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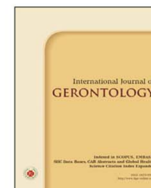

Editorial Comment

# Bridging the Gap: From Gold Standard to Practical Reality in Screening of Geriatric Health Status

The demographic imperative of an aging global population presents one of the most profound challenges to contemporary healthcare systems. At the heart of effective care for older adults lies the comprehensive geriatric assessment (CGA), rightly hailed as the gold standard for its holistic, multidimensional approach to identifying vulnerabilities and crafting personalized care plans. Yet, a persistent and critical gap exists between this ideal and daily practice. The time-intensive nature, need for specialized training, and reliance on multiple instruments render routine implementation of CGA impractical for busy emergency departments, crowded primary care clinics, and under-resourced community settings. This creates a dangerous paradox: the patients most in need of holistic assessment, i.e., those with complex, interacting conditions, are often those least likely to receive it in a timely manner. A brief screening instrument would be an initial step to identify the potential geriatric problems and determine the necessity for further comprehensive evaluation or specific interventions in primary healthcare practice.[1]

The main challenge for clinicians and policymakers is not only identification of at-risk older adults, but how to do so effectively, efficiently, and equitably within real-world healthcare constraints. The emergence of tools like the Taiwan Seniors at Risk (TSAR), FIND-NEEDS, and the Integrated Self-Screening Instrument for Geriatric Health Testing (INSIGHT) represents a necessary and pragmatic evolution toward scalable, precision geriatric care. These screening tools offer complementary signposts across the continuum of care, each addressing specific points of need. They bridge the gap and become the actionable funnel that ensures precious CGA resources are deployed where they will have the greatest impact.

## Setting-specific tools

The TSAR tool, developed for the fast-paced environment of emergency department (ED), exemplifies the "right-tool-for-the-right-setting" principle.[2] Its strength lies in simplicity: six yes/no questions administered rapidly during triage. While its psychometric characteristics (AUC of 0.67) indicate moderate discriminative ability, this must be weighed against the tool's paramount objective: serving as a rapid triage filter. In ED chaos, a tool that quickly flags high-risk seniors for detailed assessment is invaluable, transforming the question from "Who gets a full assessment?" to "Who can safely not get one right now?"

In geriatric outpatient clinics, the FIND-NEEDS tool demonstrates different strengths: high convergent validity with full CGA.[3] The more domains with strong correlation with CGA ($\varphi$ = 0.81-0.97 in six domains) suggest FIND-NEEDS may act as a "CGA snapshot," efficiently directing clinician attention to identified problem areas and potentially freeing assessment time for care planning rather than exhaustive data gathering. Comparison of ICOPE-TW with CGA reveals that different screenings have different affinities: ICOPE-TW's strong correlation for vision and hearing impairment ($\varphi$ = 0.82 and 0.70) but weaker performance elsewhere highlights that tool selection must be guided by specific conditions of interest and clinical context.

The INSIGHT instrument shifts the paradigm from clinician-administered screening to self-administered health testing (Chia-Ming Chang, Ya-Li Wang, unpublished data, 2026). By distilling 13 CGA domains into a 24-item, three-point Likert scale questionnaire, INSIGHT empowers older adults to engage proactively in health assessment. This design directly tackles barriers of access and clinician time, particularly relevant for community settings or routine pre-appointment checks in primary care. The graded scale, as opposed to binary yes/no, captures the spectrum of ability and severity characterizing geriatric syndromes, where subtle declines can be detected for monitoring or further work-up.

## A stratified screening ecosystem

Since no single tool is superior, a stratified screening ecosystem is required. A tiered stepwise workflow integrates geriatric screening from ED to non-ED settings (Figure):

### *Step 1: Rapid triage screening in ED*

This step prioritizes sensitivity and speed. In EDs, ultra-brief screening tools (TSAR, ISAR, TRST, etc.) rapidly identify at-risk patients, triggering more detailed assessment. The purpose is binary: "Flag for further intervention" or "Routine ED care." Based on onset and urgency, geriatric syndromes (syndemics) can be classified into acute conditions (delirium, injurious falls, elder abuse, etc.) requiring immediate intervention, and non-acute conditions (malnutrition, dementia, depression, incontinence, etc.) better managed in outpatient settings after ED discharge.[4]

### *Step 2: Multi-domain screening in non-ED settings*

After ED discharge or at first contact in non-ED settings, more comprehensive but efficient tools like FIND-NEEDS, INSIGHT, or ICOPE are administered. Choice depends on the setting: FIND-NEEDS or TaGA for clinician-facilitated efficiency in hospitalization, FIND-NEEDS, ICOPE, BRIGHT, or EARRS, etc. in outpatient clinics, primary care or community services, INSIGHT or BRIGHT for self-administered breadth. This step provides a prioritized action map, directly informing scope and urgency of subsequent comprehensive assessment — whether full CGA, specialist referral, or targeted intervention for specific domains.

To maximize success in identifying risky older adults without adding staff workload, demographic characteristics such as age $\geq$ 75 years, Clinical Frailty Scale $\geq$ 4,[5] or multiple chronic diseases may be considered before screening implementation. Criteria can be adjusted by execution capacity of non-ED settings.

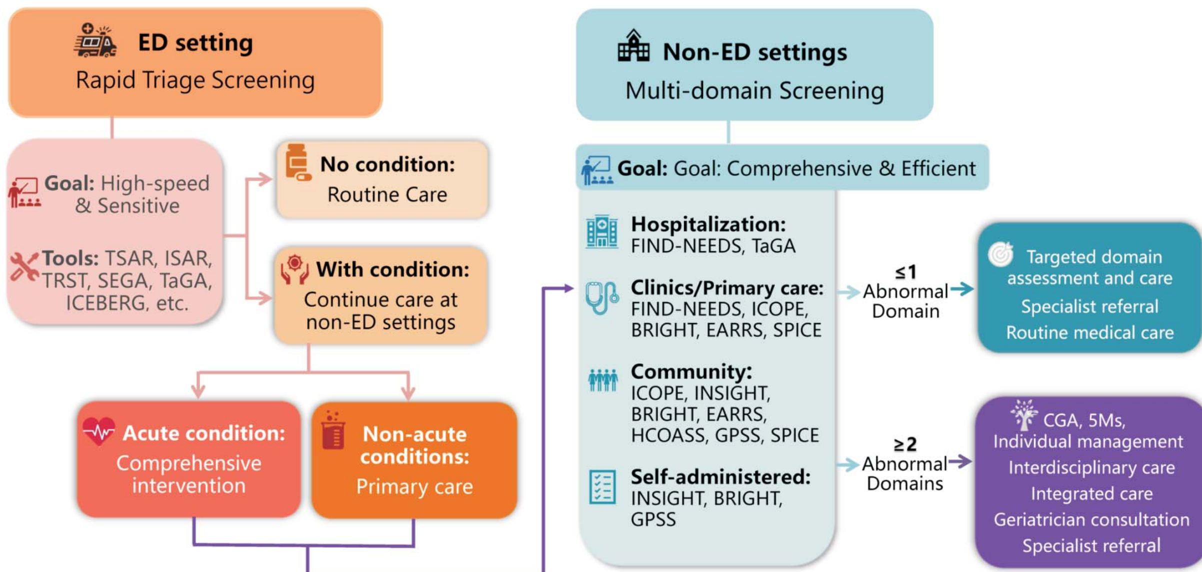


**Figure.** Stratified stepwise workflow for integration of geriatrics screening to assessment. Abbreviations: BRIGHT: Brief Risk Identification of Geriatric Health Tool; EARRS: Elderly At Risk Rating Scale; GPSS: Geriatric Postal Screening Survey; HCOASS: High-need Community Older Adults Screening Scale; ICEBERG: Identification of elderly patients in the emergency room with Consultation needs for Early rehospitalization, Better nursing care needs, Early mortality, Readmission, and Geriatric assessment; LWAH-RS: Live Well at Home Rapid Screen Tool; SEGA: Short Emergency Geriatric Assessment; SPICE: Senses, Physical ability, Incontinence, Cognition and Emotional distress; TaGA: Targeted Geriatric Assessment.

### *Step 3: Targeted action*

The action of the next step is determined by screening results:

- Single abnormal domain: Focus on traditional medical treatment and in-depth assessment of the individual domain problem.
- Multiple abnormal domains: Require formal CGA and multidomain intervention, or geriatrician consultation for integrated care.

This model balances efficiency with early detection, ensuring comprehensive resources are reserved for patients with complex needs. Automated risk stratification may create efficient workflows for high-risk subgroups while maintaining standard pathways for low-risk patients. These screening tools may be used to create healthcare delivery pathways integrated into existing system workflows.[6]

## Implementation challenges and future directions

Successful integration of geriatric screening into clinical practice requires brief, user-friendly tools embedded within electronic health records (EHRs) to facilitate workflow and interdisciplinary communication. However, routine implementation faces organizational barriers, disrupted workflows, and inconsistent digital systems. Overcoming these challenges necessitates clear clinical pathways linking screening to action, supported by adequate systems, leadership, interdisciplinary collaboration, and staff training.

Future efforts should focus on embedding these systems within structured care pathways, with research needed to assess long-term impact on outcomes and costs. Greater attention to patient perspectives, including baseline function, recent changes, and personal goals, will help interpret screening results and guide follow-up decisions.

## Conclusion

The pursuit of practical geriatric screening tools is not an abandonment of the comprehensive ideal but its essential enabler. Tools like TSAR, FIND-NEEDS, and INSIGHT represent significant advances in making geriatric assessment scalable, accessible, and workflow-integrated across different settings. While their long-term predictive validities for outcomes like hospitalization, disability or mortality requires further study, the challenge ahead lies in health systems research: embedding instruments into EHRs, training frontline staff, and creating care frameworks that turn screening results into timely interventions. By adopting a stratified approach matching tool complexity to clinical context, we can move closer to a system where every older adult receives the right level of assessment at the right time, ensuring that CGA's gold standard becomes an accessible reality through systematic screening leading to timely, person-centered interventions for all who need it.

## References

1. Lau LK, Lun P, Gao J, Tan E, Ding YY. Application and implementation of brief geriatric assessment in primary care and community settings: A scoping review. *BMC Geriatr.* 2025;25(1):2. doi:10.1186/s12877-024-05615-9
2. Cheng WW, Shih HI, Chang CM, et al. Development and initial psychometric evaluation of a screening tool for Taiwan Seniors at Risk (TSAR). *Int J Gerontol*. 2026;20(2):89–92. doi:10.6890/IJGE.202604_20(2).0001
3. Lee HL, Lin DC, Huang CC, et al. Screening for geriatric conditions: comparison of FIND-NEEDS, ICOPE-TW, and comprehensive geriatric assessment. *Int J Gerontol*. 2026;20(1):67–72. doi:10.6890/IJGE.202601_20(1).0011
4. Chang CM. Geriatric syndrome, conditions, or syndemics: a modifiable intermediary and vicious cycle between medical treatment and long-term care. *Int J Gerontol*. 2025;19(3):128–129. doi:10.6890/IJGE.202507_19(3).EC3
5. Tseng HK. The geriatric traffic light model and corresponding care recommendations. *Int J Gerontol*. 2024;18(4):204–205. doi:10.6890/IJGE.202410_18(4).EC3
6. Haimovich AD, Shah MN, Southerland LT, Hwang U, Patterson BW. Automating risk stratification for geriatric syndromes in the emergency department. *J Am Geriatr Soc*. 2024;72(1):258–267. doi:10.1111/jgs.18594

Chia-Ming Chang [a,b]
[a] *Department of Medicine, College of Medicine, National Cheng Kung University, Tainan, Taiwan*
[b] *Institute of Gerontology, College of Medicine, National Cheng Kung University, Tainan, Taiwan*
*E-mail address:* 10108040@gs.ncku.edu.tw