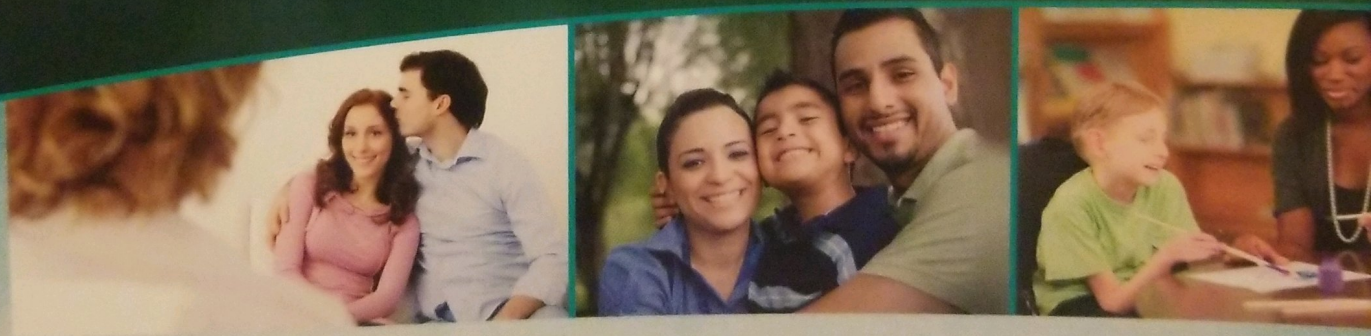


Social Work Practice

with

Individuals *and* Families

Evidence-Informed Assessments and Interventions



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Chapter 7

Assessment of the Elderly

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Purpose: The purpose of this chapter is to provide the reader with an understanding of comprehensive geriatric assessment and its various aspects.

Rationale: As more social workers are confronted with older adult clients, it is critical that they understand how to initially assess older adults who come in to receive care.

How evidence-informed practice is presented: Information is presented on Mental Status exams and the usefulness of those instruments in assessing for initial signs of dementia; data are presented on various instruments for assessing functional status and their importance in determining need for services.

Overarching question: When working with older adults, how could I best include elements of an assessment into my interview, and which elements should I include?

Comprehensive geriatric assessment (CGA) has emerged as an important method for helping social workers address the needs of older adults, particularly as the number of older adults and their need for services continues to grow within the United States.

CGA is a process of engaging in a total evaluation of older adults. It requires that the practitioner gather information in multiple areas of client functioning, including medical history, cognitive status, emotional well-being, the ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs), the person's social-support system, the physical environment in which the person lives, and many other areas of the older person's life. Such a process requires that the social work practitioner have a broad command of all areas of aging practice. One must understand how to effectively gather medical information; assess current cognitive status, the emotional well-being of the client, ADLs and IADLs, and the person's social-support system; and conduct an effective and thorough assessment of the older adult's physical environment (Gallo & Bogner, 2006). Finally, the social work practitioner must be able to comprehensively link the findings from the assessment to an intervention plan for the individual client (Gallo, Fulmer, Paveza, & Reichel, 2000).

Because the process of CGA is not a single subject but rather an amalgamation of several areas, this chapter of necessity addresses both the broad subject as well as the specific elements that comprise a CGA.

This chapter details a process for gathering and organizing information rather than a specific intervention or method of engaging in practice. As such, this chapter is organized differently than other chapters in this book. This chapter reviews each of the elements that comprise a CGA, discusses some of the instruments that may be of assistance for obtaining information in that area of the assessment, summarizes some of the unique issues encompassed in that area of the assessment process, and looks at the import of the area for arriving at a care plan. The chapter concludes with a discussion concerning the integration of the elements of the assessment into a whole that informs a recommended care plan for the client and a review of the literature on effectiveness of the process.

The elements that are recommended for inclusion in a CGA have broadened over the past several years. This is evident when one reviews any text on geriatric assessment with multiple editions. A perfect example is the *Handbook of Geriatric Assessment*. The first edition, published in 1988, consists of 10 chapters totaling 231 pages of text and index, with a single contributed chapter (Gallo, Reichel, & Andersen, 1988). By the second edition, published in 1995, the book still has 10 chapters, but it has expanded to 257 pages of text and index, with 2 contributed chapters (Gallo, Reichel, & Andersen, 1995). The third edition of the *Handbook* consists of 13 chapters with 361 pages of text and index, with 5 contributed chapters (Gallo et al., 2000). The latest edition of the *Handbook*, the fourth edition, has expanded to 20 chapters with 473 pages of text and index, and 18 of the chapters include authors other than the editors of the book (Gallo, Bogner, Fulmer, & Paveza, 2006). These changes in the *Handbook* suggest that both the amount and complexity of information has so expanded that no single group of authors can adequately address the topic.

As stated at the beginning of this chapter, CGA is not an intervention technique but rather a process for gathering comprehensive information on older adults within the context of the older person's environment. Given the breadth and depth of this biopsychosocial environmentally cognizant approach to gathering information on older adults, one might suspect that the approach was developed by social workers to address their work with older adults. Unfortunately, there is no substantive evidence to support this contention. Rather, this approach seems to be built on the experiences of early geriatric physicians. They discovered that, when working with older adults in in-patient settings, information beyond that of the medical history and presenting medical problems was required in order to effectively create a treatment plan for their older patients (Gallo et al., 1988).

Historical Background

CGA is a direct outgrowth of the earlier movement within geriatric medicine to develop comprehensive geriatric assessment units (GAUs).

GAUs identified the need for a comprehensive assessment process, usually beginning with a physical exam and medical history and then adding information on functional status—that is, the ability to perform basic activities of daily living, mental health, size of the social-support network, and interactions that support network, economic needs, and environmental considerations (L. A. Rubenstein, 1995). These domains with some modifications continue to remain the focus of CGA (Mouton & Esparza, 2006; Chang & Mamun, 2008). A comprehensive assessment should consist of assessment in at least six areas: mental status, functional assessment, social and environmental assessment, nutritional- and health-practices review, medical history and treatments, and assessment of emotional well-being (Paveza, 1993). The consistency across authors and across disciplines in identifying the areas essential to the assessment process suggests that there is a generally accepted concept of the information that needs to be gathered to adequately address the care needs of the older adult patient, whether that person is in the hospital or residing in the community.

Moving from this historical perspective, let us begin a more in-depth discussion of the elements comprising the assessment process. Each of these elements is discussed from the perspective of how the element helps us understand the current biopsychosocial status of the older adult, techniques and instruments the practitioner can use to assess an element of the comprehensive assessment, potential problems with using some of the discussed instruments, and the relationship of that element of the assessment to care planning for the older adult.

Elements of the Comprehensive Assessment

I have already suggested that the comprehensive-assessment process should address some common areas, including current medical problems and medical history, assessment of the person's ability to perform the basic activities of daily living, assessment of emotional problems, and social and economic issues (Gallo et al., 1995; Mouton & Esparza, 2006; Paveza, 1993; L. A. Rubenstein, 1995). Beyond these basic elements, authors differ on the other elements to be included in the assessment. When discussing the assessment of functional status, several authors also suggest that, in addition to basic activities of daily living, the assessment of functional status must include the instrumental or independent activities of daily living (Older Americans Resources and Services [OARS] Methodology, 1978). The addition of assessment for elder mistreatment has also recently been suggested as important to a thorough and complete assessment (Fulmer & O'Malley, 1987; Gallo et al., 2000; VanderWeerd, Firpo, Fulmer, & Paveza, 2006). The need to assess values and the impact of those values on do-not-resuscitate directives and durable power of attorney for health care have also been added to the growing list of items to be covered in the assessment process (Doukas, McCullough, & Crane, 2006). Additional areas suggested

for incorporation into the process include older adults' ability to continue to drive, their use of alcohol and drugs, and pain assessment (Carr & Rebok, 2006; Richardson, 2006; Zanjani & Oslin, 2006). Some of these special areas of concern were originally considered to be part of one of the broader categories, such as medical history, social history, or environmental assessment, the assessment for elder mistreatment being a perfect example. In an earlier edition of the *Handbook of Geriatric Assessment*, the discussion of elder mistreatment is included in the chapter on social assessment, but in the latest edition, it merits a chapter of its own (Gallo et al., 2000; VanderWeerd et al., 2006). Although these special areas are addressed in this chapter, most are included under broader headings to more appropriately place them in the context of the assessment process. This chapter also discusses the elements of CGA using a modification of my previously mentioned framework. The elements of the assessment are discussed under six broad areas: mental status, functional assessment, medical history, and treatments including nutrition- and health-practices review, emotional/psychological well-being, and social and environmental assessment (Paveza, 1993).

Mental Status

The assessment of mental status should be one of the initial components, if not *the* initial component, of the comprehensive assessment. Although the social work practitioner needs to be cognizant that clients may be somewhat taken aback by the introduction of this item as the first element of the interview, I have argued consistently that, after establishing initial rapport, starting the remainder of the assessment process with the mental-status review is essential to avoid engaging in an information-gathering process that could yield little or no useful information while taking up a significant amount of both the client's and practitioner's time and money (Paveza, Cohen, Blaser, & Hagopian, 1990a; Paveza, Prohaska, Hagopian, & Cohen, 1989).

Gathering information on a client's mental status has generally been described as requiring the practitioner to assess at a minimum the client's level of consciousness, her or his orientation to time and place, and his or her attention and memory (Gallo & Wittink, 2006a). Additional areas that may be covered include information concerning language, the ability to engage in abstract thinking, and constructional ability (Chodosh, 2001; Gallo & Wittink, 2006a; Scalmati & Smyth, 2001). Each of the domains covered in a mental-status exam can provide important information concerning the client's ability to provide historically accurate information, engage in conversations that require abstract thinking, and consent to or reject care plans or elements of care plans (Paveza, 1993; Paveza et al., 1990b; Paveza et al., 1989).

Gathering mental-status information has become relatively standardized. This means that a social work practitioner can quickly ask the

questions needed to obtain information in this area. Included among the instruments commonly used are the Folstein Mini-Mental Status Exam (MMSE; Folstein, Folstein, & McHugh, 1975), Pfeiffer's Short Portable Mental Status Questionnaire (SPMSQ; Pfeiffer, 1975), and the six-item Orientation-Memory-Concentration Test (Katzman et al., 1983). Other tests that can provide additional information are category-fluency sets and the clock-drawing test. These two instruments provide some additional benefits over those more typically used for screening, with the set test generally being seen as less offensive to older adults than the more traditional screens (Gallo & Wittink, 2006a). Moreover, the clock-drawing test can provide useful information about the ability of the older adult to transition between abstract and concrete thinking and his or her use of judgment as he or she draws the clock and puts in the required elements (Gallo & Wittink, 2006a). Mental-status screening has been well researched, and a general description of some of the problematic issues with these screens can be found in the *Handbook of Geriatric Assessment*, fourth edition (Gallo & Wittink, 2006a); the *Geropsychology Assessment Resource Guide* (National Center for Cost Containment, 1993); and *Measuring Health: A Guide to Rating Scales and Questionnaires* (McDowell & Newell, 1996).

In general, issues of importance when interpreting a mental-status screen focus on the level of formal education of the older adult, with those having less formal education often scoring lower than their actual level of cognitive functioning and those with higher levels of education often appearing to do better than their actual level of cognitive functioning (Gallo & Wittink, 2006a). For this reason, as well as others discussed in the literature, the clinician should never use the results of any single mental-status assessment to arrive at a diagnosis of dementia, nor should a client accept this diagnosis based solely on a mental-status screen. The diagnosis of dementia must be arrived at in a manner that addresses all criteria established either in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (American Psychiatric Association, 1994), or in the NINCDS-ADRDA Consensus Criteria (McKhann et al., 1984). The purpose of the mental-status exam is to assist the clinician in determining whether the client can provide useful information for consenting to treatment and for planning care, and whether the client needs referral for a complete neuropsychological exam.

Functional Assessment

Probably the most critical element of the assessment is determining the client's functional ability. Functional ability is the capacity of the individual to perform certain personal-care behaviors that are seen as essential to being able to care for him- or herself independently in a community-living environment. The original seven behaviors seen as essential to being able to function in the community, and usually referred to as activities of daily living, are feeding, bathing, grooming, dressing, continence, toileting, and

and practices of the older adult. This area is often overlooked because of the clinician's discomfort in seeking this type of information from the older adult. Yet unless some time is spent talking about this important area of functioning, an area of potential emotional distress and risk-taking behavior in some older adults will be missed (Nicklin, 2006).

The clinician should also include in this section an assessment of pain. Many older adults experience pain from the same causes as younger adults, to which can be added the pain impact of many chronic illnesses. Although it was once believed that older adults did not experience pain with the same intensity as younger adults, recent literature suggests this is not true. Moreover, older adults are often given the impression that they should be able to tolerate the pain they are experiencing based on this mistaken notion that their qualitative perception of pain is diminished. Simple assessments of pain include the Numeric Rating Scale, in which a client is asked to rate his or her pain on a scale from 0 to 10, with 0 equaling "no pain" and 10 equaling "the worst pain the person can imagine." A Visual Analog Scale—in which a 10-cm line is shown to the client, with one end being labeled "no pain" and the other end labeled as "worst imaginable pain" on which the client then indicates where his or her pain falls—is another alternative for quickly assessing the current level of pain experienced by the client. Although both of these measures are useful for monitoring pain, because they can be used to detect small changes in the client's experience of pain, it is important to remember that these scales do not provide information on changes in psychological distress or physical function that may be caused by pain (Richardson, 2006).

To assess pain in areas other than intensity, one must consider the use of a multidimensional pain scale, such as the McGill Pain Questionnaire (MPQ). This instrument assesses pain in sensory, affective, and evaluative areas. Although the MPQ has been used in a variety of settings, it can take up to 20 minutes to complete and may not be appropriate for use during the initial assessment of the client. Rather, the clinician may wish to indicate that, as part of the care plan, a more comprehensive assessment of the client's pain be conducted with a referral to a pain clinic.

Having completed this portion of the medical history and assessment of health behaviors and practices, it is important for the clinician to include recommendations in the care plan that will help mitigate or remove the impact of any deficiencies (Wallace et al., 2006).

The final area to cover as part of the medical history and assessment of health behaviors and practices is an assessment of emotional well-being.

Assessment of Emotional Well-Being

The assessment of emotional well-being as part of the comprehensive assessment should focus at a minimum on the presence of depression and/or anxiety. However, if at all possible, the clinician should explore

a range of psychiatric symptoms and the psychiatric illnesses associated with those symptoms.

The assessment for depression in older adults is probably the most easily accomplished because of the amount of clinical anecdotal information on the frequency of depression in older adults, the research suggesting that rates of depression in older adults are higher than for younger populations, or the belief that depression is considered to be among the more treatable of emotional conditions experienced by older adults (Gallo & Wittnik, 2006b). Regardless of the reason for this focus on depression, it is important that it be assessed. Because of the amount of attention paid to depression, the availability of aids to assist in determining the presence of depression is extensive. A discussion of those aids occurs in almost any book addressing the care of older adults as well as those that specifically address mental-health issues with this population (Blazer, 1998, 1999; Chiu & Ames, 1994; Gallo et al., 2006; Kurlowicz, 2001; Schneider, Reynolds, Lebowitz, & Friedhoff, 1994). What the clinician must remember is that whichever aid he or she chooses, the focus should be on ease and simplicity of administration during an extended information gathering process.

Assessment of anxiety is also important with older adults, and Blazer (1998) probably provides one of the more cogent discussions of the need for assessing this area of emotional well-being in older adults. One particular reason for assessing anxiety is the fact that, in older adults, depression and anxiety can present with similar symptom pictures. Thus, an appropriate differential diagnosis assessment of both becomes important (Blazer, 1998; Diffenbach, 2001).

Additionally, should the older adult present with symptoms or describe symptoms to the social work practitioner that suggest the presence of other psychiatric illnesses, the clinician should assess for that emotional problem as well or, at the very least, refer the older adult for a complete psychiatric evaluation.

Once the clinician has completed gathering information on medical history, nutritional status, health practice and behaviors, and emotional well-being, the focus of the interview should turn to obtaining information on the social, economic, and environmental well-being of the older adult.

Assessment of Social, Economic, and Environmental Well-Being

The assessment of the social, environmental, and economic well-being of the older adult client as part of a CGA encompasses a wide range of topics. It is also during this part of the interview that the clinician will interview those providing care to the older adult to determine the stability of the caregiving relationships and the stress that those providing care may be experiencing (Morano & Morano, 2006). This is the area

of assessment in which the social work practitioner is likely to be most comfortable, because it mirrors those areas of assessment in which the social worker has received extensive training and has had the most practice experience.

Social Assessment

The focus of the social assessment should be on both the extent of the social system or social network that surrounds the older adult and on the quality of that system. The clinician needs to determine the number of persons who make up the support system; the number of persons in the support system whom the client identifies as significant; the relationship to the older adult of each person who is identified as significant; and the amount, intensity, and quality of contact that the older adult has with those as identified as significant. Some sense of the amount and quality of contact with those identified as less significant should also be determined. The clinician needs to particularly identify those serving as caregivers to the older adult and determine the amount of care that each is providing. Once this information has been obtained from the client, the clinician should seek permission from the client to, at a minimum, meet and talk with those providing care.

Interaction with the caregivers should focus on the medical conditions, ADLs, IADLs, and other areas in which care is provided; the amount of care required by the client in terms of hours per day; how the caregiving load is distributed among the various caregivers; the extent to which each caregiver experiences providing care as a burden; and the degree to which each of the caregivers derives satisfaction from the caregiving experience. Morano and Morano (2006) provide an excellent discussion of these elements of social assessment.

Unique areas included with the social assessment of older adults include specific assessment for the presence of elder mistreatment, assessment of spiritual well-being, and values clarification to assist with advanced directives. The assessment for elder mistreatment should focus on determining whether the older adult has been or is the victim of physical abuse, caregiver or self-neglect, psychological abuse, and financial exploitation (VanderWeerd et al., 2006). Assessing for the possibility of elder mistreatment is particularly important when conducting an assessment in which the older adult has a dementing illness, because the research suggests that the presence of elder mistreatment in these families is significantly higher than in the general population (Paveza et al., 1992).

In addition to assessing for elder mistreatment, the clinician should spend some time assessing the spiritual well-being of the older adult. This is a time in the older adult's life when he or she may rekindle his or her spirituality. Other older adults, who may have always been spiritually active, find themselves cut off from those activities that have been part of their spiritual life (Morano & Morano, 2006). For this reason, it is important

to determine previous level of spiritual activity, current level of activity, and desired level of activity as well as some understanding of the general importance of spiritual beliefs and activity in the older adult's life. Building on this, the clinician should determine whether there has been a change in the level of activity, information concerning the older adult's perception of the importance of such activity in his or her life, and any impact that a change in participation may be having on the older adult's quality of life (Morano & Morano, 2006).

The exploration of the importance of spirituality in the older adult's life can also serve as a good starting point for a discussion of values and a clarification of values related to the older adult's wishes concerning end-of-life care. What are the older adult's beliefs concerning the use of heroic measures to being kept alive? Are there circumstances in which the older adult would not wish to be resuscitated? What are they specifically? It is also important to explore whether the older adult has designated health-care surrogates and whether the appropriate documents are in place to permit his or her wishes concerning end-of-life health care to be acted on. It is important to determine whether the older adult has shared with the health-care surrogates his or her wishes about health-care choices so that, if the older adult is no longer able to make those decisions, the health-care surrogate can effectively act for the older adult.

If this discussion has not occurred, then the information obtained during this part of the assessment can be used as part of the care-planning process to engage family members around these wishes and have everyone who might have an interest in the well-being of the older adult clearly aware of what the person's wishes are concerning end-of-life care. In far too many instances, the older adult may have in place a do-not-resuscitate document, a durable power of attorney for health care and possibly for finances, and a living will; however, the older adult has never had a conversation with family members about these things. With a lack of clear direction from the older adult, family members often end up disagreeing about the type and level of care to be provided. Significant animosity can and does develop in families around such decisions, often resulting in lifelong disruptions in family relationships. With a little planning and preparation, the older adult can be assisted by the clinician to engage with other members of the family about the specific type and level of care he or she desires under various circumstances. This information can then be reduced to a written document that is provided to all relevant members of the family. Although not a perfect solution, it is likely to reduce the frustration that family members experience when having to make health-care decisions for their parents or siblings (Doukas et al., 2006).

With the completion of the assessment of the social network and related elements, the clinician can turn his or her focus to the final two areas of the assessment process: economic well-being and environmental assessment.

Economic Well-Being

Assessment of economic well-being involves determining not only how much income the older adult has but also the number of persons dependent either completely or in part on that income. However, economic well-being goes beyond a simple accounting of income and those dependent on it. The assessment needs to determine what demands are placed on that income in terms of expenditures and whether the older adult perceives that income to be sufficient to meet his or her needs and those of the persons dependent on that income (Fillenbaum, 1988; Morano & Morano, 2006). A thorough review of the older adult's economic well-being permits the clinician to have a clear sense of what types of economic assistance the older adult might need and how willing the person is to accept help.

Environmental Assessment

The final area for review in the comprehensive assessment is the assessment of the older adult's physical-living environment. This requires the clinician to visit the place where the older adult lives, whether this is an independent-living situation, an assisted-living facility, or a long-term-care facility. If the clinician is conducting an assessment prior to a hospital discharge, it will be important for the clinician to consider making a visit to the place to which the older adult will be initially discharged and also to the place where the client will permanently live, if it is different.

Environmental assessment should include a complete tour of the residence, with the clinician paying particular attention to elements in the environment that may affect the quality of life for the older adult or pose a physical impediment or hazard. Elements that the clinician needs to observe, for instance, are the presence of handrails and grab-bars in bathing and toileting areas, presence of stairways, and how often they must be used by the older adult. Additionally, the clinician should note the presence of throw rugs and/or electrical extensions that may pose a hazard to the older adult with mobility problems. Attention should be paid to whether heating, cooling, and ventilation are adequate for both summer and winter, whether lighting is adequate to permit objects to be seen and recognized, whether knobs on faucets can be turned easily and water temperature adjusted without the older adult being scalded or burned, and whether door knobs can be easily opened and closed as well as some general sense of the atmosphere of the living environment. Morano and Morano provide an excellent checklist in the *Handbook of Geriatric Assessment*, fourth edition (2006). A consideration during this review should be determining the number of persons who occupy the physical environment. The clinician needs to determine whether there is ample room for all to live adequately and for all to have some privacy when needed.

Once the clinician has completed the review of the older adult's actual living quarters, attention needs to be directed to the surrounding

environment. Things to be considered include the safety of the neighborhood; ease and access to transportation, including a thorough review of whether the older adult is still driving; and whether this is still in the older adult's best interest (Carr & Rebok, 2006; Morano & Morano, 2006). Other items of interest should include the availability of sidewalks and their state of repair in relation to the impact this might have on the older adult's mobility. Depending on the information obtained during the review of the client's total environment, important recommendations may need to be included in the care plan concerning modifications to the living environment and its surroundings, the older adult's ability to continue driving, and transportation alternatives that can help ensure that the older adult can obtain food, pay bills, and keep doctor's appointments (Carr & Rebok, 2006).

The Care Plan

On conclusion of the assessment process, the clinician needs to compile a complete report that summarizes all the relevant findings from the assessment. What specifically should be included in the report depends on what the clinician uncovers during the assessment process. At a minimum, information from all the areas explored should be included in the care plan, including findings on mental status, functional ability, medical history, nutrition and health practices, social network, economic well-being, and the living environment. The plan should report on the older adult's ability to function in the community and on the older adult's quality of life as well as provide information that supports the recommendations for services or assistance. A person reading the report should be able to connect any intervention recommended as part of the care plan to a clearly stated finding from the assessment process by referencing specific links to elements of the assessment (Gallo et al., 2000). The format of the report should be such that both a layperson—most likely the older adult, the caregiver, or some other family member—as well as paraprofessionals working in the health-care and social-service fields and professionals working in a variety of medical-care and social-service settings, can all easily understand the recommendations and the information that brought the clinician to those recommendations. Such a report will make it easier for the clinician to negotiate and advocate for the older adult as the clinician seeks appropriate services for him or her.

In making recommendations, the clinician needs to be prepared to draw from a wide range of potential interventions, particularly when working with community-dwelling older adults. Recommendations might include education for family caregivers to assist them with improving their skills in caring for the older adult, family counseling to help the family cope with the stress of their situation, and community-based health and social services, including home health care, adult day care, and other services. Also included in the services to be considered is placement in either an assisted-living facility or other more intense long-term-care living

arrangement. The clinician needs to be prepared to support and assist the older adult and the family members as they review the recommendations and make their choices. The clinician must always remember that the ultimate choice in selecting interventions belongs to the older adult and those providing care to that older adult, not to the person doing the assessment and making recommendations.

Conclusion

In concluding this chapter, I wish to briefly discuss the literature that provides some insight into the effectiveness of CGA. Findings concerning the effectiveness of CGA have been mixed. Several studies have raised questions about the effectiveness of CGA, with Ruben et al. (1995) clearly showing that such assessments did not improve the health or survival of hospitalized geriatric patients, and Siu et al. showing that assessments carried out prior to hospital discharge did not improve outcomes for frail elderly (1996). On the other hand, Rubenstein et al., Struck et al., Alessi et al., Naylor et al., Buurman et al., Ellis et al., and Pilotto et al. all provide evidence for the effectiveness of comprehensive assessment in improving outcomes and delaying disability in older adults, helping identify new problems when assessment is repeated annually and in fewer recurring hospitalizations (Alessi et al., 1997; Buurman, Parlevliet, van Deelen, de Haan, & de Rooij, 2004; Ellis, Whitehead, Robinson, O'Neill, & Langhorne, 2011; Naylor et al., 1999; Pilotto, Addante, D'Onofrio, Sancarl, & Ferrucci, 2009; Pilotto et al., 2011; L. Z. Rubenstein, Stuck, Siu, & Wieland, 1991; Stuck et al., 1995b). The meta-analysis of several studies clearly suggests that although the evidence might be divided, the majority of the studies included in the meta-analysis and the meta-analysis itself conclude that CGA enhances implementation of care recommendations and client adherence to those recommendations (Stuck, Wieland, Rubenstein, Siu, & Adams, 1995a).

Conducting a CGA as described here is likely to improve the care provided to older adult clients and result in delaying more negative outcomes.

Key Terms

Geriatric assessment

Mental status

Effectiveness of
geriatric assessment

Functional status

Care planning

Review Questions for Critical Thinking

1. Why do I need to have an understanding of CGA for my practice?
2. What are the critical elements for me to include in my work with older adults, and what is my rationale for including those elements?

3. How can I effectively include such elements in my interview and practice that allow me to gather this information while maintaining my relationship with my clients?

Online Resources

http://hometownhealthonline.coursehost.com/engine/Academic/Tools/CoursePublicize.asp?pk=76426&LID=1&ky=d_BPDiQVRgHzDiPRUmf_DgHzKrvOMqjz HomeTown Health University offers an online course to learn how to conduct comprehensive assessment in geriatrics. This course is designed to instruct health-care personnel on how to provide a CGA.

http://www.medscape.com/viewarticle/465308_4 General information about the components of a CGA as well as various screening tests that are offered (brief description of each). The site also gives information regarding who would benefit from this screening.

<http://www.uptodate.com/contents/comprehensive-geriatric-assessment> This website outlines components of CGAs, its efficacy, and its indications. Sections are outlined that review the assessment team, how to conduct the assessment, assessment tools, and so on.

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