Comprehensive Functional Assessment for Elderly Patients

Health and Public Policy Committee*, American College of Physicians

The American College of Physicians believes that maintenance of patients' functional well-being is a fundamental goal of medical practice. Assessment of the impact of illness on physical, mental, and psychosocial functioning is an essential element of clinical diagnosis, a major determinant of therapeutic choices, a measure of their efficacy, and a guide in the planning of long-term care for the dependent elderly.

Although most elderly noninstitutionalized adults are functionally competent, the percentage who need help doing everyday activities doubles with each successive decade up to age 84, and triples between ages 85 and 94 (1). Although physicians may identify these needs through communication and observation during office visits, failure to recognize them should be minimized by structured and reliable assessment procedures (2-5).

Measures of functional competence embracing the domains of activities of daily living, instrumental activities of daily living, environmental conditions, mental status, and emotional and psychosocial functioning have been increasingly used for this purpose by geriatricians, visiting nurses, social workers, and specialists in rehabilitation over the past 30 years (6-8). The time required for their completion, and in some cases the need for interviewers trained in their administration, have discouraged their routine application in medical practice. Thus, an efficient, short-form procedure that could be widely used with elderly patients in the office or hospital and that could show the need for more detailed investigation of functional deficits is needed.

Positions

1. Functional assessment screening by the physician is useful for evaluating the health status of elderly patients and determining their needs for in-home assistance, home-health services, or institutional placement. In the acute care setting, functional assessment in selected patients facilitates discharge planning, and is essential in patients over 75 years of age. The American College of Physicians recommends that primary care practitioners incorporate within their routine medical management of older adults procedures for measuring functional deficits and identifying dependency needs.

Among persons aged 75 or over, restricted activity is twice as common among persons aged 45 to 64 (3). The growing number of elderly persons who have debilitating chronic conditions demands some shifting of emphasis from the treatment of acute self-limited illness to such problems as occlusive vascular disease, degenerative joint disease, and alterations in cognitive function, as well as incontinence, frequent falling, social isolation, and poverty. An elderly patient may have several of these conditions, yet still be able to function without extensive use of health care resources. On the other hand, a patient with less advanced disease may have more severe functional impairment. With no assured correlation between medical diagnosis and functional status, measures of the patient's environment, mobility, activities of daily living, cognitive and emotional status, and social supports provide the best overall indicator of present and future dependence on health and social services.

Functional status assessment has proved useful in improving diagnostic and therapeutic outcomes (3, 4, 9, 10). Recognition of functional impairment can result in the discovery of previously undiagnosed and often highly treatable conditions. Identifying the patient's specific obstacles to independent living may lead to adoption of less costly and more agreeable alternatives to institutional care. If standardized functional status measures are repeated at intervals, changing needs of the patient can be recognized earlier and the prognosis in chronic illness can be more accurately determined.

2. Several assessment instruments are available that can either be self-administered by the patient or employed by ancillary staff in 10 minutes or less. Although no single test is universally recommended, selection of a comprehensive screen followed by a group of targeted instruments can be useful in systematically assessing functional deficits that otherwise might be overlooked by conventional examination methods.

Numerous complex functional status measures have been developed and tested for validity and reliability by investigators in this field (6-8, 11-13). Validation of several short-form procedures has been reported or is in progress (14-18). Although the limitations of existing scales of function leave much room for improvement through future research (19), the interpretation of available tests by well-informed and observant play-

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Physicians should yield substantial benefits to their patients (20).

The purposes served by these procedures in clinical practice would include the following:

1. Detecting, quantifying, and identifying the source(s) of decreased functional capacity.
2. Providing a needed measure of functional outcome, by comparing changes in function over time as affected by disease and other life events (such as bereavement), and the subsequent management of these problems.
3. Guiding management decisions, taking into account the patient's total functioning and quality of life in the choice of therapeutic alternatives.
4. Guiding the efficient use of community resources for health and social services to the elderly, both in hospital discharge planning and in ambulatory care.
5. Improving the prediction of the course of chronic disease in the elderly.

Using functional assessment instruments complements but does not substitute for the clinical judgment derived from interview and observation of the patient. It is by their correlation with basic clinical findings, just as any laboratory test confirms a clinical impression, that they are ultimately useful.

Although many of these instruments can be adapted to routine use in office or hospital practice, they should prove most helpful when used selectively and sensitively in resolving the problems of multiple concurrent disease conditions or of unexplained dysfunction ("failure to thrive") in elderly persons.

The purposes of screening may be well served by measures of instrumental activities of daily living (14, 16, 21), because these complex learned activities require adequate mobility, manual coordination, and intact sensory and cognitive functions. Alternatively, certain short comprehensive assessment measures (15, 17, 18) can be used efficiently to screen for specific domains of functional impairment, which in turn can then be explored further by other procedures. The latter might include short-form procedures that assess activities of daily living (22), mental status (23-25), or affective state (26). Many of these procedures are adaptable to the detection of functional impairment in primary care patients, and can lead to appropriate use of specialist services in their diagnosis and treatment.

At the discretion of the primary physician, such measures may be usefully employed in elderly patients on admission to an acute hospital; before discharge from an acute hospital; on a first or subsequent office visit; periodically during prolonged ambulatory care; or periodically during extended care in nursing home or home care programs.

3. Relevant skills and procedures for assessing the functional capacity of elderly patients should be systematically integrated into the curricula of undergraduate and graduate education of physicians. Through continuing medical education, practicing physicians should be prepared to perform and to utilize such examinations.

There has been singularly little teaching of assessment procedures at the medical school or graduate level. There is a profusion of scales and tests, and though these are analyzed and compared in literature reviews, clinicians need guidance in selecting tests that are valid, reliable, and appropriate to the individual patient.

In the last decade, excellent geriatric assessment services have been established in which interdisciplinary teams of health professionals use standardized functional assessment tools in the diagnosis, monitoring, treatment, and rehabilitation of patients, and in the determination of optimal placement. Research and education are important facets of many programs. The geriatric assessment units in veterans hospitals, teaching hospitals, and nursing homes should prove to be a valuable resource for educating students at the graduate level about functional assessment.

Orientation in the theory and methods of comprehensive assessment should be made part of undergraduate medical students' physical diagnosis courses. This early training would be usefully reinforced through additional experience during clinical clerkships, wherein a short-form functional assessment measure should become a required section of the medical record of elderly patients.

Physicians and other providers could learn about techniques of comprehensive assessment through continuing education courses. The American College of Physicians will offer courses in geriatric assessment, covering the evaluation of medical, psychological, environmental, and social aspects of functional disability in the elderly.

Agencies that set and enforce standards of medical education and of the quality of medical care can and should provide powerful and specific incentives to the appropriate use of functional status measures as an element of quality health service to the elderly. These incentives might include the following.

1. Questions on functional status determination in examinations of the National Board of Medical Examiners, and other licensure examinations.

2. Questions in medical specialty certifying examinations, especially in internal medicine and family practice, but not excepting other specialties that often serve the elderly, such as psychiatry, orthopedics, ophthalmology, and urology.

3. A requirement by the Joint Commission on Accreditation of Healthcare Organizations that explicit records of functional status of frail elderly patients be maintained through chart audits and through regular use in the process of discharge planning.

4. Medicare, and other agencies which set standards for payment for physicians' services, should recognize periodic assessment of functional status of the elderly as a discrete procedure, supplementary to the current standards of practice on which levels of reimbursement are based. Professional time and other resource costs for this procedure should qualify for specified reimbursement in fee schedules.
The most important applications of functional status assessment in the care of the elderly are and will be assessments done by primary care physicians, whose fees allowed under current payment practices are so low as to have been called the "loss leaders" of the health care industry (27). Although the average duration of an initial visit to a primary care physician is between 15 and 30 minutes, the time required for a brief functional assessment is not less than 5 to 10 minutes. The diagnostic and prognostic value of the information thus gathered, and the professional knowledge and skills required in obtaining and interpreting it, equal or exceed those skills involved in routine electrocardiography or flexible sigmoidoscopy. As a formal functional status assessment need not and should not be applied to all persons seen in primary care settings, it would be wasteful and unrealistic to incorporate its costs into the allowable charges for visits to physicians.

For all these reasons functional assessment procedures should be recognized as identifiable, specific cognitive services that, when appropriately supplied, should be compensated for at rates commensurate with their value and resource costs.

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References