Institute *for* Healthcare Improvement

Age-Friendly Screening and Assessment Tools

Age-Friendly Health Systems

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

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Description of Screening and Assessment

What is a screening tool?

A screening tool is used as an initial brief measure of whether a condition may be present or the person may be at risk. This is important for early detection of symptoms but is not diagnostic. It identifies when further assessments are necessary.

If a screening result is positive, that suggests the need for a more in-depth assessment.

What is an assessment tool?

An assessment tool is used when a screening is positive and to more fully evaluate, diagnose, or understand the severity of a condition. It is a more comprehensive ongoing and detailed clinical process to help guide care planning, diagnosis, and treatment. Assessments can sometimes identify potentially reversible causes of certain conditions and unique strengths and needs.

Screening flags a concern (initial step). Assessment confirms and characterizes the concern for further actions (treatment, care plan). They are usually conducted sequentially.

What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care. The questions below can be used as guidance of What Matters questions to implement when providing age-friendly care.

Understanding Life Context and Priorities

These broad conversations explore what is important to older adults in their lives outside of their health (e.g., children, family, pets, hobbies), both overall and on the day of the conversation.

Questions should ideally be asked by a variety of health care clinicians in their everyday interactions with older adults in different settings.

Guiding Questions: Understanding Life Context and Priorities
What is important to you today?
What brings you joy? What makes you happy? What makes life worth living?
What do you worry about?
What are some goals you hope to achieve in the next six months or before your next birthday?
What would make tomorrow a really great day for you?
What else would you like us to know about you?
How do you learn best? For example, listening to someone, reading materials, watching a video.

Anchoring Treatment in Goals and Preferences

"What Matters" conversations are anchored to an older adult's health status and care needs and may be most appropriate when there is a new diagnosis, treatment decision, or change in health status. Questions need to focus on how treatment could facilitate or impede his or her ability to do the things they enjoy (e.g., walking, cooking, everyday activities) or attain certain life goals (e.g., attending a meaningful event). Questions also should focus on a specific time frame, such as six months or by the next birthday.

Guiding Questions: Anchoring Treatment in Goals and Preferences
What is the one thing about your health care you most want to focus on so that you can do [fill in desired activity] more often or more easily?
What are your most important goals now and as you think about the future with your health?
What concerns you most when you think about your health and health care in the future?
What are your fears or concerns for your family?
What are your most important goals if your health situation worsens?
What things about your health care do you think aren't helping you and you find too bothersome or difficult?
Is there anyone who should be part of this conversation with us?

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care. Each older adult must be assessed for *all* of the following medications.

- Benzodiazepines
- Opioids
- Highly-anticholinergic medications (e.g., diphenhydramine)
- All prescription and over-the-counter sedatives and sleep medications
- Muscle relaxants
- Tricyclic antidepressants
- Antipsychotics
- Mood Stabilizers

The American Geriatrics Society (AGS) Beers Criteria[1] is an accepted measure used to assess for potentially harmful mediations. Often, these medications have side effects that are more impactful than the benefits of the medications. This criteria is update regularly (every 2-3 years) so please look for most up to date version on the AGS site.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Cognitive Impairment (dementia, and related disorders)

Cognitive Impairment (e.g., dementia and related disorders including some reversible conditions) impacts the older adult's memory, thinking, and judgment, ranging from mild changes to severe impairment. Neurocognitive disorders are identified by progressive symptoms in older adults. Both screening and assessment are needed to enable early detection of reversible conditions, promote acess to medical and non-pharmacologica interventionsl, behaviorial support, caregiver support, and ongoing care planning to reduce complication and increase quality of life.

Screening Approach

Here are two widely used tools to screen for cognitive impairment such as dementia and related disorders:

- Mini-Cog
- Clinical Dementia Rating Scale

Assessment Approach

If a person screens positive for possible dementia or related disorders, a more detailed assessment of their cognitive status by a trained clinician is usually warranted. This is important because there are a few conditions (e.g., B12 deficiency, hydrocephalus, depression, delirium) that are potentially reversible if identified. Assessment is also important to guide treatment options and care planning. Please note, further clinical evaluation such as lab work or neuropsychological tests may be warranted should the assessment identify any impairment.

The following tools are evidence-informed assessment measures:

- **SLUMS:** The SLUMS exam measures attention/executive functioning, working memory, learning and memory, orientation, and visual-spatial abilities. This assessment tool is used for mild cognitive impairment and dementia.
- **MOCA:** The Montreal Cognitive Assessment is used to detect mild cognitive impairment, especially in people whose cognition may appear normal on simpler tests. It evaluates multiple cognitive areas to identify subtle cognitive deficits across a wide range of neurological and medical conditions.
- **Brief Interview for Mental Status (BIMS):** is a standardized 0–15 point assessment tool used in long-term care to screen cognitive function, focusing on repetition, orientation, and memory. It identifies impairment levels—Intact (13–15), Moderate (8–12), or Severe (0–7)—to guide care planning and track changes.
- **The Blessed Dementia Scale (BLESSED) (with caregiver):** a hetero-applied psychodiagnostics instrument (it is not the patient who answers it, but an informant) specially focused on evaluating dementia. The scale consists of 22 items that are asked to an informant close to the patient. It is scored from 0 to 28, with higher values indicating a deterioration in the functional capacity of the evaluated person.

- **BOMC (Blessed Orientation Memory Concentration):** The Blessed Orientation–Memory–Concentration (BOMC) test is designed to identify cognitive impairment by assessing orientation, memory, and attention. It consists of 6 verbally administered items and is used to quickly flag individuals who may require more comprehensive cognitive evaluation.
- **General Practitioner Assessment of Cognition (GPCOG):** The General Practitioner Assessment of Cognition is used in primary care to identify possible cognitive impairment or dementia. It includes a short patient assessment and, when needed, an informant interview to determine whether further evaluation is needed.
- **Mini Mental Status Exam (MMSE):** The Mini-Mental State Examination was developed to provide a quantitative measure of overall cognitive function. It assesses orientation, attention, memory, language, and visuospatial skills to help identify cognitive impairment and track changes over time.
- **Mini-Addenbrooke's Cognitive Evaluation (Mini-ACE):** The Mini-Addenbrooke's Cognitive Examination is used to detect possible dementia by assessing orientation, memory, language, and visuospatial abilities. It provides a measure of global cognitive function to identify individuals who may require further diagnostic evaluation.
- **Montreal Cognitive Assessment – Blind:** The MoCA-Blind modifies the Montreal Cognitive Assessment for people with visual impairment, screening core cognitive domains while minimizing visual bias.
- **Short Blessed Test:** The Short Blessed Test is a verbal cognitive screening tool that assesses orientation, memory, and concentration. It is used to identify global cognitive impairment and to distinguish normal cognition from dementia.
- **Global Deterioration Scale (GDS):** The GDS is a clinical staging tool that characterizes the progression of cognitive decline across 7 stages, from normal aging to severe dementia. It is used to describe severity, track disease progression, and support clinical assessment rather than to screen or diagnose cognitive impairment.
- **Kimberley Indigenous Cognitive Assessment (KICA):** The Kimberley Indigenous Cognitive Assessment was developed for use with older Indigenous Australians. It assesses global cognition using culturally appropriate tasks to identify possible dementia while minimizing educational, linguistic, and cultural bias present in standard cognitive tests
- **Psychogeriatric Assessment Scales (PAS):** The PAS is an assessment of the clinical changes seen in dementia and depression. It is used to quantify severity and distinguish dementia and depression in older adults using subject and informant interviews.

Delirium

Delirium is a rapid, acute change of mental status which includes increased confusion, disorganized thinking, inattention, and altered consciousness. These sudden changes occur between several hours to days and even weeks. Delirium causes may be multi-factorial (e.g., dehydration, pneumonia, infection, medications) and are generally reversible if treated promptly. The following screening and assessment tools may be used to identify and assess severity of delirium. A full list of other accepted tools can be found on the Network for Investigation of Delirium: Unifying Scientists website.

- **UB-CAM:** The UltraBrief Confusion Assessment Method is a two-step delirium screening protocol designed for identifying delirium in hospitalized older adults. It typically takes about one minute to complete. It combines a two-item ultra-brief screen with 3DCAM items to quickly rule out delirium or confirm its presence.
- **CAM:** The Confusion Assessment Method is a delirium diagnostic screening developed to enable non-psychiatrically trained clinicians to identify delirium accurately at the bedside. It operationalizes core delirium features to distinguish delirium from other cognitive disorders.
- **3D-CAM:** This is a structured interview that operationalizes the CAM diagnostic algorithm into a format that can be completed in about three minutes. It is designed to rapidly identify delirium in clinical and research settings while maintaining diagnostic accuracy comparable to the full CAM.
- **CAM-ICU:** The CAM-ICU is a brief delirium assessment tool adapted from the original CAM for use with critically ill or mechanically ventilated patients who may be nonverbal. It evaluates acute onset, inattention, altered consciousness, and disorganized thinking to identify delirium reliably in 2–3 minutes.
- **Brief Confusion Assessment Method (bCAM):** is a delirium assessment that takes approximately 1 to 2 minutes to perform. It is a modified CAM-ICU and these modifications were designed to improve sensitivity in non-critically ill patients. It uses objective testing with prespecified cutoffs to determine the presence of inattention and disorganized thinking.
- **Nursing Delirium Screening Scale (Nu-DESC):** a rapid, 5-item, nurse-driven tool used to assess for delirium in hospitalized patients. It evaluates disorientation, inappropriate behaviour, inappropriate communication, illusions/hallucinations, and psychomotor retardation, with scores ≥2 indicating potential delirium.
- **4AT:** a rapid, four-item clinical tool designed to screen for delirium and moderate-severe cognitive impairment in older adults, typically completed in under 2 minutes. It assesses alertness, orientation, attention, and acute change/fluctuation.
- **CAM-ICU (for across hospital):** CAM-ICU is used in hospital areas to rapidly screen for delirium in under a minute.

- **Delirium Triage Screening (DTS) - confirmed by bCAM:** an ultra-brief (under 20 seconds) delirium assessment that was developed to rapidly rule-out delirium and increase delirium screening efficiency.
- **Memorial Delirium Assessment Scale (MDAS):** is a 10-item, clinician-rated tool designed to measure the severity of delirium in hospitalized patients.
- **NEECHAM Confusion Scale:** (Neelon and Champagne) is a 9-item nursing assessment tool designed for early detection and monitoring of acute confusion and delirium in hospitalized older patients. It scores patients (0–30) on cognitive, behavioral, and physiological factors, aiding in identifying both hypoactive and hyperactive delirium, particularly in ICU settings.
- **Stanford Proxy Test for Delirium (S-PTD):** is a rapid, 1-minute, 13-item screening tool used by nurses to detect delirium in hospitalized patients.
- **Delirium Observation Screening Scale (DOS):** is a 13-item tool used by nurses to detect early delirium symptoms in hospitalized patients, particularly older adults, based on observations during routine care. It covers consciousness, attention, and cognitive functions, with a score of 3 or higher indicating potential delirium.
- **Intensive Care Delirium Screening Checklist (ICDSC):** is an 8-item tool used by bedside clinicians to screen for delirium in critically ill patients, including those who are intubated.

Depression

Depression is a mood disorder that causes persistent sadness, loss of interest in usual activities, low energy/fatigue, irritability, and changing in thoughts, physical health, and daily life. The following tools can be used for early detection and assessment of symptom severity.

- **Patient Health Questionnaire (PHQ-2):** The PHQ-2 is a two-question screening tool designed to identify individuals who may have depression and who should undergo further evaluation, rather than to diagnose or measure depression severity.
- **Patient Health Questionnaire (PHQ-9):** The PHQ-9 is a screening and severity assessment tool that directly reflects the DSM-IV criteria for major depressive disorder. It is used to screen for depression, estimate symptom severity, and monitor changes in depressive symptoms over time.
- **Geriatric Depression Scale (GDS) - short form**: The GDS15 is a brief 15-item yes/no screening tool designed to identify depression in older adults while avoiding somatic symptoms that may overlap with medical illness. It is commonly used in outpatient and long-term care settings.
- **Geriatric Depression Scale (GDS):** is a 15 or 30-item, self-report screening tool (yes/no questions) designed to detect depression in older adults. It focuses on mental/emotional symptoms rather than physical ones, and is designed for use in settings like primary care or with patients experiencing cognitive impairment
- **Cornell Scale for Depression (CSD):** is a 19-item, clinician-administered tool designed to assess depression in individuals with dementia or cognitive impairment. It relies on both patient interviews and caregiver reports to identify symptoms.
- **Hospital Anxiety and Depression Scale (HAD):** HAD is a self-report screening tool that assesses anxiety and depression separately while minimizing overlap with physical illness symptoms.
- **Mental Health Inventory (MHI)-13:** The MHI-13 is a shortened version of the Mental Health Inventory designed to measure psychological distress and well-being, including depressive and anxiety symptoms.
- **Mental Health Inventory (MHI)-17:** The MHI-17 is a short-form mental health measure that evaluates anxiety, depression, behavioral control, positive affect, and general distress. It provides a broader assessment of overall emotional functioning.
- Primary Care Evaluation of Mental Disorders (PRIME-MD): PRIME MD is designed for use in primary care to identify depressive and other mental disorders. It combines a patient completed symptom questionnaire with a clinician administered diagnostic interview based on DSM criteria.

Mobility

There are numerous available assessment tools for mobility, several of which are described below. Keep in mind as you are choosing your tool, that our goal is to assess mobility, not just fall prevention. Other factors to consider are: your population, and practical aspects of the tests' administration.

- ***Timed Up and Go (TUG)** or **Get Up and Go**: Patients are asked to rise from a standard chair, walk a distance of 3 meters (10 feet), turn 180 degrees, walk back to the chair and sit down. Use of an ambulatory device is acceptable. For the TUG, the time it takes to complete the activity is recorded with shorter times indicating better performance. For the Get Up and Go, a qualitative assessment of the patient's ability to complete all parts of the test is documented.
- **Short Physical Performance Battery (SPPB)** or **Gait Speed Alone**: The SPPB has three components, hierarchical balance assessment, a 5 times sit to stand test and a short usual gait speed over a 3 meter (10 foot) distance. Scores range from 0 – 12 with higher scores indicating better performance. Gait speed alone asks the patient to walk at their usual speed over a distance that ranges from 3 – 8 meters. The resulting score is in meters per second.
- ***Performance-Oriented Mobility Assessment/Tinetti Mobility Test:** Includes 13 balance tasks and 9 items for gait assessment. A number of versions with modifications have been developed which shorten the assessment time. Higher scores indicate better gait and balance performance.
- **4 – Item Dynamic Gait Index (DGI)**: Developed to examine functional stability during gait activities. The four components include: Horizontal head turns; Vertical head turns; Gait on level surfaces; and Changes in gait speed. Need to have a distance of 20 feet to complete the test. Each item is scored from 0 – 3, with higher scores indicating better function.
- **Hierarchical Assessment of Balance and Mobility (HABAM)**: HABAM provides a clinical assessment of in-bed mobility, transfers and ambulation. The patient is asked to stand, transfer from the bed and walk as far as they are safely able. Their performance is observed and recorded for each of the three domains being measured (balance, transfer and mobility). Scores range from 0 – 28 with higher scores indicating better performance.

  Setting: Hospital
- ***Johns Hopkins Highest Level of Mobility Scale**: THE JH-HLM scale is a nurse assessment that documents a patient's mobility during the shift and ranges from 1 (lying in bed) to 8 (walked 250+ feet). It has been validated in the hospital setting by comparing nursing and physical therapy assessments.

  Setting: Hospital

- **Banner Mobility Assessment Tool**: The MAT has 4 assessment levels that include: Sit and shake (hands), stretch and point, stand, and walk. Patients are rated as pass or fail for each of the progressively more difficult levels.
- **Functional Independence Measure (FIM)**: The FIM is used by healthcare practitioners to assess and grade the functional status of a person based on the level of assistance they require. The FIM has a motor and a cognitive subscale. The most important component will be the assessment of transfers and locomotion.
- **AM-PAC (Activity Measure Post Acute Care)** or **6 Clicks**: The AM-PAC consists of six domains: Applied Cognitive, Personal & Instrumental/Daily Activity, Movement & Physical/Basic Mobility, Communication, and Grooming and Hygiene. The sum of scores for each item provides a raw score from 6 to 24 that can be standardized to a t score. The AM-PAC "6-Clicks" instruments include basic mobility and daily activities. Scores range from 6 – 24 for both with lower scores indicating higher dependency.
- **Mobilizing Our Vulnerable Elders (MOVE):** is a quality improvement initiative designed to prevent functional decline in hospitalized seniors. It promotes early mobility by encouraging staff to assess mobility within 24 hours of admission, use scaled, progressive exercises, and mobilize patients at least three times daily.
- **Spinal Cord Independence Measure (SCIM):** The Spinal Cord Independence Measure Version III (SCIM-III) is designed for individuals with spinal cord injury (SCI) and assesses performance in activities of daily living and mobility. Guidelines were created for 2 subscales: self-care (6 items) and mobility (9 items). A total score out of 60 can be obtained, with self-care scores ranging from 0-20 and mobility scores ranging from 0-40. Higher scores indicate increased independence.
- **PROMIS Physical Function 5 (PF5)**: PROMIS PF is typically administered in a clinic setting. Because a minimal amount of time (less than 1 minute) is needed to complete the outcome measure, it can be easily administered to a patient before their initial evaluation. Since the outcome measure is a self-report survey with no direct observation by a licensed clinician, the patient's responses may not accurately reflect their actual level of function for each test item.
- **VA MSST:** The VA MSST is an evidence-based flowchart screening and decision support tool that demonstrates excellent interrater reliability across disciplines and settings. VA MSST has strong face and content validity, as well as good concurrent and construct validity.
- **Comprehensive Mobility Evaluation Tool (CMET):** The CMET was developed by an interdisciplinary team for use in acute care with results of a validation study with comparison to BMAT. This mobility assessment tool supports nurses to assess mobility status and predict the level of assistance needed for safe mobility progression.

* Strongly recommended (included on the 4Ms Care Descriptions form).

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