The Basic Geriatric Assessment

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Disclosure Information

We have no relevant financial relationships to disclose

Geriatric Education Center
http://aging.slu.edu/

• This presentation will discuss how the strengths of interdisciplinary team members can be utilized to provide efficient and effective basic assessment and interventions in a geriatric primary care practice. Case examples will be used to demonstrate how team members can work together.
Mrs. H.

- Mrs. H, a 82 year old female with pmh significant for hypothyroidism and OAB who presented as a consult from PCP. The patient and husband are not sure why they are here. The patient has been hospitalized twice in the last month. She had a fall in the living room which resulted in severe back pain from a vertebral compression fracture. Her hospitalization was complicated by delirium from pain medications and muscle relaxers. She was discharged and quickly readmitted with a UTI and urinary retention. Her oxybutinin was stopped and she left the hospital with a Foley catheter, which is still present today. Her back pain is poorly controlled, the lidocaine patch helps greatly but they only use it when she has pain, when the pain comes on its "terrible". She described it as a "pushing" sensation and 10/10.

Redesigning Primary Care

- Primary Care defined in the ACA as: "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (PL 111-148)

- Primary Care practices must be designed to achieve the Triple Aim:
  - Improved patient experience of care
  - Improved population level health outcomes
  - Controlled cost

Integrated Care

According to SAMHSA:

The systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

* http://www.integration.samhsa.gov/about-us/what-is-integrated-care
Chronic Disease in Primary Care

Chronic diseases have overtaken infectious diseases as the leading cause of death and disability.

Almost half of all adults have one chronic condition.

Chronic diseases account for 7/10 deaths in US (including heart disease, cancer and stroke which account for 50% deaths).

25% of people with chronic conditions have difficulty with daily activities such as walking, bathing, etc.

“Eighty percent of the health care dollars are spent by 20 percent of the population.” (http://www.politifact.com)

Chronic diseases share common risk factors which are modifiable.

(CDC, 2013; Fryer et al., 2010; IDF Diabetes Atlas, 2008; MSH, 2007; Union for International Cancer Control World Cancer Congress 2012; WHO, 2005)

The Social Work Advantage

Barb Beckermann, MSW, LCSW, ACHP-SW
The Social Work Advantage

Who is a social worker?

What makes them important?

Where do they fit in to the team?

How do they make a difference?

The Social Work Advantage

NASW Code of Ethics

The Primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems with living.

The Social Work Advantage

– Service
– Social Justice
– Dignity and worth of the person
– Importance of human relationships
– Integrity
– Competence
The Social Work Advantage

These core values, embraced by social workers throughout the profession’s history, are the foundation of social work’s unique purpose and perspective.

The Social Work Advantage

Who is a social worker?

What makes them important?

Where do they fit in to the team?

How do they make a difference?

Adding a social worker to the team provides insight into.....

- Living Conditions
- Family Dynamics and Communication
- Social support
- Advanced Planning
- DPOA
- Finances
- Spirituality
- Safety Concerns
The Social Work Advantage

Who is a social worker?

What makes them important?

Where do they fit in to the team?

How do they make a difference?

The Social Work Advantage

Interdisciplinary Team

The Patient

The Social Work Advantage

Interdisciplinary Team

The Family
The Social Work Advantage
Interdisciplinary Team

Patient

Family

OT

Occupational Therapy

Social Work

The Social Work Advantage
Interdisciplinary Team

Patient

Social Work

OT

The Physician
The Social Work Advantage

Social Support:
- Who helps you out?
- Tell me about your family?
- How often do you see family members and do they help with certain things?
- If you had to make a major healthcare decision – who would you contact or call?
- Do you get out of the home to socialize?
- Do you maintain contact with any friends?

The Social Work Advantage

Financial/Legal:
- What insurance do you have?
- How much do you pay in medication co-pays or for healthcare costs?
- What is your monthly income and the source?
- Are you a Veteran or a spouse of a Veteran?
- Have you ever consulted an attorney for estate planning?
- Have you set aside money for prepaid burial plans or discussed what you want?

The Social Work Advantage

Safety Issues:
- Have you struggled with changes in your ability to care for yourself?
- Have you thought about who would help if you needed more care?
- Do you feel safe in your home and neighborhood?
- Do you feel there are changes that can be made in your home to help you stay at home long term?
The Social Work Advantage
Preferences About Environment:

- What do you like most about where you live?
- Who do you like to visit you?
- Have you ever thought about moving?
- What gives you most comfort where you are?

The Social Work Advantage
Advanced Care Planning:

- Do you have a Durable Power of Attorney? Who is it?
- Have you discussed your wishes for medical care with anyone?
- Has anyone ever talked to you about how your illnesses progress and the problems that may arise?
- Have you ever completed and Advanced Directive?

The Social Work Advantage
Spirituality/Culture:

- What helps you through difficult times?
- Where do you get your strength to deal with your current needs?
- Would you consider yourself religious or spiritual?
- Are there beliefs that you have that affect how you make your healthcare decisions?
- What do you consider Quality of Life?
The Social Work Advantage
Complicated Anticipatory Grief:

- Do you have regrets in your life that sometimes bother you?
- Do you have things you still want to accomplish?
- Do you feel down or sad because of your health?

The Social Work Advantage
Ability To Talk About End Of Life Care:

- Do you have fears about your health?
- Do you have any unmet needs?
- Does the idea of death or talking about death bother you?
- What are a few of the most important things you want me to know about you?

The Social Work Advantage
Comprehensive Social Work Assessment:
The Social Work Advantage

Who is a social worker?

What makes them important?

Where do they fit in to the team?

How do they make a difference?
The Occupational Therapy Advantage

Who is an OT?

What makes them important?

Where do they fit in to the team?

How do they make a difference?

Occupational Therapy

(AOTA.org)

“In its simplest terms, occupational therapists and occupational therapy assistants help people across the lifespan participate in the things they want and need to do through the therapeutic use of everyday activities (occupations).”
According to the Manitoba Society of Occupational Therapists (2005)

“How people perform their occupations is believed to be an important determinant of health and is influenced by personal factors, environments, and the occupations that people do. Occupational therapy is the **only health profession** whose education is entirely devoted to the study of occupational performance and its impact on peoples’ health and wellness”.

(p. 2)

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**PEO-P Model**

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**Determination of purposeful activity needs & desires for client**

**Begins with assessment of clients current level of functioning**

- Discussion of individuals current & desired roles, habits and routine
- What type of family support is available
- What is their expected.desired environment and roles
OT Assessment

- Identifying what physical & cognitive limitations may limit clients participation
- Differentiate between AROM and functional AROM
- Assess clients with use of functional questions...“can you grasp your fork and bring it to your mouth”
- Includes communication limitations
- ADL/ Functional Assessment
- Identify strengths of the client that will aid in a successful outcome

From AOTA.org


Barthel Index Scoring Form

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care</td>
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<td>60-80</td>
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<td></td>
<td>80-100</td>
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<td>Transfer (Bed to Chair)</td>
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<td>60-80</td>
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<td>80-100</td>
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<tr>
<td>Bathing</td>
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<td>80-100</td>
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<tr>
<td>Mobility (5 ft/walk distance)</td>
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<td>40-60</td>
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<td>60-80</td>
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<td>80-100</td>
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<tr>
<td>Bladder Control</td>
<td>0-20</td>
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<td></td>
<td>20-40</td>
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<td>60-80</td>
</tr>
<tr>
<td></td>
<td>80-100</td>
</tr>
</tbody>
</table>
**Modified Barthel Index**

1. The index should be used as a record of what a patient does, not as a record of what a patient could do.
2. The main aim is to establish degree of independence from any help, physical or verbal, however minor and for whatever reason.
3. The need for supervision renders the patient not independent.
4. A patient's performance should be established using the best available evidence. Asking the patient, friends/family and nurses are the usual sources, but direct observation and common sense are also important. However direct testing is not needed.
5. Usually the patient's performance over the preceding 24-48 hours is important, but occasionally longer periods will be relevant.
6. Middle categories imply that the patient supplies over 50 per cent of the effort.
7. Use of aids to be independent is allowed.

[https://www2.massgeneral.org/stopstroke/pdfs/barthel_index.pdf](https://www2.massgeneral.org/stopstroke/pdfs/barthel_index.pdf)

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**NIH PROMIS Measures**

- Patient Reported Outcome Measures Information System (PROMIS)
- Allows identification of unique information from patients thereby enabling improved quality of care
- Rigorous qualitative and psychometric evaluation and refinement
- Efficient, precise, valid, and responsive indicators of a person's health status

[https://www2.massgeneral.org/stopstroke/pdfs/barthel_index.pdf](https://www2.massgeneral.org/stopstroke/pdfs/barthel_index.pdf)
NIH PROMIS Measures Cont.

- PROMIS Pediatric self-report instruments are available for children ages 8-17 and parent proxy reports are available for children ages 5-17.
- Adult versions
- 2 formats: Computerized Adaptive Testing (CAT) and traditional static pencil/paper
- Development was completed with total population samples
- Included persons with chronic illnesses/diseases

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PROMIS Adult Self-Reported Health

- Physical Health
  - Physical Function
  - Pain Intensity
  - Pain Interference
  - Fatigue
  - Sleep Disturbance
  - Pain Behavior
  - Pain Quality
  - Sleep-related Disturbance
  - Sexual function
  - Bodily pain
  - sentinel symptoms
  - Disability

- Mental Health
  - Depression
  - Anxiety
  - Anger
  - Cognitive Function
  - Alcohol Use
  - Consequences, & Impact
  - Psychosocial distress
  - Self-Efficacy
  - Smoking

- Social Health
  - Ability to Participate in Social Roles & Activities
  - Satisfaction with Social Roles & Activities
  - Social Support
  - Social isolation

http://www.nihpromis.org/measures/domainframework1

PROMIS Measures available

- Emotional Distress – Anger
- Emotional Distress – Anxiety
- PROMIS-Cancer – Anxiety
- Emotional Distress – Depression
- PROMIS-Cancer – Depression
- Applied Cognition – Attention
- Applied Cognition – General Cognition
- Psychosocial Stress Impact – Positive
- Psychosocial Stress Impact – Negative
- Alcohol – Risky Use
- Alcohol – Problem Consequences

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Key PROMIS Measures Available

<table>
<thead>
<tr>
<th>Adult</th>
<th>Pediatrics</th>
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</thead>
<tbody>
<tr>
<td>Emotional distress – Anxiety</td>
<td>Emotional distress – Anxiety</td>
</tr>
<tr>
<td>Emotional distress – Depression</td>
<td>Emotional distress – Depression</td>
</tr>
<tr>
<td>Hope</td>
<td>Hope</td>
</tr>
<tr>
<td>Pain</td>
<td>Pain</td>
</tr>
<tr>
<td>Pain – interference</td>
<td>Pain – interference</td>
</tr>
<tr>
<td>Pain – intensity</td>
<td>Pain – intensity</td>
</tr>
<tr>
<td>Physical function</td>
<td>Physical function</td>
</tr>
<tr>
<td>Sleep structure</td>
<td>Sleep structure</td>
</tr>
<tr>
<td>Satisfaction with participation in social roles (11 item)</td>
<td>Satisfaction with participation in social roles (11 item)</td>
</tr>
</tbody>
</table>

PROMIS Software Demonstration

- [http://www.nihpromis.org/software/demonstration](http://www.nihpromis.org/software/demonstration)
Falls Assessment

Fall Risk Assessment: Although not all falls can be prevented, it is possible to minimize the risk of falling. The most important first step to do this is to use validated (well-tested) instruments to assess risks or "risk factors" for falls. This will allow you and your team to design individualized care plans to reduce these risks and lead to reduced numbers of falls and fall injuries.

This video shows how to administer several such instruments, specifically: The Get Up and Go, Five-Chair Stand, Dual-Tasking, Orthostatic Hypotension, Postprandial Hypotension, Polypharmacy, Vitamin D Deficiency and Post-Fall Assessment.


Who is a Geriatrician?

• Doctor who specializes in the elderly
  — Completed IM for FM residency
  — Completed Geriatrics Fellowship
  — Board Certified in Geriatrics
• Focuses on Geriatric Syndromes
  — Continence
  — Memory
  — Mood
  — Falls
  — +++++++

Urinary Incontinence (UI)

• Prevalence in those >65
  — 15 – 30% of Community Dwellers
  — 60 – 70% of LTC Patients
• Affects women > men 2:1
  — After age 80 1:1
• Annual Cost $26 billion/yr

DuBose, GRS, 2013.
Consequences of UI

- Impairs Quality of Life
- Embarrassment/Poor Self Perception
- Dermatitis/Cellulitis
- Pressure Ulcers
- UTIs
- Falls
- Sleep Deprivations
- Social Withdrawal
- Depression
- Sexual Dysfunction
- Increased Caregiver Burden

DuBeau, GRS, 2013.

UI Screening

- 50% of patients do not report symptoms
- Do you have problems with bladder control?
- Do you have problems making it to the bathroom on time?
- Do you ever leak urine?

DuBeau, GRS, 2013.

UI Screening

- If you leak Urine, Clarify
- Do you leak urine with activity, coughing, sneezing, lifting, or exercise?  
  - STRESS
- Do you leak urine with activity and sense of urgency?  
  - STRESS + URGE
- Do you leak urine are other times unrelated to physical activity or sense of urgency?  
  - OVERFLOW? FUNCTIONAL?
Prompted Voiding in the Nursing Home

- Reduces daytime UI
- For the Cognitively Impaired
  - State name, Transfer with a max assist of 1
- Prompt toileting q2-3 hours
- Provide Positive Feedback
- If patient can participate 75% of the time for 72 hours, continue
- Scheduled toileting is not effective
- Same outcomes as a 4 week trial of extended release oxybutynin

DuBeau, GRS, 2013

Bladder Relaxants?

- 2011 Randomized Controlled Trial
- 50 LTC women with Urge Incontinence and Cognitive Impairment
- Oxybutynin vs Placebo
- No significant difference in UI, frequency and dryness

Lackner, JAMDA, 2011

Depression

- Older adults are less likely to endorse a depressed mood
  - MINIMIZERS!!!
- “Subsyndromal” Depression
  - Increased use of health services
  - Increased disability
  - Poor health outcomes
  - Higher mortality

Kennedy, GRS, 2013
Depression

- Major Depressive Disorder Prevalence
  - Primary Care Clinic, 6-10%
  - Nursing Home Residents, 12-20%
  - Inpatient, 11-45%
  - Mental Health Setting, >40%

Depression Screening

- Patient Health Questionnaire/PHQ-9
  - Use first 2 questions for screening
    - >3 in depressed mood + anhedonia
    - Continue with PHQ-9
    - 3 points in anhedonia
    - Continue with PHQ-9
PHQ-2/PHQ-9

- > 10 = good sensitivity and specificity for MDD
- > 15 +/- suicidal ideation = psychiatry consult
- Serial testing can be used to assess treatment
  - Change of 5 is clinically significant
  - <5 Remission


Geriatric Depression Scale

- 15 Items
- Convenient: yes or no
- Does not address
  - Somatic complaints
  - Sleep
  - Suicidal Ideation
- Not useful in assessing treatment response

Kennedy, QRS 2013

Geriatric Depression Scale (Short Form)

Choose the best answer for how you felt over the past week.

1. Are you basically satisfied with your life? yes/no
2. Have you dropped many of your activities and interests? YES/no
3. Do you feel that your life is empty? YES/no
4. Do you feel fatigued? YES/no
5. Are you in good spirits most of the time? yes/no
6. Are you worried that something bad is going to happen to you? YES/no
7. Do you feel happy most of the time? yes/no
8. Do you feel that you have lost interest in life? YES/no
9. Do you prefer to stay at home, rather than going out and being with people? YES/no
10. Do you feel that you have less energy than usual? YES/no
11. Do you feel that you don’t have anything to look forward to? YES/no
12. Do you feel that your situation is hopeless? YES/no
13. Do you feel that you are a burden to those you care about? YES/no
14. Do you feel that you are not able to do the things you want to? YES/no

Scoring: Score highest answer (1 point for each of these answers).

0–5 = normal, =2 moderate depression,

Cornell Scale for Depression in Dementia, CSDD

- Designed specifically for elderly patients with dementia
- Based on signs and symptoms within the last week
- Patient, Informant, and Direct Observation are used to complete form
- If discrepancy
  - Test Administrator/Rater re-interview patient and informant
  - Final Score is the rater's clinical impression
- Takes about 20 minutes

Alexopoulos, Biol Psychiat 1988

### CSDD

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>Unable to evaluate</td>
</tr>
<tr>
<td>1</td>
<td>Mild intermittent</td>
</tr>
<tr>
<td>2</td>
<td>Severe</td>
</tr>
<tr>
<td>3</td>
<td>Probable Depression</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Anxiety (dysphoria, hopelessness, worthlessness)</td>
</tr>
<tr>
<td>2.</td>
<td>Sleep (difficulty falling asleep, early awakening, excessive sleep)</td>
</tr>
<tr>
<td>3.</td>
<td>Activity (loss of interest - usual activities)</td>
</tr>
<tr>
<td>4.</td>
<td>Appetite (eating less than usual)</td>
</tr>
<tr>
<td>5.</td>
<td>Energy (feeling fatigued, feeling lethargic)</td>
</tr>
<tr>
<td>6.</td>
<td>Fatigue (excessive tiredness)</td>
</tr>
<tr>
<td>7.</td>
<td>Self-depreciation (negative self-esteem, self-blame)</td>
</tr>
<tr>
<td>8.</td>
<td>Suicide (thought of suicide, preoccupied with death, self-directed violence)</td>
</tr>
<tr>
<td>9.</td>
<td>Food (increase or decrease in appetite or weight loss)</td>
</tr>
<tr>
<td>10.</td>
<td>Sexual desire (sexual interest, sexual activity)</td>
</tr>
</tbody>
</table>

Alexopoulos, Biol Psychiat 1988

### Hearing Impairment

- Prevalence
  - 65 – 75 10%
  - >75 25%
  - Nursing Homes 50 - 100%
- Males > Female
- Caucasian > African American
- Smokers > Nonsmokers
- We all know who these people are by interacting with them!
Priority Number 1

- Rule Out Cerumen Impaction
- Cerumenolytics x several days are effective 40% of the time
  OR
- Use 15-30 minutes before irrigating with warm water
- Still can't get it out, refer to ENT/Audiology

Bade, GRS, 2013

Assistive Listening Device

- Personal Amplifier
- Hearing Aids can cost $1,200 - $5,400
- Medicare may or may not reimburse the full amount, or at all!

Bade, GRS, 2013

Visual Impairment

- Definition: Acuity worse than 20/40
  - 20-30% of those > 75
- Blindness: Acuity worse than 20/200
  - 2% of those > 75
  - Account for 50% of the blind population

Giancoli, Sarraf, Coleman, GRS, 2013
Causes of Blindness

- 1/3 of new cases can be avoided
- Reversible: cataracts
- Irreversible
  - Age-Related Macular Degeneration
    - Central Vision Loss
    - Tx: Injections and Laser
  - Glaucoma
    - Peripheral Vision Loss
    - Tx: Eye drops, Laser, Surgery

Visual Impairment Screening

- American Academy of Ophthalmology
  - Eye exam every 1-2 years if > 65

Cognitive Deficit Reversal

- Saint Louis VA Retrospective Chart Review
- Pts completed SULMS in 2003 and 2010
- Interventions after baseline exam were tracked
- 223 patient completed the study
- 24% Reverted Back to Normal Cognitive Function
- Significant Interventions
  - Correction of Vision Loss – p = 0.005
  - Discontinuation of Anticholinergic Medications – p = 0.002
Polypharmacy

- NH resident with dementia are on 7-8 meds/day
  - Does this make sense?
  - Can they report side effects?
  - Did the clinical trials for these meds include the frail elderly?
  - Could any of these worsen cognition?
  - Are they at the end of life?
  - Will they receive benefit from this drug?
    - Ex: live long enough?

Onder, JAMDA, 2013.

Polypharmacy

- Polypharmacy = 10+ drugs
- NH resident
- Limited Life Expectancy
- Severe Cognitive Impairment
- Following for 1 year
- Increased Mortality with Polypharmac
  - HR = 2.19 (1.15 – 4.17)

Onder, JAMDA, 2013.

Is this normal?

Deliurium vs. Dementia vs. Normal Aging
Delirium

- Definition
  - Sudden onset of confusion impairing attention and thinking

- Prevalence
  - Inpatients: 1/3 (>70)
  - ICU: 75%
  - ED: 1/3
  - SNF: 16% of new admission
  - End of Life: 85%
  - Community: 1-2% (recently discharged)

Marcantonio, GRS, 2013

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Delirium Prognosis

- Can last for weeks – months!
- Systematic review- Persistence Rates of Delirium

<table>
<thead>
<tr>
<th>Month Post DC</th>
<th>0</th>
<th>1</th>
<th>3</th>
<th>6</th>
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</thead>
<tbody>
<tr>
<td>Delirium %</td>
<td>45%</td>
<td>33%</td>
<td>26%</td>
<td>21%</td>
</tr>
</tbody>
</table>

- If >85 and preexisting cognitive impairment can take weeks to months to clear

Cole, Age and Aging, 2008
Marcantonio, GRS, 2013

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Delirium Outcomes

- Meta-Analysis
- Increased Risk of
  - Death, OR 2 (1.5 – 2.5)
  - Institutionalization, OR 2.4 (1.8 – 3.3)
  - Dementia, OR 12.5 (11.9 – 84.2)

WitLox, JAMA, 2010
Confusion Assessment Method

- Feature 1: Acute onset and fluctuating course
- Feature 2: Inattention
- Feature 3: Disorganized thinking
- Feature 4: Altered consciousness

Day of week backwards

Hyperacute, Drowsy, Lethargic, Comatose

Illogical, Rambling, Disoriented, Delusional

Tolerate, Anticipate, Don’t Agitate

- Video Example

Normal or Not?

- Normal Aging
  - Slowed Information Processing
    - ≠ functional decline
- Dementia
  - Decline in 2+ Cognitive Functions
    - ≠ progressive functional decline


Cognitive Function

- **Basic**
  - Attention
  - Working Memory
  - Manipulate current info
  - Long Term Memory
  - Perception
    - Ability to see and hear

- **High Level**
  - Speech/Language
  - Decision Making
  - Executive Control
    - Plan, Organize, Coordinate a Novel Task

Gilroy, Brain Aging 2007

Dementia Prevalence and Cost

- **Prevalence**
  - 6-8% if > 65
  - ↑2x every 5 yrs after 60
  - 45% ± if > 85

- **Cost**
  - 2010 Stats
    - $604 billions/year
    - Family Caregivers
      - 17 billions hours = $202.6 billion

Threlfall, Barton, Yaffe, GRS, 2013

AD-8

- Eight-Item Interview to Differentiate Aging and Dementia
- Tests Memory, Orientation, Judgment and Function
- Initially Informant Bases, Validated for patients to self evaluate
- Sensitivity 84%
- Specificity 80%

The AD-8: The Washington University Dementia Screening Test (Eight-Item Interview to Differentiate Aging and Dementia) is a copyrighted instrument of Washington University, St. Louis, Missouri.
The AD8: The Washington University Dementia Screening Test

AD-8 Scoring

- Scoring
- 0-1 Normal Cognition
- > 2 Cognitive Impairment is Likely

Rapid Cognitive Screen (RCS)

- 3 items from Veterans Affairs Saint Louis University Mental Status
- 5 word recall
- Clock Drawing Test
- Listen to story, remember location of city and answer what state that is in
RCS

- < 5/10 = Concern for Dementia
  - Sensitivity 89%, Specificity 94%
- < 7/10 = Concern for Mild Cognitive Impairment
  - Sensitivity 87%, Specificity 70%
- Higher RCS scores protective against:
  - NH (OR=0.85, 95% CI: 0.73-0.98)
  - Mortality (OR=0.84, 95% CI: 0.77-0.91)

What did we forget?

- Besides her medical history what else do we need to know?
We Forgot.....

• Function:
  - Needs help with dressing and shower
  - No longer drives, cooks or cleans
  - Did have a fall resulting in injury
  - What does she do for fun?

• Memory
  - Of Mexican Heritage, forgotten how to cook her favorite Mexican meals
  - Husband thinks she seems "confused" sometimes

• Mood
  - Says its, "OK"

We Still Forgot.....

• Can she see and hear?
  - Reports no problems

• Medication Reconciliation
• What’s going on with this Foley?
  - Urinary Incontinence

• Psychosocial
  - Is she safe at home?
  - Who helps her?
  - What are her goals? How are we going to reach them?

Resources

Resources


Resources