REUE | Original article

Differences in characteristics and 30-day outcomes of older adults discharged from the Emergency Department According to the Functional Index eMergency (FIM)

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OBJECTIVE. To identify distinct profiles of older adults discharged from hospital emergency departments (EDs) according to Functional Index eMergency (FIM) categories, based on patient characteristics and 30-day adverse outcomes (AOs).

MATERIAL AND METHODS. Secondary analysis of the FRAIL-ED-Madrid registry, which included patients older than 75 years discharged from 10 EDs in Madrid over 3 consecutive months between 2018 and 2019. Frailty screening variables and a geriatric assessment adapted for the ED were collected. The primary endpoint was the occurrence of any AO (ED revisit, hospitalization, functional decline, and/or death) within 30 days after discharge. Differences among FIM categories were analyzed.

RESULTS. A total of 619 patients (mean age 84 [SD, 6] years; 59 % women) were included. Of these, 233 (37.6 %) were classified as FIM-1, 191 (30.9 %) as FIM-2, 124 (20.0 %) as FIM-3, and 71 (11.5 %) as FIM-4. From FIM-1 to FIM-4, progressive increases were observed in frailty, age, dependency, comorbidity, and clinical complexity (*P* for trend < .001). Compared with FIM-1, higher FIM categories were independently associated with greater odds of experiencing an AO (FIM-2: adjusted OR, 2.56; 95 % CI, 1.51–4.33; *P* < .001; FIM-3: adjusted OR, 4.07; 95 % CI, 2.16–7.67; *P* < .001; FIM-4: adjusted OR, 5.01; 95 % CI, 2.85–8.79; *P* < .001).

CONCLUSIONS. The FIM distinguishes different profiles of older adults discharged from the ED. FIM-1 represents robust, low-risk patients; FIM-2 indicates frail but independent individuals at moderate risk; FIM-3 corresponds to chronically dependent, complex patients; and FIM-4 identifies dependent individuals with advanced chronicity and the highest risk at the end of life.

Keywords: Older patient. Emergency Department. Frailty. Dependency. Complexity. Adverse outcomes.

Diferencias en las características y los resultados a 30 días de adultos mayores dados de alta de urgencias según el Functional Index eMergency (FIM)

OBJETIVO. Identificar diferentes tipos de adultos mayores dados de alta de los servicios de urgencias hospitalarios (SUH) según las categorías del *Functional Index eMergency* (FIM), atendiendo a sus características clínicas y a los resultados adversos (RA) posteriores.

MATERIAL Y MÉTODOS. Análisis secundario del registro FRAIL-ED-Madrid que incluye pacientes > 75 años dados de alta de 10 SUH de la Comunidad de Madrid durante 3 meses consecutivos, entre 2018 y 2019. Se registraron variables de cribado de fragilidad y de una valoración geriátrica adaptada a urgencias. La variable de resultado fue algún RA (revisita en SUH, hospitalización, deterioro funcional y/o muerte) a los 30 días del alta del SUH. Se analizan las diferencias según las categorías del FIM.

RESULTADOS. Se incluyeron 619 pacientes, con edad media 84 años (DE 6) y 59 % mujeres. 233 (37,6 %) fueron identificados como FIM-1, 191 (30,9 %) FIM-2, 124 (20,0 %) FIM-3 y 71 (11,5 %) FIM-4. Del FIM = 1 al FIM = 4 se describen rasgos clínicos diferenciales entre categorías y una tendencia creciente en la fragilidad, edad, dependencia, comorbilidad y complejidad (p tendencia lineal < 0,001). El FIM identifica diferentes tipos de adultos mayores. FIM-1 corresponde a un paciente robusto de bajo riesgo. FIM-2 a uno frágil no dependiente de riesgo. FIM-3 al paciente dependiente crónico complejo y FIM-4 al dependiente con cronicidad avanzada de mayor riesgo en el final de la vida. Las diferentes categorías del FIM (referencia: FIM-1) se asociaron de manera independiente con algún RA [FIM 2: ORa 2,56, IC 95 % 1,51-4,33, p < 0,001; FIM 3: ORa 4,07, IC 95 % 2,16-7,67, p < 0,001; y FIM 4: ORa 5,01, IC 95 % 2,85-8,79, p < 0,001].

CONCLUSIONES. El FIM se postula como una alternativa al CFS para identificar a pacientes en cuatro grupos de riesgo, con diferentes características clínicas y RA a los 30 días del alta del SUH.

Palabras clave: Paciente mayor. Urgencias. Fragilidad. Dependencia. Complejidad. Diferencias. Resultados adversos.

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Introduction

Urgent care for older adults has progressively increased worldwide due to population aging. At least 1 out of every 4 patients treated in emergency departments (EDs) is 65 years.[1] It is well known that these patients are more complex and experience worse clinical outcomes than younger adults.[2]

Older adults are a heterogeneous group of ED patients with very different characteristics, for whom individualized decisions must be made, avoiding ageist or discriminatory attitudes based on age.[3] To categorize older patients, there is neither a dual geriatric triage system nor a standardized geriatric assessment adapted to emergency care (GAEC).[4] Frailty screening tools are recommended to identify patients at higher risk of AOs (AO), who would benefit most from GAEC and in whom a series of clinical, functional, mental, and social problems can be identified and addressed.[5]

To identify frail older patients, Fried's criteria have been used, which define frailty as a syndrome characterized by chronic fatigue, weakness, inactivity, slow gait, and weight loss.[6] From another perspective, tools such as the Identification of Seniors at Risk (ISAR)[7] and the Clinical Frailty Scale (CFS)[8] emerged, which conceptualize frailty as a continuous and progressive accumulation of deficits. The FRAIL scale combined both approaches, simplified Fried's criteria, and incorporated a question on comorbidity burden.[9]

The Functional Index Emergency (FIM) is a tool designed to perform a brief visual functional assessment as an alternative to instruments such as the Barthel Index. In a simple manner, both the healthcare professional and the patient or caregiver determine whether the patient lives independently or has mild, moderate, or severe dependence in performing basic activities of daily living (BADL) according to a four-pictogram test (Figure 1).[10]

The Frail-ED-Madrid registry was created to identify frail older patients treated in EDs to develop individualized care plans and achieve favorable clinical outcomes. In its initial study, FIM,[10] CFS,[8] and ISAR[7] were used, and all three tools demonstrated good predictive capacity for identifying frail older patients at high risk of 30-day AOs after ED discharge. A strong concordance between CFS and FIM was observed.[11]

The European Task Force on Geriatric Emergency Medicine[12] and the Geriatric Emergency Medicine Working Group of the Spanish Society of Emergency Medicine (GEM-SEMES)[13] recommend the CFS as a frailty screening tool functioning as a dual geriatric triage, distinguishing four risk groups: fit or robust older adults, frail non-dependent older adults, chronically dependent complex older adults, and patients with advanced chronic disease at the end of life. FIM is recognized as a possible alternative to CFS.[13]

Based on the above, the present study was designed to identify types of older adults discharged from EDs according to FIM categories, considering their characteristics and 30-day adverse outcomes.[13]

Materials and methods

We conducted a secondary analysis of the FRAIL-ED-Madrid registry. This was a prospective, multicenter, multipurpose observational cohort study that included, through convenience sampling, patients aged ≥ 75 years who were discharged directly from the ED of 10 hospitals in Madrid *(Hospital Universitario de la Princesa, Hospital Universitario Clínico San Carlos, Hospital Universitario de Getafe, Hospital Universitario Severo Ochoa, Hospital Universitario Rey Juan Carlos, Hospital Universitario Infanta Leonor, Hospital Universitario del Tajo, Hospital El Escorial, Hospital Universitario del Henares,* and *Hospital Universitario de Fuenlabrada)* over a 3-month period (November 2018 to January 2019). All patients or their legal representatives provided written informed consent. The study was approved by *Hospital Clínico San Carlos* Ethics Committee (Madrid, Spain) (PI-816).

Patients from the FRAIL-ED-Madrid registry with available FIM data and 30-day follow-up variables were included in this analysis.

The FIM classifies subjects into 4 categories from 1 to 4 (Figure 1). The physician recorded the patient's or caregiver's response to the question: Which best represents your baseline status prior to the current illness? Frailty screening additionally included CFS and ISAR; patients were considered frail if CFS ≥ 4[8] and ISAR ≥ 2.[7]

Within the GAEC, demographic variables (age and sex); clinical and care-related variables (ED visit in the past 6 months, hospitalization in the past 3 months, arrival by ambulance, urgent triage level [1–3] according to the Manchester Triage System, categorized chief complaint [cardiovascular, abdominal, infection, general malaise, neurological, trauma, extremity problems, other], comorbidity

Figure 1. Functional Index eMergency (FIM).

measured by the Charlson Comorbidity Index [CCI],[14] non-mental geriatric syndromes [falls in previous six months, habitual urinary incontinence, current pressure ulcer, malnutrition risk according to the short form of the Mini Nutritional Assessment (MNA-SF < 12 points),[15] number of chronic drugs, and excessive polypharmacy if ≥ 10 medications[16]]); functional variables (baseline BADL according to the Barthel Index [BI][17] and functional decline defined as loss of ≥ 10 BI points vs baseline); mental variables (past medical history of dementia and depression, delirium in ED assessed by the Confusional Assessment Method [CAM][18]); and social variables (living alone with insufficient support, residence in long-term care facility) were collected by the study physician at discharge planning.

All patients were followed for 30 days post-discharge through telephone contact and/or electronic health records. Outcome variables included ED revisits, hospitalization, functional decline (loss of ≥ 10 BI points), death, and a composite outcome of any adverse event within 30 days of ED discharge. Differences in patient characteristics and AOs were analyzed across FIM categories.

Statistical analysis

Categorical variables are expressed as absolute and relative frequencies, and the quantitative ones as mean and standard deviation (SD). Non-normally distributed variables are presented as median and interquartile range (IQR). Patient characteristics across the four FIM categories were compared by evaluating linear trends using the chi-square test for trend for categorical variables, analysis of variance (ANOVA) for normally distributed quantitative variables, and the Jonckheere–Terpstra non-parametric test when normality assumptions were not met.

Multiple logistic regression models were estimated to assess the effect of FIM (reference: category 1) on outcomes of ED revisit, hospitalization, functional decline, and any adverse outcome at 30 days after ED discharge. A sensitivity analysis excluding functional decline from the composite outcome was performed. Crude and adjusted odds ratios (OR and aOR) are presented. Due to the small number of deaths, only crude estimates for mortality are shown. Each adjusted model included age, sex, chief complaint, medications, CCI, nutritional status, baseline functional status, mental status, and social situation.

Statistical significance was set at 5% ($P < .05$). Data processing and analysis were performed using SPSS 26.0® (SPSS Inc., Chicago, IL, USA).

Results

Of the 820 patients included in the Frail-ED-Madrid registry, 619 cases (75.5%) were analyzed. Twenty-four patients (2.9 %) were excluded due to missing FIM data, and 177 (21.6 %) because of incomplete outcome variables. A total of 233 patients (37.6%) were classified as FIM-1, 191 (30.9 %) as FIM-2, 124 (20.0 %) as FIM-3, and 71 (11.5 %) as FIM-4.

Table 1 illustrates the frailty screening results and the clinical, functional, mental, and social characteristics collected within the Geriatric Assessment in the ED (GAE). The typical patient profile was a frail (CFS, 4, ISAR, 2) octogenarian woman (59.1%), with prior ED attendance (41.8 %), who arrived by her own means (73.8 %) for various urgent complaints (Manchester Triage System levels I–III: 65.1%). Notable features included moderate or severe comorbidity (50.6 %), excessive polypharmacy (55.0 %), geriatric syndromes, mild dependency (Barthel Index, 90), and living in the community (90.6 %).

Analysis of GAEC characteristics according to FIM categories is shown in Table 1. From FIM-1 to FIM-4, a progressive increase was observed in frailty, age, female sex, prior ED attendance, ambulance arrival, urgent triage level, general malaise, trauma and neurological complaints, higher comorbidity, geriatric syndromes, excessive polypharmacy, dependency, acute functional decline, mental disorders, and residence in long-term care facilities (linear trend $P < .001$).

Distinct clinical profiles were identified across FIM categories. FIM-1 patients were predominantly men (56.7 %), aged 80 years, robust and non-frail (CFS, 2, ISAR, 1), with moderate comorbidity (Charlson Index = 2), presenting mainly with cardiovascular or abdominal complaints (66.5 %), and fully independent in basic activities of daily living (Barthel Index, 100). FIM-2 patients were mostly women (60.2 %), frail (CFS, 4, ISAR, 2), older (mean age, 84.7 years), with higher comorbidity (Charlson Index = 3), polypharmacy, nutritional risk (71.7 %), presenting with similar complaints but with mild dependency (Barthel Index, 90). FIM-3 patients were predominantly women (77.4 %), older (86.2 years), with moderate frailty (CFS, 6, ISAR, 4), greater complexity marked by severe comorbidity (56.5 %), geriatric syndromes, frequent prior ED visits (46.0 %), more frequent ambulance arrival (46.0 %), diverse complaints, and moderate-to-severe dependency (Barthel Index, 55). Finally, FIM-4 patients were mostly women (76.1 %), very old (87.4 years), with advanced frailty (CFS, 7, ISAR, 4), high rates of prior ED attendance (54.9 %) and hospitalization (39.4 %), severe comorbidity, excessive polypharmacy (74.6 %), a higher prevalence of geriatric syndromes and mental disorders (dementia, 62.0 %; depression and delirium, 47.0 %), ambulance arrival (59.2 %), severe-to-total dependency (Barthel Index, 25), and residence either in the community or in long-term care (38.0 %).

Within 30 days after ED discharge, 228 patients (36.8 %) experienced at least 1 AO: 135 (21.8 %) had to go back to the ED, 79 (12.8 %) were hospitalized, 114 (19.1 %) experienced functional decline, and 22 (3.6 %) died. AOs according to FIM categories are displayed in Figure 2. From FIM-1 to FIM-4, a progressive increase was observed in the probability of ED revisit, hospitalization, functional decline, mortality, and any adverse outcome within 30 days (linear trend $P < .001$).

In multivariable analysis, increasing FIM categories (reference: FIM-1) were independently associated with ED revisit (FIM-2: aOR, 1.89, 95 % CI, 1.04–3.46, $P < .001$; FIM-3: aOR, 1.85, 95 % CI, 1.09–3.85, $P = .023$; FIM-4: aOR, 3.02, 95 % CI, 2.28–7.12, $P < .001$), hospitalization (FIM-2:

Table 1. Frailty screening and emergency department–adapted geriatric assessment (ED-AGA) according to Functional Index eMergency (FIM) categories

Variables n (%)	Total N = 619 n (%)	FIM = 1 233 (37.6) n (%)	FIM = 2 191 (30.9) n (%)	FIM = 3 124 (20.0) n (%)	FIM = 4 71 (11.5) n (%)	*P* value
Frailty screening						
Baseline CFS, median (IQR)	4 (2-5)	2 (2-3)	4 (3-5)	6 (5-7)	7 (7-8)	< .001
ISAR, median (IQR)	2 (1-4)	1 (1-2)	2 (2-3)	4 (3-5)	4 (3-5)	< .001
Assessment adapted to emergency care (GAEC)						
Demographic variables						
Age, years, mean (SD)	83 (7)	80.4 (6.1)	84.7 (5.4)	86.2 (6.2)	87.4 (5.9)	< .001
Female sex	366 (59.1)	101 (43.3)	115 (60.2)	96 (77.4)	54(76.1)	< .001
Previous health care use						
ED visit in previous 3 months	259 (41.8)	80 (34.3)	83 (43.5)	57 (46.0)	39 (54.9)	.001
Hospitalization in previous 6 months	144 (23.3)	35 (15.0)	38 (19.9)	43 (34.7)	28 (39.4)	< .001
Current episode						
Arrival by ambulance	162 (26.2)	29 (12.4)	40 (20.9)	51 (41.1)	42 (59.2)	< .001
Urgent triage level (I–III)	403 (65.1)	144 (61.8)	120 (62.8)	86 (69.4)	53 (74.6)	.035
Chief complaint						
Cardiovascular	180 (29.1)	80 (34.3)	61 (31.9)	26 (21.0)	13 (18.3)	
Abdominal	164 (26.5)	75(32.2)	52 (27.2)	28 (22.6)	9 (12.7)	
Infection	25 (4.0)	13 (5.6)	4 (2.1)	5 (4.0)	3 (4.2)	
General malaise	44 (7.1)	6 (2.6)	12 (6.3)	12 (9.7)	14 (19.7)	< .001
Neurological	26 (4.2)	10 (4.3)	5 (2.6)	7 (5.6)	4 (5.6)	
Trauma	55 (8.9)	10 (4.3)	16 (8.4)	16 (12.9)	13 (18.3)	
Limb problems	45 (7.3)	13 (5.6)	17 (8.9)	12 (9.7)	3 (4.2)	
Other	80 (12.9)	26 (11.2)	24 (12.6)	18 (14.5)	12 (16.9)	
Comorbidity						
Charlson Index, median (IQR)	3 (1-4)	2 (1-4)	3 (2-4)	3 (1-5)	3 (2-6)	< .001
Moderate–severe comorbidity (CCI > 3)	313 (50.6)	92 (39.5)	105 (55.0)	70 (56.5)	46 (64.8)	< .001
Geriatric syndromes						
Falls in previous 6 months	152 (24.6)	22 (9.4)	56 (29.3)	49 (39.5)	25 (35.2)	< .001
Urinary incontinence	217 (35.1)	37 (15.9)	53 (27.7)	72 (58.1)	55 (77.5)	< .001
At nutritional risk	435 (70.3)	114 (48.9)	137 (71.7)	116 (93.5)	68 (95.8)	< .001
Pressure ulcers	17 (2.7)	0 (0.0)	1 (0.5)	5 (4.0)	11 (15.5)	< .001
Medication						
Number of drugs, mean (SD)	8.2 (3.6)	6.9 (3.5)	8.4 (3.7)	9.6 (3.6)	9.7 (3.8)	< .001
Excessive polypharmacy (≥ 10 drugs)	327 (55.0)	86 (38.9)	102 (55.4)	89 (72.4)	50 (74.6)	< .001
Functional status						
Baseline BI, median (IQR)	90 (70-100)	100 (100-100)	85 (80-95)	55 (45-75)	25 (10-40)	
Discharge BI, median (IQR)	90 (65-95)	100 (100-100)	85 (75-95)	55 (40-70)	20 (5-35)	< .001
AFD (Baseline-discharge BI≥ 10 points)	102 (16.7)	12 (5.1)	35 (18.3)	35 (28.2)	20 (28.2)	
Mental health						
Dementia	126 (20.4)	12 (5.2)	26 (13.6)	44 (35.5)	44 (62.0)	< .001
Depression	165 (26.7)	34 (14.6)	52 (27.2)	45 (36.3)	34 (47.9)	< .001
Delirium	95 (15.3)	5 (2.1)	19 (9.9)	37 (29.8)	34 (47.9)	< .001
Social situation						
Lives alone with insufficient support	112 (18.1)	41 (17.6)	35 (18.3)	23 (18.5)	13 (18.3)	.899
Institutionalized	58 (9.4)	7 (3.0)	7 (3.7)	17 (13.7)	27 (38.0)	< .001

CFS: Clinical Frailty Scale; ISAR: Identification Senior At Risk; CCI: Charlson Comorbidity Index; BI: Barthel Index; AFD: acute functional deterioration; ED: emergency department.

aOR, 3.26, 95 % CI, 1.31–8.13, *P* < .001; FIM-3: aOR, 4.29, 95 % CI, 1.53–12.02, *P* < .001; FIM-4: aOR, 10.60, 95 % CI, 3.46–32.48, *P* < .001), functional decline (FIM-2: aOR, 3.92, 95 % CI, 1.82–8.45, *P* < .001; FIM-3: aOR, 8.60, 95 % CI, 3.59–20.57, *P* < .001; FIM-4: aOR, 9.28, 95 % CI, 3.21–25.61, *P* < .001), mortality (FIM-2: OR 8.75, 95 % CI, 1.07–71.74, *P* < .001; FIM-3: OR 9.63, 95 % CI, 1.11–83.36, *P* < .001; FIM-4: OR 33.05, 95 % CI, 4.11–265.68, *P* < .001), and any AO (FIM-2: aOR, 2.56, 95 % CI, 1.51–4.33, *P* < .001; FIM-3: aOR, 4.07, 95 % CI, 2.16–7.67, *P* < .001; FIM-4: aOR, 5.01, 95 % CI, 2.85–8.79, *P* < .001) (Figure 3). After sensitivity analysis excluding functional decline from the composite outcome, FIM categories remained independently associated with any adverse outcome (FIM-2: aOR, 1.81, 95 % CI, 1.01–3.35, *P* < .001; FIM-3: aOR, 1.85, 95 % CI, 1.11–4.25, *P* < .001; FIM-4: aOR, 3.99, 95 % CI, 1.24–12.78, *P* < .001).

Discussion

This study provides several important findings. First, the FIM identified older patients with different frailty states: approximately 4 out of 10 older adults were categorized as non-frail, 3 out of 10 as mildly frail, 2 out of 10 as moderately frail, and 1 out of 10 as having advanced frailty. Sec-

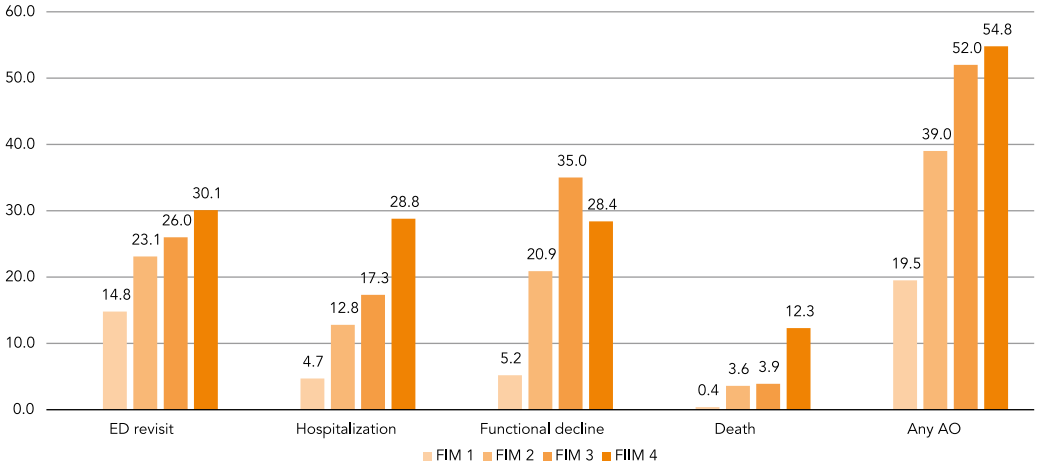

Figure 2. Adverse outcomes 30 days after discharge from the emergency department *Functional Index eMergency* (FIM).

ond, the FIM identified older patients with clinical, functional, mental, and social problems that were subsequently confirmed through a comprehensive Geriatric Assessment in the ED (GAE) performed within each category. Third, at least 1 out of 3 older patients discharged from the ED experienced at least 1 AO (ED revisit, hospitalization, functional decline, and/or death) within thirty days. The FIM identified older patients with different levels of risk for AOs, which were present in at least one out of three older adults. Fourth, as a consequence of the above, the FIM emerges as an alternative to the CFS for identifying patients in four risk groups with distinct clinical characteristics and 30-day AOs after ED discharge.

FIM-1 corresponded to a robust older male without comorbidity and with a low risk of AOs after discharge, particularly ED revisits. FIM-2 represented a frail woman with comorbidity but without dependency, with double the risk of AOs compared with FIM-1, notably ED revisits, hospitalization, and especially functional decline. This patient profile closely approximates the classic frailty phenotype[6]—"neither very well nor very ill"[8]—who may lose autonomy after an acute medical event but whose deterioration may be potentially reversible with appropriate intervention.[6-8] In contrast, FIM-3 represented a frail older woman with comorbidity and severe dependency, more frequent prior ED visits, and up to 4 times the risk of AOs (particularly ED revisits, hospitalization, and functional decline) compared with FIM-1, and almost double the risk compared with FIM-2. According to current nomenclature, FIM-3 may be considered a patient with complex chronic disease (PCC).[13,19] Finally, FIM-4 referred to a very old woman with advanced frailty, severe comorbidity, multiple geriatric syndromes, and severe-to-total dependency, with one in three arriving at the ED by ambulance from a long-term care facility. The risk of AOs was five times higher than FIM-1 and twice that of the other groups, particularly hospitalization and death. This profile may be considered that of a patient with advanced chronic disease (PCA) or MACA *(Malaltia Crònica Avançada)* at the end of life, with a high probability of death within the following six to twelve months, as assessed by the NECPAL tool,[20] PROFUND index or PALIAR,[21] 6M-UCE score,[22] or a CFS ≥ 8.[23]

Progress in frailty screening is essential. The use of tools such as the CFS, ISAR, or FIM has allowed the identification of frail patients or those at high risk of AOs.[6-13] These tools do not replace a comprehensive geriatric assessment but allow early risk stratification upon ED arrival. However, frailty screening must avoid becoming an indiscriminate category that includes patients with heterogeneous characteristics and outcomes. Some authors consider frailty as a state preceding disability[6] and propose frailty screening using the FRAIL scale in patients who are independent or have only mild dependency according to the Barthel Index.[24] Thus, among patients currently labeled as "frail," it is important to distinguish the pre-disability frail patient from those with moderate-to-severe dependency.

Following this stratification, ED care planning should be individualized. Existing geriatric intervention models in the ED define four levels of diagnostic assignment and therapeutic intensity (MADiT),[25] closely resembling both the risk groups described in the recent GEM-SEMES consensus document[13] and the FIM-based patient profiles identified in this study.

Frailty, as measured by the CFS, is increasingly considered in urgent decision-making, including ICU admission.[26] Age alone should not constitute an exclusion criterion for ICU care,[27] particularly when older adults are classified as robust (FIM-1 or CFS 1–3) or vulnerable/frail (FIM-2 or CFS 4–6). In contrast, severe dementia[28] and severe-to-total dependency[29] are independent predictors of high mortality. The global COVID-19 pandemic catastrophe should serve as a lesson, emphasizing the need for structured tools to support complex decision-making for the benefit of patients and health systems alike.

This study has several limitations. First, it is a secondary analysis, which may limit statistical power. Second, FIM categories may not discriminate between older patient types as precisely as desired. Third, the association with the composite adverse outcome may be overestimated by including functional decline. Finally, the FIM has not yet undergone

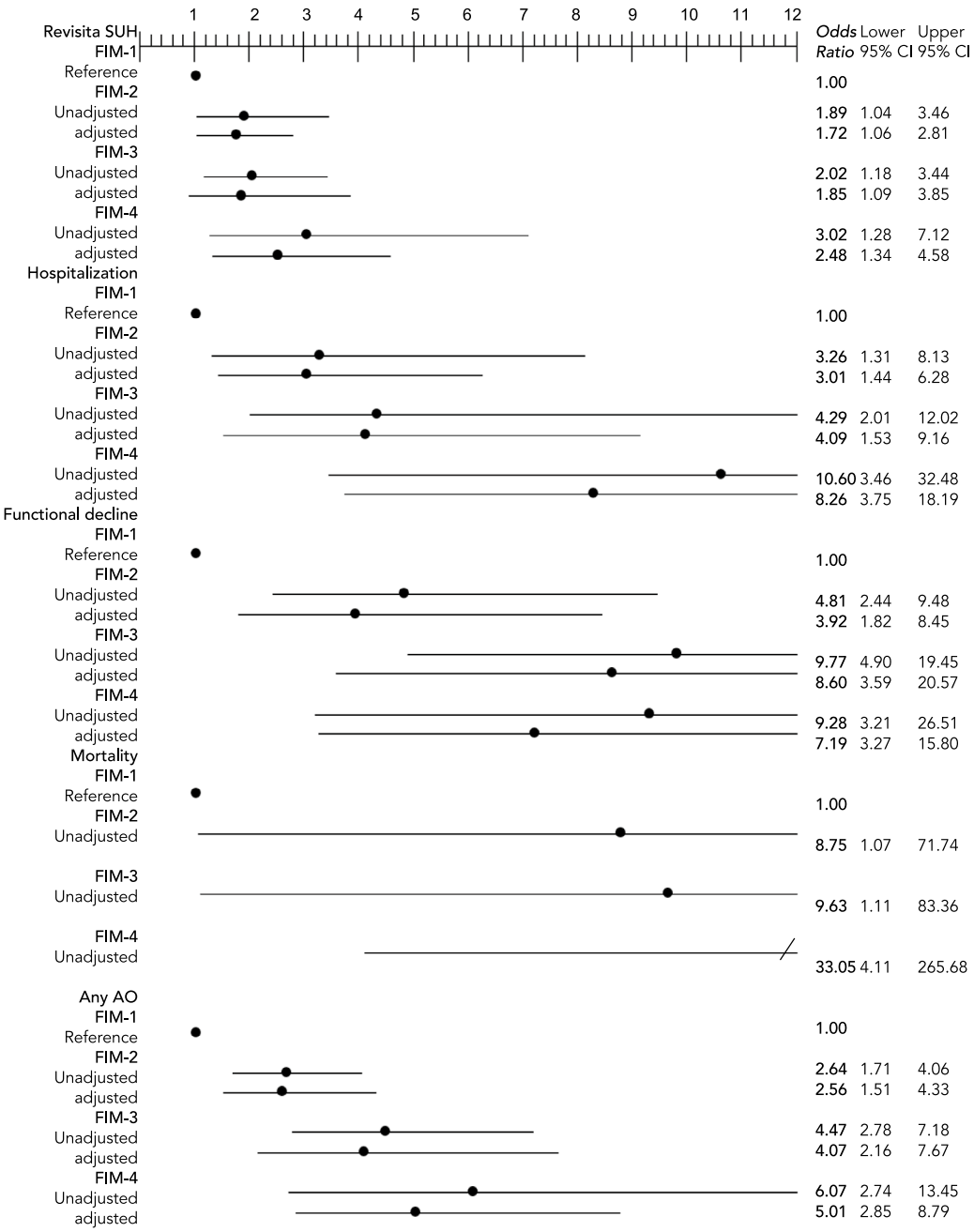

Figure 3. Multivariate analysis of adverse outcomes upon discharge from the emergency department, according to the categories of *Functional Index eMergency* (FIM).
Model adjusted for age, sex, reason for consultation, medications, CCI, nutritional status, baseline functional status, mental health issues, and social situation.

external validation, nor has its performance been evaluated when applied by physicians or nurses at ED arrival.

In conclusion, the FIM represents a potential alternative to the CFS for dual geriatric triage in the ED, allowing classification of older patients into robust, frail non-dependent, complex chronic dependent, and end-of-life advanced chronic disease categories. Nevertheless, additional evidence is required in our setting. Older adults represent one of the major challenges for health systems, and they deserve individualized care aligned with their clinical condition and needs.[30]

ARTICLE INFORMATION

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Open Data Availability: The data are available upon request from the corresponding author.

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ADDENDUM

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