

Geriatric Assessment: An Interprofessional Model

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Learning Objectives

1. Describe the core dimensions of the geriatric assessment model
2. Understand the roles of interdisciplinary team members
3. Understand loss of function and establishing a plan of care in the geriatric population
4. Gain knowledge of how to integrate interprofessional education in clinical settings

Case Presentation: Martha

- 92 year-old woman lives alone
- Multiple chronic health problems (Cardiac, Pulmonary, Diabetes, Arthritis)
- Hospitalized for shortness of breath and chest pain twice in the last 3 months
- Falls at home, paramedics arrive and find her with right leg pain and unable to walk
- Taken by ambulance to the hospital

Case Presentation: Martha (cont'd)

- At the hospital diagnosed with hip fracture
- Admitted for surgery and day #2 develops worse shortness of breath, complaints of pain, nausea, and constipation
- Fearful of falling, hard time using walker
- Discharged to nursing home (skilled nursing facility) for rehabilitation

Case Presentation: Martha (cont'd)

- 4 weeks of rehabilitation; family is concerned about her returning home alone
- History of "memory problems" and several falls at home without injury
- Concern she is "taking her medications wrong" and "always wearing dirty clothes"
- Discharged back home after 6 weeks

Case Presentation: Martha (cont'd)

- Two days later...
- Family brings Martha back to Emergency Department at the hospital
- Increased confusion, not eating/drinking
- Pressure ulcers on sacrum and both heels
- Admitted to the hospital with pneumonia, dehydration, and "failure to thrive"

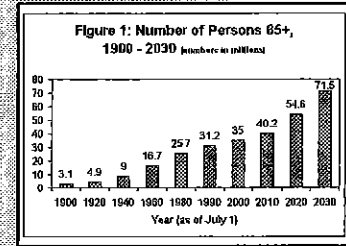
Martha's Story

- What are the next steps in management?
- How could this have been prevented?
- What do you think about?
 - Prior level of function at home
 - Rehabilitation course in nursing home
 - Hospital management
 - Cognitive & psycho-social strengths and challenges
 - Family caregiving & interface with the formal care system

7

Why is this important?

- Patients are aging
- Largest increase in Age > 85
- Older adults are seen as patients /clients in all health care settings



Source: Administration on Aging, January 2004

8

Where are older adults interfacing with service providers?

- Home (independent in the community)
- Home (with Home Care Services)
- Independent or Senior Housing
- Assisted Living Facilities
- Adult Day Care Programs
- Long-Term Care Facilities (Nursing Homes)
- Rehabilitation Centers
- Hospitals

9

What challenges do older adults experience as they age?

- **Disability** (loss of function)
- **Comorbidity** (chronic medical conditions)
- **Frailty** (vulnerability?)
- Multiple Losses (compounding effect)

10

Why is assessment important?

- Goal: decrease disability and dependence
- Identify "pre-clinical" disability
- Majority older adults live independently
- 50% Lifetime Risk of nursing home placement



11

Geriatric Syndromes

- Vision impairment
- Hearing loss
- Incontinence
- Falls/Mobility
- Depression
- Memory disorders



12

What is geriatric assessment?

- Method to identify problems/ challenges early
- Goal to maintain or improve FUNCTION
- Screen for common problems of aging (geriatric syndromes)
- Identifies the strengths/resilience of the individual and family system
- Performed by interdisciplinary team
- Focus on chronic disease management and effective resource utilization to enhance quality of life

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12

Working in Teams

- Multidisciplinary
- Interdisciplinary
- Interprofessional

13

Benefits of an Interprofessional Team Approach

- Interprofessional approaches to health and social care are linked to improved clinical services and enhanced problem-solving

(Mitchell, Parker & White, 2010)

14

UR Geriatric Assessment Clinic

- Established in 1980 by Dr. T. Franklin Williams and has since become known a national model for subsequent clinical programs.
- Goals:
 1. maintain frail older adults in the community at the most independent level through an interdisciplinary approach of comprehensive geriatric assessment
 2. Main teaching site for the University of Rochester and other local health professional schools for training in geriatrics.

15

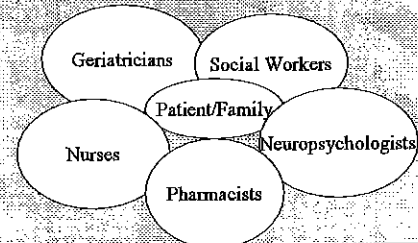
Educational Partnerships

- University of Rochester School of Medicine & Dentistry (medical students, residents, geriatric medicine, psychiatry and dental fellows)
- University of Rochester School of Nursing (gerontological nurse practitioner students)
- SUNY College at Brockport (graduate social work students)
- St. John Fisher College (pharmacy students)

17

Interprofessional Team Interface

- Each team member's professional domain knowledge is recognized. Collaborative team practices are central to the model. Allowing for contextual understanding of complex issues.

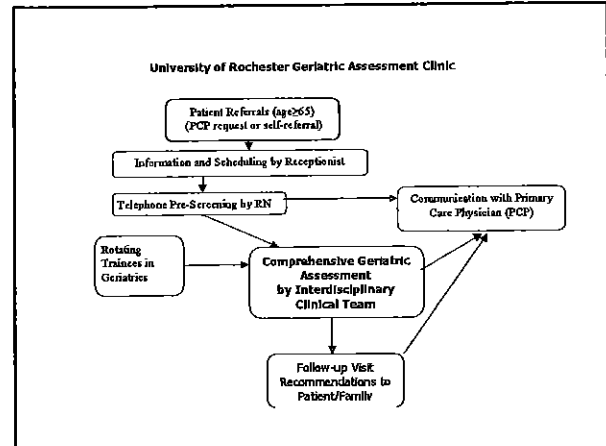


18

The Geriatric Assessment Model

- Comprehensive assessment is performed by an interdisciplinary team
- Personalized recommendations are provided to patients, families, caregivers, and primary care physicians
- Information shared regarding community resources and service agencies to assist older adults in the Greater Rochester area.

19



Components of Geriatric Assessment

- Medical
- Functional
- Psychological
- Cognitive
- Social
- Economic
- Family Dynamics

21

Addressing Complexities Through an Interprofessional Approach

Interface of Geriatric Competencies
Functional Assessment

Medicine	Nursing	Social Work
Assess & describe baseline and current functional abilities in an older patient (ADLs/IADLs) by collecting historical data and performing a confirmatory physical exam.	Demonstrate within care-plan appropriate intervention to promote function in response to change in ADLs and IADLs.	Conduct a comprehensive bio-psycho-social assessment identifying older adults strengths and problems, social supports, social functioning, ADL and IADLs.

22

Interface of Competencies

Medication Management

Medicine	Pharmacist	Nursing
Explain impact of age-related changes on drug selection and dose based on knowledge of age related changes in renal & hepatic function, body composition & CNS sensitivity	Perform basic elements of geriatric pharmacotherapy assessments, interpret physical, laboratory and diagnostic test results, monitor drug therapy, provide medication counseling	Assess barriers, drug interactions, that impact patients' understanding of information, following directions and making needs known.

23

Medical Assessment

- Past Medical and Surgical Histories
- Family History
- Physical Exam
- Review Medications
 - Polypharmacy
 - "Bad Drugs"
- Geriatric Syndromes:
 - Vision & Hearing
 - Incontinence
 - Falls/Mobility
 - Memory/Mood
 - Nutrition
 - Pain

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24

Review Medications



- Drug distribution and metabolism altered with aging
- Adverse Drug Reactions & Drug-Drug Interactions
- Number of medications
- OTC and herbal/dietary
- "Inappropriate" Meds: falls, urinary problems, delirium, hospitalizations

25

Functional Assessment: Activities of Daily Living (ADL)

- **Dressing**
- **Eating**
- **Bathing/Hygiene (personal care)**
- **Toileting (+/- continence)**
- **Mobility**
 - Ambulating
 - Transferring

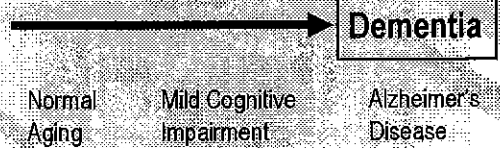
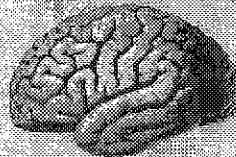
26

Instrumental Activities of Daily Living (IADLs)

- **Shopping**
- **Housekeeping (cleaning, laundry)**
- **Finances**
- **Cooking**
- **Using telephone**
- **Medications**
- **Transportation (driving, buses, etc.)**

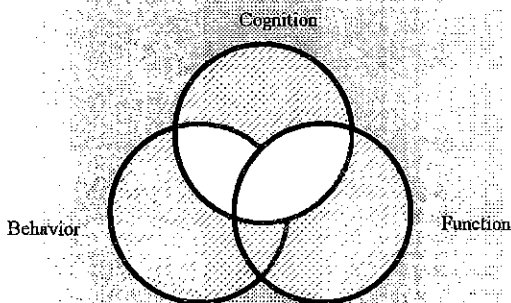
27

Cognitive Dysfunction



28

DEMENTIA



Psycho-Social

- **Social History**
 - Contextual understanding of who the patient is
- **Presenting Challenges & Goals**
 - Patients perspective
 - Families perspective
- **Mental Health Assessment**
 - Coping skills, stressors, risk factors, depression screen
- **Social Functioning Assessment**
 - Social skills, social activity level, social supports
- **Caregivers' Needs /Levels of Stress**

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30

Geriatric Assessment

Assessments depend on context and location:

- Hospital – discharge planning
- Clinic/office – comprehensive assessment
- Nursing Home – improve or maintenance
- Home – mobility and safety
- Rehabilitation – improve function

21

Core Areas

- Functional assessment (observations)
- Areas of concern (mobility impairment, weakness, ROM, falls, etc.)
- Medical Conditions (dementia, CHF, etc.)
- Rehabilitation tolerance and potential
- Psycho/Social Assessment

22

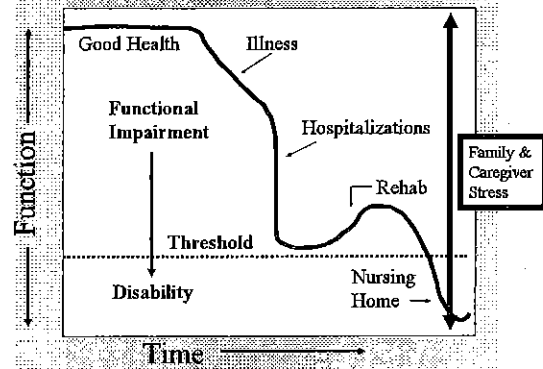
Establishing Goals with Older Adults

- Individualized and patient-centered
- Maintain independence longer
- Reduce stress or burden on caregivers
- Gradual or stepwise loss of function common in patients
- Some patients' function may "plateau" after an illness or injury
- Small improvements in physical function go a long way (high "investment payoff")

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23

Model of Functional Decline:



Martha's Story

- 92 yo living alone, memory problems, decline in ADL, hip fx, hospitalization, and rehab
- Functional Assessment:
 - Prior level of function at home
 - Rehabilitation course in nursing home
 - Hospital post-operative evaluations
 - Family supports & environment
- Goals: safe discharge, independence, quality of life, anticipation of problems (dementia?)

25

Conclusion

- Geriatric assessment emphasizes functional status and the goal of maximizing independence and quality of life
- Loss of function is common but small improvements go a long way
- Recommendations need to be specific and targeted to the patient and family

26