

Winter August 2012

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Rappaport Musson, Judith B. (2012) "Comprehensive Geriatric Assessment: Assuring Appropriate Medical Treatment and Improving Quality of Life," *Marquette Elder's Advisor*. Vol. 4: Iss. 3, Article 2. Available at: <https://scholarship.law.marquette.edu/elders/vol4/iss3/2>

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Comprehensive Geriatric Assessment: Assuring Appropriate Treatment and Improving Quality of Life

By Judith B. Rappaport Musson

The Comprehensive Geriatric Assessment (CGA) is an effort by an interdisciplinary team of professionals whose goal is to advocate for elder patients and help restore them to optimum health and functionality. This article presents an analytic look at this powerful and underused tool.

Years ago, I read the following statistic: “In 1901, there were more blacksmiths than physicians in the United States.” Although the source is long gone from my files, I continue to use the comparison to remind myself and others how often we miss the medical mark on assessing and treating our elders’ needs. I suspect that in 2002, more than a century later, there still may be more blacksmiths in the United States than there are geriatric physicians—and that’s where the problems begin.

Imagine that your seventy-five year-old parent or client visits her regular physician with a bruised knee. Her physician is dedicated and caring, but is

not a geriatric specialist. The physician will probably examine the seventy-five year-old woman in the same manner he would examine a forty-five year-old with the same symptoms: he will X-ray her knee, smile, and tell her, “Good news, Mrs. Jones, it’s just a bruise. Nothing is torn or broken.”

Without special training, and with the time limitations most physicians now impose on their patients, his next step will likely be to quickly write two prescriptions and tell her, “These will reduce the inflammation and ease your pain. If you don’t feel better in five or six days, call me.” The physician will move on to his next patient, pleased that his patient wasn’t seriously hurt and content in the knowledge that he has sent her home to heal just as he has done with hundreds of other patients. But has he?

In reality, his lack of understanding of the process of aging may have actually increased her risk for further injury. It may be unnecessary to investigate the cause of a forty-five year-old patient’s bruised knee, but it is vitally important to detect, assess, and treat the root cause of an elder’s symptoms and to evaluate the potential risks the patient faces because of the problem. In many cases, adding two more medications to the four to six medications the seventy-five year-old may already take will create its own risk potential. Increasing medication intake to six to eight per day may significantly add to the possibility of an adverse drug reaction, which may increase the patient’s risk of falls and hip fractures, have a serious impact on cognitive function, or even result in death. At least 25% of older adults living independently take the wrong prescription medicines, placing them at risk for adverse effects such as

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nervousness, confusion, memory loss, and depression.¹ Researchers estimate that 23.5% of all older persons in community settings received at least one potentially inappropriate drug—one-fifth of these used two or more harmful drugs and some used as many as five.² These two preceding estimates consider only the prescribing of potentially dangerous drugs, not harmful interactions. Consequently, their conclusions represent just the tip of the iceberg.³

Think back to the seventy-five year-old client who visited her physician for assistance with her bruised knee. A skilled geriatric physician would try to relax the seventy-five-year-old patient, see to her comfort, and then begin trying to determine whether her bruised knee might have been caused by a decline in her vision that might have caused her to bump into furniture. In the future, her poor vision might also cause her to miss a step and fall down a flight of stairs and could easily lead to life-altering or deadly consequences when she gets in her car to drive home from the doctor's office. The client could also have bruised her knee because of shuffling steps (rather than lifting feet up and putting them down). Shuffling steps can be an indication of Parkinson's or Alzheimer's disease. Or, she might have become dizzy and fallen from adverse medication reactions, low blood pressure, a heart attack, or a mini-stroke.

The truth is, most of the time we never know if Mrs. Smith's bruised knee might have been caused by a simple everyday accident, self-neglect, or physical abuse. Elderly patients who might be successfully treated and returned to a reasonable quality of life are instead inaccurately diagnosed, chronically overmedicated, and habitually inappropriately placed in Alzheimer's facilities or other types of nursing homes—without ever having had access to the restorative care that might help them regain their dignity and quality of life.

In the current medical climate, the comprehensive geriatric assessment may be the only tool that allows professionals the time to search out the information that is necessary for appropriate treatment and to effectively combat the erroneous assumption that we should treat illness and disease as a part of growing older. "Age is not an excuse for a lack of medical attention. 'At her age, what do you expect?' is not a diagnosis, it is ageism and

it's wrong."⁴

Here's a look at the current situation:

Fact: Americans over the age of sixty-five represent over one-half of physician visits annually.

Status: Only a tiny percent of healthcare professionals have any formal geriatric training to provide optimal care for their older patients.⁵

Fact: Adverse Drug Reactions (ADRs) account for up to 140,000 deaths annually in the United States.⁶

Status: Of the nearly 200,000 pharmacists in the United States, only 720 have geriatric training.⁷

Fact: In 2002, Medicare reduced fees paid for each medical service by 5.4%; fees are scheduled for a total reduction of 17% from 2002 to 2005.⁸

Status: By 2004 the United States is expected to have as few as 6,100 physicians (out of 650,000 currently licensed) certified in geriatric medicine. To adequately meet the elderly population's need, the United States should have 20,000 geriatric-trained physicians.⁹

What would life be like if professionals who served the elder community could access a medically accepted, clinically proven, readily available, comparatively inexpensive tool that could help safeguard their parents and clients from many errors or omissions in a healthcare system where less than one percent of doctors have geriatric training?¹⁰ The answer, of course, is that elders and their caregivers would find their emotional, physical, and financial quality of life improved beyond any levels we or they can imagine. If that sounds like an exaggeration, it isn't; if anything, the benefits have probably been understated.

Comprehensive Geriatric Assessment (CGA) Explained

This life-altering tool is called the comprehensive geriatric assessment (CGA). CGA is a joint effort by an interdisciplinary team of licensed professionals who are totally focused on intervening and

advocating for the patient, with the goal of restoring the patient to a functional medical, psychological, social, and environmental quality of life. The team includes a doctor who is a geriatric specialist or a primary care physician, a professional geriatric care manager who is a registered nurse and/or a social worker with advanced certifications, an elder law or trust and estate attorney, a financial consultant, a physical therapist, and when necessary, a nutritionist and a guardian of the person or property. If a geriatric physician is not available, the geriatric care manager leads the team and liaisons with the primary care and other physicians. Because many areas do not have the benefit of a geriatric physician, this article focuses on the benefits of the CGA when the team coordinator is a geriatric care manager.

The team creates a “multidisciplinary evaluation in which the multiple problems of older persons are uncovered, described, and explained ... and in which the resources and strengths of the person are catalogued, need for services assessed, and a coordinated care plan developed to focus interventions on the person’s problems. In addition, CGA will help in determining appropriate use of potentially harmful diagnostic and therapeutic interventions, in monitoring outcomes of illnesses and treatments, and in making prognostic statements in the planning for long-term care.”¹¹

I’m far from alone in my admiration of CGA’s power as a preventative and restorative tool for medical and quality of life needs. The American Geriatrics Society states:

A growing body of literature documents that frail elderly patients benefit from GA (Geriatric Assessment) when it is linked to follow-up programs. Beneficial outcomes include:

- Improved diagnostic accuracy
- Improved living environment
- Improved functional and mental status
- Reduced medications
- Decreased use of nursing home and acute care services
- Prolonged survival
- More appropriate health care services
- Generally reduced health care costs

- ...the vast majority have shown significant positive impacts.¹²

In a separate position paper, the American Geriatrics Society concludes:

- Practicing physicians should be encouraged to utilize the expertise of other disciplines that deal with the functional integrity of these patients through the application of CGA.
- ...elements of CGA should be incorporated into the acute and long-term care provided to elder individuals.
- ...principles, procedures, and applications of CGA should be a priority for all public and private healthcare funding agencies.
- ...[the] comprehensive geriatric assessment should be an integral part of the curriculum for all medical training programs.¹³

How the CGA Does Its Job

The frail elderly have complex medical, psychological, and social needs that must be addressed simultaneously for individual treatments to succeed. Because of this, interdisciplinary teams are more effective in assessing patient needs and creating an effective care plan than are professionals working alone. The benefits extend past the elderly patient to the caregivers, whose strengths and needs can be incorporated into the care plan.¹⁴

The team members’ special training often allows them to spot areas of concern that the family is not aware of. The benefit of a professional geriatric assessment is that it promotes problem-solving and encourages proactive behavior. A professional assessor views the patient and the family with objectivity, and is thereby able to provide a sound, carefully thought-out care plan that targets the patient’s and family’s needs.¹⁵

The CGA is vastly different than those assessments performed in physicians’ offices, hospitals, nursing homes, or assisted living facilities. The following four points illustrate the differences:

1. The CGA is a one- to two-hour interview in the patient’s residence (private home, assisted living facility, skilled nursing home) where the patient is more relaxed and the assessor can

observe firsthand the patient's medications, nutrition, and ability to meet her own needs and care for herself in her own environment.

2. As opposed to one or more physicians—often working independently of one another to treat purely clinical problems—the CGA team's holistic sphere of influence includes anything and everything that affects the patient's daily life and ability to remain independent or function to maximum ability in his or her own home.
3. The CGA includes a care plan that designates a team member (often working in conjunction with a family or paid caregiver) to follow up and implement, monitor, coordinate, supervise, and adjust services to meet the elder's need; obtain and maintain appropriate medical care; ensure compliance with physicians' orders; and troubleshoot in all areas.
4. The goal of the CGA is not limited to treating medical problems, but also to restoring the elder to society with an improved quality of life and helping the elder live to his or her maximum level of independence.

The Importance of the In-Home Assessment

Assessing in the client's residence allows the geriatric care manager to view the elder's ability to live safely in his or her own home. Can she walk, rise from a chair or her bed? Can he cook, feed, medicate and toilet himself? Can she evacuate in an emergency? Can he dial a telephone number, see, or hear appropriately with his current telephone?

Many elderly people are able to present "up" in a doctor's office. When the doctor asks, "Do you live alone?" the patient may answer, "No, I live with my daughter, she's on vacation this week." If the answer were spoken in a normal tone, without testing for confabulation, few physicians would question the patient. If a daughter emphatically tells the doctor, "My mother never missed a meal in her life!", the physician may question that declaration, but accept it anyway without knowing that the daughter visits only twice a year, is in extreme denial, and still sees her mother as she was, not as she is. Without a home visit, the doctor

can neither protest nor prove that the mother has had only spoiled food in her refrigerator for the past eight months because she forgot how to cook or shop, or even what her refrigerator is for, and the only time she really eats is when her neighbor brings her food.

The in-home assessment gives the geriatric care manager an opportunity to peel away the denial and confabulations. The care manager can see firsthand how many people really live in the home, how well it is cared for, and what type and how much food is in the refrigerator. An inspection of the furniture and bedroom will reveal whether the person is continent and whether the furniture arrangement and lighting suggest a risk for stumbles or falls.

A chat with the caregiver and a review of the patient's medications in their original bottles will help expose duplications, inappropriate prescriptions, improper use, and expired labels. Where confusion or memory loss is present, an in-home visit frequently uncovers dosage problems such as more than one physician prescribing the same medication, elders who are taking medications that they don't need, or others who only refill one medication out of the two prescribed. The one they did not refill may be the one that neutralizes the confusion or dizziness caused by the other one!

Case History #1¹⁶

Mrs. Green's neighbors described her behavior as increasingly bizarre. Her niece also found her aunt's behavior increasingly confused and disoriented, and was concerned about the continued decline in energy and cognition of this previously vibrant, energetic, socially engaged woman. After Mrs. Brown was found wandering in the mailbox area of her apartment building insisting she was there to "do her wash", she was sent to the emergency room and admitted to the hospital with a diagnosis of dehydration and electrolyte imbalance. Mrs. Green's niece called a geriatric care manager to assess her aunt.

The nurse performed the assessment in three parts:

1. She visited Mrs. Green at the hospital,
2. She visited her independent living residence, and

3. She visited Mrs. Green in the skilled nursing health center of the continuing care community where she was sent after being discharged from the hospital.

Clinical assessments by physicians and the community stated that because of physical limitations and obvious dementia, Mrs. Green could no longer live independently and that she would remain a patient for custodial care in a nursing home for the rest of her life.

The nurse's visit to Mrs. Green's apartment indicated potentially severe complications related to the use of multiple prescription and non-prescription medications, including Risperdal to induce sleep (2 mg. taken twice daily); Paxil to relieve depression (30 mg. taken once daily); Ambien to induce sleep (5 mg. at bedtime); Vioxx for arthritic pain (25 mg. at bedtime); and Xanax to relieve anxiety (.25 mg. as needed).¹⁷ It was doubtful that Mrs. Green could comply with dosing instructions because of her declining cognitive status, but if she had followed dosing instructions, she might have become even *more* impaired due to adverse medication reactions. The community's physician, a psychiatrist, and a private attending physician had all seen and treated Mrs. Green.

The nursing home health center later discovered that Mrs. Green also had a diagnosis of post right thyroidectomy that required supplementation with Synthroid to maintain her thyroid function—however, there was no evidence of Synthroid in her apartment.¹⁸ The assessor's visit to Mrs. Green's apartment also revealed multiple packages of Depends® briefs and previously unmentioned evidence of incontinence.¹⁹

At the time of her hospital discharge, Mrs. Green needed assistance with all her activities of daily living. While she needed assistance to prepare her meals, she was able to eat her meals without assistance. Her weakened condition, poor balance, history of falls, and unsteady gait put her at risk for future falls. The use of psychotropic medications such as Xanax, Risperdal, and Paxil increased that risk.

Mrs. Green's other physical problems included the following:

- osteoporosis: diagnosed, but no current treatment or medication prescribed;

- right-sided hand tremor: undiagnosed, no treatment prescribed;
- poor nutrition: undiagnosed, no treatment prescribed;
- unsubstantiated complaints of constipation: the assessor suspected dehydration and electrolyte imbalance due to excessive laxative and enema use; and,
- fractured pelvis and hip replacement two years prior: difficulty walking due to pain from that injury, but no physical therapy or pain control evaluation prescribed.

In all, the assessment contained twenty-one different recommendations to further diagnose and treat Mrs. Green that had not been recommended prior to the care manager's investigation. An integral part of Mrs. Green's care plan was for her to establish a trusting relationship with a care manager who would monitor her progress, medical treatment, and care in the facility. In effect, the care manager would act as her "personal advocate." Unlike a nursing home, the care manager's goal would be to restore Mrs. Green as closely as possible to her previous level of health, independence, and quality of life. A recent Yale University study concluded that "[This] restorative approach to care appears to be both effective in maintaining or improving function and symptoms, in reducing the number of home care and emergency visits and potentially saving costs."²⁰

Under the care manager's direction, Mrs. Green's medications were reevaluated and she was treated for chronic pain. Mrs. Green also received physical therapy and strength training, which restored her ability to walk safely with the use of a cane and/or walker. She ate a well-balanced diet, her hydration was increased, a toileting routine was established to retrain her, and laxatives were limited to once each week.

At the end of five months, Mrs. Green moved out of the nursing center and into the assisted-living center in the community. It is doubtful whether she will ever return to her independent apartment, but her current status allows her to live semi-independently, without the services of a home care aid. She is currently continent, almost

pain-free, has excellent cognitive abilities, reads voraciously, socializes with friends, and travels outside the facility to restaurants, movies, and the theatre without problems.

The CGA provided the newly chosen coordinating physician with the detailed information that allowed effective treatment and prevented Mrs. Green from almost certainly living the rest of her life as a bedridden invalid in constant pain in a nursing facility filled with others living similar barren lives. There is no accurate tally of the financial savings, but at prevailing rates, we can safely estimate \$50,000-\$100,000 annually for nursing home care, and higher costs if her family decided to care for her at home.

If this sounds too fantastical, too simple, or too good to be true, read on. It happens every day, it is far from simple, and it is definitely true.

Case History #2

Mrs. Smith's attorney received a call from the life-care community she had resided in for several years. The community's representative stated that she had become physically and verbally abusive to the point of disrupting the lives of other residents. They described her behavior as totally out of control, and they were, in fact, giving verbal notice of their intent to evict her. In their capacity as health-care professionals, they recommended to the lawyer that she be declared incompetent and moved to a secure Alzheimer's facility or a psychiatric hospital for her own safety. Fortunately, the attorney relied on an interdisciplinary team of eldercare professionals to serve his clients. He called a geriatric care manager and requested a comprehensive assessment.

The care manager met with Mrs. Smith and confirmed that she was behaving as described. There was a home health aide in attendance. When the care manager audited Mrs. Smith's file at the community, the following information became part of her assessment:

1. Mrs. Smith, currently eighty-seven, had previously been a gentle woman who had always spoken softly and interacted well with other residents;
2. Approximately two years prior to the date of

the care manager's audit, Mrs. Smith's behavior became so bizarre that the community forced an examination by its house physician to evaluate and assess the problem;

3. The physician's notes provided, "Mrs. Smith is no longer capable of living independently or making sound decisions on her own behalf.";
4. There were no supporting details. The physician did not include a diagnosis nor did he refer Mrs. Smith for testing or treatment;
5. The home care aide reported that Mrs. Smith took no medications. When the care manager looked through the apartment, there were no medications found anywhere;
6. Mrs. Smith's home health service began the same day as that physician appointment. Since that time, she had received twenty-four-hour care, formatted into three eight-hour shifts, from a home care agency that had contracted with the community to supply services to residents;
7. It appeared Mrs. Smith, who in the doctor's own words, was "unable to make sound decisions on her own behalf" was the only source of approval for the home health service. The charge to Mrs. Smith had been \$15/hour or \$360 per day, plus holiday and weekend surcharges, for over two years;
8. After having spent more than \$266,450 on around-the-clock private duty care in the last two years, the only food in Mrs. Smith's apartment was spoiled macaroni and cheese;
9. The care manager asked the "life care" community why they proposed to evict Mrs. Smith instead of simply move her to their skilled nursing facility. The administrator replied, "Our nursing facility doesn't accept dementia patients." It is important to remember three points:
 - This happened in a life-care community where residents paid a fee, hoped to age in place, and believed they would be taken care of for the

rest of their lives;

- The Alzheimer's Association reports a 50% or more incidence of Alzheimer's-type dementia in elders over eighty-five years of age, so it should be have been obvious that the nursing area would need care for Alzheimer's-type dementia; and,
- If this woman had been without professional representation, as so many of our elders are, no one would have questioned the contract that denied her the care she undoubtedly thought she had purchased.

10. The care manager, a licensed healthcare professional, reported her findings and recommendations back to the attorney in the form of a care plan. Working with a professional guardian, they obtained emergency temporary guardianship so that Mrs. Smith could be adequately cared for. Because she worked as part of a geriatric-assessment team, the care manager was able to access her network to set an immediate appointment with a neurologist who specialized in cognitive disorders. She also hired a new home care team to care for Mrs. Smith, recommended a review of Mrs. Smith's contract to determine whether it excluded dementia in the nursing home, and investigate as to who authorized the expense for two years of home care after the facilities doctor declared her incapable of making sound decisions on her own behalf;
11. The neurologist reported that Mrs. Smith's behavior was not caused by Alzheimer's disease, but by a very curable urinary tract infection that had gone undiagnosed and untreated for years, and an easily managed vitamin B deficiency;
12. The geriatric team stayed in place and continued fulfilling the care plan until Mrs. Smith was well enough to continue without their supervision; and,
13. With ongoing proper care and supervision, Mrs. Smith was returned to her previously frail,

but non-demented state.

"It would be impossible to overestimate the value of an accurate diagnosis. [You] cannot create a realistic or appropriate care plan without one. An early diagnosis of many illnesses often leads to a cure and a complete recovery."²¹

The CGA helped save Mrs. Smith from what might have been a life of continuous fear and pain most likely lived out in a locked psychiatric unit. Instead, she was able to regain most of her previous quality of life, retain her dignity, and live to her optimum level of ability. We can only surmise that she also saved tens of thousands—if not hundreds of thousands—of dollars in nursing home fees.

Case History #3

Mrs. Porter, age eighty-five, lived alone in a one-bedroom apartment. After hospitalization for pneumonia, her primary care physician recommended that a home health aide visit her daily to cook her meals, provide transportation for pleasure outings (malls, church, or other activities), and for social interaction until she was well enough to resume these activities on her own. Mrs. Porter began to deteriorate. She became confused and forgetful, more than a little paranoid, and a total enigma to her primary care physician.

Without further testing, the physician diagnosed Alzheimer's-type dementia and advised her daughter that when there was an underlying dementia, a period of hospitalization such as Mrs. Porter had experienced often exacerbated the problem. Her daughter wanted confirmation of the diagnosis. She called a geriatric care manager to assess her mother and recommend a plan of action. Unlike the physician, who only saw Mrs. Porter in his office—"his environment"—the care manager met with Mrs. Porter in "her environment." The care manager had complete access to the home, the companion, and all medical records.

Mrs. Porter's daughter reported that her mother's symptoms appeared suddenly and escalated rapidly. The problem started a few days after she returned home from the hospital. The care manager knew that although anything was possible, "sudden onset" was not usually a symptom of Alzheimer's. She counted the pills in the medica-

tion bottles, matched the remaining number of pills to the dates the prescriptions had been filled, and concluded that the correct number of pills appeared to have been taken. Her interview with the homecare worker revealed that at 3:30 p.m. each day, she left Mrs. Porter to manage her evening dose of medications without supervision.

Further investigation exposed this amazingly simple scenario: Before the homecare worker left each day, she prepared a plate of food and left it on the counter next to the microwave. When Mrs. Porter was ready for dinner, she would heat the food in the microwave and have a hot, nutritionally balanced evening meal. The homecare worker left the afternoon and evening medication doses on the plate where Mrs. Porter could see them so she would remember to take them. You can guess the rest: Mrs. Porter microwaved the medications along with her dinner! This altered their chemical composition, which resulted in an adverse medication reaction and Mrs. Porter presenting with symptoms of dementia.

The CGA included a care plan with supervision and follow-up. The entire process, from assessment through follow-up, helped prevent future risks, decreased the cost of care to both Mrs. Porter and her insurance provider, improved the quality of life for the patient and her family, and allowed her recovery process to proceed without dementia symptoms and with the potential to regain her former quality of life.

A Holistic Care Plan

While many elderly people can seem emotionally, physically, or cognitively intact for a short period of time—such as an eleven-minute consultation in the doctor's office—it is very difficult for them to maintain that “well” presentation for a forty-five to sixty-minute assessment. When the elderly person can no longer maintain the façade and finally shows her true condition, a trained geriatric care manager often discovers illnesses and problems that physicians and even family members have no knowledge of. This information is documented in the CGA, along with information gleaned from the family, caregivers, and physicians.

The result is a comprehensive holistic care plan that profiles the patient's current status, reports suspected and documented physical, psychologi-

cal, social, and environmental problems, and then recommends treatment and follow-up care to address all the patient's issues with a strong emphasis on quality-of-life needs. It contains the following information:

Patient Name: includes address(es), telephone number(s), directions to residence(s);

Family Names: includes addresses, telephone numbers, relationships, emergency contacts;

Professional Advisors: names, addresses, telephone numbers;

Physicians: names, addresses, telephone numbers;

Patient's Religion: for use if clergy is needed;

Diagnoses: documented diagnoses by physicians, suspected diagnosis for follow-up;

Daily functional ability: degree of difficulty preparing meals, eating, dressing, bathing, transferring between bed and chair, using the toilet, controlling bladder and bowel, performing housework, taking medications, shopping, managing finances, using the telephone;

Medications: name of prescription drugs used and name of prescribing physician, name of nonprescription drugs used, adverse drug reaction potential, outdated prescriptions, and inappropriate self-medication;

Gait, Balance: Risk of falls, number of falls in the past six months, and ability to ambulate safely and independently;

Assistive Devices: use of personal devices such as a cane, walker, or wheelchair and use of environmental devices such as grab bars, shower bench, hospital bed, lift chair, or car;

Caregivers: names, schedules, and skill levels of family or paid caregivers;

Psychosocial: mood, behavior, and current level of social activity as compared with previous involvement;

Cognition: testing the elder's ability to recall three objects after one minute; orientation to person, place, and time; and the ability to calculate numbers;

Affect: feelings of sadness, depression, or hopelessness and the lack of interest or pleasure in doing things;

Vision and Hearing Ability: documented defects or obvious inability to hear normal conversations or see objects in plain sight, hearing aids used, glasses used;

Environmental Risks: appropriateness and safety of home;

Nutrition/Hydration: height, weight, stability of weight (has the patient lost or gained a significant amount of weight in the past few months without trying?);

Dental: apparent or documented ability or inability to eat and chew;

Pain Management and Control: does patient or caregiver report chronic pain? Is pain obvious in patient's movements?;

Allergies: diagnosed allergies, undiagnosed reported symptoms;

Use of entitlements and insurance: is patient accessing all benefits?;

Advance Directives: possession of a living will or do not resuscitate order, establishment of power of attorney, and/or durable power of attorney; and

Long Term Planning: what are the long-term medical and financial implications of patient's status?²²

The information collected in the original assessment becomes the baseline for treatment and documenting outcomes. According to THE LANCET (publication of The British Medical Association), the differences in the outcomes of CGA patients and those receiving traditional medical care were substantial. Patients who used the comprehensive Geriatric Assessment technique showed the following one-year outcomes:

- Lower mortality rates,
- Fewer admissions to nursing homes,
- Shorter acute hospital stays,
- Lower direct cost of institutional care,
- Improvement in morale,

- Improvement in functional status,
- Better ADL scores,
- Better general well-being and health status,
- Greater improvements in mental states,
- Fewer medications, and
- Decreased institutional care.²³

The Future of CGA

There are no excuses or exemptions. For professionals trained in geriatrics, every association must begin with a comprehensive geriatric assessment of the person's medical, physical/functional, psychological, and social/environmental status.

It would be difficult to overstate the importance of the assessment in diagnosing a problem. Without it, the physician's care plan has greater potential for failure. The care manager may be the only person in the patient's sphere of influence who has the opportunity to report misuse of medications, home safety issues, isolation and depression, substance abuse, environmental and safety problems (old wiring, dark stairwells), self-neglect, or financial or physical exploitation or abuse by a family member or neighbor. It's easy to see the influence that these problems have on the patient's ability to remain well or recover from an illness, yet most healthcare advisors do not investigate them.

It is unrealistic to expect ill, elderly patients to tell anyone about the depth of their problems. Some are demented and don't recognize their problems. Others were taught as children not to "hang their dirty linen in public" and to "keep it in the family." As adults, they realize that the more people who "know" about their problems, the more likely it is that someone will take action without their knowledge or permission. They've watched friends removed from their homes against their wills and placed in assisted living communities or skilled nursing facilities; they've seen couples separated after sixty years of marriage, perhaps one to an Alzheimer's community, another to a different community with no means of visiting each other. For the most part, considering our history of institutionalizing and warehousing the elderly, they have good reason to keep their problems quiet.

We can paraphrase the great statesman Winston Churchill when he requested funding for WWII from Parliament with the phrase, "Give us the tools and we'll do the job." Age in and of itself does not mandate disabling illness. We have the tools. It's our

turn to do the job and open a new frontier to give our elders the same chance we would want for ourselves: An accurate diagnosis and humane treatment that presents them with a fighting chance to continue their lives with quality and dignity.

Endnotes

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14. Terry Fulmer & Kathy Hyer, *Geriatric Interdisciplinary Teams*, THE MERCK MANUAL OF GERIATRICS ONLINE § 1, at http://www.merck.com/pubs/mm_geriatrics/sec1/ch7.htm, (last visited May 2002).
15. BEERMAN & RAPPAPORT MUSSON, *supra* note 4 64.
16. Case histories (#1, #2, #3) are adapted from actual geriatric care management files. All names and places have been altered to protect confidentiality.
17. These medications were ordered by several doctors and easily can cause exponential interactions. The sleep aid, Risperdal, was ordered by two different doctors with different dosing schedules. All the listed medications, except Vioxx, are psychoactive and each alone can cause cognitive problems. The combination created a potent, potentially toxic cocktail of anti-depressant and anti-anxiety medications, plus three sleep aids—counting Risperdal twice.
18. Hypothyroidism can be a contributing factor to depression and cognitive problems.
19. Did Mrs. Green's incontinence stem from an organic or cognitive problem, i.e.: because of her dementia did she forget how to go to the toilet?
20. Dorothy Baker, et al., *Restorative Rather than Usual Home Care for Elderly Patients Enhances Their Function and Well Being*, OFFICE OF PUBLIC AFFAIRS AT YALE – NEWS RELEASE ONLINE (April 24, 2002), at <http://www.yale.edu/opa/newsr/02-04-24-01.all.html> (last visited May 2002).
21. BEERMAN & RAPPAPORT MUSSON, *supra* note 4 260.
22. *See generally*, THE MERCK MANUAL OF GERIATRICS ONLINE at Table 4-1, at http://www.merck.com/pubs/mm_geriatric/tables.4tl.htm (last visited May 2002).
23. J.H.K. Luk, et al., *Using the Comprehensive Geriatric Assessment technique to assess elderly patients*, 342 THE LANCET ONLINE 1032 (2000).