

EDITORIAL

INVOLVING PRIMARY CARE HEALTH PROFESSIONALS IN GERIATRIC ASSESSMENT

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The screening and management of geriatric conditions, such as frailty and cognitive impairment, are now priorities, and their implementation in the clinical routine can no longer be ignored. Primary care is the first contact point of health services for community-dwelling individuals in many countries (1). It is a core component of the healthcare system where preventive strategies and care for the frail persons usually occur. Unfortunately, a good proportion of health professionals acting in this setting still have very limited training on geriatric principles and caring for older adults with geriatric syndromes and multi-morbidity. In addition, the resources from primary care practitioners that they can afford to spend for these purposes are often sparse. In order to promote a more geriatric responsive culture, a number of brief screening instruments for age-related conditions has been developed over the last few years (2, 3). These include the Rapid Geriatric Assessment that has been developed in United-States; the Gerontopôle screening tool in Toulouse; the Kihon Checklist (KCL) in Japan; the Vulnerable Elders 13 Survey (VES-13); and the Easycare Two-step Older persons Screening (Easycare-TOS) in the United Kingdom.

Rapid Geriatric Assessment (RGA)

The RGA is a tool developed to support the quick identification of four geriatric syndromes: frailty, sarcopenia, anorexia, and cognitive dysfunction. At the same time, the instrument inquires if the person has provided advanced directives (4, 5). It was developed to be used in conjunction with the Annual Medicare Wellness Visit (6). It takes less than 4 minutes to be administered. The components of the RGA are the FRAIL for frailty (7–10), SARC-F for sarcopenia (11–14), SNAQ for anorexia (15–18), and the Rapid Cognitive Screen (19, 20). All these screening tools have been used worldwide and are currently available in up to 30 languages. Moreover, their predictive value has been demonstrated; for example, in a

group of persons with diabetes mellitus, both the SARC-F and FRAIL were strongly associated with incident disability and hospitalization (7).

Thanks to its implementation in the clinical routine, educational interventions have been possible in different settings, from academic centers to rural counties. To date, over 6,000 persons have been evaluated either adopting it as part of case finding processes at the physicians' offices as well as during screening campaigns in the community. Preliminary results from this database show that the prevalence of frailty, sarcopenia, anorexia, mild cognitive impairment, and dementia might be relatively common (23%, 32.8%, 34.7%, 19.3%, and 23.9%, respectively).

Interestingly, a computerized assessment and management program for physicians' offices has been developed for use with this screening model. The software is designed to support the physician in the design of personalized interventions according to the screening results. It is noteworthy that this approach has shown to be well accepted by general practitioners (5).

Gerontopôle Frailty Screening Tool (GFST)

The GFST was developed to help healthcare professionals at identifying community-dwelling older adults with frailty (21, 22). The GFST is not aimed at measuring the severity of frailty, but simply at activating a dedicated pathway for disability prevention in the healthcare system.

The GFST includes questions about social aspects, involuntary weight loss, exhaustion, mobility issues, and memory complaints. However, the result of the tool is driven by the clinical judgment of the physician who, in the light of the positive answers to the previous questions, can provide robust and framed conclusions. The positive result at the GFST should then refer the individual to a geriatric clinic for further assessment (23). Although the agreement with the frailty phenotype was moderate (kappa of 0.45) (24), it was found that

the GFST had good ability to identify true positive cases (25).

Kihon Checklist (KCL)

The KCL is a self-reported comprehensive health checklist for assessing physical, social, and mental functions of older persons who are vulnerable to frailty or higher risk of becoming dependent (26, 27). It is suitable for screening frailty in the clinical setting as well as in the community. Moreover, it can be used by healthcare professionals for identifying the target and evaluating the effectiveness of interventions, because the KCL consists of assessing ADL, motor abilities, nutrition, oral function, socialization, cognition, and mood. Based on the total KCL scores, older persons can be classified as robust, pre-frail, and frail. The KCL score is predictive of adverse health outcomes (28, 29).

Vulnerable Elders Survey-13 (VES-13)

This VES-13 tool is a self-administrated questionnaire (30), whose aim is to identify community older people at increased risk of death or functional decline (31). It includes 13 items concerning self-reported health, physical activity and physical impairments. It takes less than 10 minutes to be completed (32). A score greater than or equal to 3 indicates a vulnerable individual (30, 33).

Easycare Two-step Older persons Screening (Easycare-TOS)

The lack of a standardized instrument to efficiently assess the physical, mental, and social domains of the older person led to the development of the Easycare model in 1994 by Philip and colleagues. The components of the Easycare model were gathered from a variety of validated tools using a consensus process among healthcare professionals in Europe. In the original acceptability studies, the model was found to be useful for the outpatient clinic, in particular to identify levels of unmet clinical needs in community-dwelling elders (34). Philip and colleagues developed a brief standardized method for assessing the perceptions of older people about their health and care needs/priorities: the Easycare-TOS (35, 36).

The model is based on a two-step approach. First, a short instrument allows a pre-screening of older persons based on the general practitioner's knowledge. In particular, the physician reviews the patient's records and answers 14 questions about the functioning of the individual. The 14 questions are meant to raise awareness in the general practitioner about relevant aspects of his patient's health status. On the basis of these results, the physician decides whether the patient is frail or not, or whether the existing information is insufficient to draw robust conclusions. The patients who are considered as frail (or for which an insufficient amount of information is available) become eligible for the second step, which is focused at

collecting more details through a structured in-depth evaluation conducted by a primary care nurse.

Conclusions

This list of examples is surely not exhaustive, and suggests that there are opportunities for conducting high quality case finding for geriatric conditions in primary care. In many low-middle income countries, primary health care is not well resourced with few doctors. Screening tools that can be administered by trained workers that are not doctors would be of great help as a first step in identifying suitable patients in primary care.

In this context, it is always good to keep in mind that the first step to prevent disability in older adults is to raise awareness about these often neglected geriatric conditions with public health authorities, health professionals, and the general population (37). Older persons and their caregivers should be educated at not underestimating signs and symptoms that too often are labelled as "due to old age". Individuals should be empowered by a greater understanding of their own health status and given responsibility for promptly acting (especially in adopting healthy lifestyles). At the same time, healthcare professionals need to be trained about the nature and consequences of geriatric conditions. The World Health Organization, with support from 30 experts in geriatric medicine, has initiated the development of evidence-based guidelines on Integrated care for older people (38). Targeted at non-specialist health workers, they will guide home-based interventions for older people that can prevent, reverse or slow declines in intrinsic capacity. Geriatric services have to stay available for referral of the most complex older patients.

Finally, case finding needs to be part of the overall care systems and must take advantage of available formal and informal contacts that the older person may have with health care and social services. Public health authorities must become familiar with the increasing burdens that disability will impose on these systems, and become more proactive in the planning and implementation of care models that priorities multidisciplinary and integrated services (39).

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