EDITORIALS

Functional Status

The Sixth Vital Sign

What does the medical record reveal about functional status? Well, not much.¹ The initial reaction of a casual reader perusing the pages of this month's issue of *JGIM* may very well be "Duh!" Anyone who has ever read or recorded in a hospital chart assumes this to be the case. Nevertheless, this simple study draws attention to a fundamental barrier to improving the quality and outcomes of care for older adults, as well as for building the evidence base needed to do so—lack of reliable and valid information about functional status. The findings are indeed cause for concern.

The prime objective of health care for older adults is to maintain independence, prevent functional decline, and improve health-related quality of life (HRQoL). Without documentation, it is not possible to assess whether these goals are achieved. Optimizing functional status is a central tenet of geriatric practice. However, generalists provide the lion's share of care to the elderly. Furthermore, the relevance of functional status as an outcome of care is not limited to the elderly, but is of major concern for individuals of all ages with chronic illness or disability.

The importance of focusing on functional health outcomes has recently been highlighted by a number of diverse sources. One of the two overarching goals of Healthy People 2010 is to increase the quality and years of life. The recent Institute of Medicine (IOM) report "Crossing the Quality Chasm," emphasizes that a goal of the U.S. health care system is "to improve the health and functioning of the people of the United States."² In Winter 2002, functional health outcomes of Medicare beneficiaries enrolled in Medicare+Choice plans will be publicly reported for the first time as a quality measure in the Health Plan Employer Data and Information Set (HEDIS). The Agency for Healthcare Research and Quality Task Force on Aging identified the need for evidence on cost-effective interventions to enhance functioning and HRQoL, as well as the need for evidence on how to translate existing evidence on improving functional health outcomes into practice as its primary focus.³ In this context, the findings of Bogardus et al. take on added significance.

To assess documentation of functional status, the investigators did a thorough review of the entire chart. In addition to physician notes, notes from nursing staff, physical and occupational therapy staff, social workers, and other health professionals, where one might expect to find this information, also were reviewed. Agreement between the medical record and patient interviews was

poor, (sensitivity 9% to 44%, κ 0.10 to 0.31 for limitations in individual basic activities of daily living [BADL] and instrumental activities of daily living [IADL]). When any vague mention of functional status such as "independent" or "functionally impaired" was considered evidence of documentation of BADL or IADL impairment, the sensitivity was 71% and the κ was 0.41. The authors convincingly demonstrated that the hospital record does not provide reliable data on functional status. They cited multiple studies in which absence of mention of functional limitations in the records is assumed to indicate functional independence, and underscored how the resulting misclassification bias is likely to be large and therefore influence study findings.

We cannot tell from the Bogardus study to what extent the problem is lack of documentation or failure by health care providers to adequately assess functional status. We know from the literature that physicians do not always assess functional status,⁴ and that they may be unaware of functional limitations experienced by their patients.⁵ As second year medical students in physical diagnosis we were taught that when WNL was recorded, it often meant "without no looking" rather than "within normal limits." As third year students, with the time to do leisurely histories and physicals on hospitalized patients, we quickly learned that this was indeed true. It is likely that both factors come into play here. The failure to assess functional status results in missed opportunities to intervene to improve health-related quality of life and suboptimal discharge planning. The failure to document functional status makes it impossible to monitor outcomes, effectiveness, and quality of care.

The failure to document unimpaired functioning may be equally problematic. Age-specific rates of disability are declining. Older Americans are healthier and more active than at any time in history. There is growing evidence for effectiveness of clinical interventions at the extremes of age. Ageism may be a factor in clinical decision making. It is possible that failure to recognize excellent functional status in an elderly patient could result in less aggressive care than is in fact indicated.

The Bogardus study examines 2 indicators of functional status among elderly hospitalized patients, BADL and IADL limitations. Other measures of functional status are likely to be important to assess and document. In this study, limitations were defined as needing the help of another person to perform the activity. Use of a

compensatory or adaptive device was considered not to represent impairment. Yet, preclinical disability defined as task modification, but reporting no difficulty in performing a specific activity, is an important predictor of future functional decline and disability.⁶ It is at this point that interventions such as risk factor modification, or improved management of chronic conditions and geriatric syndromes may have the biggest impact. It is important for clinicians to also be aware of these earlier changes in functional status.

Collection of data on functional status is now required by the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) in skilled nursing homes and by home care agencies through mandatory use of patient assessment instruments; the Minimum Data Set (MDS) or the Outcome and Assessment Information Set (OASIS), respectively. In 2000, Congress enacted the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Benefits Improvement and Protection Act (BIPA). Section 545 of this act, entitled "Development of Patient Assessment Instruments," requires the Secretary of Health and Human Services to submit a report to Congress by January 2005 on the development of standard instruments for the assessment of health and functional status for Medicare beneficiaries across multiple sites and settings of care. These include inpatient and outpatient hospital and rehabilitation services, skilled nursing facilities, home health services, and physical and occupational therapy. The development of this report will provide the opportunity for dialog about what measures to collect, how to collect them, and in what format.

We can look forward to a future in which advances in the science of health status measurement coupled with advances in information technology provide us with standardized, accessible, and valuable information about the health and functioning of our patients as they transition across care settings. Inclusion of this information

in both electronic medical records and administrative data will be a great leap forward. In the meantime, we should include functional status as the "sixth vital sign" (after pain, the fifth), and work to ensure that functional status is routinely recorded in medical charts. —**ARLENE S. BIERMAN, MD, MS**, *Agency for Healthcare Research and Quality, Center for Outcomes and Effectiveness Research, Rockville, Md.*

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