



USCDI Draft Version 3 (Jan. 2022) Comments

Functional Status Data Element

Comment: The American Physical Therapy Association strongly supports the addition of a Functional Status data element within the Health Status data class in USCDI Draft Version 3 (Jan. 2022) and submits the following comments:

APTA believes that the Functional Status data element should reflect the World Health Organization’s International Classification of Functioning, Disability and Health categories and subcategories, located at <https://apps.who.int/classifications/icfbrowser/>. In 2001, the World Health Assembly approved ICF as a framework for describing and organizing information on functioning and disability. APTA adopted ICF in 2008.

As discussed in ICF, functioning is a dynamic interaction between a person’s health condition, environmental factors, and personal factors. Functioning refers to all body functions, activities, and participation, while disability refers to impairments, activity limitations, and participation restrictions. Functioning is what a person with a health condition can do in a standard environment (their level of capacity), such as in a clinic, as well as what they do in their usual environment (their level of performance) such as the home, office, etc. A better way to describe the Functioning data class would be “activities and participation” as described in ICF, specifically, “mobility”; “self-care”; “domestic life”; “major life areas” and “community social and civic life.”

The ICF is the framework that has been the main construct of the physical therapy profession that focuses on movement and function of individuals and communities. The ICF concepts are taught in the physical therapy educational programs, are included within licensure exams, and forms the framework that informs current physical therapist clinical practice. Physical therapists use the concepts of the ICF to evaluate, diagnose and develop individualized plans of care that take into consideration the physical, behavioral, environmental and social determinants of the individual.

Multiple studies have demonstrated the strength of ICF as a strong framework for classifying functioning and disability. ICF has been described as the “gold standard for collecting and analyzing functioning information in rehabilitation.”¹ It provides a unified, standard language, and framework that enables the collection of data for practice and research — language that describes how people function in their daily lives rather than focusing exclusively on their medical or disease-specific diagnosis. The universality of the ICF language and framework permits a shared conceptual understanding of health, bridging disciplines, sectors, cultures, and geographic regions. ICF assists in adding “structure to the description and understanding of physical functioning-related domains in acute care settings.”² One study referred

¹Clinical Implementation of ICF-based Functioning Information as Outcomes in Rehabilitation. Available at: <https://www.frontiersin.org/research-topics/17568/clinical-implementation-of-icf-based-functioning-information-as-outcomes-in-rehabilitation>.

²González-Seguel P, et al. International Classification of Functioning, Disability, and Health Domains of 60 Physical Functioning Measurement Instruments Used During the Adult Intensive Care Unit Stay: A Scoping Review. *Phys Ther.* 2019;99(5):627–640. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6517362/>.

to ICF as “an essential tool for identifying and measuring efficacy and effectiveness of rehabilitation services, both through functional profiling and intervention targeting,” and that “[t]he ICF, in short, offers an international, scientific tool for understanding human functioning and disability for clinical, research, policy development and a range of other public health uses.”³

APTA has long endorsed ICF and uses it to develop evidence-based practice guidelines that will enhance diagnosis, intervention, prognosis, and assessment of outcomes for a variety of musculoskeletal conditions. APTA has produced over 17 [clinical practice guidelines](#) based on ICF, including:

- Interventions for the Management of Acute and Chronic Low Back Pain: Revision 2021 (<https://www.jospt.org/doi/full/10.2519/jospt.2021.0304>), authored by the Orthopaedic Section of APTA (October 2021).
- Ankle Stability and Movement Coordination Impairments: Lateral Ankle Ligament Sprains Revision (<https://www.jospt.org/doi/10.2519/jospt.2021.0302>), authored by the Academy of Orthopaedic Physical Therapy of APTA (March 2021).
- Physical Therapy Management of Older Adults With Hip Fracture: (https://www.orthopt.org/uploads/content_files/files/PT_Management_of_Older_Adults_with_Hip_Fracture.pdf), authored by the Academy of Orthopaedic Physical Therapy and the Academy of Geriatric Physical Therapy of APTA (February 2021).
- Patellofemoral Pain (<https://www.jospt.org/doi/full/10.2519/jospt.2019.0302>), authored by the Academy of Orthopaedic Physical Therapy of APTA (August 2019).
- Achilles Pain, Stiffness, and Muscle Power Deficits: Midportion Achilles Tendinopathy Revision 2018 (<https://www.jospt.org/doi/pdfplus/10.2519/jospt.2018.0302>), authored by the Orthopaedic Section of APTA (May 2018).
- Pelvic Girdle Pain in the Antepartum Population (https://journals.lww.com/jwhpt/fulltext/2017/05000/pelvic_girdle_pain_in_the_antepartum_population_7.aspx), authored by APTA’s Section on Women’s Health and the Orthopaedic Section of APTA (May 2017).
- Hip Pain and Mobility Deficits — Hip Osteoarthritis: Revision 2017 (<https://www.jospt.org/doi/10.2519/jospt.2017.0301>), authored by the Orthopaedic Section of APTA (May 2017).

Speaking on behalf of its 100,000 member physical therapists, physical therapist assistants, and students of physical therapy who are actively involved in providing care to individuals, APTA recommends ONC to incorporate the following into USCDI Version 3 based on ICF:

- **Move the “Functional Status” data element currently in the USCDI Draft Version 3 out of the “Health Status” data class, and into its own data class entitled “Functioning Status.”**
- **Include several data elements within this newly proposed “Functioning Status” data class to model subcategories within the “Activities and Participation” category of ICF, specifically:**

³ Üstun TB. The International Classification of Functioning, Disability and Health: a new tool for understanding disability and health. *Disabil Rehabil.* 2003;25(11-12):565–571. Available at: <https://pubmed.ncbi.nlm.nih.gov/12959329>.

“mobility”; “self-care”; “domestic life”; “major life areas”; and “community social and civic life.”

- **Advance the “Functioning” data class from the “Comment” level to the “functioning” data class currently in “Level 2” in USCDI version 3.** As shown below, ONC should elevate the “Functioning” data class from “Comment” to “Level 2” based on overall value of the data elements and broad use of activities and participation data information by the community.
- **Move the data elements in the “functioning” data class currently in the “Comment” section to the “functioning status” and “disability status” data elements in “Level 2.”** Namely, place the following into the “functioning status” data element in “Level 2”: “Self-care,” “Mobility,” “Domestic Life/Instrumental Activities of Daily Living (IADLs),” “ECOG” and “Karnofsky,” and place the following into the “disability status” data element: “Accommodation,” HHS Disability Status - Activities of Daily Living,” “HHS Disability Status – Cognitive,” “HHS Disability Status – Hearing,” “HHS Disability Status- Independence,” “HHS Disability Status – Mobility,” “HHS Disability Status – Vision.”

Mobility encompasses changing and maintaining body position, carrying, moving, and handling objects, and walking and moving, among others. Self-care encompasses washing oneself, toileting, dressing, and eating, among others. Domestic life encompasses household tasks and caring for household objects and assisting other people, among others.

If there are impediments to a person’s function, such as the inability to walk, lift, and carry due to a health condition (e.g., an injury or illness) or a barrier (such as stairs for a person with weakness in the legs), the person may be unable to perform routine tasks such as shopping to get food, picking his/her child up from the crib, driving a car, etc. Functioning impairments like the inability to walk or the increased effort required to move from one place to another can lead to sedentary lifestyle behaviors such as lack of exercise, decreased movement, or contractures in joints, which in turn can lead to obesity, elevated blood pressure, and other more serious health conditions. Prevention of these secondary complications is key to ensuring patients’ health and well-being.

Functioning is pervasive across all aspects of care, and as such, other health care providers depend upon physical therapists to relay information about patient functioning; it is relied upon when making determinations about whether a patient can be safely discharged to their home/community or whether additional care is more appropriate, for example.

Functioning is also important for socialization and participation in society such as employment, going to school, or attending religious activities. Disruption to a person’s functioning or the inability to function can lead to social isolation and strained personal relationships.

APTA conducted an informal survey in February 2021 seeking information from physical therapists regarding documentation of functioning and how information on functioning is shared with other providers. We received feedback from more than 200 organizations across the continuum of care:

- Large health systems (four).
- University outpatient system (four locations).

- Rehab agency (one).
- Home health agency (one).
- Rehabilitation contract therapy company (one) that works with skilled nursing facilities and home health agencies.
- Physical therapist private practices (urban and rural), including:
 - 200+ companies representing 650 locations and 2,650 providers.
 - One company with 500+ locations.

As outlined in detail below, the most common subdomains of functioning captured within EHR systems across settings are mobility and self-care. This information about functioning is consistently being shared among providers and across health care settings as well as with patients.

Every provider indicated that their EHR system allows them to capture information on function. EHRs used by these providers include but are not limited to:

- A2C.
- Athena Health.
- Cadurx.
- Caretracker.
- Cerner.
- Clinicient.
- Clinic Controller.
- Epic.
- Fusion WebClinic.
- Gentiva.
- HomeCare HomeBase.
- Net Health.
- NextGen.
- Office Ally.
- RainTree.
- WebPT.

As listed below, functioning is documented in a variety of ways across these EHRs:

1. General text.
2. Discrete data (rolling, sitting, transfer from supine to sit).
3. Subcategories (mobility, self-care) and general text.
4. General text and subcategories.
5. General text; subcategories (mobility, self-care, etc.); free text; and discrete data.
6. Results of reliable and valid tests and measures such as performance-based measures or patient reported outcome measures.

All providers surveyed reported that they share information on functioning with providers outside of their organization, although the method of communicating information on patient functioning to other providers varies. While small practices reported difficulties in sharing information in a standardized format, large practices and large health systems are sharing it consistently using data standards like direct messaging, C-CDA Level 1, and C-CDA Level 3 documentation.

Mechanisms for sharing such information include:

- Send records using data standards (C-CDA Level 1, Level 3).
- Allscripts.
- Direct messaging.
- Secure portals.
- Print and fax records.
- Print the entire note and send to another provider in a HIPAA-compliant fashion.
- Secure email with PDF.

As demonstrated above, information on functioning is broadly collected, used, and exchanged in different settings and within different EHR systems. It is collected upon evaluation and is relied upon to inform the plan of care; functioning is documented within each treatment note, progress report, and upon discharge. Clearly, patient functioning pertains to most or all patients and is relevant to all providers who care for all patients, such as those with diagnoses within medical, surgical, and primary care. The elevation of the functioning data class to Level 2 status, which is currently in the USCDIv3 draft, as well as future continued elevation of functioning data elements to Level 2 status, in addition to a uniform standardization based upon ICF would help EHR communities better understand the direction that ONC is moving toward and the importance of sharing aspects of functioning and the importance of function for all individuals.

In conclusion, APTA urges ONC to incorporate the following into USCDI Version 3:

- **Move the “Functional Status” data element currently in the USCDI Draft Version 3 out of the “Health Status” data class, and into its own data class entitled “Functioning Status.”**
- **Include several data elements within the new “Functioning Status” data class to model subcategories within the “Activities and Participation” category of ICF, specifically: “mobility”; “self-care”; “domestic life”; “major life areas”; and “community social and civic life.”**
- **Advance the “Functioning” data class from the “Comment” level to the “functioning” data class currently in “Level 2” in USCDI version 3. As shown below, ONC should elevate the “Functioning” data class from “Comment” to “Level 2” based on overall value of the data elements and broad use of activities and participation data information by the community.**
- **Move the data elements in the “functioning” data class currently in the “Comment” section to the “functioning status” and “disability status” data elements in “Level 2.” Namely, place the following into the “functioning status” data element in “Level 2”: “Self-care,” “Mobility,” “Domestic Life/Instrumental Activities of Daily Living (IADLs),” “ECOG” and “Karnofsky,” and place the following into the “disability status” data element: “Accommodation,” HHS**

Disability Status - Activities of Daily Living," "HHS Disability Status – Cognitive," "HHS Disability Status – Hearing," "HHS Disability Status- Independence," "HHS Disability Status – Mobility," "HHS Disability Status – Vision."