
What Is Functional?

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It has become almost impossible to write a treatment plan or submit a claim to a third party payer without using the word *functional*. A speech-language pathologist must identify functional goals, using functional tasks, and show functional gains, or reimbursement for treatment is likely to be denied. This position paper argues that the definition of *functional* has changed over time and now is becoming synonymous with *basic skills*. This terminological evolution has far-reaching implications for choosing our treatment candidates and determining treatment goals, as well as dramatically influencing the future of clinical aphasiology.

The term *functional* has a rich history in the field of aphasiology. Beginning in the 1960s with a description of a “Functional Communication Profile,” (Taylor, 1965) to the recent development of the “ASHA Functional Assessment of Communication Skills for Adults” (ASHA FACS) (Thompson, Frattali, & Holland, 1995), aphasiologists have been interested in assessing and treating language behaviors that are related to natural language use. From the 1960s through the 1980s, *functional* appeared to take on two different meanings. One meaning of functional involved communication “action” and referred to how communicators exchange messages in an interaction (Aten, 1986; Davis, 1986; Davis & Wilcox, 1985; Goldblum, 1985; Holland, 1977, 1980, 1982; Skinner, Wirz, Thompson, & Davidson, 1984). For example, Holland (1982) defined *functional* as “getting messages across in a variety of ways ranging from fully-formed grammatical sentences to appropriate gestures, rather than being limited to the use of grammatically correct utterances” (p. 50). In contrast to this “action” definition, Smith’s (1985) functional treatment involved the communication “tasks” and considered “which activities are viewed by the dysphasic individual as important for their own way of living. Therefore an assessment of each patient’s communicative needs is required” (p. 32). This

definition of *functional* was often interchanged with such terms as *realistic*, *naturalistic*, or *daily contexts* and emphasized the activities or tasks chosen for treatment (Aten, Caligiuri, & Holland, 1982; Hahn & Klein, 1989; Lomas, Pickard, Bester, Elbard, Finlayson, & Zoghaib, 1989; Pulvermuller & Roth, 1991; Taylor, 1965). In fact, many authors combined both *action* and *task* meanings in their discussion of functional communication (Aten, 1986; Davis, 1986; Frattali, 1992; Green, 1984; Simmons, 1989).

These uses of the term *functional* seem appropriate, although at times confusing, since the reader must determine which definition is being used. The “action” usage of *functional* emphasizes the importance of communicating the message via any means and furthers the discussion of compensatory strategies and methods. The “task” usage of *functional* emphasizes the importance of choosing relevant tasks for all clients and furthers discussion of ways to individualize treatment. We would argue that these definitions and ensuing discussions have been fruitful for aphasiology and, most importantly, for those individuals with aphasia.

Currently, third party payers appear to be redefining the term *functional*. Busch (1994) described the Medicare guidelines for treatment goals. In reference to the *Medicare Intermediary Manual*, Busch states, “The long term functional goals must reflect the final level the patient is expected to achieve, be realistic, and have a positive effect on the quality of the patient’s everyday functions, that is, on the patient’s ability to communicate basic physical needs and emotional states, and carry out communicative interactions in the community” (p. 15). Our recent experience with some California managed care organizations is that those authorizing speech-language services are frequently interpreting functional goals to include only basic communicative behaviors. The criterion set to reach “functional” has therefore been set quite low. The result is that we are unlikely to receive reimbursement for treatment that focuses on goals

that go beyond these basic communicative behaviors because the patient has been deemed “functional” on these extremely elementary tasks. Thus, the definition of functional has appeared to move away from considering the communicative “action” or “task” to considering a set of “basic skills.”

How does this new definition of *functional* affect our treatment? Must our philosophy of aphasia treatment now be shaped by this definition? What should we do with treatment techniques that have been scientifically validated and found efficacious but may no longer be considered functional, given third party payer definitions? Do we have a good idea of the quantity and quality of the daily communication, both at home and in the community, of individuals with no brain damage? If so, whose daily communication is set as a standard? A lawyer? A janitor? An aphasiologist? As Elman (1994) stated, “there are no universal functional treatment plans. Functional treatment plans are those that are relevant to the circumstances and needs of an individual patient. What is desired, possible, and functional for one patient, may very likely prove to be inadequate for the next” (p. 12).

The recent interpretation of functional offers little to individuals having mild aphasia (Darley, Helm, Holland, & Linebaugh, 1980; Kagan & Gailey, 1993; Linebaugh, 1984; Marshall, 1993; Parr, 1994; Sacchetti & Marshall, 1992). A client of ours, PG, with mild aphasia, as classified on our battery of standardized tests, was adamant that his aphasia continued to affect his premorbid abilities profoundly. PG was frustrated that a previous facility had terminated therapy because the severity of his aphasia no longer affected “basic” communicative skills. PG literally shouted to us, “I am *not* functional!” This retired dentist told us that he could no longer maintain his premorbid role as the joke teller, debater, or group discussant at social or business functions. He pleaded with us to enroll him in our research project so that he could have a chance to regain his person-

ality. Of course, PG is not alone. We have been surprised by the numbers of mildly aphasic individuals who have responded to our request for subjects in an intensive treatment trial. These individuals assert vehemently that although they are judged functional given a "basic skills" definition, they are not functional in everyday life. Importantly, the concept of quality of life, which recent literature states is critical to consider when treating individuals with aphasia (Lafond, Joannette, Ponzio, Degiovani, & Sarno, 1993; Le Dorze & Brassard, 1995; Lyon, 1992; Parr, 1994; Sarno, 1993), is missing in this most recent definition of functional. How many of us would be satisfied to stop treatment as soon as basic communication skills were acquired? In fact, such a "basic skills" definition of *functional* includes a majority of skills acquired by children in the first grade (Hirsch, 1991).

The definition of *functional* is more than semantics, since third party payers now require us to document functional improvement using their definition of what or who is functional. Therefore, we are now limited as to which individuals with aphasia are considered treatment candidates. The current definition of functional also creates justification for the extremely short duration of treatment that managed care and health maintenance organizations are authorizing for our clients. These decisions are based not on response to treatment, or data-based research studies, but on an arbitrary definition that has financial incentives for the payer. As Teisberg, Porter, and Brown (1994) state, "The conflict of interest between payers and patients creates incentives for payers to compete on the basis of creative and complicated methods of denying coverage to people who might need expensive care. The payer becomes the patient's adversary, rather than advocate, denying payment on claims whenever possible" (p. 132).

We would argue that the earlier definitions of *functional* are appropriate for payers to consider. That is, speech-language pathologists and payers should consider the modalities by which an individual with aphasia could get his or her message across, as well as the individual tasks that might be most meaningful for that individual. It is not appropriate for a payer to define *functional* as applying to only the most basic communicative skills, therefore not reimbursing effective, relevant treatment that goes beyond basic communicative tasks. We are concerned that third party payers may misuse results from assessment tools such as the ASHA FACS by denying treatment to those individuals who receive a high score on

those basic communicative skills tested, but who would benefit greatly from continued speech-language treatment. In the past, aphasiologists rightly emphasized functional assessment and treatment in an effort to make therapy more meaningful and successful. However, we believe that the term *functional* is now becoming distorted and is being used against a client's best interest to justify no more than basic treatment.

Treatment costs are an important issue for consideration, as Boysen and Wertz (in press) and Loverso, Alexander, Broadbent, Goode, and Kearns (1994) have discussed. Health care reimbursement issues, including dramatic potential Medicare changes, are currently in the news on a daily basis. However, we would argue that working with patients requiring "basic communicative skills" may not translate into the most cost-effective use of our health care dollars. Alexander and Loverso (1993) discussed treatment costs associated with globally aphasic individuals and suggested that certain patients might benefit more from family teaching than traditional treatment programs. However, the currently applied definition of *functional* may make it more likely that these severely impaired individuals will receive reimbursement for speech-language services rather than those who may receive considerable enhancement of their lives for fewer dollars. If we don't have these quality of life and cost data, we need them.

What should we as a profession do to assert that individuals with aphasia deserve more than basic communication skills? One step in fixing a problem is identifying it. Papers presented at earlier Clinical Aphasiology Conferences have discussed issues relevant to this problem, including functional assessment measures and related methodological, clinical and reimbursement considerations (Busch, 1993; Kearns, 1993; Loverso et al., 1994; Warren, 1993; Warren, Loverso, & DePiero, 1991), as well as a model of functional aphasia treatment (Horner & Loverso, 1991). We hope that this paper adds to the ongoing *functional* discussion. A suggested next step would be for aphasiologists to advocate strongly for modification of both the definition and scope of what third party payers may currently consider functional, and therefore reimbursable. Without a change in the current use of *functional*, our services may be greatly reduced. Individuals with aphasia deserve and, if they could, would demand more.

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