# American College of Physicians - Internal Medicine Meeting 2026
# San Francisco, CA

Hands-On Geriatrics: A Practical Workshop

## Faculty Information

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Posted Date: March 10, 2026

# Mini-Cog©

# Instructions for Administration & Scoring

ID: _____ Date: _____

## Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

| Version 1 | Version 2 | Version 3 | Version 4 | Version 5 | Version 6 |
|---|---|---|---|---|---|
| Banana | Leader | Village | River | Captain | Daughter |
| Sunrise | Season | Kitchen | Nation | Garden | Heaven |
| Chair | Table | Baby | Finger | Picture | Mountain |

## Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

## Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

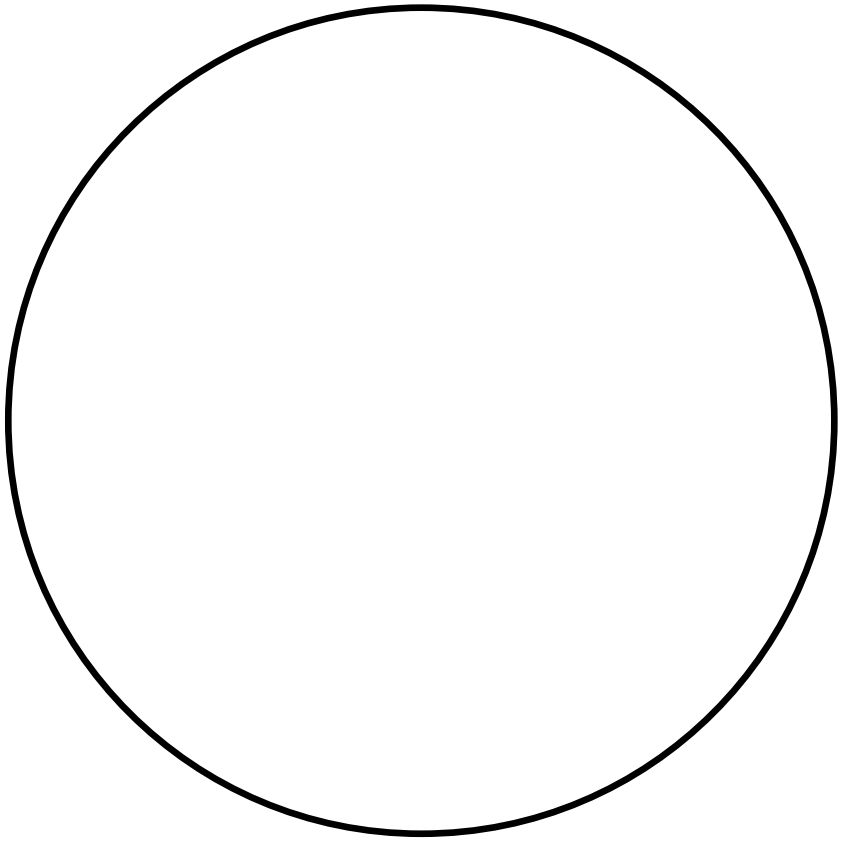
Word List Version: _____ Person's Answers: _____ _____ _____

## Scoring

| | |
|---|---|
| Word Recall: _____ (0-3 points) | 1 point for each word spontaneously recalled without cueing. |
| Clock Draw: _____ (0 or 2 points) | Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored.<br>Inability or refusal to draw a clock (abnormal) = 0 points. |
| Total Score: _____ (0-5 points) | Total score = Word Recall score + Clock Draw score.<br><br>A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status. |

# Clock Drawing

ID:_____ Date:_____



## References


1. Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population based sample. J Am Geriatr Soc 2003;51:1451–1454.

2. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21: 349–355.

3. Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June; 20(3): 459–470.

4. Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.

5. McCarten J, Anderson P et al. Screening for cognitive impairment in an elderly veteran population: Acceptability and results using different versions of the Mini-Cog. J Am Geriatr Soc 2011; 59: 309-213.

6. McCarten J, Anderson P et al. Finding dementia in primary care: The results of a clinical demonstration project. J Am Geriatr Soc 2012; 60: 210-217.

7. Scanlan J & Borson S. The Mini-Cog: Receiver operating characteristics with the expert and naive raters. Int J Geriatr Psychiatry 2001; 16: 216-222.

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** *(Use "✔" to indicate your answer)* | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**FOR OFFICE CODING** 0 + _____ + _____ + _____

**=Total Score:** _____

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| **Not difficult at all** | **Somewhat difficult** | **Very difficult** | **Extremely difficult** |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

general assessment series

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Best Practices in Nursing Care to Older Adults

From The Hartford Institute for Geriatric Nursing, NYU Rory Meyers College of Nursing

Issue Number 13, Revised 2019

Editor-in-Chief: Sherry A. Greenberg, PhD, RN, GNP-BC
New York University Rory Meyers College of Nursing

# The Confusion Assessment Method (CAM)

*By: Donna McCabe, DNP, APRN-BC, GNP*
*New York University Rory Meyers College of Nursing*

**WHY:** Delirium is a serious, potentially preventable, neuropsychiatric disorder occurring in association with other underlying medical conditions (DSM V, 2013). Delirium is under-recognized and underdiagnosed making accurate prevalence and incidence difficult to gauge. A point-prevalence study conducted in 2016 examined over 1800 older adults, with a mean age of 82 +/- 7.5 years, in hospital settings and found one in five of these individuals had delirium (Bellelli et al., 2016). Other sources report that delirium can affect up to 50% of individuals over the age of 65 years in hospitals (Inouye, Westendorp, & Saczynski, 2014). Delirium often occurs after an acute illness or hospitalization and is associated with loss of physical function, increased morbidity and mortality, nursing home placement, and high health care costs (Oh, Fong, Hshieh, & Inouye, 2017). Predisposing risk factors for delirium include older age, dementia, severe illness, multiple co-morbidities, alcoholism, vision impairment, hearing impairment, and a history of delirium. Precipitating risk factors include acute illness, surgery, pain, dehydration, sepsis, electrolyte disturbance, urinary retention, fecal impaction, and exposure to high risk medications. Delirium is often unrecognized and undocumented by clinicians. Rates of unrecognized delirium, which is defined as the diagnosis of delirium after being unrecognized by a primary physician or nurse is estimated to be about 60% of all cases (Oh, Fong, Hshieh, & Inouye, 2017). This high rate of unrecognized delirium underscores the need for screening to detect delirium early. Early recognition and treatment can improve outcomes. A key issue in recognizing delirium is understanding the older adult's baseline and quickly identifying changes, which in the case of delirium can occur within hours. Therefore, older adults should be assessed frequently using a standardized tool to facilitate prompt identification and management of delirium and underlying etiology.

**BEST TOOL:** The Confusion Assessment Method (CAM) is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings. The CAM includes four features found to have the greatest ability to distinguish delirium from other types of cognitive impairment. There is also a CAM-ICU version for use with non-verbal mechanically ventilated patients (See *Try This:*® CAM-ICU). The CAM-S is a companion tool to the CAM that can be used to assess the severity of delirium (Inouye, Kosar, Tommet et al., 2014).

**VALIDITY AND RELIABILITY:** Both the CAM and the CAM–ICU have demonstrated sensitivity of 94-100%, specificity of 90-95% and high inter-rater reliability (Oh, Fong, Hshieh, & Inouye, 2017). Several studies have been done to validate clinical usefulness.

**STRENGTHS AND LIMITATIONS:** The CAM may be incorporated into routine assessment and has been translated into several languages. The CAM was designed and validated to be scored based on observations made during brief but formal cognitive testing, such as brief mental status evaluations. Training to administer and score the tool is necessary to obtain valid results. The screening tool alerts clinicians to the presence of possible delirium. A positive screening test result should lead to further investigation.

**FOLLOW-UP:** The presence of delirium warrants prompt intervention to identify and treat underlying causes and provide supportive care. Vigilant efforts need to continue across the healthcare continuum to preserve and restore baseline mental status

## MORE ON THE TOPIC:

Best practice information on care of older adults: https://consultgeri.org.
The Hospital Elder Life Program (HELP), Yale University School of Medicine. Home Page: https://www.hospitalelderlifeprogram.org
Bellelli, G., Morandi, A., Di Santo, S.G., Mazzone, A., Cherubini, A., Mossello, E., ... & Musicco, M. (2016). "Delirium Day": A nationwide point prevalence study of delirium in older hospitalized patients using an easy standardized diagnostic tool. *BMC Medicine, 14*(1), 106.
Cole, M.G., Ciampi, A., Belzile, E., & Zhong, L. (2009). Persistent delirium in older hospital patients: A systematic review of frequency and prognosis. *Age and Ageing, 38*(1), 19-26.
Diagnostic and Statistical Manual of Mental Disorders, 5th Ed. Washington, DC: American Psychiatric Association; 2013.
Inouye, S.K. (2006). Delirium in older persons. *NEJM, 354,* 1157-1165.
Inouye, S.K., Kosar, C.M., Tommet, D., Schmitt, E.M., Puelle, M.R., Saczynski, J.S., ... & Jones, R.N. (2014). The CAM-S: development and validation of a new scoring system for delirium severity in 2 cohorts. *Annals of Internal Medicine, 160*(8), 526-533.
Inouye, S., van Dyck, C., Alessi, C., Balkin, S., Siegal, A. & Horwitz, R. (1990). Clarifying confusion: The confusion assessment method. *Annals of Internal Medicine, 113*(12), 941-948.
Maldonado, J.R. (2008). Delirium in the acute care setting: Characteristics, diagnosis and treatment. *Critical Care Clinics, 24*(4), 657-722.
Oh, E.S., Fong, T.G., Hshieh, T.T., & Inouye, S K. (2017). Delirium in older persons: Advances in diagnosis and treatment. *JAMA, 318*(12), 1161-1174.
Rice, K.L., Bennett, M., Gomez, M., Theall, K.P., Knight, M., & Foreman, M.D. (2011, Nov/Dec). Nurses' recognition of delirium in the hospitalized older adult. *Clinical Nurse Specialist, 25*(6), 299-311.
Tullmann, D.F., Fletcher, K., & Foreman, M.D. (2012). Delirium. In M. Boltz, E. Capezuti, T.T. Fulmer, & D. Zwicker (Eds.), A. O'Meara (Managing Ed.), *Evidence-based geriatric nursing protocols for best practice* (4th ed., pp 186-199). NY: Springer Publishing Company, LLC.
Vasilevskis, E.E., Morandi, A., Boehm, L., Pandharipande, P.P., Girard, T.D., Jackson, J.C., Thompson, J.L., Shintani, A., Gordon, S.M., Pun, B.T., & Ely, E.W. (2011). Delirium and sedation recognition using validated instruments: Reliability of bedside intensive care unit nursing assessments from 2007 to 2010. *JAGS, 59* (Supplement s2), S249-S255.

## The Confusion Assessment Method Instrument:

1. ***[Acute Onset]*** Is there evidence of an acute change in mental status from the patient's baseline?

2A. ***[Inattention]*** Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

2B. ***(If present or abnormal)*** Did this behavior fluctuate during the interview, that is, tend to come and go or increase and decrease in severity?

3. ***[Disorganized thinking]*** Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

4. ***[Altered level of consciousness]*** Overall, how would you rate this patient's level of consciousness? (Alert [normal]; Vigilant [hyperalert, overly sensitive to environmental stimuli, startled very easily], Lethargic [drowsy, easily aroused]; Stupor [difficult to arouse]; Coma; [unarousable]; Uncertain)

5. ***[Disorientation]*** Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?

6. ***[Memory impairment]*** Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?

7. ***[Perceptual disturbances]*** Did the patient have any evidence of perceptual disturbances, for example, hallucinations, illusions or misinterpretations (such as thinking something was moving when it was not)?

8A. ***[Psychomotor agitation]*** At any time during the interview did the patient have an unusually increased level of motor activity such as restlessness, picking at bedclothes, tapping fingers or making frequent sudden changes of position?

8B. ***[Psychomotor retardation]*** At any time during the interview did the patient have an unusually decreased level of motor activity such as sluggishness, staring into space, staying in one position for a long time or moving very slowly?

9. ***[Altered sleep-wake cycle]*** Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?

## The Confusion Assessment Method (CAM) Diagnostic Algorithm

***Feature 1: Acute Onset or Fluctuating Course***
This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

***Feature 2: Inattention***
This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

***Feature 3: Disorganized thinking***
This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

***Feature 4: Altered Level of consciousness***
This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal]), vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

**The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.**



Inouye, S., van Dyck, C., Alessi, C., Balkin, S., Siegal, A. & Horwitz, R. (1990). Clarifying confusion: The confusion assessment method. *Annals of Internal Medicine, 113*(12), 941-948.

try this: general assessment series
Best Practices in Nursing Care to Older Adults
A series provided by The Hartford Institute for Geriatric Nursing, NYU Rory Meyers College of Nursing
EMAIL: Nursing.HIGN@nyu.edu HARTFORD INSTITUTE WEBSITE: www.hign.org
CLINICAL WEBSITE: www.ConsultGeri.org

## Mind

**History:** What is the patient's baseline cognitive status? Was patient oriented and able to pass brief delirium screen (e.g. reciting months of year backwards) on admission? Confusion or memory loss? Anxiety or depression? Change in hearing/vision?

**Impact on Care:**
- Do I need to write important things down for the patient?
- Does a caregiver need to be at the visit?
- Check for understanding during and after the visit
- Does the patient need glasses or hearing aids to participate in the visit?
- Can I re-orient the patient to the day, time, purpose of our visit if they are confused, or open the curtains to help with sleep/wake cycle?
- Does the patient seem engaged in the visit? Interacting appropriately?
- Are they on medications that can impact their cognition?

**Tip: Speaking to Patients with Hearing Impairment:**
- Low and slow (high pitched hearing loss), face the patient
- Rephrase, use pictures or write things down
- Check ears for wax (carbamide drops + ear cleaning)
- Request a pocket amplification device
- Hearing aid evaluation with audiology

**Consider Referrals for:**
- Audiology, Optometry
- Geriatric Mental Health
- Neurology for head imaging
- Psychology, Social Work for counseling, testing

**Helpful Resources:**
- www.hospitalelderlifeprogram.org – for delirium precautions
- www.alz.org - For Alzheimer's and other dementias
- VA Dementia Home Safety Toolkit www.va.gov/geriatrics/docs/HOME_SAFETY_BOOKLET_March_2019.pdf
- www.mocatest.org – MoCA assessment
- www.geron.org – Communicating with Older Adults

## Mobility

**History:** What is the patient's baseline mobility and function? Does patient live in community or facility? What type? Any recent falls or fear of falling?

**Impact on care:**
- Can the patient get to our appointment on time? Transportation needed?
- Can the patient get onto the exam table? Sit/stand from the chair in my office?
- Do we need a bigger clinic room to accommodate a mobility aid or caregiver?
- Are we concerned about fall risk? Notice slow or unsteady gait?

**Tools for Mobility:**
- **Functional Status:** Has function changed over past 6 months? *Rate ADLS and IADLs: Independent/ Needs Assistance/ Dependent.*

| Activities of Daily Living (ADLs or Basic ADLs) | Instrumental Activities of Daily Living (IADLs) |
|---|---|
| - Feeding<br>- Bathing<br>- Grooming<br>- Dressing<br>- Toilet use, incontinence<br>- Transfers (bed to chair)<br>- Mobility | - Telephone use<br>- Grocery shopping<br>- Food preparation<br>- Housekeeping, laundry<br>- Mode of transportation<br>- Medications<br>- Finances |

**Consider Referrals for:**
- Home Safety Evaluation
- Life Alert
- Occupational Therapy
- Physical Therapy

**Helpful Resources**
- CDC Steadi Fall Risk Reduction Toolkit: www.cdc.gov/steadi,
- The Patient who falls: Tinetti & Kumar JAMA 2010

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
*Geriatric Research, Education, and Clinical Centers*

# GERIATRICS 5Ms* Interprofessional Care for Older Adults

VA Boston Healthcare System
New England GRECC

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*Tinetti, Molnar and Huang, *The Geriatrics 5M's*, JAGS 2017.

Adapted from: Holliday AM, Hawley CE, Schwartz AW. Geriatrics 5Ms Pocket Card for Medical and Dental Students. JAGS 2019; 67(12):E7-E9.

## Multicomplexity

**History:** Ask about day in the life. Assess living conditions, support system. Recent weight loss? Life changes or stressors? How are teeth and toes (warning signs of needing more help)? What are comorbidities and which ones affect day-to-day life the most?

**Tools for Multicomplexity: Consider the most supportive option in the context of:**

- Patient priorities
- Caregiver
- Home supports/modifications
- Medication deprescribing
- Support independence

**Care for Caregivers** (Adelman et al, JAMA 2014)

| **C**aregiver Well-being | **A**dvanced Care Plan | **R**espite | **E**ducation |
|---|---|---|---|
| • *Explore caregiver well-being*<br>• *Identify ADLs and iADLs not being met*<br>• *Social work consult* | • *Start discussion on goals of care & wishes*<br>• *Health Care Proxy, POLST/ MOLST*<br>• *Long-term care?* | *Identify opportunities for respite for the caregiver - others to care for patient, time away, adult day health program* | Resources<br>• *Case manager Counseling & 1:1 CBT*<br>• *Non-medical home services*<br>• *Caregiver support groups*<br>• *Council on Aging*<br>Disease-specific<br>• *Symptom-focused skills* |

**Consider Referrals for:**

- Dental
- Geriatrics
- Nutrition
- Podiatry
- Social Work

**Helpful Resources:**

- www.healthinaging.org/
- www.patientprioritiescare.org
- www.caregiver.va.gov
- www.eprognosis.org
- www.gerischolars.org/

## Medications

**History:** How many medications is patient taking? How many times per day? Who manages the medications?

**Impact on care:**

- Are there issues with medication adherence?
- Can patient physically take all the medications? (i.e., read labels, open bottles, swallow pills, put on patches or ointments, administer drops, keep track of changes?)
- Could a new symptom be a medication side effect?
- Is there confusion about why patient is taking certain medications?

**Tools for Polypharmacy**

- Remember to Start Low, Go Slow
- Avoid high risk medications when possible (AGS Beers list)
- Look out for **prescribing cascades** (drug → adverse effect → new drug). E.g., Iron → constipation → stool softener
- Think about appropriate deprescribing
- Remember non-pharmacological strategies for pain, mood
- Can medications taken more than once a day be switched to once a day, long-acting formulations?

**Consider Referrals for:**

- Nursing
- Pharmacy
- Speech-language Pathology (swallowing)

**Helpful Resources:**

- AGS Beers list of medications to be used with caution in older adults **(**JAGS 2019)
- www.deprescribing.org
- www.medstopper.com

## Matters Most

**History:** How can we help in the most meaningful way? What does patient want to do more of? Are there chronic conditions that are more important to the patient that we can address? *These discussion are relevant to all care and treatment planning, not only at end of life!* (see patientprioritiescare.org)

**Impact on care:**

- Is what I have to offer in line with the patient's goals?
- Is patient not adhering to recommendations because of personal values or beliefs?
- Are there alternatives I can offer for this patient that are in line with the patient's goals?

**Tools for Matters Most:**

- Does patient have a **Health Care Proxy?**
- **Values Assessment:** What is important to this patient? How can providers take steps to ensure that the patient can do the things that are important on an individual level?
- **GOOD mnemonic** for goals of care conversations: Goals, Outcomes, Options, Document.

**Consider Referrals for:**

- Chaplaincy
- Palliative Care
- Psychology

**Resources**

- www.massmed.org/healthcareproxy
- www.patientprioritiescare.org
- Consider www.prepareforyourcare.org for advanced care planning for patients with lower health literacy (Sudore et al, JAMA IM 2017)
- Consider www.theconversationproject.org for patients with higher health literacy