

**Reykjavik, Iceland
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Title: **Roadmap for the implementation of the ICF: a proposal for an implementation vision and strategy**

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Purpose: for discussion and decision

Recommendations:

- Discuss and agree about
- Definition of implementation of ICF
- Draft short term, mid term and long term plan for ICF implementation
- Short term activities
- Concrete projects

Abstract:

Since the ICF was launched by WHO in 2001 after a long period of revision work, there has been a considerable amount of activity concerning the ICF on a national as well as international basis. Some lucky countries could start to develop training and implementation of the ICF in several areas of application because their language version was made available by WHO. Other countries had to start translation activities in order to be able to promote the use of the ICF in their language area. Now implementation of the ICF is seen as the most important issue concerning this young member of the WHO-FIC. During the Cologne meeting in 2003 it has been decided to develop a plan and strategy for the implementation of the ICF and as a start a workgroup carried out a SWOT analysis. Since the Cologne meeting the workgroup worked by e-mail correspondence and members were invited to send their comments and thoughts based on a global outline of the “roadmap” and a draft of the full paper. As a result a discussion paper is available which will be presented by Diane Caulfeild and Marijke de Kleijn during an Implementation Committee session in order to discuss and agree about the items mentioned above

ROADMAP FOR THE IMPLEMENTATION OF THE ICF

Discussion paper by Diane Caulfeild and Marijke de Kleijn, 15 September 2004

Introduction

Since the International Classification of Functioning, Disability and Health (ICF) was launched by the World Health Organization (WHO) in October 2001, there has been considerable activity towards the implementation of ICF on a national and global basis. Some countries are well down the path to implementing ICF in various settings and forms. Some are researching various applications of the classification while others are training users and using the framework and terminology throughout governmental agencies. During the WHO-FIC meeting October 2003 a timetable has been set for the creation of an Implementation Strategic Plan for ICF that will coordinate and monitor the implementation initiatives around the world (Annex 1).

This Roadmap is contingent on the WHO timetable and the Strategic and workplan agreed upon in October 2003. As a starting point during the WHO-FIC meeting in Cologne, a "review" was undertaken using a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis. This analysis, along with a draft of this document "Roadmap for the Implementation of ICF" was circulated to the Roadmap Working Group (see Annex 3) of the WHO-FIC Implementation Committee for a critical review. Their comments have been synthesized into a draft document, which has been distributed among the workgroup members again. Based on their comments and suggestions this discussion paper with a condensed version of the adapted SWOT analysis (Annex 2) is prepared for presentation and discussion during the Implementation Committee meetings in Reykjavik.

ROADMAP FOR THE IMPLEMENTATION OF ICF

Definition

Before we go too far down the road with this initiative we must understand what we mean by Implementation.

The Merriam-Webster dictionary defines the verb *implement* as:

1. carry out, accomplish; *esp*: to give practical effect to and ensure of actual fulfillment by concrete measures
2. to provide instruments or means of expressing for – <implementation>”.

Marijke de Kleijn, Head WHO Collaborating Centre for the Family of International Classifications (FIC) in The Netherlands, makes these comments about the Implementation of ICF:

“In my view implementation means “use of the ICF in practice”, this can be in one area or more so there is a kind of degree of implementation possible.

Translation, acceptance by a government, funding, organized training, etc are conditions for implementation but do not mean implementation as such.

There are many areas of implementation, so the scope for implementation is almost endless and could in theory range from 0% (no use) to almost 100% (use in possible every area).

Regularity of use may also vary by circumstances (eg, assessment for eligibility for disability payments, assessment in rehabilitation as patient profile etc) and ad hoc use (as in a one-off survey or research project or pilot projects). Instruments directly developed based on the ICF and indirect use (existing instruments mapped to ICF codes) is also possible and can regarded as a form of implementation.”

At this stage of putting ICF into practice around the world, it would seem most appropriate to maintain a broad, open-ended understanding of the Implementation of ICF as it is phased-in and adopted in countries and Collaborating Centers.

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Objectives of the Roadmap for the Implementation of ICF

- Encourage, assist, whenever possible, and monitor implementation of the ICF in parts of the world where ICF has not been implemented;
- Encourage, assist, whenever possible, and monitor ICF activities in those parts of the world where implementation has been and/or is yet to be initiated.
- Adopt the distinct implementation requirements of the different applications of ICF, e.g. clinical, academic, research, survey, administrative, policy, education, use by consumers (PWD).
- ICF implementation includes derived classifications such as the ICF-CY

This will be accomplished by:

- Sharing information and experiences about ICF and its application among countries;
- Making ICF tools available (e.g. WHO-FIC-in-a-Box when it is instituted, country-specific training videos and tools, a roster of experts); and
- Establishing a means to gather and store comments and experiences that may inform a possible future updating of the ICF.
- Collaborating with the WHO-FIC Education Committee to coordinate efforts for implementation through education/training.

Implementation Vision and Strategy

To develop an ICF implementation vision and strategy we need to analyze the SWOT associated with ICF (see annex 2) as a starting point for discussion. This will lead to recommendations for embarking on the phases of the Circle of Implementation (see Annex 4) and will be followed by identification of priority activities with facilitators.

Discussions to develop an ICF implementation vision and strategy will take place at the WHO-FIC Implementation Committee Meeting in Reykjavik October 2004.

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Short term activities

After evaluating the SWOT analysis with reviewers' comments, three short-term activities are proposed as minimum requirements:

- 1 *Development, implementation and completion of the common framework for exchange of information.*
The ACC developed and circulated the framework that will be presented and discussed as a separate document in a joint session with the Education Committee. It is necessary to achieve consensus with the framework and the manner of implementing the framework (WHO website, centres websites, links). The next step should be the collection of information and data to complete the framework. Paul Placek proposed to use a checklist in order to collect initial information in a structured way, see Annex 5 as an example. This should be in line with the framework.
- 2 *Development of an educational plan.*
In the joint session (WHO-FIC EC and IC), a discussion will take place on the formation of a needs assessment and an education plan (international versus national level).
- 3 *Mapping measurement instruments.*
The proposal would be to include in the system of websites based on the common framework available mappings between existing instruments and the ICF, noting that they have not been approved by WHO or a committee. A mapping protocol (procedure and methodology) should be developed that will allow the quality of the mapping to be tested. See an example in Annex 6. Researchers would be encouraged to use the mapping protocol and submit results to the ICF Implementation Committee. At a later stage, approved mappings could be included in the system of websites.
In the proposed protocol the paper by Cieza et al should be taken into account (Cieza a, Brockow T, Ewert T, Amman E, Kollerits B, Chatterji S, Ustun B, Stucki G, Linking health status measurements to the International Classification of Functioning, Disability and Health. J Rehabilitation Medicine, 34:205-210 (2002).
See website:
http://www.rehabnet.ch/index.htm?./html/left/rhLRCSSENSW.htm&./html/e_RC_Software.htm&./html/rhEMenu.htm

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Concrete projects

WHO recommended the development of concrete projects in the context of ICF implementation. Our proposal is to agree about some concrete projects in the light of facilitating the implementation of the ICF. We know that several centres have already workplans including concrete projects, such as ACC and NACC.

The ACC workplan with 21 elements of work related to ICF implementation covers four main areas: leadership on ICF implementation; education, information, promotion and advice; measurement and application; record keeping and evaluation. The NACC conference was intended to agree about an ICF research agenda.

As another example we mention two planned concrete Dutch projects: Use of ICF and ICPC together (Annex 7) and a Dutch pilot study on A and P distinction (Annex 8).

We should be aware of those plans and see whether one or more of them are interesting for international cooperation or just for exchange of information.

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Proposed next Steps

Discussion and agreement in the WHO-FIC Implementation Committee meeting Reykjavik October 2004 on:

- 1 *Definition of "implementation";*
- 2 Based on the condensed SWOT analysis results, recommendations for activities and facilitators related to the phases of the Circle of Implementation (see Annex 3); this should result in a *short term, mid term and long term plan for ICF implementation;*
- 1 Short term activities to be undertaken ;
- 2 *Concrete projects to be started .*

Annexes

- 1 Activities/timelines
- 2 Condensed SWOT analysis
- 3 Roadmap working group of the WHO-FIC Implementation Committee
- 4 Circle of implementation
- 5 Example of a checklist
- 6 Example of a mapping protocol
- 7 Use of ICF and ICPC together, European pilot project
- 8 A/P Dutch pilot project

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Annex 1 Activities / Timelines

#	Activity	Date	Achieved
1.	Distribute the long version of the SWOT to the Working Group	Dec. 2003	March 2003
2.	Analyze SWOT findings and develop the recommendations within three months through electronic discussion with members of the ICF Implementation Working Group (see Annex 2). The analysis will consider maximizing strengths, taking advantage of opportunities, turning threats into opportunities and diminishing the impact of weaknesses	Feb. 2004	March – August 2003
3.	Identify areas where ICF should/could be used	April 2004	
4.	Complete one identified activity by October 2004 and report to the 2004 WHO-FIC meeting	Oct. 2004	
5.	Draft the strategy and work plan for the Circle of Implementation for discussion by the WHO-FIC Implementation Committee	Oct. 2004	
6.	Undertake a feasibility and pilot study of the ICF Implementation plan	Oct. 2005	
7.	Evaluate the pilot study and implementation plan	Oct. 2005	

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ANNEX 2

Condensed SWOT analysis

The original SWOT analysis that was undertaken in Cologne, October 2003 was a typical SWOT analysis and provided a review at that point in time. This was done to address one of the ICF tasks identified in the 'Implementation of WHO-FIC' work plan that was agreed to at the October 2003 WHO-FIC network meeting in Cologne, namely 'Future directions for ICF implementation strategy'. The SWOT analysis was undertaken as it is a technique that is useful when launching a strategic analysis process and to provide guidance and future direction to the process.

The following table is a condensed version of the October 2003 SWOT analysis and incorporates the feedback of the Working Group. An important next step will be for members of the Implementation Committee and the Working Group to carry out SWOT analyses in their own countries and use the results to direct their own national ICF implementation work plans.

It should be noted that, although there has been an attempt to prioritize and align the SWOT analysis (note: alignment was a 'best-fit' effort) this will be useful for the consideration of future directions in the context of particular applications of the ICF, or specific implementation initiatives, vis à vis which strengths can be maximized, which opportunities should be addressed first, how do we minimize our weaknesses and which threats can be eliminated or avoided. It should be recognized that it is difficult to prioritize the SWOT analysis for the overall international ICF implementation agenda.

	Strengths	Weaknesses	Opportunities	Threats
1.	There are experts who have made a long-term commitment to ICF. Some countries have funded the implementation of ICF and are willing to share experiences and tools with other countries. A strong ICF network is recognized within WHO-FIC.	Changing players in some stakeholder groups The network is geographically dispersed and there are a limited number of players Enthusiasm wanes without strong leadership.	Capitalize on local initiatives and expertise.	Discontinued involvement of stakeholders. Gaps in enthusiasm and international drivers occur from time to time.

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	Strengths	Weaknesses	Opportunities	Threats
2.	Marketing and implementation experience of other WHO-FIC Classifications can be transferred to ICF.	Lack of ICF marketing and implementation expertise	Advanced telecommunication and marketing opportunities exist through the internet. A central web site could be established to share ICF information. Joint ventures or strategic alliances could be created with other WHO-FIC Classifications and initiatives (e.g. Maintenance and Updating, Education). The Updating process used for ICD can be studied for an updating process for ICF.	Lack of approval and co-operation at the country level
3.	ICF can be applied in different venues – surveys, clinical settings, policy making	Difficult to embed ICF in the Primary Health Care field	Universities have embraced ICF. There is widespread interest in ICF in the research community. Move into new segments and countries after piloting an implementation plan.	Inconsistent use/application of ICF at the international level
4.	Data on functional outcome of interventions to disease and health related problems (ICD) can be collected with ICF.		Some governments and clinicians are looking for outcome data. ICF can provide linkages to ICD and Intervention classifications and offer data on the continuum and effectiveness of care. ICF assists Decision Makers organize data and outcome information. A number of countries are promoting the Electronic Health Record (EHR).	Functional status not routinely collected in acute care settings. No champion for the use of ICF in the EHR.
5.	People with Disability – PWD have been involved in development of ICF	The ICF and its potential benefits not well established or understood	There has been a reduction of most stigma associated with the disability community.	

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Strengths		Weaknesses		Opportunities		Threats	
	<p>(in the UK, PWD is now thought not to be politically correct. It also does not fit in with the ICF understanding of disability. Here we use the term disabled people). DPI had formally recognized the ICF and its definition of disability.</p>			<p>Consumers' (People with Disability - PWD) rights are being recognized.</p>			
6.	<p>ICF offers a common language and international standard, based on scientific principles, with a strong conceptual framework that is applicable throughout the world. ICF is culture, etiology and provider neutral. It has a multidisciplinary perspective. It has been translated into the WHO six official languages and many other languages.</p>	<p>Location of business – geographically dispersed</p> <p>Personal factors missing in ICF</p>		<p>There is increasing government interest in many countries in the segment of the population with disabilities and the aging population.</p>		<p>There is a wide variation of political stability around the world. Governments change and political agenda shift. Different countries having different priorities in health-related information development. The reason or driver for collecting data on functioning has not been identified or championed. New regulations are emerging and evolving within countries that impact of the acceptance and implementation of ICF Political instability exists in some countries.</p>	

What is the role of supranational organisations within the SWOT analysis?

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Summary of Comments from the Working Group on the SWOT Analysis

The following is a brief summary of some of the feedback received from the Working Group on the SWOT analysis and the first draft of the Roadmap for the Implementation of ICF paper.

Communication / sharing

It's especially important that we implement the information collection mechanism that we have discussed, so we can begin sharing information about research and implementation strategies.

We want to draw on our expertise in promoting the key concepts of ICF and support each other. We need to collect and discuss ICF issues that are causing uncertainties.

We need to learn from each other and listen to the "implementation stories" from different countries as much as possible.

Every effort should be made to complement the work across the different countries and Collaborating Centers and avoid redundant duplication.

A coordinated international effort can benefit all involved countries by combining resources and eliminating duplication of effort. For instance, an internationally representative team that works together in developing educational materials will benefit multiple countries. Resources of developed countries will benefit developing countries.

It should be noted that an inconsistent use of ICF at international level may provide a valuable opportunity to share information on experiences with different approaches to using the ICF, which may then lead to international development of more standardized uses/applications.

A central web site would serve as a central repository of international ICF activities and information. Such a web-based mechanism for sharing information and experience on ICF implementation activities including ICF awareness and education in different countries will help reduce some of the internal weaknesses.

The network would benefit from broader membership, particularly more representation from non-English speaking and developing countries.

The Australian Collaborating Center, with input from others, has developed a draft framework for sharing information on ICF implementation activities. The next step will be to use this framework to develop a standard web page format that can be adopted by Collaborating Centers (and others) for making information on ICF applications and initiatives readily accessible on their web sites. Sharing experience is crucial at this early stage in the life of the ICF, and this is a concrete and meaningful step that should be achievable by October 2004.

National Seminars, small National working groups under ICF expert Leadership and regular electronic newsletters are an excellent means to share experiences with ICF activities, projects and research.

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Governments

Shifts in political agenda can mean new opportunities arising, as well as potential loss of support for initiatives already under way.

Marketing

Develop a marketing strategy or specific implementation initiatives for each context in which ICF can be used emphasizing the strengths for each of these different applications of ICF. It would be difficult to develop an all-inclusive workable marketing strategy that would embrace each of the applications of ICF. Some solid examples of country implementation/use in one or more venues, even limited examples, could help drive future implementation.

A central web site would serve as a central marketing channel for ICF.

Lack of ICF marketing and implementation expertise is due to the fact that the ICF is still fairly new. But there is expertise in marketing and implementing other tools – experience which can be applied to implementing the ICF.

The WHO-FIC Implementation Committee and Education Committee have to address the fact that ICF products and benefits are not well established or understood.

Mapping

Cross-walking ICF to established assessment and measurement tools across disciplines would enhance the potential of using ICF.

Mapping SNOMED-CT to ICF will be very important for identifying gaps in SNOMED-CT and educating people about the relationship between the two.

Many different measurement and assessment tools are in use; the ICF provides a way of linking information collected using different tools.

Some constituencies are advancing the use of SNOMED-CT in lieu of classifications (e.g., ICD-10 and ICF). We need to develop educational materials that clearly explain the relationship between terminologies and classifications and the important role of each. We also need to conduct research studies that demonstrate how granular terminological data can be mapped to ICF and ICF.

Along with the mapping of ICF to assessment and measurement tools, we can encourage the development of ICF-based assessment tools.

The mapping or cross walking of existing assessment and measurement tools with ICF is a very important first step in implementation. It will emphasize the fact that ICF has widespread application and utility in conjunction with these tools.

Mapping ICF with SNOMED CT is crucial to get ICF related terms mainstreamed in clinical systems.

Electronic / IT / Data Collection

There is clearly scope for people familiar with ICF to promote its potential for use in the Electronic Health Record (EHR).

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Reasons for collecting data on functioning are being explored and promoted in some countries, along with the potential of the ICF to meet this need. International sharing would be useful to help countries identify information needs and opportunities.

By identifying the reason / driver and champion for collecting the data with one or more concrete venues/applications, the value for doing so can be demonstrated.

In some countries there appear to be opportunities currently for promoting the ICF as a basis for collecting more, and more comparable information on functioning in health information systems.

In the clinical area, we should focus on rehabilitation fields, where there already is experience in collecting information on functional status. Physical therapy, occupational therapy and speech and language pathology are all good opportunities.

Some clinicians are skeptical about the ICF because they do not want to learn a new system, especially one that is lengthy as the ICF classification with all those codes. But indicating how the ICF can be used along with their typical tools especially with an electronic version will be a helpful selling point.

Applications

Many of the opportunities may be more relevant to consider at a national rather than an international level, i.e. for developing national ICF implementation work plans.

Piloting

We could undertake "experimental displays" to authorities (decision makers) of how ICF can offer them data that is comprehensive and easy to interpret in an integrated manner.

It may be appropriate to look at the feasibility of an ICF pilot in high visibility areas and where there is currently work with ICF occurring – children and youth with disabilities at work, in school and lifestyle; families with crises in the health condition context.

We should undertake different types of ICF piloting projects in different countries in order to study a number of implementation scenarios.

The clinical setting would be the most powerful place to initiate a pilot study as a demonstration of the implementation of ICF from functional assessment to intervention planning and documentation for decision makers.

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Guidelines

The American Psychological Association is developing guidelines for the use of ICF in the clinical setting and a German group is developing code sets; these need to be coordinated and disseminated. We need to study the APA guidelines to determine if they would help our understanding of ICF-items and their use in a unified way. The fact that multiple national professional organizations are supporting the development of the ICF clinical manual in the U.S. is a strong endorsing point of the ICF's value. The number of professional associations is increasing.

The lack of definitive guidelines at this time allows different groups to trial different approaches to using the ICF; sharing their experiences will provide a valuable basis for future development of more standardized uses/applications. . Different views on developing coding guidelines need not be a problem if countries are free initially to explore these different approaches and there is a commitment to evaluating and sharing experience before an attempt is made to develop internationally endorsed guidelines.

Promotion / Education

Highlighting cases where ICF is being implemented will promote the use of ICF in other countries and in other venues.

Emphasize the fact that the ICF facilitates data collection on disability and functioning that is comparable across countries as an international classification and standard.

Promote the fact that ICF is electronically available which will facilitate use especially by clinicians and educators. It is a user-friendlier format and helpful tool for users.

Stress the fact that the ICF recognizes and includes a list of environmental factors.

It is important to educate people in ICF-terms before going in finer nuances of ICF-use. Concerning mainly the clinical use of ICF, an effort should be made to use ICF-language in everyday tasks (assessments, planning of interventions and finding services for reducing limitations and increasing functioning) as much as possible. ICF language should be communicated in all interactions, documentation and within vocabularies.

Promoting the use of ICF in educational settings at all levels is important. The ICF has been used to educate individuals at the undergraduate, graduate, and professional levels in understanding the framework of disability and functioning.

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Other comments

Although disability people were involved in development work of ICF they may not have been heard enough and are therefore feeling that ICF is a threat for them. We need to involve the people with disability to cooperate in our endeavours and work alongside us.

A comprehensive search (literature and otherwise) should be pursued to ascertain and synthesize research, clinical, and educational applications of the ICF.

A commitment to moving forward on identified tasks, particularly information sharing, is important.

The WHO FIC Implementation Committee and Collaborating Centres need to demonstrate strong and lasting leadership.

As ICF is used in various applications, the updating proposals will need to be vetted and test the ability of the Update and Revision Committee (as expanded with ICF experts) to address them and the willingness of WHO to implement them.

We need to consider if the ICF specialists / experts have a conceptual frame of reference which is unified enough so that the implementation of ICF would in fact be carried through appropriately in different countries. "We are said to have a common language by ICF but are we really defining the key concepts of ICF (such as health, functional status, disability, functioning etc.) in similar ways?"

In our enthusiasm we don't want to kill the "healthy critics" we must maintain an open-minded approach to our implementation work.

The multidisciplinary nature of the ICF is not clear: the bio-psycho-social concept varies between the developers of ICF developers.

The missing personal factors is a real internal weakness. We remain vigilant of the risk of strengthening the medical model by concentrating disease specific core-sets. (Disagreement: use is better than no use; I also support core sets of activities or participation. We have to think about the research uses of the ICF as well as clinical or survey applications) We want to avoid turning ICF into the same kind of classification of consequences of diseases as ICIDH.

It is important for countries to capitalize on ICF opportunities that exist in whatever area.

Health information systems should be discussed at the Reykjavik Meeting in October 2004; distinctions between:

- information systems (IS) using ICF (or intending to use ICF) strictly for epidemiological purposes (cf. Washington Group, national statistical institutes' surveys, etc.),
- IS using ICF (or intending to) for different purposes: to monitor health services management and planning, populations management, rights of persons with disabilities, etc., which combine epidemiological information and assessments of disability situations.

The use of ICF as a framework for surveys and assessment tools is promising, but probably will not result in the use of ICF as a coding/classification system. Nonetheless, we need to promote the ICF model and its importance for terminological development.

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ANNEX 3

Roadmap ICF Working Group of the WHO-FIC Implementation Committee

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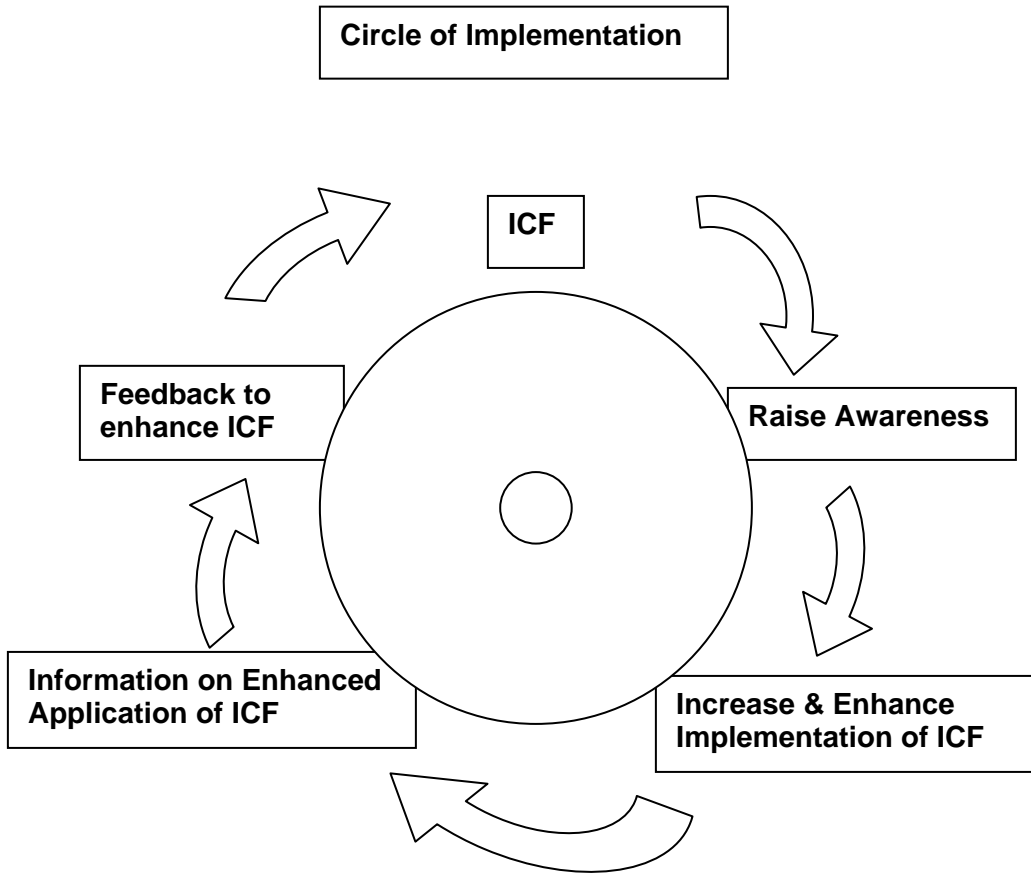
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ANNEX 4

Circle of ICF implementation

The following diagram provides a schematic model of the phases of ICF Implementation. A country or Collaborating Centre could be at one stage of implementation for a particular sector and a different phase for another sector. It is depicted as a cyclical, continuous process. For example, as ICF evolves and is updated there will be a need to inform stakeholders and as stakeholders use and implement ICF, feedback will be received on successes and how the process and classification can be improved. ICF is a 'living' classification and will continue to grow and evolve. There is no end to the road, it is more like the British 'round-about' – although there is 'light at the end of the tunnel'!



ANNEX 5

Example of a draft checklist proposed by Paul Placek

List to be filled out for every country or language area:

Translation into major language

Named in public law on policy (do we need to consider draft policy or policy proposals?)

Workshops and training programs + year

Country specific ICF training tool

ICF inclusion in education at Universities

Focal point

Website

Disseminated ICF books/cd-roms

Availability of country specific training tool

Survey back coded to ICF

New survey conducted using ICF definitions

Clinical record keeping using ICF

ICF brochure in national language(s)

Governmental funds allocated for ICF research

Representative to WHO-FIC meeting 2004

Representative to Washington City Group

Hosted national or international ICF meeting /workshops + year

ICF use in regional or national health care delivery

ICF used in assessments

PS

Similar checklist could be developed for ICD and other members of the WHO-FIC.

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ANNEX 6

Example of a mapping protocol

ICF – “Cross-walking Protocol – Draft 3

This section describes a methodology recommended to be used when “cross-walking” existing outcome measures or survey instruments to the ICF. This methodology is described for “cross-walking” questionnaires on physical performance or emotional state rather than tests of capacity. These latter tests (eg. walking speed, endurance, strength tests) would most likely provide information to qualify the severity of an impairment (I), activity limitation (AL), and participation restriction (PR). We are not in a position at the moment to define levels of severity using tests of capacity except when age- and gender-norms exist.

When applied to questionnaires of physical performance or emotional state, the methodology described will yield a list of “endorsed” codes for each item of each measure “cross-walked”. The aim of using standard methodology is to (1) improve communication and exchange of information among ICF users and researchers and (2) to produce reliable estimates of prevalence and severity of I, AL, and PR that are independent of the measurement tool used. In addition, a standardized methodology will allow for a feasible and consistent way to “cross-walk” measures for researchers wanting to incorporate the ICF in their own work. It may also encourage greater involvement in mapping projects, projects that will be imperative to the implementation of the ICF in clinical settings.

Methodology	Suggested Procedure
Types of measures	Questionnaires on physical performance or emotional state
Number of raters	10 (see justification below)
Characteristics of raters	More than 2 disciplines represented; Mix of academic/research and clinician Should include persons with disability when relevant and appropriate (clients) Raters should all have a fundamental understanding of the ICF
Training	Formal presentation of framework; definitions. Practical exercise: find how ICF would be used to represent relevant global constructs (these would be domain specific; eg. Walking, speech, depression) Training on existing coding rules. These have been set out in the following publication: <i>Cieza A, Brockow T, Ewert T, Amman E, Kollerits B, Chatterji S et al. Linking health-status measurements to the international classification of functioning, disability and health. J Rehabil Med 2002; 34(5):205-210.</i> Viewing of training video and completion of training activities on video followed by a discussion of

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	<p>differences and similarities which can be done through email or face-to-face meeting.</p> <p>WCPT and APA have developed training videos – we should screen these for applicability in this context.</p>
Rating	Each rater must select codes independently without discussion with other raters.
Selecting codes	Instruct raters to 1 st select <u>all</u> codes that could apply and 2 nd to choose what they felt was the <u>best</u> code.
Selecting qualifiers	Same methodology as for selecting codes based on response options attached to the item being ICF coded (source item)
Endorsement of codes	A Delphi approach is recommended to select endorsed codes. Once raters have completed the coding procedure, the forms will be returned to the project leader. The results will be collated and the raters will be provided with feedback on the frequency with which each code was used. Raters will then be given the opportunity to endorse a particular code from the ones selected by other panel members. Comments will be collected as explaining their choices. This process will be repeated until 70% of respondents agree with a particular code. Codes with 70% agreement or more would be endorsed as <u>best codes</u> until further data are available to modify the endorsement. Codes not endorsed by 70% of raters will be listed and identified as unendorsed.
Reporting agreement	Report the number of items for which agreement before and after Delphi consensus on <u>best</u> code was: 100%; then report the codes that achieved greater than 70% agreement and codes that achieved less than 70% agreement even after Delphi consensus approach. Report items where no code can be identified.
Understanding items with no endorsed codes	Go back to the item and do cognitive debriefing as to what the item means to the respondent and what is known from the literature as to its meaning to respondents;
Validity of endorsed codes	The “cross-walking” of all items of each measure to ICF code will yield a list of coded functional status indicators (FSI). However, it is possible that this translation to ICF may not accurately reflect individual’s impairments, activity limitations or participation restrictions. To validate the coding, a test sample, of clients should be evaluated using the measure and using the ICF codes including qualifiers.

Justification for number of raters: Based on putting a confidence interval around the desired estimate of agreement of 70%, 15 raters is required to have 95% confidence that the true population level of agreement on a code is not less than 40%. However, this assumes that the raters are a random sample of all raters rather than raters chosen for

ROADMAP FOR THE IMPLEMENTATION OF ICF

their expertise and training. Because of this and because we are using the Delphi procedure, we recommend 10 raters.

This Delphi approach to consensus should not take more than 3-5 iterations and it might be achieved after two. The advantage of this procedure is that the endorsement is done independently and the results are reported back without attribution to particular panel members. There would be no need to bring the raters together, and the procedure is designed to build consensus in a way that avoids undue influence from outspoken or senior persons. The result of this process should be a thorough consideration of appropriate codes by an appropriate group of experts, and a defensible consensus on how the items are coded.

It is very likely that some instruments will not be easily coded, particularly those that have more than one activity given in the item. For example, the SF-12 or SF-36 item refers for difficulty with moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf. Thus, one item could potentially yield several codes and persons could have one or more of these problems. This illustrates the importance of the validation stage before an ICF code is endorsed for a particular item of a measure.

We recommend that 'mapping projects' in progress be identified so that duplication of efforts is avoided. However, it is possible that once a mapping project is listed, that interested people may sign on as raters. This would also help with logistics if one group could not identify 10 trained raters. We would look to the ICF Collaborating Center to assist with this effort.

Here is an example of the reporting of a mapping exercise that was carried out on the SF-12 (Mayo et al. JAMIA, *In Press*, 2004).

Table 1. Agreement on ICF codes for the SF-12

SF-12 Item	Agreement on coding by 8 raters		
	100%	70-99%	<70%
1- Evaluating own health	Not ICF definable		
2- Doing moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf.			d920 d640
3- Climbing several flight of stairs	d4551		
4 to 7 ² Interference in work or regular activities due to physical and/or emotional health			d859
8- Pain interfering with work or housework		b280	
9- Feeling calm and peaceful		b1263	
10- Having a lot of energy	b1300		
11- Feeling downhearted and blue			b1265
12- Interference with social activities		D9205	

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Table 2 illustrates the challenge in arriving at severity qualifiers as the items of measures often have different response options. For example, 3 different response options were used for 12 items of the SF-12. Here is an example of translating SF-12 response options to ICF severity ratings.

Table 2. ICF Severity Rating of the Response Categories of the SF-12 Items

(SF-12 Question) Impairment or Disability	Complete	Severe	Moderate	Mild
	.4	.3	.2	.1
(2) d6409 Housework	Limited a lot			Limited a little
(3) d4551 Climbing stairs	Limited a lot			Limited a little
(8) b2800 Pain	Extremely	Quite a bit	Moderately	A little bit
(9) b1263 Psychic stability *	All of the time	Most of the time / A good bit of the time	Some of the time	A little of the time
(10) b1300 Energy*	All of the time	Most of the time / A good bit of the time	Some of the time	A little of the time
(11) d1265 Optimism	All of the time	Most of the time / A good bit of the time	Some of the time	A little of the time
(12) d9205 Socializing	All of the time	Most of the time	Some of the time	A little of the time

Footnote for Table 2: SF-12 items are given in brackets: item 9 (feeling calm and peaceful) and item 10 (having a lot of energy) are worded positively whereas the ICF coding refers to disability so all of the time would be a very severe impairment.

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Annex 7

Use of ICF and ICPC together, European pilot project proposal, draft outline, a Dutch example of a planned concrete project

Introduction

- In October 2003, ICPC was accepted as a WHO-FIC member for use in primary health care (see Report of 2003 Cologne meeting of Center Heads, and letter Richard Madden to WONCA, November 2003); therefore, studies into the potential relations between ICPC and other WHO classifications are important;
- Since 2002, a Belgian-Dutch project on linking ICPC-2, ICD-10, and ICF, is working on linking a selection of ICF codes (Function and Activity/Participation) to the reason for encounter codes -28 (limitations in function) and the process codes -43 and -49 of all ICPC chapters; first results will be on the agenda of the August 2004 meeting of the WONCA International Classification Committee (WICC);
- In order to evaluate the results of this ICPC-ICF linkage proposal, a pilot study is recommended.

Aims of the pilot study

- To assess the distribution of the selected ICF codes by ICPC 28-codes in order to come up with a pragmatic recommendation for the use of ICF codes in the reason for encounter in primary health care
- to evaluate the usefulness and feasibility of these selected ICF codes in routine primary health care (for documentation and communication with physical therapists) in order to estimate the potential for practical implementation
- to provide a practical basis for the second part with regard to the application of ICF in the process mode of ICPC.

Proposed design of the pilot study

- testing the selected ICF codes as linked to code -28 of chapter L (and Z?) of ICPC in the reason for encounter mode
- testing to be done by family doctors who are familiar with using the ICPC
- in European countries: Belgium, Denmark, Germany, Malta, Netherlands, Norway, Russia, Serbia, Spain (NB Finland and Australia seem to be interested as well)
- other countries to be discussed: e.g. Canada
- selected ICF codes operationalized in a checklist for use by the family doctor
- in each country a certain number of cases in a certain amount of time (e.g. 50 cases in one month?) for patients visiting the doctor for complaints included in chapter L of the ICPC; to be discussed: all ages or a selected age group, e.g. 25-64 (where sickness certification is required)?

Steps

- first step: invitational conference for discussion of a draft protocol, in order to be able to take local situations into account; result: design of pilot study
- second step: pilot study
- third step: presentation of results and proposal for implementation during a second invitational conference

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Organizational issues

- project team
- steering committee
- local project leaders and teams

Duration of project

- Step 1: preparation, including invitational conference (4 months)
- Step 2: data collection and analysis (12 months)
- Step 3: preparation of report, including invitational conference (4 months)

Sponsors (tentative)

- Step 1: WONCA
- Step 2: EU for European part? What about non-European part?
- Step 3: WONCA?

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Annex 8

Dutch pilot study on A & P distinction, a Dutch example of a proposed concrete project

Introduction

A high number of international experts on former ICIDH and present ICF, agreed for the time being, on the combined A & P list as published in the International Classification of Functioning, Disability and Health (ICF) in 2001.

The CC could try to stipulate the definition of both concepts, as presented in the ICF. The question is if this will lead to an appropriate solution in the codes and terms as presented in ICF. Implementation of these definitions in combination with the given list of codes, terms, constructs and qualifiers is not a straightforward thing to do. It needs a lot of explaining and discussing before health care workers start to understand what is meant by A or P in ICF, and even than get puzzled by the complexity of it and the ambiguity of assigning a code by means of the qualifiers.

In daily practice there is a quest for a clear distinction between A and P, and for two separate lists of corresponding codes.

The thought is that A and P can only be understood, and the reliability of definitions checked in real live context. That is why the Dutch Centre wants to undertake a systematic collecting of terms concerning A & P, and study what makes something an Activity item or a Participation item.

Theorising about concepts and definitions is important, checking the reliability of this theorising is the next step.

Aim of the pilot study

- The pilot study is aiming at understanding, what in the Dutch situation, and in practice, is understood as an activity-item and what is understood as a participation-item in the context of functioning, disability and health,
- To provide a basis for a clear distinction of A & P, by means of a categorial structure for A and for P that can be used for further discussion.

Design* of the pilot study

- Structured collection of expressions on A & P with corresponding codes, and on questionnaires, the Dutch Centre will organize the ICF Response Centre.
- Collecting data from a selected group of ICF experts in various fields of expertise concerning A & P, by means of ICF (Activities and Participation – D component with Qualifiers - version),
- Data analysis and categorial model construction.

Steps* of the project

- organisation of the pilot study, preparing the tools, preparing the ICF –A&P, developing the structured data format, selecting the expert group, informing and instructing the expert group,
- Pilot study, including preparing results,
- Presentation of results in the expert group, disussion and follow-up.

ROADMAP FOR THE IMPLEMENTATION OF ICF

Organisation of the pilot

- Expert group
- Project team

Duration of the pilot

- Organisation, etc, 3-4 months
- Pilot study, 12 months
- Report and presentation 3-4 months

Sponsors (tentative)

- Organisation, partly Dutch WHO FIC CC, & tools?
- Dutch WHO FIC CC
- Dutch WHO FIC CC & ?

*Ad Design and Steps of the pilot

User Group

- a controlled group of ICF users are invited to contribute to this work on A & P. Specific interested parties can be invited to participate, if the Centres criteria for participation are met. These criteria will be made explicit.
- the selected group of ICF users needs to be equipped with the ICF Response Centre as part of the electronic Classification Browser software. Once the ICF Response Centre is activated, information about the selected class will automatically be shown within the first four fields. Comments on separate codes and classes can be stored, and mailed as a batch to the central server on any convenient moment.

Terminological Analysis on A & P

To discover what the difference is between an activity and participation item, and what defines A and P, the submitted descriptions will be analysed using a method for modelling medical terminology (MMT). This method has been developed in analogy with the development of the French Classification of Procedures (CCAM), and further developed by the Medical Informatics Group of Nijmegen University. As part of the method a class concept diagram for Activity and Participation will be modelled. The concept diagram describes the class constructs with their relations. The diagram will be modelled in the Unified Modelling Language (UML).

The Terminological Analysis is a contribution in the answer to the question if separate lists of classes for A & P are sensible and possible. In other words, if the present A & P list can be reconstructed and separate A's and P's can be explicitly defined.

The Dutch CC wants to explore the possibility of applying this approach to A & P on an international level and expansion of the scope to all of ICF in a next step.

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