

Overview of High Yield Geriatrics Assessment for Clinic and Hospital



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KEYWORDS

- Geriatric assessment • Geriatrics • Functional status • Cognition
- Geriatric syndromes • Polypharmacy

KEY POINTS

- Geriatric assessment is critical for all providers, in the hospital, in the clinic, or in the home care setting, to consider in caring for older adults.
- Geriatric assessment should focus on careful evaluation of older patients' cognition and physical function and should include an assessment for common geriatric syndromes.
- As part of a comprehensive geriatric assessment, providers should provide a careful assessment of patients' medications and be able to identify medications that may put older patients at risk for adverse events.
- Geriatric assessment should be tailored to patient values and goals and take into consideration multimorbidity and life expectancy.

INTRODUCTION

Older adults face unique social and health challenges, and, as the population of the United States continues to age, it is critical that practitioners are able to develop and use a framework for assessing older adults. Geriatric assessment refers to the comprehensive, multifaceted, and interdisciplinary evaluation of medical, socioeconomic, environmental, and functional concerns that are unique to older adults. Data from several investigations demonstrate that comprehensive geriatric assessment, especially for patients in the inpatient setting, offer significant benefit for older adults despite higher cost; patients who underwent geriatric assessment were more likely to survive hospitalization and remain in their own home after discharge.¹ Although providers may perceive it to be challenging to care for older adults, geriatric assessment can provide a helpful framework by which to evaluate multimorbidity, ultimately

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allowing providers to more easily and safely manage medical complaints, uncover social or economic issues that may impact medical care, and provide high-value care according to patients' goals and priorities.²

A geriatric assessment can take place in a variety of settings, including in the home, in the clinic, in the hospital, or in the rehabilitation setting, and may require a brief, focused examination or a more extensive, broader review within a larger number of domains, depending on the needs of the patient and the concerns of the clinician. A geriatric assessment should be a team-based effort and include collaboration among team members in pharmacy, nursing, social work, and rehabilitation (including occupational, physical, and speech therapy). The Medicare Annual Wellness Visit provides an opportunity to screen for concerns requiring further exploration in many of the domains covered in a comprehensive geriatric assessment.

COMPONENTS OF A COMPREHENSIVE GERIATRIC ASSESSMENT

Function, Cognition, and Assessment for Geriatric Syndromes

In assessing older adults, priority should be given to screening for common geriatric syndromes, constellations of clinical concerns that may cause significant morbidity for older adult patients. **Table 1** summarizes brief assessment tools that can be used in the evaluation of older patients.

Functional assessment	ADLs/IADLs Katz Index of Independence in Activities of Daily Living Lawton Instrumental Activities of Daily Living Scale
Cognitive impairment Dementia	Mini-Cog (screening) Montreal Cognitive Assessment (MoCA) Mini Mental State Examination (MMSE) Saint Louis University Mental Status Exam (SLUMS)
Delirium	CAM CAM-ICU
Depression	PHQ-2 Geriatric Depression Scale (GDS)
Falls	Timed get-up-and-go
Urinary incontinence	Michigan Incontinence Symptom Index (M-ISI)
Nutritional assessment	Mini Nutritional Assessment—Short Form (MNA-SF) Short Nutritional Assessment Questionnaire (SNAQ)

Functional Assessment

Functional status refers to patients' ability to perform the tasks necessary to meet their basic daily needs. Chronic disease often results in functional limitations and disability. Because a significant portion of older adults lives with chronic disease, it is important for the clinician to perform an assessment of an older adult's function. Clinicians may use this information to identify remediable conditions, the types of assistance needed, and potential interventions to allow the older adult to maintain independence.³ In addition, functional status correlates with quality of life and is a predictor of longevity.⁴

Functional abilities have been classified as basic activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (**Table 2**). ADLs include tasks that are

Activities of Daily Living	Instrumental Activities of Daily Living
Bathing	Using the telephone
Dressing	Preparing meals
Transferring	Laundry
Toileting	Housework/cleaning
Grooming	Shopping
Feeding	Transportation
	Managing medications
	Finances

necessary for maintaining basic self-care on a daily basis. IADLs include tasks necessary to maintain independence in a community.

A comprehensive geriatric assessment should include evaluation of an older adult's ability to perform the tasks listed in **Table 2**. The Katz Index of Independence in Activities of Daily Living and the Lawton Instrumental Activities of Daily Living Scale are tools that have been developed to assist the clinician in measuring functional status.⁵

Deficits in ADLs and IADLs occur when there is disconnect between patients' capabilities and their environmental demands. Inability to perform any of these tasks independently should prompt further assessment and rehabilitation, which often requires consultation from interdisciplinary team members, including physical and occupational therapy.⁶ The clinician should also consider what, if any, supports are currently in place to help patients accomplish such tasks. Such supports may include delegation to a caregiver, environmental modifications, or even nursing home placement.

Gait, Balance, and Falls

Falls are a common cause of injury in older adults and, therefore, risk factors should be considered part of a functional assessment for all geriatric patients. In performing this part of the geriatric assessment, clinicians should ask their patients about a history of falls in the last year, fear of falling, or whether they perceive any balance or gait problems. A positive answer to any of these questions should prompt further investigation to identify potential risk factors.⁷

A variety of both extrinsic and intrinsic factors may put an older adult at risk of falling, but assessment of transfers, gait, and balance has the advantage of being easily observable in a variety of clinical settings. Much can be gleaned from observing an older patient rise from a seated position and ambulate several feet. Rising from a seated position requires core and proximal muscle strength. Some patients may experience postural hypotension, which can be evaluated with orthostatic vital signs. Features of an older adult's gait, including balance, speed, arm swing, and turns, may also provide useful information and should be closely observed.

The "timed get-up-and-go" is a validated tool whereby the older adult must stand from a seated position, ambulate 10 feet, turn around, walk back, and return to a seated position while being timed by the observer. A time of greater than 12 seconds has been linked to a greater risk of falls.⁸ In addition, gait speed less than 0.8 m per second has also been shown to be predictive of falls, frailty, and mortality in older adults.⁹

Cognition and Mental Health

Changes in memory and cognitive function commonly go underrecognized in older patients. These changes can have significant impact on older adults' ability to manage medical comorbidities, perform necessary ADL, and successfully remain independent and active in their community.

In assessing cognitive impairment, providers should ask patients about any concerns about their memory function. Because many patients may not notice or report memory concerns, and there can be some social stigma surrounding memory loss, it may be important to obtain collateral information from patients' caretakers or family members about any memory impairments. The Mini-Cog, which includes a 3-word recall and a clock draw test, is a brief screening examination for cognitive impairment and may be performed rapidly in the office or the inpatient setting in order to identify patients who may require further workup of cognitive concerns.¹⁰

Dementia

For patients who express concerns about their memory and also demonstrate impairments in their daily function, providers should consider further evaluation for a cognitive disorder. First, providers should take care to rule out the possibility of underlying medical or "reversible" causes that may result in cognitive changes, such as electrolyte abnormalities or untreated medical conditions (ie, infection, arrhythmia, or thyroid disorders), and patients should be screened for signs and symptoms of delirium. Acute mood disorders, such as depression or anxiety, should be addressed, because these may contribute to cognitive decline. Patients with memory concerns should also undergo assessment of hearing and vision complaints. Evaluation of dementia should include a thorough physical examination, including a full neurologic assessment.

Several cognitive tests evaluate the severity of cognitive impairment and identify the specific cognitive domains affected. The Montreal Cognitive Assessment, the Mini Mental State Examination, and the Saint Louis University Mental Status Examination are short evaluations that are commonly used as first-line testing in patients with reported memory concerns.^{11–13}

A patient's clinical situation and description of symptoms should be reviewed in order to guide further assessment and testing needs. Basic evaluation may include complete blood counts, metabolic panel, thyroid-stimulating hormone, vitamin levels, or glucose and hemoglobin A1c level. Providers should consider performing brain imaging (such as noncontrast computed tomographic scan or MRI) if there is a concern for recent fall or injury (ie, to evaluate for an acute process, such as a subdural hematoma), or new or localizing neurologic symptoms (which might suggest acute cerebrovascular accident or Parkinsonism). Any patient with findings concerning for rapidly progressive memory loss may require urgent evaluation for more rare causes of dementia.

Delirium

Delirium is a common occurrence, particularly for older adults in the inpatient (hospital) setting, and has been noted to contribute to increased length of hospital stay as well as higher risk for post-hospital institutionalization (ie, nursing home placement). Commonly, delirium is seen as a postoperative complication in older adults, although it can also be seen in the intensive care unit (ICU), in the emergency room, or in palliative care or hospice setting in patients who are approaching the end of life.

Delirium is defined as an acute, reversible change in attention, awareness, and cognition. It may fluctuate in severity (and is notably separate from any preexisting dementia). It may present with signs of significant agitation or psychomotor overactivity

(“hyperactive delirium”) or with symptoms like somnolence, sedation, and slow speech and movements (“hypoactive delirium”).¹⁴

Assessment of older adult patients, especially in the hospital setting, should include screening for delirium with the Confusion Assessment Method (CAM) tool; the CAM-ICU tool may be used to assess ICU patients.^{15,16} The basic treatment for delirium should focus mostly on minimizing aspects of the physical environment that may contribute to delirium: ensuring appropriate sleep-wake cycle and minimizing disruption of sleep (ie, by limiting overnight interventions, such as vital signs monitoring), encouraging cognitive stimulation by family members or nursing staff, ensuring patients have appropriate assistive devices, such as hearing aids and glasses, and removing medical devices like urinary catheters, intravenous catheters, and telemetry monitors when appropriate. Medical interventions should focus on treating underlying medical issues that may contribute to acute confusion, such as treating infections and ensuring management of constipation or urinary retention, appropriate treatment of and prevention of pain, and avoidance or restriction of medications that may contribute to delirium (such as benzodiazepines, opioids, anticholinergics, antipsychotics, and so forth) (**Box 1**).

Mood

Depression and other related mood disorders may be underidentified and untreated in older adults.^{17,18} The US Preventive Services Task Force recommends that all adults, including older adults, receive periodic screening for depression; for most patients, the Patient Health Questionnaire-2(PHQ-2) is a useful, quick, and easy screening test that may be used in older adults.^{19,20} The Geriatric Depression Scale (GDS) is a longer, validated tool for depression screening in older adults.²¹ Patients who have underlying chronic illnesses, psychosocial stressors, a history of depression or other psychiatric illness, and those who live in long-term care facilities may be at increased risk for developing depression. Providers should monitor these patients carefully for changes in mood. Patients’ caregivers, such as family members or care providers (like home health aides or visiting nurses), may also be useful in reporting clinical symptoms of depression.

For patients with mood concerns, it is critical for providers to conduct a thorough social history, including a history of recent or remote alcohol and substance abuse. Providers should be sure to ask about other associated symptoms, such as sleep and appetite. A positive PHQ-2 or GDS assessment, report of a personal history of

Box 1

Strategies for management and prevention of delirium in older adults

- Treatment of underlying/precipitating medical issues
- Removal of unnecessary medical devices (intravenous catheters, urinary catheters, and so forth)
- Ensuring appropriate sleep-wake cycle (ie, limiting sleep disruption)
- Encourage normalization of daytime routine (out of bed, ambulating if able)
- Social stimulation (nursing staff, family, friends, and so forth)
- Treat and prevent pain
- Discontinue or limit medications that may contribute to delirium
- Ensure access to appropriate assistive devices (glasses, hearing aids)

depression or other underlying psychiatric disorder, or the presence of severe psychiatric symptoms should prompt further psychiatric assessment.

Other Geriatric Syndromes

Vision impairment

Visual impairment can be a significant concern for older adults and can play a large role in older patients' ability to successfully age in the community. Patients should be asked about recent changes in their vision or perceived decrease in visual acuity; ophthalmologic history, including use of glasses or bifocal lenses, should be obtained. Routine ophthalmologic assessment and visual acuity testing should be encouraged. Poor vision can contribute to low mood and social isolation and may put patients at risk for harm as a risk factor for falls; patients expressing concern about low vision should be referred for ophthalmologic assessment, and providers should consider formal home safety assessment or modifications for patients with significant visual impairment.

Hearing impairment

Age-related hearing loss is common among older adults and may have significant impact on patients. Poor hearing is known to be a risk factor for dementia and may contribute to social isolation and depression.^{22,23} Patients and family members should be asked about hearing concerns, and providers should encourage formal hearing assessment and, if indicated, consideration for hearing assistive devices (such as hearing aids).

Weight loss and nutritional assessment

A geriatric assessment should include a review of the patient's weight and diet. Patients may perform a "dietary recall," which may help the practitioner to understand the frequency and content of meals. If there is a concern for weight loss, providers may perform a review of systems, including constitutional symptoms, such as fevers or night sweats, dental concerns (such as caries and tooth pain), and gastrointestinal symptoms (such as dysphagia, odynophagia, abdominal pain, vomiting, changes in bowel habits), which may guide further assessment. Assessment of potentially contributing medications or medical comorbidities should be performed by clinicians, and providers should consider further assessment by a registered dietitian or nutritionist if there are concerns in regards to dietary intake. For patients who report dental concerns, referral to a dentist may be required, especially in patients who may require adjustment of dentures or other dental devices. Patients should be asked about financial stressors, access to food, and possible food insecurity, and, if necessary, providers should work to identify food resources for patients in need. Providers may perform a brief nutritional assessment or administer a malnutrition screening tool (such as the Mini Nutritional Assessment short-form or Short Nutritional Assessment Questionnaire) to better assess older patients' risk for malnutrition and weight loss.^{24,25}

Incontinence

Urinary incontinence is a common geriatric syndrome that can severely impact older patients' quality of life, and urinary incontinence can also represent a significant concern for caregivers of older patients. Patients should be asked about urinary symptoms, such as urinary frequency, urgency, voiding patterns (including daytime and nighttime voiding), and fluid intake; utilization of a urinary incontinence screening tool, such as the Michigan Incontinence Symptom Index, may be useful.²⁶ Patients concerned about urinary issues should have a thorough medication review, with

particular focus placed on use and timing of diuretics, as well as anticholinergic medications, such as antidepressants, antipsychotics, opioids, and benzodiazepines, which may contribute to urinary retention.

Older adults may also experience fecal incontinence, and providers should also ask patients about their usual bowel function, regularity, and ability to maintain control of bowel movements.

Polypharmacy and Medication Review

A careful medication review is an essential part of a geriatric assessment. Polypharmacy, defined as the simultaneous use of multiple medications, increases older patients' risk for medication interactions, adverse side effects, poor adherence, and increased financial burden; polypharmacy may also contribute to increased health care–related costs.²⁷ Performing a “brown-bag” review, in which the patient brings their medication bottles to each appointment with a provider, can serve as a useful tool to ensure patients are filling and taking their prescriptions appropriately, and may help providers uncover potential safety issues because of old or expired prescriptions, duplicate prescriptions, or other inaccuracies in a patient's medication list.

In addition, older adults may be at increased risk for adverse events for common medications. The Beer's criteria proposes a list of medications that may potentially be inappropriate for use in older adults because of a high risk of side effects or adverse events and can serve as a reference for identifying potentially high-risk medications²⁸ (Table 3). An additional resource for providers is the STOPP-START (Screening Tool of Older Persons' Prescriptions–Screening Tool to Alert to Right Treatment) criteria, which provides an evidence-based review in support of (or against) the use of certain medication classes for specific clinical indications.²⁹

It is important to consider other factors that may make medication management challenging for older adults. For example, memory disorders or poor cognitive function may make medication adherence challenging for patients. Poor vision also may present a challenge for patients who may need to visualize pill bottle instructions, for individuals who rely on visual function for dosing of medications (ie, for drawing up insulin in a syringe), or for reading medication instructions. The Medi-Cog is 1 tool that may be used in the ambulatory setting to determine a patient's ability to safely manage their medications.³⁰

Additional Components of a Comprehensive Geriatric Assessment

Routine health maintenance

As for all patients, health maintenance should be systematically and routinely reviewed as part of routine care for older adults. One opportunity to do so is during the Medicare Wellness Visit. This annual visit is free to Medicare beneficiaries and provides an opportunity for clinicians to perform a health risk assessment and develop a personalized prevention plan.

Cancer screening can be a difficult topic for clinicians to discuss with their older patients, in part because of challenging conversations that may arise when taking patients' overall health, medical comorbidities, and life expectancy into consideration for cancer screening decisions. The American Board of Internal Medicine's “Choosing Wisely” campaign recommends that providers take into consideration individual patients' life expectancy when considering whether to offer cancer screening, although in practice, both clinicians and patients have described a lack of comfort in navigating these conversations.^{31,32} A trusting physician-patient relationship, with clear understanding of the patient's personal and health-related goals and preferences, is critical in making decisions about screening for breast, colorectal, lung, or prostate cancer.³³

Table 3	
2019 Beers criteria—selected medications that may cause harm in older adults	
Class of Medication	Potential Harm
Antihistamines, first generation Chlorpheniramine Diphenhydramine Hydroxyzine Meclizine Promethazine	Anticholinergic side effects (confusion, dry mouth, constipation)
Antispasmodics Dicyclomine Scopolamine	Anticholinergic side effects; uncertain effectiveness
Antipsychotics, first and second generation	Increased risk of stroke; increased mortality in patients with dementia
Benzodiazepines Alprazolam Clonazepam Diazepam Lorazepam	Increased risk of cognitive impairment, delirium, falls, fractures
Benzodiazepine receptor agonist hypnotics Eszopiclone Zaleplon Zolpidem	Increased risk of delirium, falls, fractures; minimal improvement in sleep latency and duration
Clonidine	Adverse central nervous system effects, bradycardia, orthostasis
Digoxin	Increased risk of toxic effects; avoid using as first-line agent for atrial fibrillation or heart failure
Megestrol	Minimal effect on weight; increased risk of thrombotic events
Metoclopramide	Extrapyramidal effects, including tardive dyskinesia
Muscle relaxants Cyclobenzaprine	Anticholinergic effects; sedation; increased risk of fractures; questionable effectiveness
Nifedipine, immediate release	Hypotension, myocardial ischemia
Nitrofurantoin	Avoid if creatinine clearance <30 due to increased risk of toxicity
Nonsteroidal anti-inflammatory drugs, non-cyclooxygenase-selective Diclofenac Ibuprofen Indomethacin Meloxicam Naproxen	Increased risk of gastrointestinal bleeding or peptic ulcer disease; can increase blood pressure and induce kidney injury
Peripheral alpha-1 blockers Doxazosin Prazosin Terazosin	High risk of orthostasis
Proton-pump inhibitors Omeprazole	Avoid scheduled use >8 wk (unless high-risk patient) due to risk of

(continued on next page)

Table 3 (continued)	
Class of Medication	Potential Harm
Pantoprazole Lansoprazole Esomeprazole	<i>Clostridioides difficile</i> infection, bone loss, and fractures
Sliding scale insulin without concurrent use of basal insulin	Higher risk of hypoglycemia without improvement in hyperglycemia management
Sulfonylureas, long-acting Glimepiride Glyburide	Higher risk of severe prolonged hypoglycemia
Tricyclic antidepressants Amitriptyline Nortriptyline	Anticholinergic side effects; sedation; orthostatic hypotension

Data from 2019 American Geriatrics Society Beers Criteria Update Expert Panel. American Geriatrics Society 2019 Updated AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. *J Am Geriatr Soc.* 2019 Apr; 67 (4): 674-694.

Clinicians should ensure that older patients are receiving other appropriate preventive health interventions, in particular, vaccinations for influenza, pneumococcal pneumonia, herpes zoster (shingles), and pertussis (whooping cough); other routine vaccinations should be considered according to an individual patient's needs and medical comorbidities.³⁴

Providers should be sure to discuss other routine health maintenance concerns that may often be overlooked in older adults, such as sexual health (and concerns about sexual function), and tobacco, alcohol, and other substance use.

Physical activity

The US Department of Health Guidelines recommend 150 minutes of moderate- to high-intensity physical activity weekly for most older and younger adults as part of a healthy lifestyle. For older adults, the guideline further recommends multicomponent physical activity, including balance, strength training, and aerobic exercise.³⁵ Physical activity has many health benefits, which together can reduce disease and disability while improving quality of life, including decreased risk of early death, fall prevention, and improved cognitive function.³⁶

Clinicians should ask older adults about current levels of physical activity as part of the geriatric assessment and recommend 150 minutes of multimodal exercise. For patients with physical and medical limitations, an exercise regimen can be tailored to their needs; even smaller amounts of physical activity have been shown to have health benefits.³⁵

Social assessment

The social assessment of an older adult should include information about the older adult's living situation, available support services (such as home health aides), and social network, including emergency contacts or legal power of attorney. Adequate social support is important for health because it can improve the management of chronic disease and decrease hospital utilization.²

As they age, approximately 90% of older adults remain in their own homes. Of those living in the community, about one-third live independently.³⁷ Thus, a comprehensive geriatric assessment should include an evaluation of the older adult's home

environment and safety. If concerns are detected, home safety evaluations can be requested and performed by local home care agencies. It is also important to consider any social or financial hardships that may place patients at risk. Suspicions of abuse or neglect should be reported to the local agency on aging.

Driving

Older adults are at higher risk of automobile accidents because of a variety of conditions that are more prevalent in older age. Some states require clinicians to report to their local department of motor vehicles if there is an older adult about whom they have concerns for unsafe driving. Conditions that affect an older adult's ability to drive may include visual impairment, hearing impairment, cognitive impairment, physical disability, and medication use. Recognizing their own limitations, many older adults may independently opt to modify their driving patterns. Some may choose to only drive short distances, to avoid highways or high traffic areas, or to only drive during daylight hours.³⁸

For those who continue to drive, the clinician should ask about automobile accidents and screen for conditions that may hinder an older adult's ability to drive safely. An evaluation of driving safety should begin with asking the older adult about history of automobile accidents. The clinician may wish to engage family members in this discussion. Asking a family member whether they feel comfortable riding with the older driver can often yield useful information. If concern is present, the clinician should consider any pertinent medical history and review medications in detail. Physical examination should focus on visual acuity, range of motion, and balance. Cognitive testing may identify cognitive impairment and executive dysfunction, although results have not been shown to consistently correlate with driver safety and must be interpreted in context.³⁹

Because many older adults depend on driving to maintain their independence, it is important to recognize that the recommendation that a patient discontinue driving may be a difficult conversation. For older adults, relinquishing the ability to drive has been associated with a loss of independence and depression.³⁸ In cases whereby there is question of a driver's ability, older adults may be referred for formal driving evaluation. These assessments are conducted by trained occupational therapists, who can confirm unsafe driving habits or offer modifications to enhance driving safety.

Goals, values, and advance care planning

Understanding a patient's goals and values is a critical part of a geriatric assessment and should be used to guide further discussions about medical testing and treatment. Typically, providers consider "advance care planning" to reflect "code status" or "do-not-resuscitate" wishes, but in actuality, a broader, clearer understanding of a patient's priorities for their life and health can be vital for providers who care for them. "What brings you joy?" may be a helpful question to ask of older adults so that clinicians can begin to learn about their patients' lives and well-being outside of the medical setting.

Advance care planning involves a patient planning for future health care decisions in the event that he or she becomes incapacitated. Clinicians should aid in this process by helping patients understand their illnesses and treatment options, discussing a patient's values and goals, and eliciting treatment preferences.⁴⁰ Patients should be encouraged to include family and/or friends in these discussions and to identify a health care proxy or surrogate decision maker. Discussion of advanced directives (such as "do-not-resuscitate" status) has been shown to improve end-of-life care.

Overall, advance care planning has been associated with lower rates of in-hospital death and hospice use.⁴¹ Prioritizing patients' values and goals, and taking into consideration their spiritual and emotional well-being, especially in the face of challenging medical decisions, can provide clarity for practitioners and ensure that patients' needs are being appropriately met.

SUMMARY

By 2030, the population older than 65 years will double to 72 million (20% of the total US population).⁴² Primary care and hospital-based providers will be on the front line in the care of the growing population of older adults. A thorough review of acute and chronic medical concerns should be prioritized and considered within the context of common geriatric syndromes. A geriatric assessment evaluating cognition, function, mood, social and environmental factors, and goals of care, combined with the traditional review of systems, can help identify needs and improve the medical care and quality of life of older adults. By understanding that a comprehensive geriatric assessment can be complex and time consuming, these domains may be addressed longitudinally over a series of visits and may be enhanced by the input of interdisciplinary team members.

DISCLOSURE

The authors have nothing to disclose.

REFERENCES

1. Ellis G, Gardner M, Tsiachristas A, et al. Comprehensive geriatric assessment for older adults admitted to hospital. *Cochrane Database Syst Rev* 2017;2017(9). <https://doi.org/10.1002/14651858.CD006211.pub3>.
2. Seematter-Bagnoud L, Büla C. Brief assessments and screening for geriatric conditions in older primary care patients: a pragmatic approach. *Public Health Rev* 2018;39(1):8.
3. Williams TF. Comprehensive functional assessment: an overview. *J Am Geriatr Soc* 1983;31(11):637–41.
4. Keeler E, Guralnik JM, Tian H, et al. The impact of functional status on life expectancy in older persons. *J Gerontol A Biol Sci Med Sci* 2010;65A(7):727–33.
5. Elsayw B, Higgins KE. The geriatric assessment. *Am Fam Physician* 2011;83(1):48–56.
6. Quinn TJ, McArthur K, Ellis G, et al. Functional assessment in older people. *BMJ* 2011;343(aug22 1):d4681.
7. Summary of the Updated American Geriatrics Society/British Geriatrics Society Clinical Practice guideline for prevention of falls in older persons. *J Am Geriatr Soc* 2011;59(1):148–57.
8. Lusardi MM, Fritz S, Middleton A, et al. Determining risk of falls in community dwelling older adults: a systematic review and meta-analysis using posttest probability. *J Geriatr Phys Ther* 2017;40(1):1–36.
9. Studenski S, Perera S, Patel K, et al. Gait speed and survival in older adults. *JAMA* 2011;305(1):50–8.
10. Borson S, Scanlan JM, Chen P, et al. The Mini-Cog as a screen for dementia: validation in a population-based sample. *J Am Geriatr Soc* 2003;51(10):1451–4.
11. Tombaugh TN, McIntyre NJ. The mini-mental state examination: a comprehensive review. *J Am Geriatr Soc* 1992;40(9):922–35.

12. Nasreddine ZS, Phillips NA, Bédirian V, et al. The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. *J Am Geriatr Soc* 2005;53(4):695–9.
13. Tariq SH, Tumosa N, Chibnall JT, et al. Comparison of the Saint Louis University mental status examination and the mini-mental state examination for detecting dementia and mild neurocognitive disorder—a pilot study. *Am J Geriatr Psychiatry* 2006;14(11):900–10.
14. Marcantonio ER. Delirium in hospitalized older adults. *N Engl J Med* 2017;377(15):1456–66.
15. Inouye SK, van Dyck CH, Alessi CA, et al. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. *Ann Intern Med* 1990;113(12):941–8.
16. Grover S, Kate N. Assessment scales for delirium: a review. *World J Psychiatry* 2012;2(4):58–70.
17. Brown EL, Raue P, Halpert KD, et al. Evidence-based guideline detection of depression in older adults with dementia. *J Gerontol Nurs* 2009;35(2):11–5.
18. Charney DS, Reynolds CF, Lewis L, et al. Depression and Bipolar Support Alliance consensus statement on the unmet needs in diagnosis and treatment of mood disorders in late life. *Arch Gen Psychiatry* 2003;60(7):664–72.
19. Siu AL, US Preventive Services Task Force (USPSTF), Bibbins-Domingo K, et al. Screening for depression in adults: US Preventive Services Task Force recommendation statement. *JAMA* 2016;315(4):380–7.
20. Richardson TM, He H, Podgorski C, et al. Screening for depression in aging services clients. *Am J Geriatr Psychiatry* 2010;18(12):1116–23.
21. Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res* 1982;17(1):37–49.
22. Lin FR. Hearing loss and cognition among older adults in the United States. *J Gerontol A Biol Sci Med Sci* 2011;66A(10):1131–6.
23. Gurgel RK, Ward PD, Schwartz S, et al. Relationship of hearing loss and dementia: a prospective, population-based study. *Otol Neurotol* 2014;35(5):775–81.
24. Kaiser MJ, Bauer JM, Ramsch C, et al. Validation of the Mini Nutritional Assessment short-form (MNA-SF): a practical tool for identification of nutritional status. *J Nutr Health Aging* 2009;13(9):782–8.
25. Kruiženga HM, Seidell JC, de Vet HCW, et al. Development and validation of a hospital screening tool for malnutrition: the short nutritional assessment questionnaire (SNAQ). *Clin Nutr* 2005;24(1):75–82.
26. Suskind AM, Dunn RL, Morgan DM, et al. A screening tool for clinically relevant urinary incontinence. *Neurourol Urodyn* 2015;34(4):332–5.
27. Maher RL, Hanlon JT, Hajjar ER. Clinical consequences of polypharmacy in elderly. *Expert Opin Drug Saf* 2014;13(1). <https://doi.org/10.1517/14740338.2013.827660>.
28. By the 2019 American Geriatrics Society Beers Criteria® Update Expert Panel. American Geriatrics Society 2019 Updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. *J Am Geriatr Soc* 2019;67(4):674–94.
29. O'Mahony D, O'Sullivan D, Byrne S, et al. STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. *Age Ageing* 2015;44(2):213–8.

30. Anderson K, Jue SG, Madaras-Kelly KJ. Identifying patients at risk for medication mismanagement: using cognitive screens to predict a patient's accuracy in filling a pillbox. *Consult Pharm* 2008;23(6):459–72.
31. Society of General Internal Medicine | Choosing Wisely. Available at: <https://www.choosingwisely.org/societies/society-of-general-internal-medicine/>. Accessed February 13, 2020.
32. Schoenborn NL, Bowman TL, Cayea D, et al. Primary care practitioners' views on incorporating long-term prognosis in the care of older adults. *JAMA Intern Med* 2016;176(5):671–8.
33. Schoenborn NL, Lee K, Pollack CE, et al. Older adults' views and communication preferences about cancer screening cessation. *JAMA Intern Med* 2017;177(8):1121–8.
34. Kim DK, Hunter P. Advisory committee on immunization practices recommended immunization schedule for adults aged 19 years or older - United States, 2019. *MMWR Morb Mortal Wkly Rep* 2019;68(5):115–8.
35. Piercy KL, Troiano RP, Ballard RM, et al. The physical activity guidelines for Americans. *JAMA* 2018;320(19):2020–8.
36. Elsayy B, Higgins KE. Physical activity guidelines for older adults. *Am Fam Physician* 2010;81(1):55–9.
37. Institute on Aging | Information on Senior Citizens Living in America. Inst Aging. Available at: <https://www.ioaging.org/aging-in-america>. Accessed February 2, 2020.
38. Betz ME, Lowenstein SR. Driving patterns of older adults: results from the second injury control and risk survey. *J Am Geriatr Soc* 2010;58(10):1931–5.
39. Bennett JM, Chekaluk E, Batchelor J. Cognitive tests and determining fitness to drive in dementia: a systematic review. *J Am Geriatr Soc* 2016;64(9):1904–17.
40. Detering KM, Hancock AD, Reade MC, et al. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ* 2010;340. <https://doi.org/10.1136/bmj.c1345>.
41. Bischoff KE, Sudore R, Miao Y, et al. Advance care planning and the quality of end-of-life care among older adults. *J Am Geriatr Soc* 2013;61(2). <https://doi.org/10.1111/jgs.12105>.
42. Ortman JM, Velkoff VA, Hogan H. *An Aging Nation: The Older Population in the United States*. Hyattsville, MD: US Census Bureau; 2014.