The Rapid Geriatric Assessment: A Quick Screen for Geriatric Syndromes

by Milta O. Little, DO

The components of the Rapid Geriatric Assessment should be viewed as routine tests given to all older adults, just like checking blood pressure.

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The comprehensive geriatric assessment (CGA) has been well-established as the geriatrician's procedure. The CGA is a systematic, multimodal, interprofessional approach to a complicated older patient with the intent to diagnose geriatric syndromes, develop targeted treatment plans, and improve patient outcomes with a focus on function and quality of life.[5, 19] Key elements are the assessment of medical status, functional capabilities, cognitive status, and psychosocial structure and support. The best time for a CGA is while the person is still functional in order to identify risk factors for decline and disability that can be ameliorated with appropriate interventions. Parts of the CGA should be repeated over time and over several patient care visits in order to continually monitor for new geriatrics syndromes.

While the CGA is the "toolbox" of the geriatrician, the various evaluation components can be completed by any member of the interprofessional team and the care plan that is derived from the assessment results is best prepared as team. While the CGA has been shown in various settings to improve outcomes,[1, 3, 5, 6, 13, 15, 17, 18, 20] it is also time-consuming, requiring two to three hours in some cases to complete. Since there are not enough geriatric providers to assess and manage all geriatric patients, it is imperative that primary care physicians and advanced practitioners, along with all members of the health care team, are equipped with tools that can quickly evaluate an older adult for geriatric syndromes.

At Saint Louis University, our team created the Rapid Geriatric Assessment (RGA), which consists of four screening tools and an inquiry into the presence of advanced directives (See Figure 1). Positive responses to the RGA should trigger further assessments and management by members of the interprofessional team. Electronic versions of the RGA, training materials on its proper administration, and patient information sheets on common geriatric syndromes are available at aging.slu.edu

The RGA consists of four short screening questionnaires: The FRAIL scale, the SARC-F scale for sarcopenia, the Simplified Nutritional Appetite Questionnaire (SNAQ), and the Rapid Cognitive Screen (RCS). These four were chosen because they can help any health care provider to quickly identify most geriatrics syndromes and none are copy written. This means that the RGA is free to use or distribute and its dissemination is encouraged. This article will briefly discuss each screening tool in turn.

Frailty

Frailty is the diminished ability to carry out important activities of daily living under stress.[12] The presence of frailty predicts dementia, hospitalizations, institutionalization,

Figure 1
Rapid Geriatric Assessment

Saint Louis University
Rapid Geriatric Assessment*

*There is no copyright on these screening tools and they may be incorporated into the Electronic Health Record without permission and at no cost.

ID#:_____ Sex:_____ Age:_____ Primary Care Provider Y / N
Ethnicity (circle): African/Am Asian Caucasian Hispanic Non-Hispanic

The Simple "FRAIL" Questionnaire Screening Tool

Fatigue: Are you fatigued?
Resistance: Cannot walk up one flight of stairs?
Aerobic: Cannot walk one block?
Illnesses: Do you have more than 5 illnesses?
Loss of weight: Have you lost more than 5% of your weight in the last 6 months?

Scoring: 3 or greater = frailty; 1 or 2 = prefrail

From Morley JE, Vellas B, Abellan van Kan G, et al. J Am Med Dir Assoc 2013;14:392-397.

SARC-F Screen for Sarcopenia (Loss of Muscle)

Component	Question
Strength	How much difficulty do you have in lifting and carrying 10 pounds? Scoring: None = 0 Some = 1 A lot or unable = 2
Assistance in Walking	How much difficulty do you have walking across a room? Scoring: None = 0 Some = 1 A lot , use aids or unable = 2
Rise from a Chair	How much difficulty do you have transferring from a chair or bed? Scoring: None = 0 Some = 1 A lot or unable without help = 2
Climb stairs	How much difficulty do you have climbing a flight of ten stairs? Scoring: None = 0 Some = 1 A lot or unable = 2
Falls	How many times have you fallen in the last year? Scoring: None = 0 1-3 Falls = 1 4 or more falls = 2

Total score of 4 or more indicates Sarcopenia

From Malmstrom TK, Morley JE. J Frailty and Aging 2013;2:55-6.

SNAQ (Simplified Nutritional Assessment Questionnaire)

My appetite is
a. very poor
b. poor
c. average
d. good
e. very good

Food tastes
a. very bad
b. bad
c. average
d. good
e. very good

When I eat	Normally I eat
a. I feel full after eating only a few mouthfuls	a. Less than one meal a day
b. I feel full after eating about a third of a meal	b. One meal a day
c. I feel full after eating over half a meal	c. Two meals a day
d. I feel full after eating most of the meal	d. Three meals a day
e. I hardly ever feel full	e. More than three meals a day

Scoring: a=1, b=2, c=3, d=4, e=5.
A score ≤14 indicates significant risk of at least 5% weight loss within 6 months.

From Wilson et al. Am J Clin Nutr 2005;82:1074-81.

Rapid Cognitive Screen (RCS)

1. **Please remember these five objects. I will ask you what they are later.**
[Read each object to patient using approx. 1 second intervals.]
Apple Pen Tie House Car

2. [Give patient pencil and the blank sheet with clock face.] **This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock**
. [2 pts/hr markers ok; 2 pts/time correct]

3. **What were the five objects I asked you to remember?**
[1 pt/ea]

4. **I'm going to tell you a story. Please listen carefully because afterwards, I'm going to ask you about it.**

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.
What state did she live in? [1 pt]

SCORING
8-10…….. Normal
6-7……. Mild Cognitive Impairment
0-5……. Dementia

From Malmstrom TK, Voss VB, Cruz-Oliver DM et al J Nutr Health Aging 2015;19:741-744.

Advanced Directive
Do you have an advanced directive? Y/N

falls, and fractures in community dwelling individuals.[7-10] It is important to note that for many people, frailty is a pre-disabled state, and identifying frailty early helps to establish care goals and more successful interventions. If one considers the bio-psycho-social model of health care, a frail elder has limitations in these domains.

For example, the presence of multimorbid disease, bereavement, social isolation, and financial distress puts the person at risk of a significant functional decline or disability given an additional stressor, such as a new medication or illness. If one can identify and address frailty, one may delay the onset of disability, slow the progression of dependency, and improve outcomes. When an additional stressor is added, the person will not experience a permanent decompensation if the appropriate interventions are in place at the time frailty is discovered.

The ICD-10 diagnosis code for frailty is R54. The FRAIL scale is a five-item yes/no questionnaire that has been validated is several different populations around the world. Scores range from 0 to 5, with a higher score indicating more frailty. A score of zero indicates a healthy older adult, a score of 1-2 indicates pre-frail or early decline, and a score of 3 or more indicates decline and frailty. It is important that people answer the questions based on how they usually feel most of the time, not just the day of the office visit or screening tests. This applies to the following tools as well.

Sarcopenia

Sarcopenia is literally translated from the Greek as "the poverty of flesh" and is the decrease in both muscle mass and function that occurs with aging. Similarly to frailty, sarcopenia in the absence of functional limitations is considered a pre-disabled state, and is best assessed and treated in those who are functionally independent. While there is certainly overlap between frailty and sarcopenia, studies have determined that these are two separate clinical

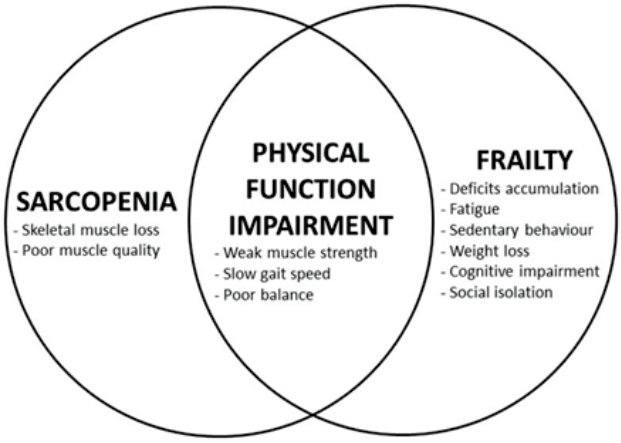

Figure 2
Relationship among sarcopenia, frailty, and physical function impairment[4].

entities, both which can lead to poor functional outcomes[4, 16] (See Figure 2). For this reason, it is important to look for both frailty and sarcopenia when assessing an older adult. The SARC-F scale has been validated in several continents and found to have good predictive ability for future dependency.[2, 22] Scores range from 0 to 10 with a score of 4 or more indicating sarcopenia. Sarcopenia as a diagnosis is now billable with the new ICD-10 code M6284.

Simplified Nutritional Appetite Questionnaire

Significant weight loss is defined as a decrease in more than 5% of usual body weight over the last six to twelve months. Whether or not the weight loss is intentional, it may be a cause for concern in those over 65 as it contributes to memory loss, decreased immune function (predisposing to infections), decreased muscle mass and weakness, loss of function, and poor wound healing. Weight loss and cachexia are also associated with an increase in mortality in older adults. Anorexia is the main contributor to malnutrition so questionnaires that assess appetite can be useful to assess risk of weight loss and malnutrition. The Simplified Nutritional Appetite Questionnaire (SNAQ) has been validated in community-dwelling older adults, hospitalized patients, and nursing home residents and a score of 14 or less is predictive of weight loss over the following six months.[14, 21] These studies also show improved functional capacity when nutritional interventions are put into place. Abnormal weight loss is billable under the ICD-10 diagnosis code R634.

Rapid Cognitive Screen

Major neurocognitive impairment (also known colloquially as dementia) is defined as memory impairment plus aphasia, apraxia, agnosia, and/or a disturbance in executive functioning. People with major neurocognitive impairment have a noticeable (although possibly subtle) decline from a previously higher level of functioning, including significant impairments in occupational or social function. Memory loss is NOT normal in older adults. It is important to distinguish dementia from mild cognitive impairment (MCI), which is memory impairment in the presence of intact activities of daily living, because early identification of a cognitive disorder allows for improved care and planning. In addition, it may be possible to reverse, prevent, or slow decline in cognition if MCI is found and treated early. It is not enough just to diagnose the presence of major neurocognitive impairment. It is also important to distinguish the various dementia syndromes (not all dementias are Alzheimer's disease), rule out reversible causes, and provide complete bio-psycho-social care to patients and family members.

Most office-based screening instruments take 8-10 minutes to complete. For the standard primary care office visit, the length of time required to complete a short screening test is still too long. The Rapid Cognitive Screen (RCS) is the shortened version of the well-validated Saint Louis University Mental Status Examination, and is useful in a busy clinical setting. It takes roughly two minutes to complete and has been validated to pick up both major neurocognitive disorder and MCI in several languages.[11] Scoring of the RCS is from 0-10. A score of 0-5 indicated dementia, 6-7 is MCI, and 8-10 is normal.

The final part of the RGA is the question, "Do you have an advanced directive?" This question is important because advanced directives are how a person communicates his desired care goals to ensure

these goals are met when he is not able to express his wishes. It also gives the person administering the RGA a chance to discuss the importance of having a primary care doctor to coordinate care goals. Some web resources that may be useful for people as they document their advanced directives are:

- Advance Care Planning - National Institute of Health https://www.nia.nih.gov/health/publication/advance-care-planning
- Missouri Form for Durable Power of Attorney for Health Care:
- http://missourilawyershelp.org/legal-topics/durable-power-of-attorney-for-health

Goals of care discussions are also now billable under Medicare using the time-based CPT codes 99497 and 99498.

In conclusion, the components of the RGA should be viewed as routine tests given to all older adults, just like checking blood pressure. For a successful assessment, the set-up is key. Be positive as they answer and allow time if they are struggling. For any RGA done at a community screening event, provide resources and encourage them to talk to their doctors.

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