Functional Assessment and Pain Management

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KEYWORDS

• Pain management • Geriatric • Functional disability

KEY POINTS

- Many geriatric adults live independently despite a disability.
- Symptoms of pain and/or signs of functional decline can track the progression of the disability. Consider coadministering screening examinations with the Medicare Wellness Visits, and at the indication of pain, functional decline, or disability.
- Prepare yourself: Focus self-education on familiarizing yourself with existing, validated tools. Build a network of the local medical and complementary care providers.
- Prepare the clinic: Improve office flow by delegating tasks.
- Office delivery: Consider using the Centers of Disease Control and Prevention's Opioid Checklist to guide the conversation through the predictable areas of pain management. Anticipate establishing a plan to treat pain. Volunteer pain control management education before the patient feels desperate for relief. Follow-up, flexible goals, and coaccountability are paramount.

INTRODUCTION

Discussions and clinical pearls regarding the geriatric adult are often focused on the complex care of the *frail* adult, formally defined as a person in a state of physiologic decline and intolerance to medical interventions.[1] However, most geriatric patients live in a gray area between robust health and frailty, with a varied spectrum of disabilities and causes of chronic pain.

To demonstrate the incidence of disability versus frailty, a 2015 study by the Centers of Disease Control and Prevention (CDC) reported that 59.8% of geriatric adults were suffering from at least one "basic action disability or complex action limitation."[2] This figure represents more than 26.5 million American geriatric adults. However, a deeper look at the numbers reveals that only a small percentage of these adults required personal care assistance from another person (3.4% at ages 65–74, and 12.0% at ages

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75 and over).[2] Thus, a large percentage of the geriatric population is maintaining independence *despite* a disability.

With a rapidly growing geriatric population, providers must be aware of those that suffer in silence, and start to anticipate the need to track signs and symptoms of disability. To do so, there are 2 additional features that copresent with disability, namely "chronic pain" and "functional decline." In essence, only the patient can perceive the cumulative effect of disability; functional decline is the objective measure of disability, and chronic pain is a mental or physical manifestation that can forecast the trajectory of the disability. For clarity, key terms and concepts within this article are listed as follows:

- Disability: an acquired condition that is restricting the patient's ability to interact with his or her environment.
- Functional Capacity: documented by a provider, this is an objective measurement of the ability to perform physical and cognitive tasks. Common measures of capacity can be surveyed by screening examinations (eg, activities of daily living, documentation of hobbies and social activities) or physical examinations (eg, the Get-Up-and-Go test).
- Chronic pain: a mental or physical sensation that is unpleasant, traditionally longer than 3 months. In this definition, chronic pain is a common manifestation of disability, reflecting disease severity from the subjective perception of the patient.

Arthritis is a prime example of a common, insidious physical disability that can manifest as a chronic pain syndrome and untreated demoralization. In 2016, nearly half (49.6%) of geriatric adults in the United States had been physician diagnosed with an arthritis-causing condition at some point in his or her life,[3] although there is little research or surveys to yet determine how well this disease and its comorbidities have been managed.

Geriatric-associated disabilities that do not usually activate physical pain nociceptors (blindness, deafness, severe Alzheimer dementia, and similar) can also carry a high-risk comorbidity of depression. Depression is another well-studied cause or trigger of both pain and functional limitation.[4] Therefore, the estimated incidence of chronic mental and emotional pain is very high in the geriatric population well before the individual is markedly debilitated or frail.

Disability can be considered a chronic condition, with a trajectory that can be affected by appropriate screening, follow-up, intervention, and anticipatory patient education. For the protection of both provider and patient, the primary care provider will need to use the existing resources efficiently to deliver fast and objective functional assessments to detect and reduce the forecasted burden of disability, particularly in the geriatric patients with mild levels of disability that remain functionally independent.

CONTENT

There are many excellent, independent risk stratification tools available in the literature to assess chronic pain, disability, and functional capacity in the geriatric adult. However, no screening or monitoring tool is effective without a means of interpreting the results and developing an appropriate treatment plan. A screening tool is also ineffective if the provider administers the examination at inappropriate intervals: either too quickly or too far apart. Administering screening examinations and transitioning treatments for the fluidity of chronic conditions is best addressed by establishing treatment guidelines.