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Title: **Use of the ICF by allied health professionals**[1]

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Purpose: for information

Recommendations: none

Abstract:

In this paper the use of the ICIDH and the ICF by allied health professionals in the Netherlands are described. It is an example for showing how in recent years the application of the ICIDH/ICF has developed within specific professions. This also includes an overview of the development of specific, more detailed, versions for specific professions.

A systematic description will be given of the use of the ICIDH/ICF on micro level (treatment of individual patients), on meso level (practice, hospital or rehab centre) and on macro level (profession as a whole). The data elements of patient descriptors documented by allied health professionals using the ICF will be described as well. Although former and present use of the ICIDH/ICF has proven to be valuable, the level of detail needed for a richer description – including more detailed items and qualifiers - of the functioning of a patient does not yet exist within the ICF. This and other arguments will be presented to stimulate the innovation process of the ICF and to indicate the need for the development of a (multidisciplinary) clinical modification, the ICF-CM.

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[1] This presentation is based on the article Past and future use of the ICF (former ICIDH) by nursing and allied health professionals. Y Heerkens, Y. van der Brug, H Ten Napel, D van Ravensberg. Disability and Rehabilitation 2003; 25(11-12): 620-7.

Introduction

For communication and for the registration of data related to the process of care of allied health professionals[2], medical terminology alone is not sufficient. Next to medical diagnostic terminology these professionals need terminology to describe the 'functional status' of their patients. It is therefore not remarkable that during the process of enhancing the transparency of these professions – necessary in improving the quality of care given - there has been a search for such a terminology. During this process the ICIDH (1) was discovered and subsequently embraced as a useful terminology. In the period 1986-1992 the first Dutch experiments took place in which the ICIDH was used for the description of the health status of patients visiting a physical therapist. These experiments were soon followed by other research.

Adapted versions

A number of adapted Dutch versions is published to meet the needs of various allied health professions; some based on the 1980 version of ICIDH, some on the Beta-1 draft and one on the ICF (2) (for dieticians). Characteristic for these adaptations is the higher level of detail. Many classes were added because the terminology of the ICIDH/ICF is considered not specific enough to describe the functioning of the clients on micro level (individual care).

Data which can be classified with the ICIDH/ICF

Several crucial data in the process of care of allied health professionals can be described using the ICIDH/ICF: patient's findings, findings of professionals, elements of the diagnosis formulated by these professionals, treatment goals and treatment results.

Overview of former and present applications

In this overview examples are given of former and present use of the ICIDH/ICF by allied health professionals in the Netherlands. This overview is far from exhaustive and is only meant to give an impression.

- (electronic) registration systems
    - an electronic information system for dieticians in university hospitals; this software contains selections of the four classifications available for dieticians, including an application of the ICF for dieticians.
    - registration systems for several categories of patients, including patients with a burned hand and persons with a mental handicap (3).
- professional guidelines

  in the last five years there has been an emphasis on the development of – 'evidence based' - guidelines for allied health professionals. In these guidelines terms of the ICIDH/ICF are used to describe aspects of the diagnostic and therapeutic process (such as complaints, findings, goals, results). Some examples are:

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[2] In the Netherlands the following professions are indicated as 'allied health professions': chiropodists, dieticians, exercise therapists, occupational therapists, physical therapists, oral hygienists, orthoptics, radiological therapists and speech therapists.

  - for physical therapy and exercise therapy: patients with genuine stress incontinence (4), chronic obstructive pulmonary disease (5), low back pain, whiplash, and osteoporosis.
  - for occupational therapy: diagnostics and treatment in patients with amyotrophic lateral sclerosis, and diagnostics directed to sitting in children with cerebral palsy.
  - for speech therapy and dietetics: diagnostics and treatment of problems with swallowing in nursing homes patients (6).

  Recently more emphasis is put on multidisciplinary guidelines, in which the use of the ICIDH-terms is even more relevant to facilitate communication between professions.

- epidemiological research & patient profiles
  - description of the patient population of allied health professions using the ICIDH-terminology; such as chiropodists (7), exercise therapists, dieticians, occupational therapists and physical therapists.
  - description of the patient population of children's physical therapists. In this study the ICF is used to document the problems in functioning, including behavioural problems, 'social' external factors (e.g. the way of handling the child by parents and teachers), and other external factors (such as the child's home, neighbourhood, school and sport environment).
- clinical trials
  - comparing the outcomes of a group of Whiplash patients treated by physical therapists and another group of Whiplash patients receiving the normal care of general practitioners. The health profile of the patients is described using terms from the Beta-2 draft. For the physical therapists four treatment protocols are available. Which protocol to follow is dependent on the pain and the limitations in activities experienced by the patient (8).
- clinimetrics
  - analysis of the ICIDH-model for use as a framework for selection, improvement and development of outcome instruments (9).
  - classification of assessment instruments relevant for patients with rheumatoid arthritis. The ICIDH was used to classify the goal of the assessment instruments as formulated by the authors.
- other uses
  - development of teaching materials.
  - inclusion of ICIDH/ICF in a list of keywords for the selection of literature.

Systematic description of (possible) use of the ICF

It is important to describe in which situations use of ICF terminology and ICF codes is useful, but also in which situations terminology and codes are superfluous and even hampering.

In communication on micro level (individual care), spoken language is most appropriate to discuss the situation of the patient. While talking with or about an individual patient with other care-givers and the referring physician, one does not need specific terms from a classification. Also in written communication free text, based on natural language, can be very informative. However in both situations the use of the basic terms of the framework of

the ICF may structure and clarify the communication: the problems of the patient are described on three levels, and negative and positive external and personal factors are indicated .

When information is generated about different patients and when data of individual patients are used to generate general information on meso level and macro level (aggregation of data), classifying and coding of data is necessary. In comparing the results of different therapists or different departments (mirror information) and in research 'numeric' data are required - data that can be added, compared and transformed.

Consequently there are different levels of applying the ICF:

– *use of the basic terms and the basic framework of the ICF*

  The basic terminology of the ICF can be used adequately when it is necessary - for instance for policy purposes - to position a certain profession or in oral and written communication on micro level when aggregation of data is not relevant.

– *use of the terminology within the classification without using the codes*

  The use of terms from the classification – without actually coding – is the most important level at this moment. Examples are the development of multidisciplinary guidelines, the selection of assessment instruments, and the development of assessment instruments.

– *use of the codes*

  The use of codes is relevant in all those cases that aggregation of data is relevant, such as in (electronic) registration systems, reimbursement, and research.

Problems in using the ICF

As indicated in the introduction the terminology offered by the ICF is very useful for allied health professions. However, actual use of the ICF is not easy and often results in discussion on the definition of the terms, the borders between functions, activities and participation, the lack of terms for specific purposes and the level of detail needed.

Need of an adapted version of ICF

The most important – and urgent - consequence of the introduction of the ICF is the perceived need and necessity to develop a more detailed version of the ICF to describe problems in functioning on micro level. There is general agreement that it is better to make one adaptation including the specific terms for all professions involved, a so called Clinical Modification, instead of separate versions for the different professions. It would not make sense when different professions use different terms for the same phenomenon.

In the development of this modification other professions, like nurses, welfare officers, psychologists and physicians should be involved to promote uniformity of language.

For specific purposes (for instance for certain groups of patients) it is possible to derive from this – comprehensive – adaptation different specialised, but compatible, versions.

Subsequent activities

The past years the ICIDH has been introduced into the curricula of many health care professions. In primary education of these professionals the terminology of the ICIDH is often used. This implicates that – with the publication of the ICF - teachers must be informed

and trained in the use of the ICF, and that all training materials must be adapted to the new scheme introduced, the new terms, the new definitions and to all other changes made. The same is true for the terms derived from the ICIDH used in the description of professional profiles, in guidelines and in all other applications of the ICIDH. This will definitely take some time, probably several years.

Introduction of the ICF in initial education is of course important, but there are still many professionals – especially those who have received their education more than 10 years ago - who are not acquainted with the ICIDH/ICF. Plans must be made to implement the ICF – and the ICF-CM – within the allied health professions as a whole by introducing the ICF in postgraduate education.

One thing is clear; it will be a major effort and challenge to introduce the ICF to the 35.000 Dutch allied health professionals and to convince them it is important to use ICF terminology in registration and in projects directed to improving the quality of care.

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