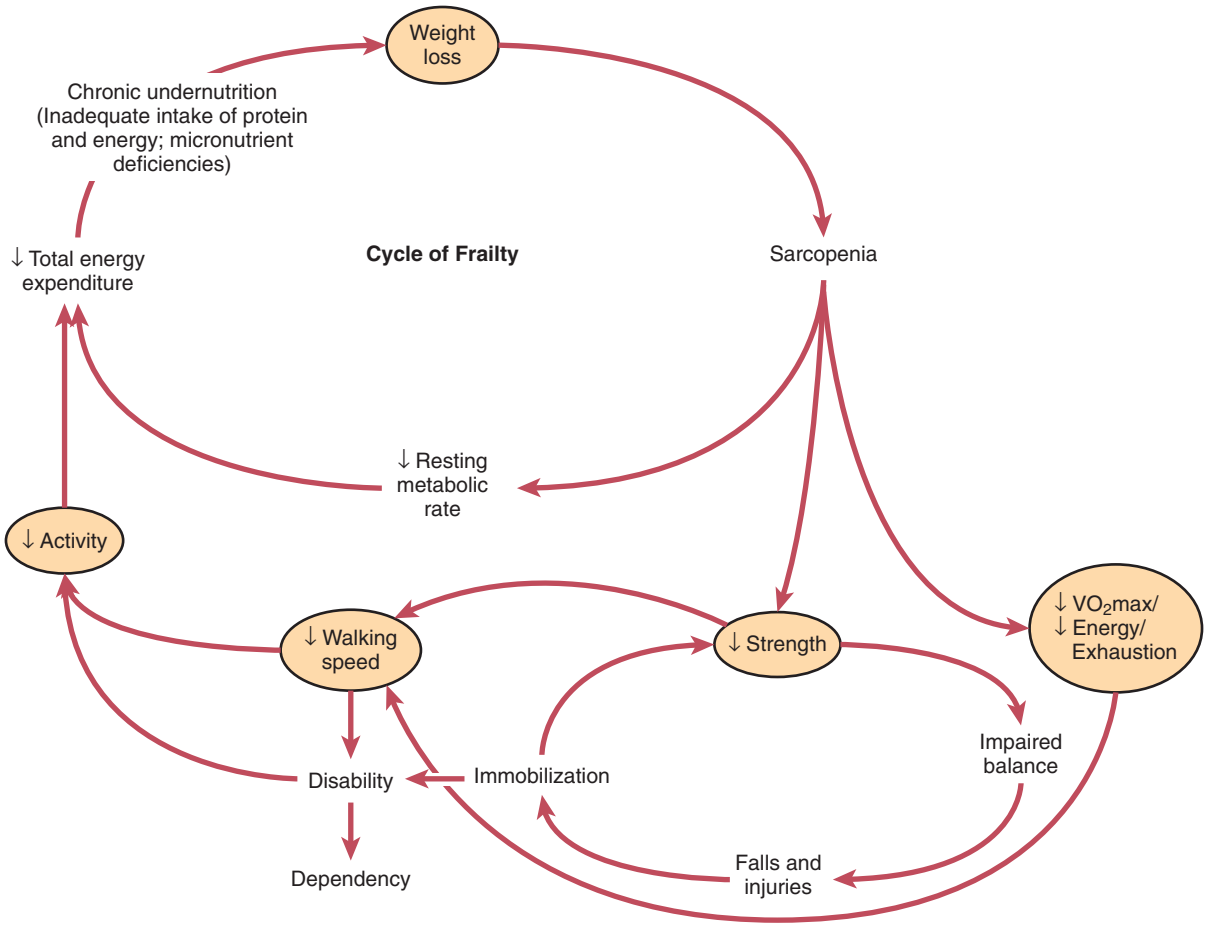

FIGURE 124-4 Cycle of frailty. (From Xue QL, Bendeen-Roche K, Varadhan R, et al: Initial manifestations of frailty criteria and the development of frailty phenotype in the Women's Health and Aging Study II, J Gerontol A Biol Sci Med Sci 63:984–990, 2008.)

function and result in disability and institutionalization. Arthritis, hearing loss, and vision impairment are all important problems in this respect. The presence of multiple comorbid conditions compounds the disabling effects of individual diseases and further complicates management. In the era of evidence and guidelines, a provider caring for a patient with several common chronic conditions, such as diabetes mellitus, coronary artery disease, and osteoporosis, may feel compelled to prescribe six or seven medications to remain in compliance with current recommendations. This practice can result in significant cost to the patient and with limited accounting for risks, benefits, and individual preferences. In addition to considering the discrete management of individual diseases, care of the older adult requires assessment of the overall impact of treatment on symptoms, function, and life expectancy. To address this common clinical challenge, the American Geriatrics Society has recently published guiding principles on care of older persons with multiple comorbid conditions that highlights the importance of accounting for complex interactions between conditions, risks and benefits of various treatment options, overall prognosis, and patient goals and preferences.

Function, defined formally by Reuben et al, is "a person's ability to perform tasks and fulfill social roles across a broad range of complexity"—more succinctly, self-care capacity. Assessing this ability provides the clinician with a means of understanding the impact of illness, assessing quality of life, identifying care needs, and estimating progress and prognosis. Comprehensive assessment of function should include questions about self-care capacity as well as objective measures of cognition and mobility (see later sections for details about the latter two). Self-care capacity is most often divided into basic, instrumental, and advanced ADLs. Basic ADLs include those actions that maintain personal health and hygiene, including transferring, bathing, toileting, dressing, and eating. Instrumental ADLs (IADLs) include activities necessary for living independently, specifically driving or using public transportation, cooking, shopping, managing medications and finances, using the telephone (or other communication device), and doing housework. Advanced ADLs include social or occupational functions associated with activities such as hobbies, employment, or caregiving. Approximately 30% of adults over age 65 and 78% of those over age 85 have difficulty with IADLs or one or more basic ADLs. Predictably, as the incidence of disability rises, so does the rate of dependence and nursing home residence. Long-term care in skilled facilities increases from 2% among those aged 65 to 74, to 14% among those older than 85 years. Impairment in ADLs is also associated with an increased risk of falls, depression, and death in the affected elder. Among older adults the assessment of self-care capacity provides key health status information independent of age and comorbid conditions.