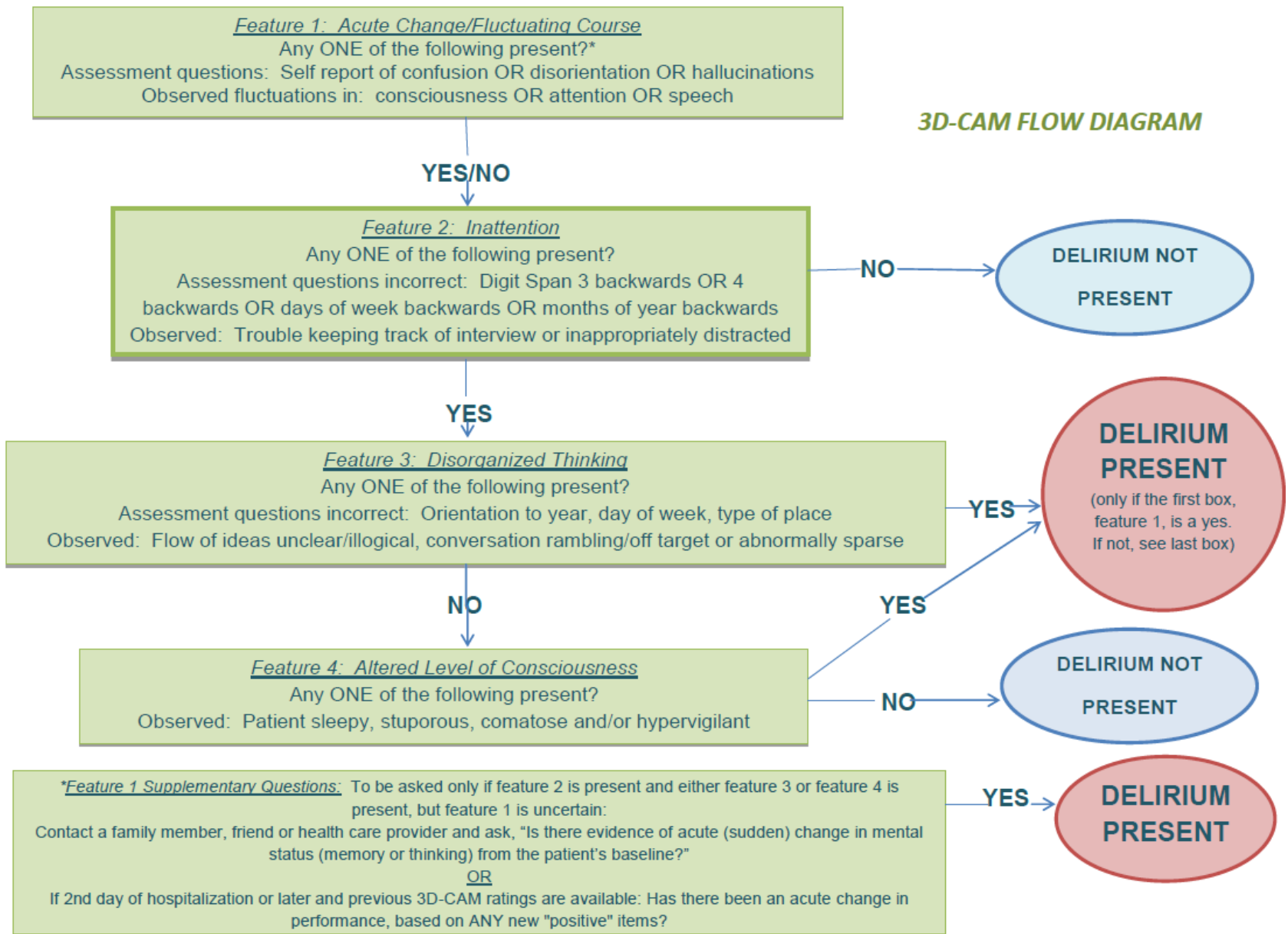
3. Disorganized thinking

- Flow of ideas illogical, rambling, sparse

OR altered level of consciousness

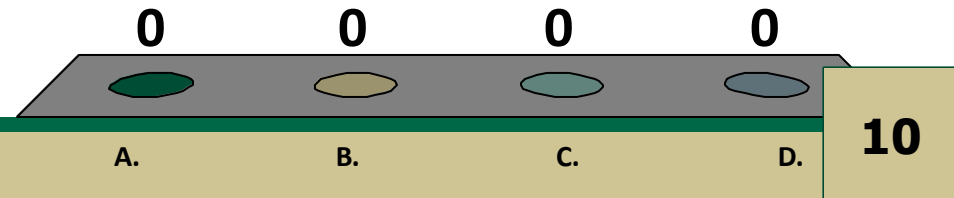
- Stuporous, comatose, hypervigilant

3D-CAM FLOW DIAGRAM



Assessing the likelihood of pre-existing dementia in Mrs. M would be best done through items from the:

- A. Folstein Mini-mental State Examination
- B. Montreal Cognitive Assessment (MoCA)
- C. Functional Assessment Questionnaire
- D. Mini-Cog



Family Report: Patient Behavior

The information provided in this questionnaire helps the doctor decide if an important memory problem is present. **It should be filled out by someone with close, frequent contact with the person with the memory problem.** Answer all questions to the best of your knowledge. If the person does not ever do the activity described, circle the answer that is your best guess as to what the person **could** do.

**The name of
the person is:**

Mrs. Smith

1. Does the person sometimes have trouble writing checks, paying bills, or balancing a checkbook?

unable

needs help

has trouble, but able

normal

2. Does the person sometimes have trouble assembling tax records, business affairs, or papers?

unable

needs help

has trouble, but able

normal

Bedside Assessment

Domain

General H&P

Drug regimen

Oral health/swallow

Nutrition

C-P reserves

Cognition

Affect

Social resources/goals

Function

Continence

Measure

QP-Usual, plus sensory, fall hx.

Q-Med list P-bag-o-drugs review

P-Note dentition, Q- query prob.

Q-Wt. change, #meals P- BMI, Alb

Q-Walk a block, climb stairs

P-Time, 3 items/recall, serial 3, IADLs

Q-Sad or depressed?

Q-Help when sick? LW/DNR?

P-gait, UE ROM/grip Q- ADL's

Q- Problem controlling urine?

Building Your Clinical Assessment Skills

Keep the outline of your targets with you (in your head?)

Have a starting strategy for each health issue

Develop your clinical intuition regarding depth of assessment: the Willie Sutton principle. Use team members when appropriate.

Let screening answers drive next questions

Learn how questions perform in research and practice

Mentally audit your performance, target issues for further evaluation by you or team

Preventing Problems

Start with “How can I help you today”

Encourage lists: problems, symptoms, medicines, treatments

Smile and redirect!

Encourage family attendance, particularly with cognitive weakness

Make decisions early regarding the agenda for the visit

Don't be afraid to take charge, kindly!

Script your exit, for when you're out of time

Face Time: Priorities

Building your relationship

- I have time for you
- Body language (take your own pulse)

Physical examination (touch!)

Medical Decision Making

- Organizing future evaluations

High priority communications

- Diagnosis, treatment, targets of education

Meta-assessment

Consider your common sites of practice:

- Location
- Available tools (EMR)
- Available personnel
- Usual patients
- Time issues
- Critical data elements: if you always need it, never ask it

Consider the targets of comprehensive geriatric evaluation

What do you often miss, or struggle to obtain?

How can you improve your quality/efficiency

Multidimensional Assessment: Next steps for Mrs. M

Physical health: problems, diseases, treatments, **endurance**, pain, organ function, sensory, dental, **nutrition**

Mental health: cognitive, **affective**, behaviors

Social resources/satisfactions:
caregivers, money,
philosophy/goals

Functional abilities: gait (falls?),
ADL, **IADL**, continence



You give the daughter a Functional Activities Questionnaire and general health history to complete while you complete the exam.

Normal vital signs and a weight of 173 pounds (height 65 inches) are noted. Mrs. M has a partial denture, with good oral hygiene and no gum inflammation. She follows one step commands but loses track of more complex requests. She briefly dozes during the exam. She has good grip strength, and can grasp her hands together behind her head. Her cardiac, pulmonary and abdominal exam are normal. Feet are warm, with normal pulses and no edema. She is comfortable and denies pain.

Her daughter lives about 40 minutes away, and describes the patient's prior living situation. Mrs. M lives alone and performs all ADL's without assistance. The FAQ score is 8.

Mrs. M's daughter states she has been cheerful and active with her church. Mrs. M has put on about 20 pounds over the past year, with a diet heavy on sugar and ice cream. She seems more out of breath when she takes her shopping. Her mother no longer drives, after trouble finding her way home. The daughter recently took over paying the bills because of a problem with the electric bill that almost resulted in interruption of service. A housekeeper was also recently hired, for cause.

A living will has been completed. Her daughter states that her mother has very strong, negative feelings about nursing home from an experience with her mother, and has often said she would rather die than live in one. Her mother lives off of her social security and a small pension from her husband. The daughter works full time with no option for more than a few days time off to care for mother.

Mrs. M Problem List

Hip fracture

HTN, diabetes

Cognitive impairment

- Delirium
- MCI/mild dementia?

Nutrition: Obesity/erratic diet

Poor C-P fitness, deconditioning

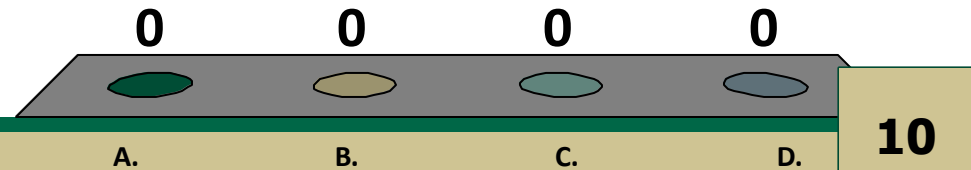
Pre-morbid IADL dependence

Crisis of support

The daughter says that the surgeon discussed the planned surgery. A hip arthroplasty was mentioned, but at the end of the discussion he proposed a pinning because of her age and poor fitness. She would remain non weight-bearing for some weeks after pinning, and would not be allowed to full weight bear for six to eight weeks. The daughter agreed with the surgeon's plan.

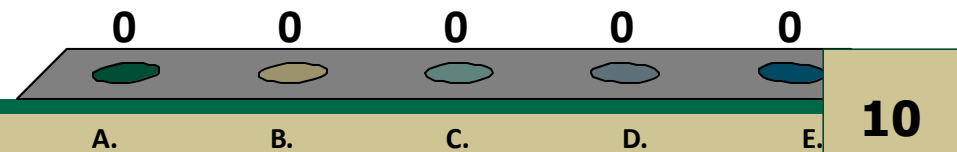
Which is true regarding SNF care for Mrs. M after hip surgery?

- A. However things go, she is allowed to stay 100 days under Medicare
- B. The duration of her covered stay depends on progress in rehab
- C. She will need to pay \$144 per day out of pocket for her stay
- D. If she needs to pay privately, nursing homes cost about \$100 a day



What outcome would you expect of six weeks of non or limited weight bearing in this woman?

- A. To NH, returns home when six weeks are up
- B. To NH, returns home alone after two weeks, on partial weight bearing
- C. Home is sold to pay for NH care when she plateaus in therapy after two weeks, because of inability to keep wt. bearing restrictions in mind
- D. Becomes depressed in NH, stops eating and dies
- E. C and D



Developing Clinical Expectations: Decision Elements

Medical facts: treatment choices, clinical expectations of each choice (benefits, burdens)

Goals/philosophy: what is burdensome, what is worthwhile (how do we weigh the expectations of each choice)

Is death the enemy?

Autonomy: requirements

Intention: planned, deliberate, conscious

- Not true for serious healthcare decisions
- Decisions often impulsive, not deliberate

Understanding: able to acquire and use substantial information on foreseeable outcomes and consequences

Absence of controlling influence

- Internal or external

Obstacles to Informed Consent

Complexity

Lack of Familiarity with decision processes

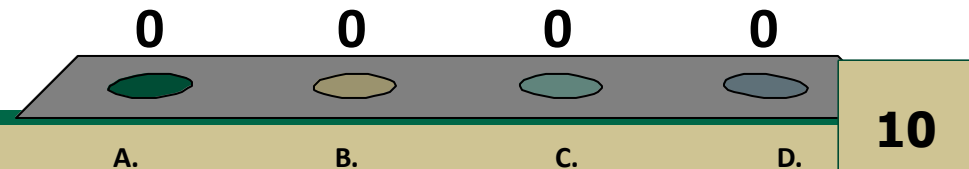
Uncertainty (understanding and using in decisions)

Emotional obstacles

Proxy biases

How should consent for hip pinning be approached?

- A. Ask the patient
- B. Ask the daughter
- C. Ask the doctor
- D. A, B and C




Decision= f (facts*philosophy)

NWB*poor cognition= long/ineffective
rehabilitation

Long rehab * no family support =
nursing home

Nursing home * rather be dead = ???

Meta-decisions: models



Model	Values/Goals	Medical intervention
Paternalism	Physician	Physician
Fauxtonomy	Physician	Patient
Full autonomy	Patient	Patient
Agent	Patient	Physician
Collaborative	Shared	Shared

Fauxtonomy (fō-ton-a-mē)

Faux (French, false)

Choices which fail to approach the criterion of the ideal combination of patient goals and a principled exploration of the medical facts

Often derived from provider bias which shapes the presentation of the medical facts, aimed at obtaining the choice preferred by the provider

Principled Exploration of Facts ?

CPR requires hundreds of hard thrusts to your chest, often breaking ribs, painful electrical shocks, and blowing air into your nose, mouth and stomach causing frequent vomiting and breathing in your vomit. You may be awake while all of this occurs. After CPR most people die after spending some time on machines.

Would you like us to do that to you?

“Providers should not quietly accept a decision by/for a patient which is unlikely to achieve the patient’s goals”

Managing difficult decisions

- before meeting, gather all necessary information: health condition and the range of outcomes of the choices on the table
- get as many of the interested parties as practical in the room, or on the phone. Include the patient, even if impaired
- ask patient/family about situation prior to illness/injury, including activities, interests, happiness, quality, problems, suffering
- provide a description of the medical facts: physiologic data, choices, modifying factors, benefits/burdens of each (include doing nothing/AND)
- ask the patient/family about goals and priorities- quality/quantity, willingness to struggle, willingness to die, etc.
- don't be afraid to offer a choice if you see one that best fits the goals

After discussion with patient and family, you approach the surgeon with the suggestion of a total hip that will allow full weight bearing immediately post-op. The surgeon agrees. Mrs. M's post-op course is marked by delirium, some atelectasis that resolves with nebulizers and chest physiotherapy. On the fifth day she is transferred to a rehabilitation hospital where three weeks of therapy achieve independence in ADL's and continence.

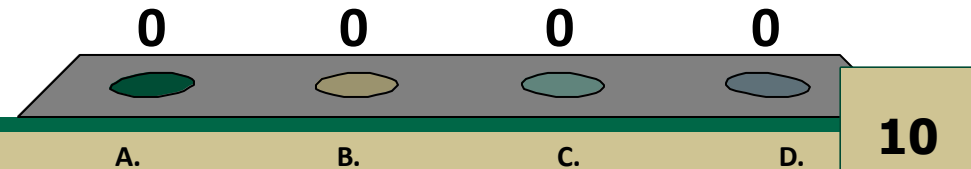
Home nursing and therapy are provided. Her daughter arranges a few days off, and helps her get settled back in her home.

Four months later she remains at home and has resumed her usual functional and social activities. A full cognitive assessment finds borderline impairment in memory.



In my own evaluation of frail older patients, I:

- A. Always assess in the critical domains of physical health, mental health, social resources, goals of care and personal function
- B. Often find my evaluation has missed one or more elements critical to developing clinical expectations
- C. Rarely see the need for evaluation in areas other than my primary interest
- D. Don't have the time to worry about this stuff



Objectives:

1. Describe the opportunities for improving efficiency in the comprehensive evaluation of older persons
2. Discuss the role of comprehensive assessment in developing clinical expectations
3. Understand the role of the clinician in facilitating good choices for care