multidisciplinary approach to management, addressing both pharmacologic and nonpharmacologic options. Effective nonpharmacologic options include scheduled toileting, bladder training, and biofeedback. Use of these strategies may avoid the use of medications with frequent adverse effects, such as anticholinergic medications for detrusor overactivity.

NUTRITION

Older adults experience high rates of malnutrition related to multiple causes, including medical illness, dental problems, or access issues related to limited mobility, cost, or cognitive problems. Approximately 15% of older outpatients and half of hospitalized elders are malnourished, and have associated increases in morbidity and mortality. The utility of general laboratory testing is limited, but a combination of serial weight measurements and inquiries about changing appetite can reveal nutritional problems in the older adults. Vulnerable elders with an involuntary weight loss of 10% or more in 1 year or less should undergo further evaluation for undernutrition, including assessment of medical or medication-related causes, dental status, problems with acquiring or preparing food, appetite and intake, swallowing ability, and previous directions for dietary restrictions.

SOCIAL AND LEGAL ISSUES

The social history for older persons includes assessment of resources for direct caregiving and financial support available. These issues become particularly important for frail older adults, given their physical and economic vulnerability.

Caregiving

The clinician should always inquire about who is providing care for the older patient, including both personal care with ADLs and help with IADLs, such as transportation, medications, food preparation, finances, and housekeeping. This list should include both formal caregivers, such as home health professionals or hired aides, and informal caregivers, such as family members, neighbors, or friends. The majority of elder care provided in the United States is delivered by informal caregivers. Over 34 million people in the United States provide informal care for older adults and, of these, 8.9 million are caring for persons suffering from dementia. The majority of informal caregivers are women and elderly themselves, with an average age of 63 years. The stress of providing daily care can have serious deleterious effects on the caregiver's health. Studies have demonstrated adverse effects on blood pressure and immune function, and increased rates of cardiovascular disease and death. In addition, caregivers have alarmingly high rates of psychological illness, with symptoms of depression reported in up to 50%. This problem is particularly prevalent in those providing care for patients with dementia. The presence of mental illness further raises the risk of verbal or physical abuse or neglect of the patient. The clinician must recognize caregiver problems early and consider referral to a social worker, patient resource manager, or, when available, a geriatric assessment team. Key risk factors for stress include a frail family caregiver; a patient with cognitive impairment, emotional disturbance, substance abuse, sleep disruption, or behavioral problems; low income or financial strain; and acute illness or hospitalization. Providers should recognize signs and symptoms of physical or mental strain, and regularly inquire about caregiver burden with an offer to talk apart from the patient if need be.

A number of resources exist to support caregivers and provide strategies for problem solving and self-care. Community-based programs provide assistance with meals, transportation, and respite care options through volunteer organizations or subsidized programs. Counseling on both the physical and emotional aspects of care has been demonstrated to reduce health risks to the caregiver and delay institutionalization, including in-home or institutional respite stays to provide caregivers with precious time off. Studies consistently demonstrate that such services are underused by caregivers.

Mistreatment

Older adults are particularly vulnerable to mistreatment due to poor health, functional dependence, and social isolation. Mistreatment is defined as either elder abuse (harm caused by others) or self-neglect. Self-neglect is thought to be the most common form of mistreatment, but true rates are difficult to estimate. Risk factors include cognitive impairment and recent functional decline. Elder abuse has been reported in 3% to 8% of the older adult population in the United States, although this is likely an underestimate due to underreporting by patients and lack of recognition by health care providers. Abuse assumes many forms including psychological, financial, physical, sexual abuse, and neglect. Studies have demonstrated that neglect and abuse are associated with higher rates of nursing home placement and mortality among older adults. Signs of physical abuse include contusions, burns, bite marks, genital or rectal trauma, pressure ulcers, or unexplained weight loss. Other forms of abuse may be more difficult to discern on examination, but can be improved with direct questions such as "Has anybody hurt you?"; "Are you afraid of anybody?"; or "Is anyone taking or using your money without your permission?" Any suspicion of abuse or neglect should be reported to Adult Protective Services. Of note, 44 states and the District of Columbia have laws mandating reporting of suspected elder abuse.

Finances

The older adult population in the United States varies widely in measures of wealth. Although the overall rate of poverty among adults over age 65 has declined over the last 50 years, 10% of older adults still live at or below the poverty line, and the percentage is higher among African Americans (24%) and Hispanics (21%). Providers should screen for financial problems because these issues have direct implications for health status and well-being. Older adults with limited means are more prone likely to have problems affording medications, meals, and basic amenities. Referrals to community resource networks can help identify options for help with basic needs, including housing options and congregate meals. Information on agencies and services in specific locales can be identified at www.eldercare.org.

Advance Directives

Advance directives come in a number of different forms and serve a variety of purposes. Ideally these documents articulate a person's preferences for care in the event of serious illness or incapacitation. Often they will describe limits on care and