



# Financial Gerontology

## THE FINANCIAL PROFESSIONAL'S ROLE IN COMPREHENSIVE GERIATRIC ASSESSMENT

Neal E. Cutler, PhD

A couple of weeks ago I was in a meeting with colleagues in geriatric medicine, geriatric nursing, and geriatric social work. One issue focused on how families should be made aware of the nature and value of "comprehensive geriatric assessment" programs for their older family members. To be sure, physicians, nurses, and social workers may be the "logical" professionals to take first notice that an older client or patient may benefit from a geriatric assessment, but clearly there are circumstances in which the financial adviser may also become a "front line" participant in this situation.

Consequently, in this examination of the connection between financial advisers and comprehensive geriatric assessment we examine three major topics and a few subtopics:

- First, what are the indicators of the need for geriatric assessment, including those that a financial adviser is likely to observe in his or her clients? Here we also look at the kinds of health concerns and worries that middle-age clients are likely to express in discussions with their financial adviser.
- Second, in response to these indicators of need, we look more directly

at what the phrase "comprehensive geriatric assessment" has come to mean, and what constitutes the multidisciplinary assessment team.

- Third, on a procedural level, resources are provided to help the financial adviser assist his or her client in locating an appropriate geriatric assessment facility either locally or nationally. To this we add a look at the somewhat uncharted waters of paying for a comprehensive geriatric assessment.

### The Role of the Financial Professional

Although not yet recognized by most gerontologists, it is quite logical and realistic that financial professionals will be on the frontline of the geriatric assessment discussion and referral process. The professional and academic activity of financial gerontology is driven, as we have written in this Journal,<sup>1</sup> by the highly publicized aging of the population. Clients with whom you have worked for two or three decades are now middle aged or elderly. At the same time, as research has also demonstrated, another important characteristic of an aging society is the fact that middle-agers are much more likely nowadays than in the past to have surviving elderly parents, a phenomenon known simply as "family aging."<sup>2</sup>

For example, in 2000, 80% of 50 year olds had at least one parent still alive, compared to only 52% as recently as 1940. Almost half (44%) of all 60-year-old "children" had at least one parent alive in 2000, compared to only 13% in 1940.<sup>3</sup> It is likely, therefore,

that a middle-aged client might be personally concerned about his or her own physical or mental health and discuss this with his or her financial adviser in the context of estate planning or long-term care insurance. Just as likely, or perhaps even more so as the volume and the complexity of family aging continue to expand, the middle-aged client will raise these questions about an elderly parent. Furthermore, from the vantage point of population aging, questions about geriatric health will become even more prevalent over the next decade since it is the oldest-old (age 85+) age group that is experiencing the most dramatic population increase.<sup>4</sup>

### Observable Indicators

Because financial advisers are not medical diagnosticians, the practical or "procedural" question becomes: What things should financial professionals look or listen for that suggest the probable utility of a comprehensive geriatric assessment? While the following list is not exhaustive, it includes many of the indicators that you or your client are able to observe. Note also that this list is *not in any order* of medical priority or urgency. Furthermore, the presence of any of these neither defines nor proves a medical problem, but is an indicator (or profile of indicators) of possible jeopardies or problems—which is why the comprehensive geriatric assessment is likely to be beneficial:<sup>5</sup>

- Over age 80
- Three hospitalizations in two months
- Confusion in taking multiple medications

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- Decline in mental health
- Decline in physical health
- Behavioral changes
- Frequent falls
- Weight loss
- Dramatic change in appetite
- Depression
- Memory loss
- Episodes of confusion
- Wandering
- No close family in the community

### Client Worries about Personal Health

Consequently, given these evolving gerontological demographics and the inevitable connections between aging and financial, estate, and retirement planning, there is an increasing likelihood that financial professionals will be asked questions about geriatric health. Questions about physical health are, perhaps, easier to deal with—a chest pain, shortness of breath, dizziness—we are more likely to see these as symptoms of a “real something” and call the doctor. Less straightforward, however, are questions about brain health and mental functioning. Our

own public opinion polling on the issue of public “health literacy” with respect to Alzheimer’s disease indicates that many people perceive forgetfulness in old age as the obvious and inevitable beginning of Alzheimer’s (which, by the way, is not true).<sup>6</sup>

How likely is it that a client will worry about and ask questions that focus on mental functioning? Based on the evidence, the answer is: *very* likely. A study I directed for the National Council on the Aging a few years ago asked people of all ages how much they were worried about their health as they looked ahead to their own old age.<sup>7</sup> We asked about being denied access to medical treatment because of age, suffering from uncontrollable pain, and losing your memory. As shown in Table 1, for both middle agers and older persons, worry is greatest in response to the question about losing one’s memory.<sup>8</sup>

Although forgetfulness in older age certainly does not automatically signal the onset of Alzheimer’s disease, if it is believed that forgetfulness is increasing, either in oneself or in one’s parents, then the worry is certainly real. Then the

question “What do I do next?” becomes very urgent. There are multiple reasons (causes) for forgetfulness as well as for other physical and mental changes that come with aging. If the symptoms accumulate or become more severe—or if the client becomes especially anguished because of the presumed causes or implications of the symptoms—then comprehensive geriatric assessment may be the appropriate response.

### What Is Comprehensive Geriatric Assessment?

Many primary care physicians, especially those who have substantial experience with older patients, can diagnose some physical and mental health conditions during an office visit. The phrase “comprehensive geriatric assessment” however, refers to a more complete and multifaceted evaluation. As summarized by the American Geriatrics Society, the National Institutes of Health Consensus Conference on Geriatric Assessment describes comprehensive geriatric assessment as a “multidisciplinary evaluation in which the multiple problems of older persons are uncovered, described, and explained...and a coordinated care plan developed to focus interventions on the person’s problems.”<sup>9</sup>

One of the key differences between this kind of geriatric assessment and an office visit is the involvement of a *multidisciplinary team* of specialists who work with the patient and also with each other. The core of the team is typically a geriatric physician specialist, a geriatric nurse, and a geriatric social worker. Depending on what is discovered through the initial tests

TABLE 1

#### Percentage of Each Age Group Who Are “Worried”<sup>a</sup>

Age group	Denied medical treatment because of age	Suffering from uncontrollable pain	Losing your memory
18-34	70	63	67
35-53	60	53	64
54-64	58	57	65
65-74	44	49	63
75+	37	49	56

<sup>a</sup>Note: “worried” = “very” + “somewhat worried” versus “not worried at all.” See text for full wording of questions.

Source: NCOA, *American Perceptions of Aging in the 21st Century* (January 2000), national sample, n = 3,033.

and evaluations, the team might also include a psychologist, a physical or occupational therapist, an ophthalmologist, an audiologist, a pharmacist, a dentist, or a nutrition specialist.

The *Merck Manual of Geriatrics* summarizes the process and its goals as follows:

A multidimensional process designed to assess an elderly person's functional ability, physical health, cognitive and mental health, and socio-environmental situation. Comprehensive geriatric assessment differs from a standard medical evaluation by including non-medical domains, by emphasizing functional ability and quality of life, and, often, by relying on interdisciplinary teams. This assessment aids in the diagnosis of health-related problems, development of plans for treatment and follow-up, coordination of care, determination of the need for and the site of long-term care, and optimal use of health care resources."<sup>10</sup>

For example, dizziness and apparent memory lapses could be a response to drug interactions, including interactions with other prescription drugs, over-the-counter drugs, food, or alcohol. The recent death of a spouse or other close friend or relative, and even the death of a pet or the loss of a job, could induce depression that either by itself or interacting with prescription drugs can affect cognition and memory. Problems with feet and lower joints can affect balance and might imply neurological issues when in fact the source is lower. Poor dental health can affect the ability and the desire to eat properly, and poor nutrition can

affect a range of physical and mental capacities. In sum, the team orientation of geriatric assessment can potentially uncover causes of problems that a less multidisciplinary examination may not find. And one more example: more often than we might imagine, what appears as forgetfulness can be the consequence of untreated hearing loss, which is characteristic of both middle-aged and older persons. As my mother complained to me a few years ago, "How can I forget what I never heard in the first place?"

To the goal of uncovering of these more benign medical explanations, I would add an equally important non-medical goal: that of minimizing as much as possible worries based on fear of the unknown. Knowing that there is no evidence of dementia, or that the recurring pain is nominal arthritis and not cancer, or that it's recurring anxiety and not a heart attack, or that a hearing aid "produces" additional memory are all positive, valuable outcomes of the geriatric assessment.

One of the more complete descriptions of the background, content, structure, goals, and procedures of comprehensive geriatric assessment is provided by the University of California at San Diego School of Medicine.<sup>11</sup> This description is unique in that it expressly identifies financial resources as part of the nonmedical components of the overall assessment.

The goals are to obtain information regarding

- current symptoms, illnesses, syndromes and functional impact
- review of current medications,

indications, side effects

- health care providers
- past medical history
- life goals and level of health promotion in lifestyle
- living environment in relation to patient's functionality and prognosis
- overall physical and social functionality
- nonmedical assets and liabilities (including health insurance and financial resources)
- cognitive status, mobility and balance, emotional health
- nutritional status
- health maintenance

### How to Locate a Comprehensive Geriatric Assessment Team

At some point a worried client will ask you about his or her own or a parent's health and aging. Part of your response should be that all aches and pains do not mean heart disease or cancer, and all instances of forgetfulness do not signal the immediacy or inevitability of Alzheimer's disease. As a trusted family adviser, you should consider suggesting the value of professional and comprehensive geriatric assessment. There are two basic approaches—local and national—to identify and locate the appropriate professionals and facilities.

#### Local Resources

As a first approach, your client simply should ask his or her own primary care physician for a referral to a specialized geriatric center, clinic, or department within a health facility. Keep in

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mind that this is not the same as asking the doctor to carry out a few tests. While many doctors have experience with their own aging patients, and a small but growing number of doctors receive formal geriatric training in medical school, comprehensive geriatric assessment as described here is carried out by a multidisciplinary team of specialists.

A second local source is a community or nearby hospital or health system. While free-standing assessment clinics or centers are emerging, most comprehensive geriatric assessment programs are units of geriatric health programs in hospitals. In searching for and reading online or printed materials, however, keep in mind that hospitals may use phrases that are more consumer-friendly than “comprehensive geriatric assessment,” such as “senior health” or “senior clinics.” At the Crozer-Keystone Health System in Delaware County, Pennsylvania, for example, the assessment program uses the acronym “GEM,” for “Geriatric Evaluation and Management.”<sup>12</sup>

### National Resources

Despite substantial searching and Internet surfing, I could not find a national listing of comprehensive geriatric assessment programs similar, for example, to [www.medicare.gov](http://www.medicare.gov), which offers state and zip code listings of nursing homes and Medicare plan options. There are, however, two national sources that can be used to locate programs either in your own area or in the area where your client's parent lives.

The local Area Agency on Aging (AAA, pronounced “Triple A”) is the local community component of the fed-

eral-state-local network of aging services. In most areas AAAs are best known for their support of senior centers and meals programs. Across the country, however, the 667 AAAs emphasize different kinds of services (e.g., meals, transportation, health screening, exercise programs, weatherization, prescription drug counseling), depending on the assessed needs of the local population. However, the one service that every AAA and its network of service providers is required to offer is information and referral (I&R). As described elsewhere,<sup>13</sup> the local AAA can be a very valuable resource for financial professionals. It is a way to know other professionals working with older persons in the community, as well as to become known by them. In the present context, the local AAA will be able to direct you or your client to hospitals or universities in the area that offer geriatric assessment programs and services.

There are two easy ways to locate a AAA. For Internet access, the Web site of the U.S. Administration on Aging includes the name, location, phone number, and Web address of all state and local AAA agencies: [www.aoa.gov/eldfam/How\\_To\\_Find\\_Agencies/Agencies.asp](http://www.aoa.gov/eldfam/How_To_Find_Agencies/Agencies.asp). This Web page starts with an alphabetical index of states; each state list includes all of its local AAAs, with their Web site and other contact information.

By telephone, contact the Administration on Aging's ElderCare Locator, at 1-800-677-1116. The locator is open Monday through Friday, 9:00 a.m. to 8:00 p.m. (ET). The service can provide the contact information

for all AAAs and can also be a first source of information about geriatric assessment services in any local area. Although developed as a telephone-based service for older persons and their care providers, a comprehensive description of ElderCare Locator services can be found at [www.eldercare.gov](http://www.eldercare.gov). The Web site notes, for example, that for non-English or limited-English speaking persons, the ElderCare phone service is available in 150 languages.

Since medical schools and teaching hospitals are the focus of geriatrics education and training, it is not surprising that many of the comprehensive geriatric assessment programs are located in academic settings. Geriatric assessment programs, however, are not only available in medical schools. Through a national program of “geriatric education centers” (GECs), universities and medical schools have teamed up with local hospitals and health systems to establish community and regional geriatric health networks.

The Bureau of Health Professions of the Health Resources Administration (within the U.S. Department of Health and Human Services) has been supporting GECs since 1985 to encourage, train, and *retrain* health professionals through geriatric residencies, internships, and fellowships. These programs also provide continuing education programs. Furthermore, the multidisciplinary team approach that characterizes geriatric assessment is central to the GEC approach to geriatric education.

Therefore, perhaps the most efficient way to locate a state-of-the-art comprehensive geriatric assessment pro-

gram anywhere in the United States is to contact the GEC closest to the client or patient. Among other valuable information resources, the [bhpr.brsa.gov/interdisciplinary/gec.html](http://bhpr.brsa.gov/interdisciplinary/gec.html) Web site includes the 2003-2004 *GEC Directory*, both as an on-line listing and as a downloadable pdf document. The pdf version includes a somewhat more comprehensive menu of information, including contact numbers for the hospitals and organizations that are affiliates of each GEC consortium or network.

## Costs and Payments

The issue of how a patient pays for a comprehensive geriatric assessment is, at present, somewhat ambiguous. Medicare currently does not recognize geriatric assessment as a separate medical category for which reimbursement is available. Medigap supplementary insurance and managed care plans are similarly unlikely to reimburse for the full range of tests and evaluations that comprise a comprehensive assessment. On the other hand, if they are part of a referral by a primary care physician for a complex geriatric consult, or in the situation of a new-patient relationship requiring relatively intensive evaluation, then many of the procedures that are typically part of a comprehensive geriatric assessment may be reimbursable using standard Medicare codes for medical diagnoses.

This discussion is at a broad level of generalization; exceptions and interpretations abound, and the patient and his or her advisers (including financial adviser) should explore all options before concluding that a comprehen-

sive geriatric assessment is unavailable for financial reasons. Consider the following possibilities:

1. Payment or reimbursement through Medicare or supplementary insurance depends on the condition of the patient and how the diagnoses and billings are made.
2. Since much geriatric assessment takes place in networks or consortia involving teaching hospitals, the bottom-line cost to the patient may wind up being relatively small.
3. The potential relationships among Medicaid, Medicare, and geriatric assessment services are also ambiguous. A quick-and-dirty Google "analysis" combining "comprehensive geriatric assessment" with "Medicaid" identified a number of centers that indicated they accept Medicaid payment; but clearly the question requires careful examination on a case-by-case basis.

Finally, from the financial perspective of financial gerontology it should be emphasized that it is the *cost-effectiveness* and not just the \$300-\$600 cost of the assessment that should be evaluated. Comprehensive geriatric assessment has now been the focus of a number of controlled field experiments, the collective results of which suggest that patients who receive the assessments experience better health and fewer negative health outcomes than those who do not. For example, in a controlled study conducted at the Graduate School of Public Health at the University of Pittsburgh, 442 older persons with health problems were included in a randomized design that contrasted

outpatient geriatric assessment clinics versus traditional community physicians' offices and included a 12-month follow-up with the patients.

The experiment showed the value of the assessment in three areas: "Geriatric assessment, in comparison with usual community care, [was able to successfully identify] a significantly greater number of patients with cognitive impairment. The group receiving a geriatric assessment had greater improvement in anxiety levels at one year. Caregivers of participants in the geriatric assessment group had less caregiver stress at one year."<sup>14</sup> Thus, even the caregivers of the patients benefited from the assessment. ■

*My thanks to Dr. William Zirker, Chief, Division of Geriatrics, Crozer-Keystone Health System, Chester, PA, for directing me to important resources describing comprehensive geriatric assessment programs; and to Kayte Davis and Alice Hasbrouck, doctoral students in Widener University's Institute of Graduate Clinical Psychology, whose classroom discussions this past semester enhanced my understanding of geriatric psychology.*

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Neal E. Cutler, PhD, is the Joseph E. Boettner/Davis W. Gregg professor of financial gerontology at Widener University, Chester, PA. His e-mail address is [nec0002@mail.widener.edu](mailto:nec0002@mail.widener.edu).

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(5) Adapted from Kim P. Peterson, "Comprehensive Geriatric Assessment," AgeNet Elder-care Network, retrieved December 2004, [www.harborassisted.com/Category\\_Pages/document\\_display.asp?Id=402](http://www.harborassisted.com/Category_Pages/document_display.asp?Id=402).

(6) Neal E. Cutler, "Someone I Know Has Alzheimer's: A Statistical Portrait Based on the First National Survey of Alzheimer's Disease," *American Journal of Alzheimer's Care and Research* 3 (1988):19-25; and Neal E. Cutler and Janie Steckenrider, "Is Alzheimer's Disease 'Normal Aging' in 2001? Exploring Science, Public Opinion, and Alzheimer's," Annual Sci-

entific Meeting of the Gerontological Society of America, 2001.

(7) The precise wording of the question was: "Think about your life at age 75. How worried are you about \_\_\_\_—very worried, somewhat worried, or not worried at all?" For respondents who were age 71 and older the question asked: "Think about your life ten years from now..."

The worries were: being denied medical treatments because of your age, suffering from uncontrollable pain, losing your memory. In the analysis, "worried" = "very" + "somewhat."

(8) A more detailed analysis of these questions and responses is reported in Neal E. Cutler, Nancy A. Whitelaw, and Bonita L. Beattie, *American Perceptions of Aging in the 21st Century* (Washington, DC: National Council on the Aging, 2002).

(9) American Geriatrics Society, "Comprehensive Geriatric Assessment Position Statement," approved by the AGS Board of Directors in 1988 and reviewed in 1993. Retrieved from

<http://www.americangeriatrics.org/products/positionpapers/cga.shtml>.

(10) *Merck Manual of Geriatrics*, chapter 4, "Comprehensive Geriatric Assessment." Reviewed on-line at [www.merck.com/mrk-shared/mm\\_geriatrics/sec1/ch4.jsp](http://www.merck.com/mrk-shared/mm_geriatrics/sec1/ch4.jsp).

(11) University of California at San Diego School of Medicine, "Comprehensive Geriatric Assessment," [meded.ucsd.edu/cgal](http://meded.ucsd.edu/cgal).

(12) For an example of how one regional system of five community hospitals presents Comprehensive Geriatric Assessment to the public, see [www.crozer.org/GEM.htm](http://www.crozer.org/GEM.htm).

(13) Neal E. Cutler, *Advising Mature Clients: The New Science of Wealth Span Planning* (New York: John Wiley & Sons, 2002), chapter 12.

(14) M. Silverman, D. Musa, D.C. Martin, J. R. Lave, J. Adams, and E. M. Ricci, "Evaluation of Outpatient Geriatric Assessment: A Randomized Multi-Site Trial," *Journal of the American Geriatrics Society* 44 (April, 1996): 478-479.

### Abstract for Contents Page

Financial advisers may find themselves on the front line of the comprehensive geriatric assessment. They should be able to recognize the indicators of the need for a geriatric assessment. They need to know what a comprehensive geriatric assessment entails. Finally, they need to know how to assist their clients in locating an appropriate geriatric assessment facility.