Historical Background

The history of comprehensive geriatric assessment (CGA) can be traced to the Industrial Revolution of the last century, when the poor and the aged sick were kept in workhouses, leading monotonous lives in gloomy environments. Many were stricken by illnesses but the prevailing attitude then was that nothing further could be done. A turning point occurred in 1935 when Dr. Marjory Warren was given the medical responsibility for one such workhouse infirmary in London with primary elderly patients labelled as “incurable”. She showed to the medical profession then that something could be done, and published her work in the 1940’s. She noted that elderly patients were heterogeneous and thus assessed and classified them according to their mobility, continence and mental states. In this way, she introduced comprehensive geriatric assessment and rehabilitation, and managed to discharge some of the institutionised elders back to the community. Thus geriatric medicine and CGA originated in the United Kingdom 60 years ago out of a reaction to neglect and apathy of elderly patients thought to be incurable and thus dumped into chronic infirmaries. CGA was introduced into Hong Kong with the establishment of the first geriatric unit in Princess Margaret Hospital in 1975 following the model of geriatrics in Glasgow.

What is CGA, and is it effective?

In simple terms, CGA is the process of knowing the frail elderly person, who is in a delicate balance between factors which impair well-being (ageing, multiple pathologies, multiple drugs) and factors which promote well-being (mental health, physical health, and social support). So, CGA is a diagnostic process focused on determining a frail elderly person’s medical, psychological, and functional capabilities in order to develop a coordinated and integrated plan for treatment and long-term follow-up. In contrast to high technology, CGA emphasises on high touch. It goes beyond patient to person, diagnosis to assessment, and treatment to management.

Since the late 1970’s, there have been controlled trials on the effectiveness of CGA, leading to publications of positive results in the 1980’s. In a meta-analysis of 28 controlled trials on CGA, Stuck demonstrated the benefit of CGA in terms of reduced risk of mortality, improved likelihood of living at home, reduced hospital readmissions, greater chance of cognitive improvement, and greater chance of physical function improvement. Since then, major international conferences have been held to discuss on this new technology of CGA.

Complications and Costs of CGA

However, this new technology of CGA does have its concerns. Complications can occur when it is overused or abused. An example is delirium from fragmented and duplicate assessment by different professions as reported by Rozzini. CGA has to be put into the context of the clinical setting with due regard to patient’s tolerance and well-being as well as appropriate clinical interpretation of the assessment results. Another concern, notably from hospital management, is the...
costs from multiple disciplines involvement. Wieland reviewed 19 randomised controlled trials which reported cost endpoints in CGA, and concluded that CGA is cost-efficient (less cost for same outcome or same cost for better outcome) for the majority, and also cost-effective for a few. A related issue is not to invest in programmes that are not effective. It is therefore important to observe the organisational elements of CGA associated with effective programmes, as concluded from previous meta-analysis and reviews on CGA. These are: targeting the frail, interdisciplinary team structure, comprehensive/multidimensional geriatric assessment, management with clinical control of treatments and care, and long-term follow-up.

Gate-keeping versus goal-keeping in caring the frail old

For the frail old with multiple problems, the question is often asked, “where should he go, whose responsibility is this?” In a time of rationing and rationalisation, modern health care tends to answer with gate-keeping, which is primarily resource driven, leaving less room for goal-keeping, which is needs-led. This was aptly described by the Canadian geriatrician, Professor Kenneth Rockwood, “Modern health care needs to reconcile itself to complex patients. There are many wrong ways to address this, each of which has the following in common: instead of getting to grips with how service is provided, they want the frail old people to go away, to some more appropriate place.”

Nevertheless, there is evidence that, through comprehensive geriatric assessment coupled with effective organisational elements mentioned above, goal-keeping can be harmonised with gate-keeping, whereby goal-keeping can lead to gate-keeping with reduction of resource utilisation, and gate-keeping can result in goal-keeping with attention to the needs of elders. Evidence in support of such cost-effective CGA programmes has been shown in a number of settings. First, the benefit of CGA prior to entry to care homes, with detection of treatable undiagnosed illnesses, improving physical function, alleviating the need for care home placement and reducing total health and social costs. Currently 6.7% of elders aged over 65 in Hong Kong are institutionalised in care homes. Timely introduction of specialist assessment prior to care home entry locally is important in checking this rising institutional rate with important implications on quality and costs of elderly health care. Second, the benefit of CGA has been shown at A&E. Recent editorials have drawn attention to the problems of A&E in managing frail elders. There have been a few studies looking at CGA at A&E, showing reduced functional decline, enhanced function, and reduced admission, and use of care homes, without increasing the cost. Studies on fall presenting to A&E also highlight the importance of CGA in this area, with reduced serious injury and subsequent bed-day utilisation. Third, a recent study showed that CGA reduced serious adverse drug reactions while reducing suboptimal prescribing. As studies have shown inappropriate medication and adverse drug reactions are important causes of hospital admissions of elders, CGA targeting at polypharmacy can be both goal-keeping in improving medical care of elders and gate-keeping in reducing iatrogenic hospitalisations.

Conclusions

When facing a frail old person with multiple illnesses, multiple medication and complex needs, we have to ask the right question. Instead of asking just where he/she should go, whose responsibility is this, we should work together and ask who is this elderly person, and how we can help to meet his/her unmet needs. Through CGA with proper organisational elements, needs-led goal keeping will be followed by resource saving gate-keeping. Co-agile pathways will be replaced by smooth paths with potential for resource saving.

References

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