Geriatric Assessments in People with HIV

17th Graying of HIV Symposium

Eugenia L. Siegler, MD
Professor of Clinical Medicine
Weill Cornell Medicine
New York, NY
September 9, 2022

Acknowledgement

The MidAtlantic AIDS Education and Training Center (MAAETC) is supported by DHHS, Health Resources and Services Administration (HRSA) as part of a cooperative agreement of $2,917,621 and 0% financed with non-governmental sources. The program aims to provides HIV training and technical assistance to USPHS Region 3 (Pennsylvania, Maryland, Delaware, the District of Columbia, Virginia, and West Virginia).

The contents in this presentation are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Disclaimer

Funding for this presentation was made possible in part by U1OHA29295 from the Health Resources and Services Administration HIV/AIDS Bureau. The views expressed do not necessarily reflect the official policies of the Department of Health and Human Services nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government. *Any trade/brand names for products mentioned during this presentation are for training and identification purposes only.*

Planning Disclosure

The staff and faculty involved with the planning of today's event **do not** have any conflicts of interest to disclose.

Needs

We have attempted to make this presentation compliant with the Americans with Disabilities Act and Section 508 of the Rehabilitation Act.

If you find that you need further accommodation, or alternate means to utilize this presentation, please contact us and we will attempt to further accommodate your needs.

Today's Objectives

- Understand the domains of geriatric assessment
- Adapt screens for aging-related syndromes to their clinical environment

Case

- A 61-year-old patient is visiting you for a regular check
- They are adherent, and viral load is <20
- They tell you they are starting to feel “old"
- What do you do?

What is your patient really telling you?

Do they need help with:

ADL	IADL
Ambulation	Finances
Bathing	Food Preparation
Eating	Housekeeping
Dressing	Laundry
Grooming	Medication
Toilet	Shopping
	Telephone
	Transportation

Do you suspect problems with:

- Executive function
- Cognition
- Mood
- Family/home situation?

Where do you begin?

A geriatric approach can help older PWH and LTS

We concentrate on the 5 Ms

https://britishgeriatricssociety.wordpress.com/2017/10/13/the-geriatric-5ms-the-5-simple-words-every-geriatrician-needs-to-know-the-new-mantra/

How can the 5Ms inform your choice of screens?

mind

medications

multimorbidity

mobility

matters most

https://britishgeriatricssociety.wordpress.com/2017/10/13/the-geriatric-5ms-the-5-simple-words-every-geriatrician-needs-to-know-the-new-mantra/

Who can screen, and in what domains?

- Assistants and technicians
- Consumers and peers
- Behavioral health professionals
- Pharmacists
- Social service providers and case managers
- Clinicians

Examples of Assessments for People Aging with HIV

- Cognition
- Financial management
- Gait and mobility
- Hearing
- Housing
- Mental health
- Nutrition
- Oral health
- Polypharmacy
- Sexual health
- Sleep pattern and quality
- Social engagement
- Substance use
- Transportation access
- Vaccination history
- Vision

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-best-team.pdf

The WHO defines healthy aging as developing and maintaining the functional ability that fosters well being

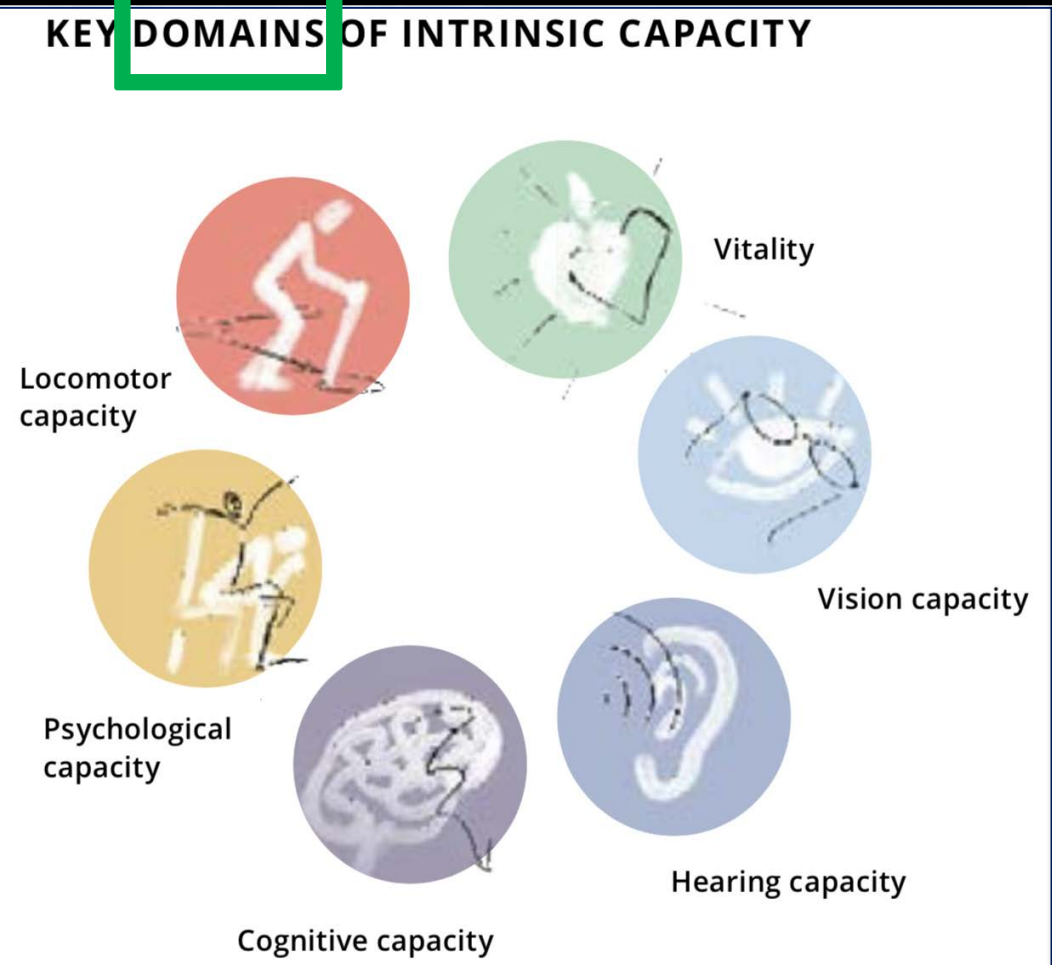
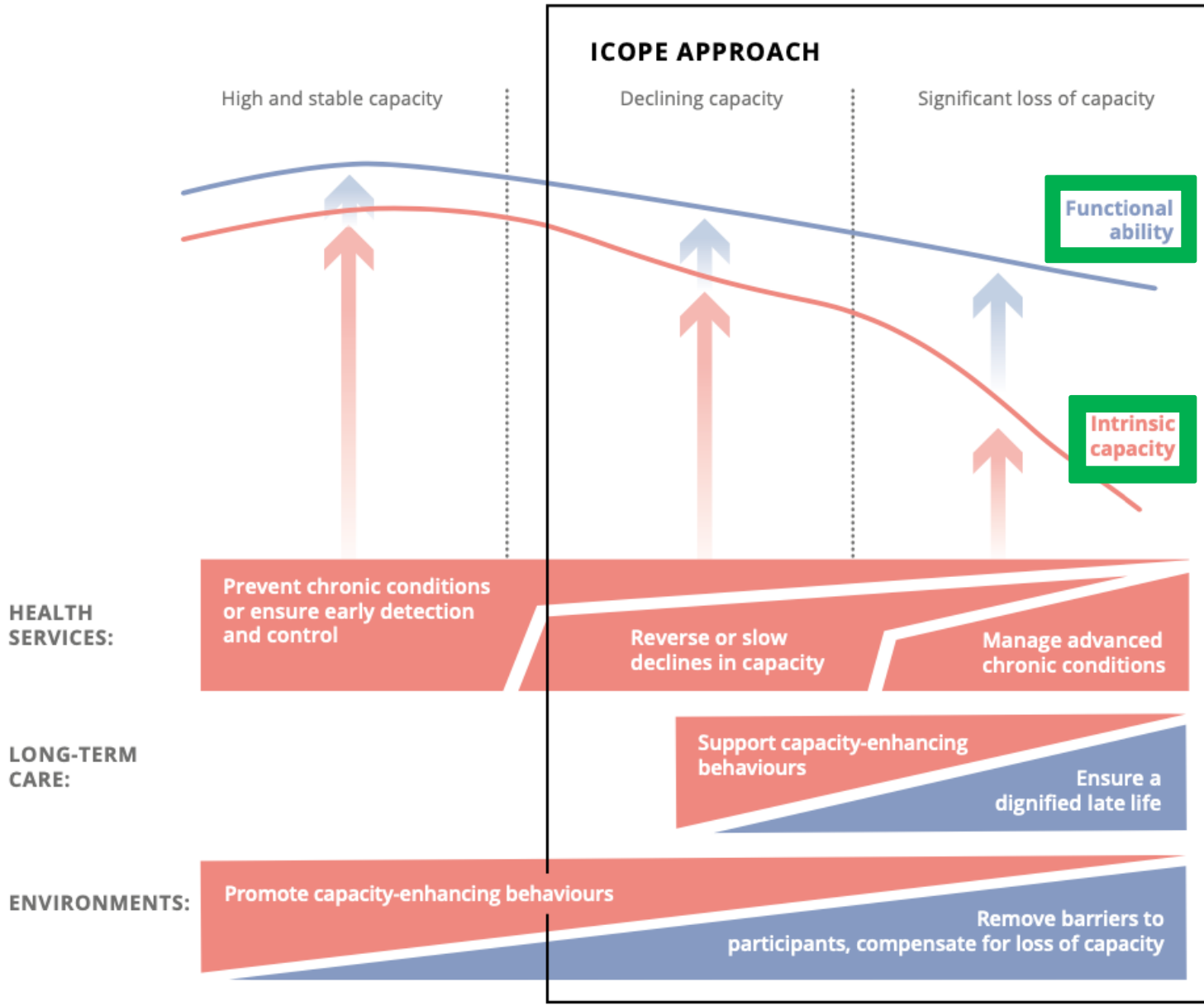
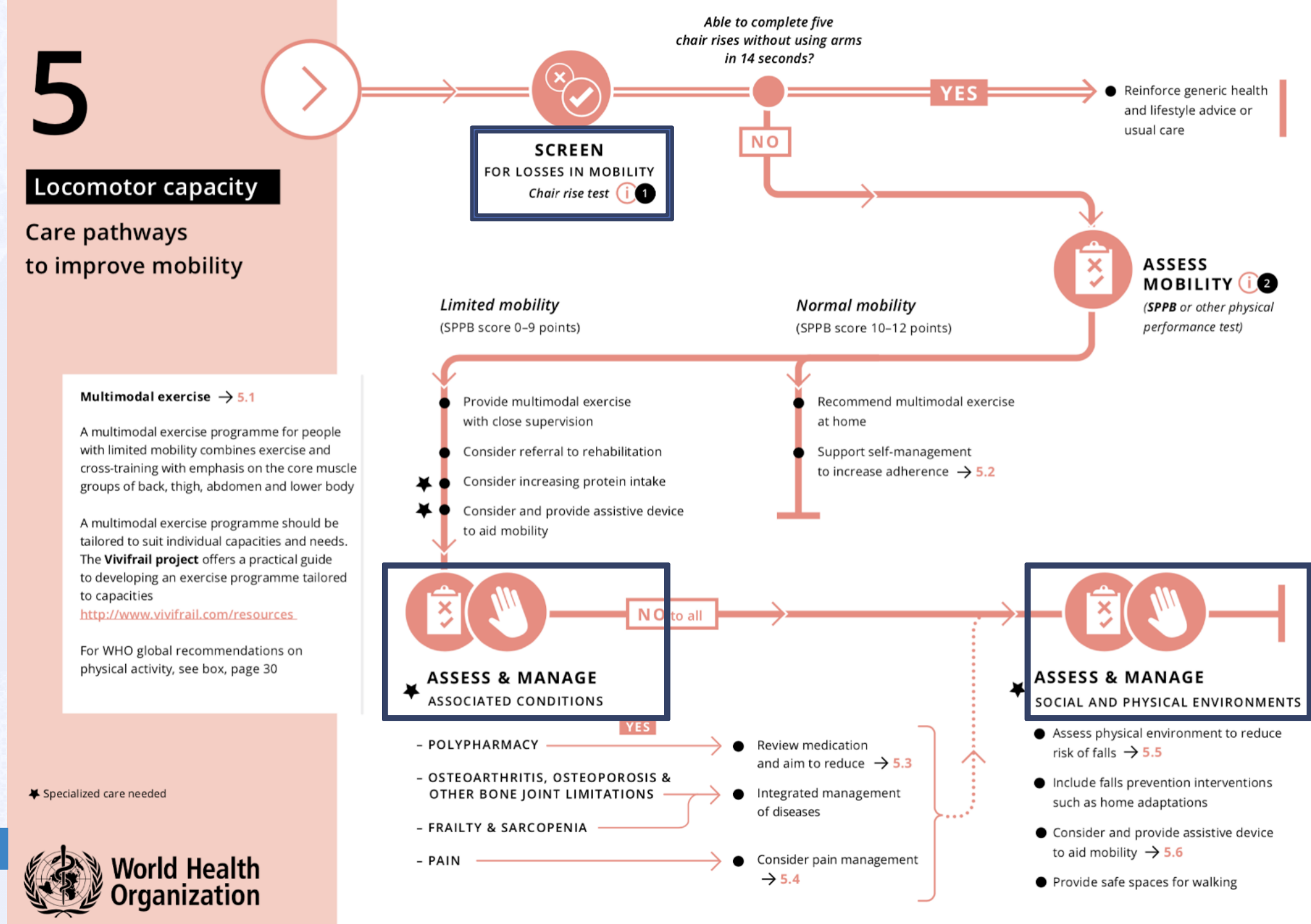


FIGURE 2. A PUBLIC-HEALTH FRAMEWORK FOR HEALTHY AGEING: OPPORTUNITIES FOR PUBLIC HEALTH ACTION ACROSS THE LIFE COURSE



Source: World Health Organization, 2015 *(1)*.

ICOPE provides examples of screening protocols for each domain



Now what?

Multimodal exercise → 5.1

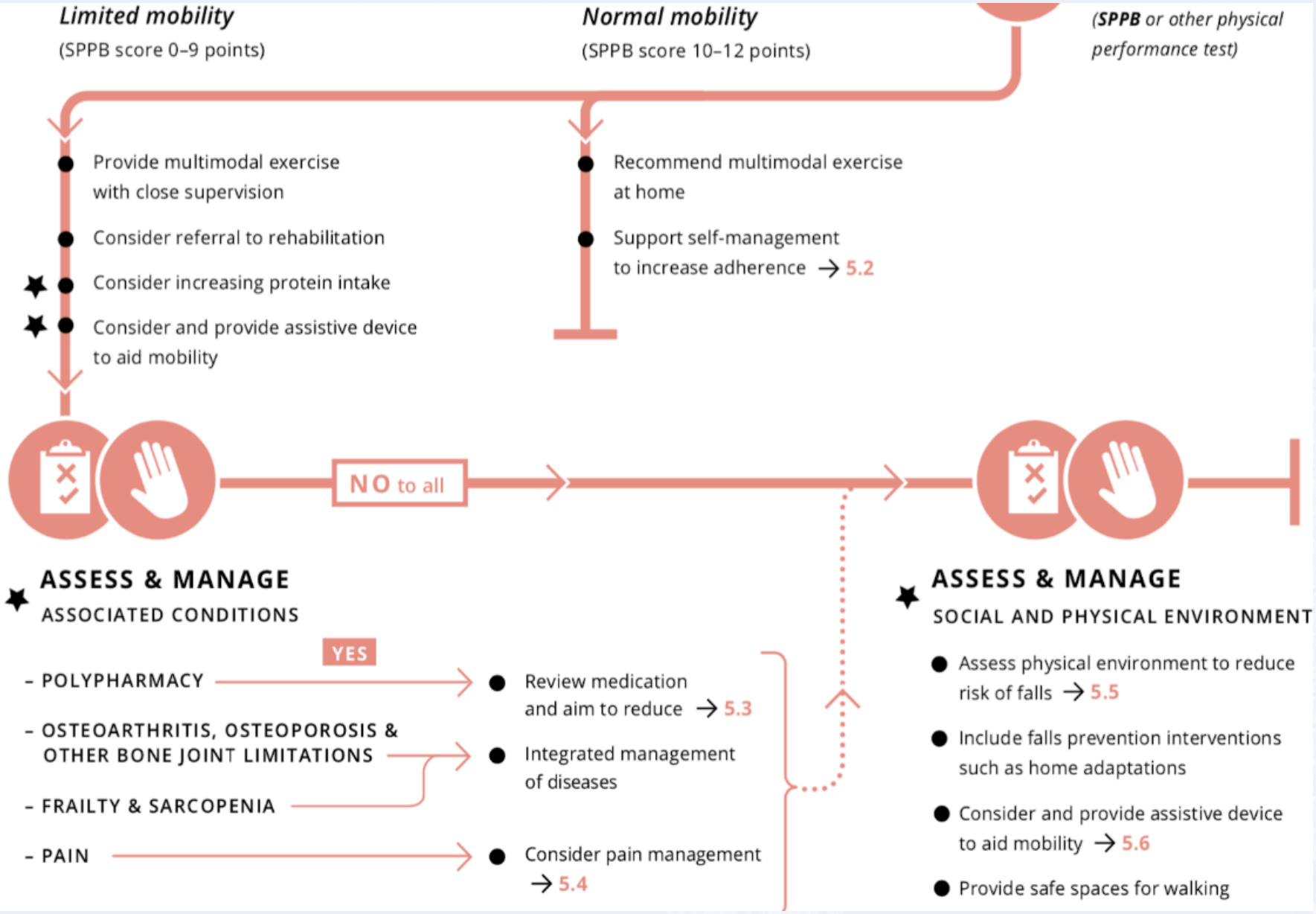
A multimodal exercise programme for people with limited mobility combines exercise and cross-training with emphasis on the core muscle groups of back, thigh, abdomen and lower body

A multimodal exercise programme should be tailored to suit individual capacities and needs. The **Vivifrail project** offers a practical guide to developing an exercise programme tailored to capacities
http://www.vivifrail.com/resources

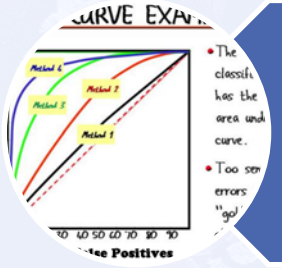
For WHO global recommendations on physical activity, see box, page 30

✸ Specialized care needed

World Health Organization



For specific domains, choose assessment tools that are useful in your setting



Test characteristics

Time/ Ease of administration

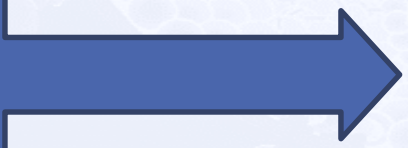
Availability in the EHR

What kind of screen do you want to use?

- General
- Cognitive
- Mobility
- Frailty
- Bone Health
- Mood
- Resources

Patients can fill out a general screen before the visit

A local PCP may have a Medicare Annual Wellness Visit template



Name:_____ Date:_____ Date of Birth:_____

A Checklist for Your Medicare Wellness Annual Visit

Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible.

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

3. During the past 4 weeks, how much bodily pain have you generally had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with

5 During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
- ☐ Very heavy
- ☐ Heavy
- ☐ Moderate
- ☐ Light
- ☐ Very light

	Yes	No
6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?	☐	☐
7. Can you shop for groceries or clothes without help?	☐	☐
8. Can you prepare your own meals?	☐	☐
9. Can you do your own housework without help?	☐	☐
10. Can you handle your own money without help?	☐	☐
11. Do you need help eating, bathing, dressing, or getting around your home?	☐	☐

12. During the past 4 weeks, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair

https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/hra.pdf

The NYS AIDS Institute is piloting a screen based on ICOPE domains

daniel.belanger@health.ny.gov

Patient Name & DOB:	Screener Name:	Screening Complete?	Date:

MODIFIED WHO ICOPE SCREENING TOOL ***Assess fully any domain with a checked box.***

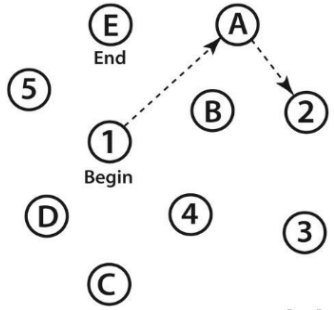
MEMORY	1. Remember three words: flower, door, rice (for example)	
	2. Orientation in time and space: What is the month, day, and year today? Where are you now (home, clinic, etc.)?	Wrong to either question or doesn't know
	3. Recalls all three words?	No
MOBILITY	1. Are you able to get around without difficulty?	No
	2. Do you require durable (e.g., cane, walker) medical equipment for moving around?	Yes
	3. **In Person Only* Chair rise test: Rise from the chair five times without using arms. Did the person complete 5 chair rises within 14 seconds?*	No
NUTRITION	1. Weight: Have you unintentionally lost more than 3kg/6.6lbs over the last three months?	Yes
	2. Appetite: Have you experienced loss of appetite?	Yes
	3. Are you able to eat without difficulty?	No
VISION	1. Are you having trouble seeing, even when wearing glasses or contacts?	Yes
	2. Have you had an eye exam in the last 12 months?	No
HEARING	1. Are you having trouble hearing, even with hearing assistance (e.g., hearing aids)?	Yes
	2. **In Person Only* Hears whispers (whisper test)* ***OR*** *Screening audiometry result is 35 dB or less* ***OR*** *Passes automated app-based digits-in-noise test*	No
MOOD	1. Over the past two weeks, have you been bothered by:	
	- Feeling down, depressed, or hopeless?	Yes
	- Little interest or pleasure in doing things?	Yes
	- Feeling lonely or isolated?	Yes
NOTES	*Space for other comments.*	

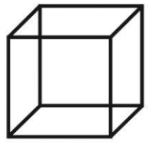
MONTREAL COGNITIVE ASSESSMENT (MOCA)

Version 7.1 Original Version

NAME :
Education : Date of birth :
Sex : DATE :

VISUOSPATIAL / EXECUTIVE



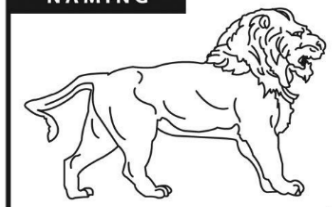


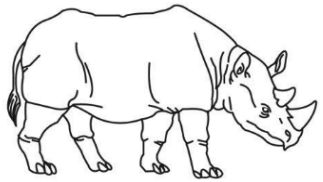
Copy cube [ ]

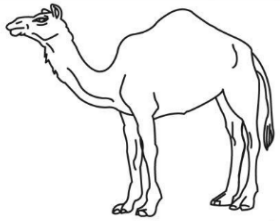
Draw CLOCK (Ten past eleven) (3 points) [ ] Contour [ ] Numbers [ ] Hands

POINTS __/5

NAMING


[ ]


[ ]


[ ]

__/3

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order [ ] 2 1 8 5 4
Subject has to repeat them in the backward order [ ] 7 4 2 __/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B __/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt** __/3

LANGUAGE Repeat : I only know that John is the one to help today. [ ]
The cat always hid under the couch when dogs were in the room. [ ] __/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words) __/1

ABSTRACTION Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler __/2

DELAYED RECALL

	Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

__/5

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

© Z.Nasreddine MD www.mocatest.org Normal ≥ 26 / 30 TOTAL __/30
Add 1 point if ≤ 12 yr edu

Administered by: _____

Cognitive screens have widely varying sensitivities

MINI-COG™

Instructions

ADMINISTRATION	SPECIAL INSTRUCTIONS
1. Get patient's attention and ask him or her to remember three unrelated words. Ask patient to repeat the words to ensure the learning was correct.	• Allow patient three tries, then go to next item. • The following word lists have been validated in a clinical study: [illegible] **Version 1**: • Banana • Sunrise • Chair **Version 2**: • Daughter • Heaven • Mountain **Version 3**: • Village • Kitchen • Baby **Version 4**: • River • Nation • Finger **Version 5**: • Captain • Garden • Picture **Version 6**: • Leader • Season • Table
2. Ask patient to draw the face of a clock. After numbers are on the face, ask patient to draw hands to read 10 minutes after 11:00 (or 20 minutes after 8:00).	• Either a blank piece of paper or a preprinted circle (other side) may be used. • A correct response is all numbers placed in approximately the correct positions AND the hands pointing to the 11 and 2 (or the 4 and 8). • These two specific times are more sensitive than others. • A clock should not be visible to the patient during this task. • Refusal to draw a clock is scored abnormal. • Move to next step if clock not complete within three minutes.
3. Ask the patient to recall the three words from Step 1.	Ask the patient to recall the three words you stated in Step 1.

Scoring

3 recalled words	Negative for cognitive impairment
1-2 recalled words + normal CDT	Negative for cognitive impairment
1-2 recalled words + abnormal CDT	Positive for cognitive impairment
0 recalled words	Positive for cognitive impairment

References

Borson S, Scanlan J, Brush M, Vitaliano P, Dokmak A. The mini-cog: a cognitive 'vital signs' measure for dementia screening in multi-lingual elderly. Int J Geriatr Psychiatry. 2000;15(11):1021-1027.
Borson S, Scanlan JM, Chen P, Ganguli M. The Mini-Cog as a screen for dementia: validation in a population-based sample. J Am Geriatr Soc. 2003;51(10):1451-1454.
McCarten JR, Anderson P, Kuskowski MA, et al. Screening for dementia in primary care: the results of a clinical demonstration project. J Am Geriatr Soc. 2011;59(8):1351-1357.

Mini-Cog

(Borson et al, 2000; 2003)

- Three-item recall + Clock Drawing Test
- Quick
- Minimally dependent on education

Review of brief cognitive tests for patients with suspected dementia (2014) doi:10.1017/S1041610214000416

Mobility and gait: Chair Rise Test

CHAIR RISE TEST

A simple test can decide whether an older person needs further assessment for limited mobility.

Instructions: Ask the person, "Do you think it would be safe for you to try to stand up from a chair five times without using your arms?" (Demonstrate to the person.)

If YES, ask them to:

– sit in the middle of the chair
– cross and keep their arms over their chest
– rise to a full standing position and then sit down again
– repeat five times as quickly as possible without stopping.

Time the person taking the test – further assessment is needed if they **cannot stand up five times within 14 seconds.**

Mobility and Gait: Timed Up and Go Test

Podsialdo et al., JAGS 1991

Time:	*Rating:*
<10 seconds	Freely mobile
>=12 seconds	Higher risk of falling

Patient: Date: Time: AM/PM

The Timed Up and Go (TUG) Test

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters or 10 feet away on the floor.

Instructions to the patient:

When I say **"Go,"** I want you to:

1. Stand up from the chair
2. Walk to the line on the floor at your normal pace
3. Turn
4. Walk back to the chair at your normal pace
5. Sit down again

On the word **"Go"** begin timing.

Stop timing after patient has sat back down and record.

Time: _____ **seconds**

An older adult who takes ≥12 seconds to complete the TUG is at high risk for falling.

Observe the patient's postural stability, gait, stride length, and sway.

Circle all that apply: Slow tentative pace ■ Loss of balance ■ Short strides ■ Little or no arm swing ■ Steadying self on walls ■ Shuffling ■ En bloc turning ■ Not using assistive device properly

Notes:

For relevant articles, go to: **www.cdc.gov/injury/STEADI**

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

STEADI Stopping Elderly Accidents, Deaths & Injuries

Assess Frailty: Frailty Phenotype (Fried et al, 2001 PMID:11253156)

- Shrinking
  - Weight loss >=10 lb lost unintentionally in the prior year
- Weakness
  - Grip strength lowest 20% (adj)
- Poor endurance/exhaustion
  - Exhaustion, unusual weakness or fatigue by self report
- Slowness
  - 4 m walk (>= 7 s for ht <=159 cm; otherwise >+6 s)
- Low activity
  - Lowest quintile of kilocalories expended per week
  - (calculated based on subject report)

- Three or more criteria = frail
- One to two criteria = prefrail or intermediate

Some Simpler Frailty Screens

“FRAIL” Questionnaire

3 or greater = frailty; 1 or 2 prefrail

- Fatigue: are you fatigued?
- Resistance: Cannot walk up 1 flight of stairs?
- Aerobic: Cannot walk 1 block?
- Illnesses: Do you have more than 5 illness?
- Loss of weight: Have you lost more than 5% of your weight in the past 6 months?

Morley et al. J Nutr Health Aging. 2012 Jul;16(7):601-8. PMID: 22836700

Gérontopôle Frailty Screening Tool

(yes to at least 1, + gestalt)

- Living alone?
- Involuntary weight loss in the past 3 months?
- Fatiguability from the past 3 months?
- Mobility difficulties for the past 3 months?
- Memory complaints?
- Slow gait speed (>4 s for 4 m)

Subra et al. J Nutr Health Aging 2012 doi: 10.1007/s12603-012-0391-7.

Clinical Frailty Scale

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

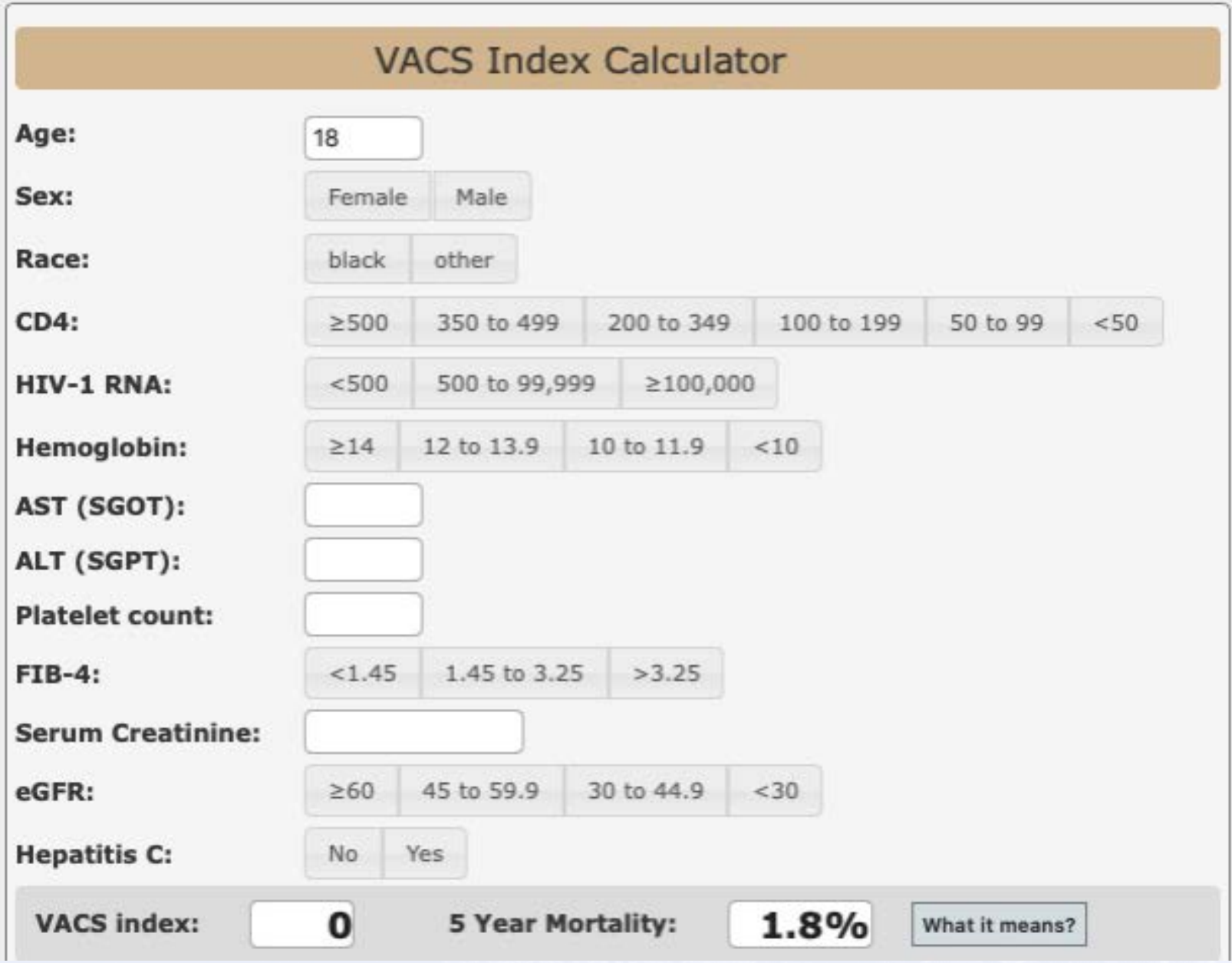
In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

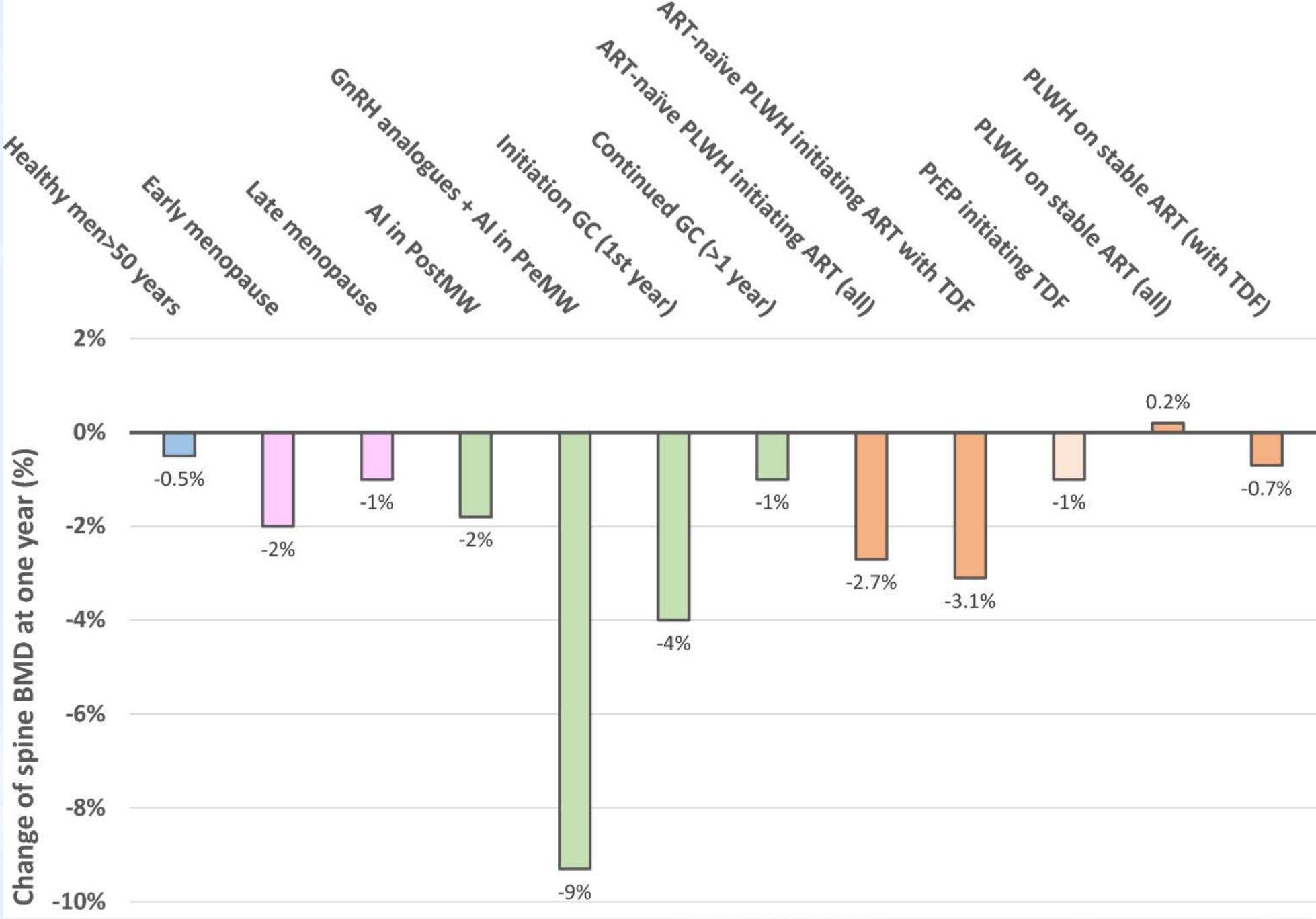
DALHOUSIE UNIVERSITY
Inspiring Minds

Assess Prognosis
VACS Calculator

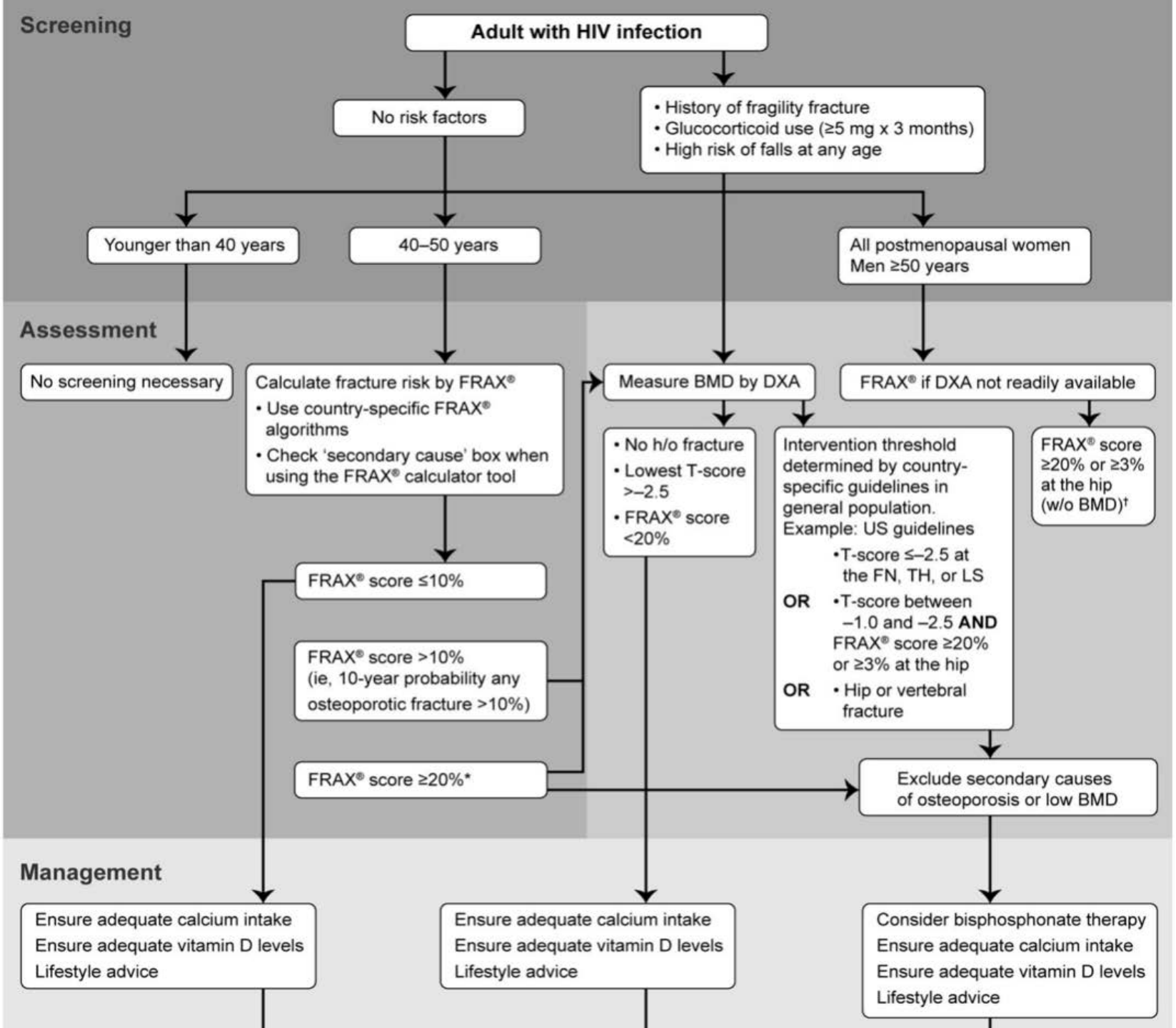


Justice et al. https://vacs.med.yale.edu/calculator/IC

Assess and manage bone health

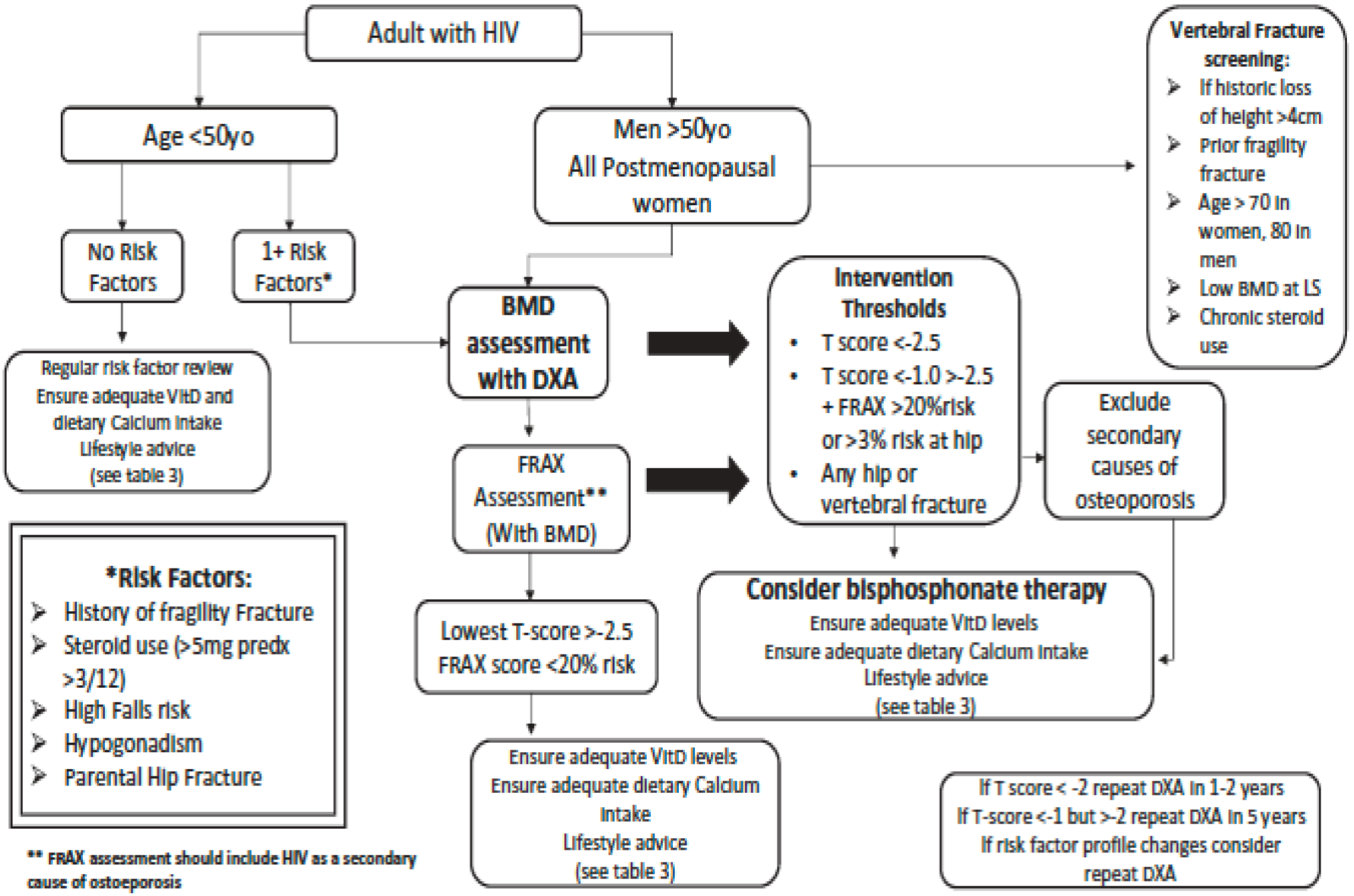


Biver, 2022 DOI: 10.1007/s00223-022-00946-4



Algorithms are available to help with bone screening

Brown et al, CID 2015 DOI: 10.1093/cid/civ010

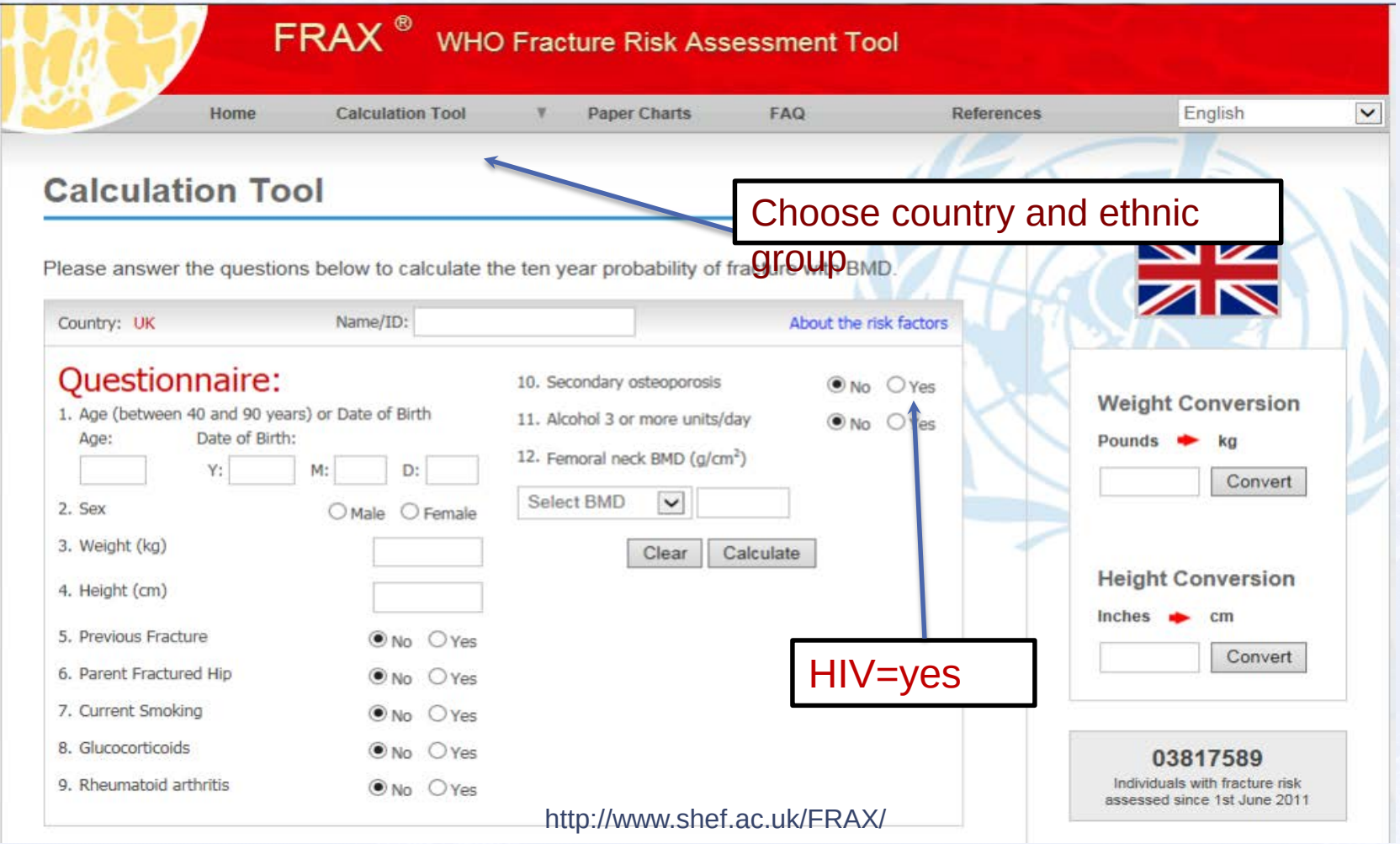


ure 1. Suggested algorithim for managing bone health in HIV infected adults.

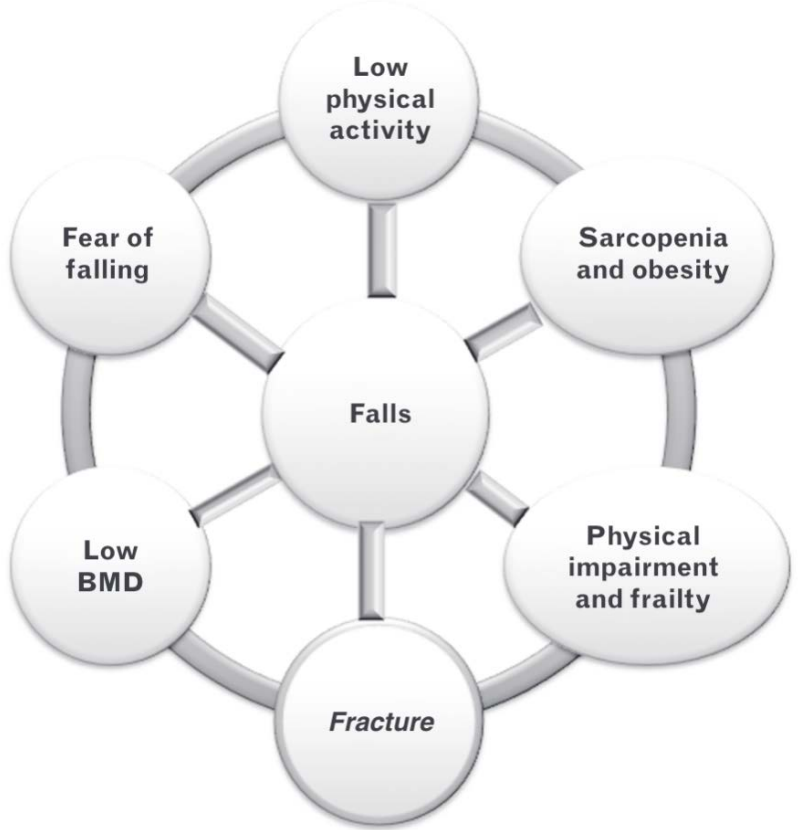
Algorithms are available to help with bone screening

McGinty & Mallon, Exp Rev Anti-infect Ther, 2016
DOI: 10.1080/14787210.2016.1184570

FRAX screen underestimates fracture risk in PWH, but it can help with initial assessment



Fractures involve more than just

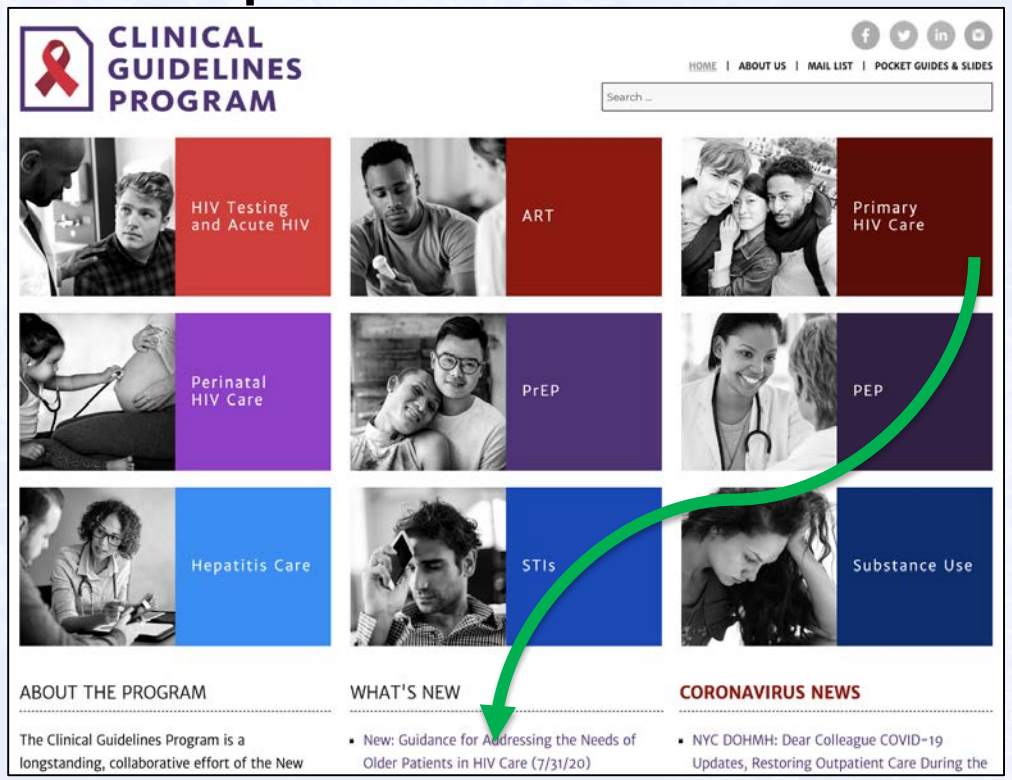


Erlandson et al, 2016
DOI:10.1097/COH.0000000000000258

Assessment Tools: Conclusions

- Formal assessment is more accurate and sensitive than clinical judgment
- Select assessment tools based on characteristics, time/ease of administration, EHR availability
- Identify action steps for positive screens in advance (planning!)
- Check the WHO ICOPE Guidance for ideas
  - https://www.who.int/ageing/publications/icope-handbook/en/

NYS Sponsored Resources



Other HRSA-sponsored Resources

- HIV and Aging toolkits:
  - https://www.necaaetc.org/guides-toolkits
  - https://aidsetc.org/toolkit/aging/home
- National HIV Curriculum: https://www.hiv.uw.edu/go/key-populations/hiv-older-patients
- GWEP sites: https://www.americangeriatrics.org/sites/default/files/inline-files/2019%20GWEP%20Grantee%20List%202018%20No%20Cost%20Extension%20GWEPs%20ed.%209.4.20.pdf

Ryan White Resources

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-new-elements.pdf
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-best-team.pdf

MidAtlantic AIDS Education and Training Center - Contact Information

Regional Partner:

Dorcas Baker RN, BSN, ACRN, MA

Center for Infectious Disease and Nursing Innovation (CIDNI)

Johns Hopkins Regional Partner

MidAtlantic AIDS Education and Training Center (AETC)

Johns Hopkins University School of Nursing

525 N. Wolfe St.

Baltimore, MD 21205

Headquarters:

MidAtlantic AIDS Education and Training Center

Department of Infectious Diseases and Microbiology,

Graduate School of Public Health,

University of Pittsburgh

412-624-1895

maaetc@pitt.edu

www.maaetc.org

Linda Rose Frank, PHD, MSN, ACRN, FAAN

Principal Investigator and Program Director

Professor of Public Health, Medicine & Nursing

University of Pittsburgh

Depression scales vary in length

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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	0	1	2	3
		add columns	+	+
		TOTAL:		

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. 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 _____

Simplest Screen: Are you depressed?

Geriatric Depression Scale (Short Form)

Patient's Name: _____ Date: _____

Instructions: Choose the best answer for how you felt over the past week.

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / NO	
2.	Have you dropped many of your activities and interests?	YES / NO	
3.	Do you feel that your life is empty?	YES / NO	
4.	Do you often get bored?	YES / NO	
5.	Are you in good spirits most of the time?	YES / NO	
6.	Are you afraid that something bad is going to happen to you?	YES / NO	
7.	Do you feel happy most of the time?	YES / NO	
8.	Do you often feel helpless?	YES / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	YES / NO	
10.	Do you feel you have more problems with memory than most?	YES / NO	
11.	Do you think it is wonderful to be alive?	YES / NO	
12.	Do you feel pretty worthless the way you are now?	YES / NO	
13.	Do you feel full of energy?	YES / NO	
14.	Do you feel that your situation is hopeless?	YES / NO	
15.	Do you think that most people are better off than you are?	YES / NO	
		TOTAL	

Scoring:

Assign one point for each of these answers:

1. NO	4. YES	7. NO	10. YES	13. NO
2. YES	5. NO	8. YES	11. NO	14. YES
3. YES	6. YES	9. YES	12. YES	15. YES

A score of 0 to 5 is normal. A score above 5 suggests depression.

Source:

- Yesavage J.A., Brink T.L., Rose T.L. et al. Development and validation of a geriatric depression screening scale: a preliminary report. J. Psychiatr. Res. 1983; 17:37-49.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ___ = Add Columns ___ + ___ + ___

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
☐	☐	☐	☐

Mental Health: GAD-7 is the most common anxiety screen

- 7-item
- Administration time 2-5 min

Spitzer RL et al Arch Intern Med. 2006;166:1092-1097.

Most efficient: PHQ-4 measures depression and anxiety

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "□ " to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

On each subscale, a score of **3 or greater** is considered positive for screening purposes

Kroenke K, Spitzer RL, Williams JBW, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4 Psychosomatics 2009;50:613-621.