# Functional Health Assessments: Are They Ready for Use in Clinical Practice?

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Functional health status assessment has grown in use, sophistication, and diversity over the past 15 years. Much of the work in this area has been directed toward measurement of the health-related function of populations or population subgroups to describe their health status or to evaluate changes in health services delivery or clinical care. Some of the measures that have been developed have been used to discern the impacts of illness[1,2] and unanticipated sequelae of treatment.[3] Physicians are likely to view these measures and their use as valuable for research and not directly applicable to the clinical care of patients.

In the past few years there has been discussion in the literature of functional status assessment as an integral part of clinical care.[4-8] Two distinct purposes are cited for such assessment. One sees functional health status measures as part of the usual clinical history of the patient to aid in discerning and diagnosing specific illnesses or conditions, in specifying appropriate treatment, and in identifying problems that may require referral. The other sees functional health status measures as part of the standard follow-up for patients with chronic disease to chart their progress and adjust their treatment. Sometimes a third purpose given for incorporating such measures into clinical practice is to provide clinicians with a measure that can be used to compare therapies, especially for patients with chronic illnesses that are not curable. Although he does not cite this purpose of functional health status assessment as such, Champlin[4] has suggested that for the elderly patient, functional assessment may help identify cost-effective care.

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Given the differences in purpose, functional health status measures developed for use as population descripters or in evaluation studies may not be appropriate for assessing functional health status in the clinical care setting. Aside from the work of Blake and Vandiver,[8] three measures have been developed specifically for use in primary care.[5-7] All three started with one of the measures developed for use in assessing large population groups. All sought to shorten and simplify the original measures while retaining items relevant to ambulatory patients seen in a primary care practice. All have shown that these measures can be used in primary care.

In this issue of *The Journal of Family Practice,* Blake and Vandiver[8] report their efforts to reduce further the Duke-UNC Health Profile (DUHP) developed by Parkerson and his colleagues[5] for use in primary care. They provide convincing evidence of the reliability and validity of their health profile, the mini-DUHP. Though they recognize that their study does not answer all the questions that can be asked about the value of the health profile to primary care practice, they suggest that it be used. Nonetheless, physicians may rightfully ask what this or any functional health status measure does that they do not already do as part of their usual history and clinical examination of the patient.

The value of functional health status measures is that they provide a systematic and standardized method for gathering information. In addition, they can be completed by the patient alone or with the help of a nonmedical assistant who has received simple training, thus placing little burden on the practice. Because they are systematic and standardized, they provide a ready evaluation of the severity of dysfunction of a particular patient and should help the physician choose the best treatment for the patient. As they become more generally used, it should be possible to develop normative values for age and illness groups, which would help refine even further the therapeutic

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choices. Moreover, incorporation of these measures may help those who care for the irreversibly ill to redirect their clinical efforts toward minimizing disability and maximizing function.[9] Explicit measures can help physicians, especially young physicians, realize the progress they and their patients have made.

These benefits of functional health status assessment to primary care practice have been posited, but not demonstrated. The recent work in functional health status measurement for clinical practice does not indicate whether measurement results were presented to the physician, whether the physician had any interest in the measurement, and how the physician used the new information. This area is one in which more research is critically needed. It is important that the primary care physicians who are to use functional health status measures in clinical practice become part of the team that adapts these measures for such use. Furthermore, it is essential that functional health status measures be examined as to their value and usefulness to primary care physicians if these measures are to become one of their clinical tools. Otherwise, functional health status assessment, like many another screening and diagnostic test, will become just another number cluttering up the patient's record but of little use to the patient's care.

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