

Creating an Interface Between the *International Classification of Functioning, Disability and Health* and Physical Therapist Practice

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The American Physical Therapy Association (APTA) has endorsed the *International Classification of Functioning, Disability and Health* (ICF) as a framework to be integrated into physical therapist practice. The ICF is a universal and inclusive platform for the understanding of health and disability and a comprehensive classification system for describing functioning. The APTA's *Guide to Physical Therapist Practice* was designed to guide patient management, given the different settings and health conditions that physical therapists encounter in their daily clinical practice. However, physical therapists may be unclear as to how to concretely apply the ICF in their clinical practice and to translate the application in a way that is meaningful to them and to their patients. This perspective article proposes ways to integrate the ICF and the *Guide to Physical Therapist Practice* to facilitate clinical documentation by physical therapists.

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The World Confederation for Physical Therapy during its 15th General Meeting in June 2003 adopted a motion¹ supporting the implementation of the *International Classification of Functioning, Disability and Health* (ICF) of the World Health Organization.² Five years later, the American Physical Therapy Association (APTA) officially endorsed the ICF.³ However, we found scarce evidence to indicate that the ICF has been integrated into physical therapist practice documentation.

There have been 2 case reports illustrating the application of the ICF in physical therapist practice.^{4,5} The ICF as a practice framework in physical therapy also has been discussed in various settings, such as in cancer rehabilitation,⁶ pediatric rehabilitation,⁷ and management of neck pain⁸ and as a model for identifying intervention strategies in multi-setting and multi-health conditions where physical therapy is one of the health services provided.^{9–11} Rauch et al¹² demonstrated the use of the ICF as a basis for developing tools for clinicians. Clinical guidelines in physical therapist practice have been linked to the ICF as a reference to navigate through the process of patient management—from examination to intervention.^{8,13,14}

All of these reports have contributed to the effort to implement the ICF in physical therapist practice. Although the support for the conceptual application of the ICF to clinical practice is evident from these reports, a well-defined documentation approach in physical therapist practice remains a challenge. Integrating the ICF into clinical documentation during clinical encounters needs to be explored. Specifically, there is a need to identify ways by which the ICF can be integrated into current forms of documentation in clinical practice. If ICF-based documentation approaches could be developed, clinical care would potentially benefit from the use of standardized documentation using an internationally agreed-upon standard. Therapists would better communicate with each other by avoiding the use of confusing or vague terms in documentation.

One purpose of this perspective article is to present arguments in favor of the systematic and well-defined utilization of the ICF in physical therapy practice documentation. A second purpose is to propose the use of a clinical evaluation template that integrates APTA's *Guide to Physical Therapist Practice*¹⁵ (herein referred to as the "Guide") and the ICF. To accomplish these purposes, this article is structured in the following way. First, we discuss the Guide and its relation to the ICF. Second, we propose and discuss 2 ways of integrating the ICF with the templates described in the Guide. We discuss the added value of the ICF and ICF Core Sets to clinical practice. Because we do not discuss the ICF in great detail in this article, we direct readers to the accompanying background paper on the ICF (see eAppendix, available at ptjournal.apta.org) if more information is needed.



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- **eAppendix:** *International Classification of Functioning, Disability and Health* (ICF) of the World Health Organization
- **Discussion Podcast:** See the PTJ Web site for participants.
- **Audio Abstracts Podcast**

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The Guide to Physical Therapist Practice

Purposes of the Guide

The Guide is a resource for students, individuals who are engaged in the clinical practice of physical therapy, and those teaching and conducting research in physical therapy. The Guide addresses issues that affect and contribute to physical therapy as an independent health care profession. The Guide was designed to serve several purposes—namely to recognize the various settings in which physical therapists practice, to provide descriptions of physical therapy as a practice, to define standard terminology and provide a frame of reference, to enumerate assessment tools and tests and interventions that can be utilized during patient encounters, and to emphasize the principles of outcome measurement to gauge the effect and quality of care provided by physical therapists. These purposes hold relevance not only to physical therapists and their patients but also to others who influence health care such as policy makers, care managers, and service reimbursers.¹⁵

The Guide also may be used by the physical therapy scientific community to study diagnostic tests^{16,17} and to explore clinical decision making, reasoning, and treatment.^{18,19} In summary, the Guide lists a set of tools and resources to assist clinicians and researchers in finding ways to optimize patient management.

Contents and Processes of the Guide

Relevant outcome measures, a guide to intervention planning, and key processes in patient management are presented in the Guide. Processes that embody patient management are divided into 5 major elements: (1) examination, (2) evaluation, (3) diagnosis, (4) prognosis, and (5) intervention.¹⁵ Reference will be made

throughout this perspective article to these terms as they are used in the current edition of the Guide.¹⁵

The Guide advises physical therapists on *what* to evaluate and provides resources (eg, questionnaires or scales, procedures, list of outcomes) on *how* to conduct the evaluation. Readers are referred to the Guide for the full contents and description of patient management.

The ICF

The ICF² was endorsed by the World Health Assembly in May 2001 to create a common language of the full spectrum of human functioning and disability. The ICF presents a system of classifications of the domains and categories of human functioning that can be used to describe the experience of health and disability and that provides a common language to communicate multiple aspects of patient care. The ICF conceptual framework of functioning and disability is based on the biopsychosocial model, in which functioning and disability are the outcomes of complex interactions among intrinsic features of the person and contextual factors, both environmental and personal. See the eAppendix for more information about the ICF.

Common Conceptual Perspectives of the Guide and the ICF

Use of Nagi's model²⁰ along with emphasis on the continuum of care, in our opinion, align the Guide and the ICF at the conceptual level. The ICF as a well-defined conceptual framework and the Guide as a defining document of physical therapist practice share a common understanding of functioning and disability; thus, the ICF and the Guide complement each other. We believe that there are several reasons why the conceptual similarity between the 2 documents can provide a path toward integrat-

ing the ICF into physical therapist practice.

Both the Guide and the ICF recognize the complex interaction between disability and functioning. For example, when treating a patient, a physical therapist can use the Guide to look for function domains that need close attention. These same function domains are defined in the ICF and are listed in the form of chapters and categories concerning the individual's *body functions*, *body structures*, individual *activities*, and *participation* in a societal context. Moreover, both also consider the whole array of *personal factors* and *environmental factors* that may affect or influence the severity of disability, coping with the disease, and level of functioning. As movement specialists, physical therapists can use the Guide and the ICF to address "dysfunction" or disability with prudent consideration, not only of the patient as an individual but also of that individual's role in the larger context of the community and through the continuum of health care—ranging from the acute setting to long-term care—irrespective of the health conditions or associated health-related events. We believe that these features support the argument that the Guide and the ICF can be made usable and practical when interfaced together.

Knowledge of the conceptual similarities of the Guide and the ICF would be helpful because it would allow users of the Guide to integrate the ICF into daily practice. In the process, clinicians benefit because an ICF-based patient evaluation goes beyond the "traditional" view of consequences of disease at the level of body functions and body structures. Use of an ICF-based patient evaluation may facilitate more attention being paid to activity and participation domains, as well as environmental and personal factors, although re-

<p>a <input type="checkbox"/> Difficulty with locomotion/movement:</p> <p>(1) <input type="checkbox"/> Bed mobility</p> <p>(2) <input type="checkbox"/> Transfers (such as moving from bed to chair, from bed to commode)</p> <p>(3) <input type="checkbox"/> Gait (walking)</p> <p>(a) <input type="checkbox"/> On level (c) <input type="checkbox"/> On ramps</p> <p>(b) <input type="checkbox"/> On stairs (d) <input type="checkbox"/> On uneven terrain</p> <p>b <input type="checkbox"/> Difficulty with self-care (such as bathing, dressing, eating, toileting)</p> <p>c <input type="checkbox"/> Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)</p> <p>d <input type="checkbox"/> Difficulty with community and work activities/integration</p> <p>(1) <input type="checkbox"/> Work/school</p> <p>(2) <input type="checkbox"/> Recreation or play activity</p>
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Figure 1. "Functional Status/Activity Level" section of the documentation template from the *Guide to Physical Therapist Practice*. Reprinted from the *Guide to Physical Therapist Practice*, 2003, rev 2nd ed, 2003, pages 702 and 704, with permission of the American Physical Therapy Association. This material is copyrighted, and any further reproduction or distribution requires written permission from APTA.

search is needed to test this hypothesis. Researchers also could develop an agenda that would foster the use and translation of ICF into practice, such as in point-of-care evaluation in the clinic.^{8,13,14} The ICF would provide a language and set of terms that will be common to the understanding of physical therapists regardless of their country of education and the region, culture, and traditional beliefs of the clinical setting in which they practice. In future revisions, the Guide could explore possibilities of how ICF categories could be made operational, practical, and feasible in a systematic manner using principles that are already fundamental to the Guide. Although the ICF provides us with "what" to measure, the Guide and future research efforts can aim to standardize ways of "how" to measure the "what."

Foundation for Clinical Application: The ICF Core Sets

For the ICF to be usable in a practical way, intermediate tools based on it are necessary. It is for this reason that the ICF Core Sets have been developed. A Core Set is a short and

manageable list of categories applicable to a health condition or health-related event that conveniently describe the most salient aspects of the disability experience related to that health condition or health event. Balancing the need for a workable instrument, in which only a small fraction of the ICF categories are used, and sufficient descriptive power to adequately describe the patient's circumstance, each ICF Core Set is the product of extensive input from experts, patients, evidence in the literature, and empirical studies.^{21,22}

A Core Set can be *comprehensive* or *brief*. A comprehensive Core Set usually is used in multidisciplinary assessment and has as few categories as possible to be practical but as many as necessary to capture the full spectrum of variables specific to a health condition or health-related event. A brief Core Set contains the minimum number of measures or categories to be included in studies on a health condition and is designed for use by a single discipline focused on a specific subset of problems, such as physical therapy.²¹ A Core Set also can be *generic* or *condition-*

specific, depending on the type of health care setting where it is being used. ICF Core Sets for specific health conditions have been published. They are available for chronic conditions²¹ (eg, low back pain,²³ stroke²⁴) and for acute and post-acute settings²⁵ (neurological, musculoskeletal, and general medical conditions such as cancer). There are more upcoming Core Sets in the areas of vocational rehabilitation, hand conditions, traumatic brain injury, sleep, cerebral palsy, dementia, and Parkinson disease that are either in the development stage or nearing completion.²⁶ Although an ICF Core Set is not available for *all* health conditions, there are many Core Sets that physical therapists can now integrate into their daily clinical practice. For conditions that do not yet have Core Sets or patients who have multiple conditions, an ICF generic Core Set has been proposed. The ICF generic Core Set consists of 28 categories from the different ICF components (body functions=10, activities and participation=17, environmental factors=1).²⁷

Application of the ICF in Physical Therapist Practice

This section of the article proposes 2 concrete ways in which the ICF could be integrated into patient management in physical therapist practice, specifically with consideration given to the documentation templates from the Guide.^{15(pp8699-8711)} First, we propose the use of the ICF generic Core Set in the subsection "Functional Status/Activity Level" of the history form in the documentation template. The second proposal is to recommend the use of condition-specific ICF Core Sets while using the elements of patient management of the Guide.

Table.

Suggested “Functional Status/Activity Level” Categories of Measures Based on the Generic Core Set of the *International Classification of Functioning, Disability and Health* (ICF)

Body Functions (b)	Activities and Participation (d)	Environmental Factors (e)
b130 Energy and drive functions	d1 Learning and applying knowledge	e450 Individual attitudes of health professionals
b134 Sleep functions	d230 Carrying out daily routine	
b140 Attention functions	d3 Communication	
b144 Memory functions	d410 Changing basic body position	
b152 Emotional functions	d415 Maintaining basic body position	
b210 Seeing	d430 Lifting and carrying objects	
b230 Hearing	d450 Walking	
b280 Pain	d455 Moving around	
b710 Mobility of joint functions	d510 Washing oneself	
b730 Muscle power functions	d530 Toileting	
	d540 Dressing	
	d640 Doing housework	
	d750 Informal social relationships	
	d760 Family relationships	
	d770 Intimate relationships	
	d850 Remunerative employment	
	d920 Recreation and leisure	
Any other body functions that the clinician may want to document outside of the generic Core Set (eg, blood pressure, respiratory rate, skin integrity)	Any other activities and participation that the clinician may want to document outside of the generic Core Set (eg, school)	Any other environmental factors that the clinician may want to document outside of the generic Core Set (eg, assistive devices, home setting, work environment, health services)

Proposal 1: ICF-based “Functional Status/Activity Level”

The documentation template of the Guide, located in the history section, contains a subsection titled “Functional Status/Activity Level.” Figure 1 lists the contents of this subsection in its current form. We contend that the “Functional Status/Activity Level” subsection in its current form is not comprehensive enough for clinical application. The items will not be able to capture all of the information pertaining to activities and participation of an individual from a personal level to the societal level.

We propose that this subsection could be replaced with the 28 categories from the ICF generic Core Set. The generic ICF Core Set was found to provide a comprehensive descrip-

tion of functioning for individuals, and there is evidence that it demonstrates satisfactory validity in a number of domains.²⁷ The generic ICF Core Set is brief enough, in our opinion, to be practical and capable of being implemented in daily practice for use with patients with multiple conditions and those for whom a specific Core Set has not been developed. The Table contains the list of categories belonging to the ICF generic Core Set.

Based on Figure 1, the patient’s functional status covers bed mobility, transfers, walking, self-care, home management, work, and community and work integration (including school and recreation). However, information may not be captured for a patient who has a complex problem involving one or more complaints

such as fatigue; pain; sleep, memory, or sensory system disturbances or complaints about aspects of mobility such as changing and maintaining body position, all of which are included in the ICF generic Core Set (Table). The Table contains categories that cover comprehensive yet practical information needed in routine clinical practice. The ICF handbook is not explicit as to whether the ICF categories should be assessed by the patient, the clinician, or both. We propose that the ICF categories be patient reported (instead of clinician rated) and that the limitation or restriction in a particular category be “qualified” using the first qualifier as presented in the ICF handbook.² The ICF qualifiers use a global rating of impairment, limitation, or restriction in the form of numerical values as the first qualifier

(0=no problem, 1=mild problem, 2=moderate problem, 3=severe problem, 4=complete problem, 8=not specified, and 9=not applicable). The category “environmental factors” can be reported as being a barrier or a facilitator to functioning. Based on the ICF handbook, each numerical value has a corresponding percentage range (0%–4%, 5%–24%, 25%–49%, 50%–95%, and 96%–100%, respectively). Therefore, a percentage value may be used as an option in addition to the numerical value.^{2(p226)} For example, if a patient reported 25% impairment in muscle power function, which is ICF category b730 (included in the generic ICF Core Set), this percentage can be coded and qualified as category b730.2, denoting that the impairment is moderate (ie, 25% impaired). In our view, the ICF qualifier is not a substitute for other measures such as validated self-report measures or performance-based measures of physical function but rather is intended to complement them, producing a common reference across clinical settings and professions. Further research investigating the assessment of the ICF categories and qualifiers and the methodological limitations associated with these assessments is needed.^{28,29}

This article suggests which domains or constructs to document as the initial basis for concretizing the ICF application. The degree or level of impairment or restriction in each ICF category of domain may be qualified according to the numerical rating scale (as the first qualifier)² and later may be assigned a percentage value. To capture other categories or measures that the clinician would like to document, a space is provided at the end of the Core Set for each component (ie, column). Only the “Functional Status/Activity Level” section relates directly to the ICF. The remainder of the templates would not require revision, in our opinion.

Proposal 2: Integration of Condition-Specific ICF Core Sets

Purpose of the Proposed Template

We created a proposed template (Appendix) using the processes from the Guide as a reference. Table 2 could be helpful in the documentation of patient encounters from the initial examination to planning the intervention. The same table also could be used during the re-examination period and may be used in a variety of clinical settings (acute care, subacute care, skilled nursing facility, home health care, or outpatient facility) and in different health conditions (acute or chronic, musculoskeletal, neurological, cardiopulmonary, or integumentary). The use of this proposed template could be extended to multidisciplinary assessments such as those in a hospital setting where a patient is being seen by at least 2 different health care professionals. We recommend the use of condition-specific ICF Core Sets, as shown in the Appendix.

Sections and Contents

An important addition of the proposed template is the inclusion of the condition-specific ICF Core Sets. The osteoarthritis Core Set³⁰ is presented here as an example. Several condition-specific Core Sets are available.^{21,22,25,26,31–35} We believe that the use of condition-specific Core Sets can make the clinical encounter both thorough and efficient.^{36,37}

When used in a clinical encounter, the suggested documentation template shown in the Appendix would be administered and used together with the history section from the Guide template, which contains items on sociodemographics and other patient-reported health information. Imaging and laboratory findings that may be essential to clinical decision making can be considered

supplementary information and can be added to the documentation. Elements of patient management mentioned earlier—examination, evaluation, prognosis (including plan of care), and intervention—and re-examination would be used similarly to how they are used in the Guide to facilitate a structured process.

Crucial to patient management is the development of goals that are functional, measurable, outcomes driven, and patient centered and have a given time frame.^{38,39} Patient-oriented short-term goals (STGs) and long-term goals (LTGs) are reported in the first row of the suggested documentation template. Short-term goals are those that could be achieved in a shorter span of time (eg, 2 weeks) compared with LTGs, which involve a longer time period (eg, 4 weeks). Short-term goals and LTGs, however, are essentially similar in that both embody what would be considered a “meaningful change” to the patient³⁷ and are ideally within the context of activities and participation of the patient. A section also is provided to specify diagnosis using Preferred Physical Therapist Practice Patterns¹⁵ or the ICD-10 codes.⁴⁰

As illustrated in the Appendix, the examination section consists of ICF categories from the Core Set. The therapist makes decisions about which categories require examination (eg, “Do we need to examine category b280: Sensation of pain?”) and which test or instrument to use to measure or evaluate that category (eg, a 100-mm visual analog scale). The test values or results (eg, visual analog scale score for pain of 70 mm) then are recorded. In addition, the form illustrated in the Appendix allows for documentation of the LTG or STG (ie, related to a specific goal). For example, category b280 is related to the STG of decreasing pain from 70 mm to 20 mm, which could be related to the LTG of being able to

walk without an assistive device. The Appendix also allows for documentation of the corresponding prognosis relevant to the category, the intervention needed (eg, joint protection technique and therapeutic exercise), and specification of the frequency (eg, 5 times per week) and duration (eg, 2 weeks) of treatment. A re-examination is performed at an appropriate time (which may vary from setting to setting or from one health condition to another) where retesting of a category is conducted (ie, retest value) and a determination of whether the previously set goal was achieved.

Near the end of the list of ICF categories, the physical therapist is provided with additional space for other ICF categories or measures that need to be documented in addition to the condition-specific ICF Core Sets being used. If during and after the examination the clinician finds personal factors such as those relating to age, sex, education, coping, and acceptance of disease that are believed to be relevant to treatment but not necessarily part of the health condition,² a space is provided for documentation and for indicating whether the personal factors have a positive or negative influence on the patient's recovery and whether they are modifiable. A full definition of personal factors is provided in the ICF handbook.² At the bottom of the proposed template, a section is provided for writing down the evaluation and overall prognosis of the patient, considering all the information that has been obtained. A discharge plan also is to be provided. Physical therapists may add additional notes that need to be documented.

By using the proposed template, intervention targets are identified according to the categories from the condition-specific ICF Core Sets with which patients were found to have an impairment or restriction that

could be addressed by the physical therapist. Thus, the physical therapist may elect to intervene on those categories that are within the scope of physical therapist practice. If other categories are identified as problematic but do not fall under the scope of physical therapy, the physical therapist can refer the patient to appropriate professionals or services.

Discussion

The Guide provides clinicians with the content and resources regarding professional issues, including treatment outcomes and tools and necessary skills, all of which are integral to competent physical therapist practice. The ICF as a conceptual framework and classification system has been in existence for about 8 years, since its approval by the World Health Assembly of the World Health Organization. However, in our opinion, a significant gap remains between the use of the ICF and documentation by clinicians despite APTA's endorsement of the ICF. There is a lack of systematic and concrete application of the ICF in clinical settings.

In our opinion, the Guide and the ICF are complementary and could play an important role in advancing physical therapist practice. The Guide can provide a clear application of theoretical knowledge and processes that define the scope of physical therapist practice, and the ICF can be utilized both as a conceptual model and comprehensive classification system of functioning. Combining the Guide and the ICF also would provide a common language to facilitate communication among and within health care professions.

In this article, we attempted to illustrate that the ICF and physical therapist practice share common conceptual perspectives. Thus, we

proposed 2 ways to integrate and apply the ICF in physical therapist practice: (1) using the ICF generic Core Set to represent the "Functional Status/Activity Level" subsection found in the documentation template of the Guide and (2) using condition-specific ICF Core Sets along with the systematic process of patient management of the Guide. The first proposal seeks to integrate the ICF in physical therapy documentation in a concise manner using modified documentation templates in the Guide. The benefit of using the ICF Generic Core Set is that it can be used in health conditions where an ICF Core Set is not available.

The first proposal provides a simple way of integrating the ICF into the template by substituting the current contents of the "Functional Status/Activity Level" subsection of the template with the ICF generic Core Set. The generic Core Set, which was developed for a wide range of conditions and health care settings, is ideally suited for the clinical examination and evaluation of the patient's level of functioning and disability. The generic Core Set is self-reported and, therefore, is based on the patient's perspective and together with other clinician-derived information would be helpful in determining appropriate goals, prognosis, and the required intervention. One important caveat is that neither the ICF, as a classification, nor the ICF generic Core Set, as an extraction from it, should be considered a substitute for standard clinical outcome measures. Psychometric evidence (reliability and responsiveness to change) for ICF-derived measures is lacking. In our view, ICF qualifiers (ie, numerical values) in concert with other specific clinical outcome instruments, such as the Medical Outcomes Study 36-Item Short-Form Health Survey (SF-36) questionnaire,⁴¹ the Oswestry Disability Index,⁴² and the Health Assessment Questionnaire,⁴³

Ways to integrate the ICF in clinical documentation:

1. Use the ICF generic Core Set to reflect functional status and activity level.
2. Use ICF condition-specific Core Sets.
3. Use the elements of patient management from the *Guide to Physical Therapist Practice*.

Benefits:

1. Implementation of a conceptual framework by the World Health Organization.
2. Standardization of outcome measures and establishment of minimum data for each clinical encounter.
3. Flexibility afforded by using ICF condition-specific Core Sets.
4. Comparability of data across practice settings and countries for clinical and research purposes.

Challenges:

1. Lack of consensus on the standard outcome measures to be used to operationalize each ICF category.
2. Administration burden to clinicians.

Figure 2.

Summary of the *International Classification of Functioning, Disability and Health* (ICF) integration in physical therapist practice.

can be used to provide a comprehensive description of patients' activity limitations and participation restrictions.

The second proposal takes the integration of the ICF further by allowing for existing condition-specific ICF Core Sets to be used instead of the ICF generic Core Set. Using the condition-specific Core Set provides the physical therapist with greater specificity in documenting variables that hold practical relevance for the patient.

Challenges and Opportunities

There are challenges to face regarding the full integration of ICF in the Guide, particularly regarding daily practice documentation. The ICF Core Sets (both generic and condition-specific) define only what to measure and not how to measure. Although the contents of the ICF categories demonstrate content validity, the reliability and responsiveness of these Core Sets have yet to be extensively tested.

Defining how to measure each category in the ICF Core Sets is a future

research need in physical therapist practice. For example, the physical therapist might want to test the category d450 (Walking) in terms of distance walked or speed of walking. The selection of "standardized" tests to operationalize each category ideally would be based on existing evidence. As an example, Paul et al⁴⁴ found that a back muscle endurance test is a good indicator of muscle function based on the brief version of the ICF Core Set for chronic LBP, and similar studies would be useful to this end. Further studies would need to be conducted to look at potential "standard" tests or procedures that could be used by clinicians. Some measures in the ICF generic Core Set, such as "learning and applying knowledge" and "communication," may be too general, although the ICF does provide more precise categories and subcategories under each measure. Although the ICF categories can be specified further by the clinician based on the ICF handbook,² this may introduce variability, making it difficult to compare patients. The American Psychological Association has pushed for efforts to standardize the operationalization of the ICF in providing ser-

vices,⁴⁵ and a similar effort in the field of physical therapy also may be useful.

Another challenge is to ensure that clinicians fully understand and can apply the ICF. This challenge could be addressed by use of the ICF handbook² or by consulting the ICF online browser (<http://apps.who.int/classifications/icfbrowser>). An e-learning tool (software) on the ICF developed by the World Health Organization was launched in 2008 and is currently being tested. The e-learning tool is expected to facilitate distance learning in a condensed and convenient way. As it has been a major issue often raised, the lack of classification of personal factors in the current version of the ICF poses some limitation because there is evidence to suggest that personal factors are an important consideration in patient care.^{46,47} To address this issue, space is provided in our proposed template to document personal factors of the patient that clinicians believe are relevant to successful treatment outcomes. As a matter of feasibility, the burden to the physical therapist may be a challenge. Implementing the ICF in clinical evaluation and documentation may mean more time spent on each encounter with a patient relative to what clinicians are accustomed. However, we believe that small increases in time spent on documentation will add value to the documentation, particularly when the patient is seen by different clinicians or when group data are examined. Keeping this burden of administration to a minimum is key to achieving clinical feasibility and wide acceptability by physical therapist clinicians.

Figure 2 summarizes the recommendations of this article on how to implement the ICF in documentation in clinical practice and the limitations. It would be beneficial for physical therapy as a field to be aligned with

the ICF model of functioning and disability in order to link physical therapists' understanding of patients and patient care with that of other health care providers in a consistent manner.⁴⁸ The proposals that we have stated here are, in our opinion, straightforward ways of integrating the ICF into the existing documentation template (proposal 1) as provided in the Guide. We have presented and discussed the interface between the Guide and the ICF, which we believe will assist in advancing the scientific practice of physical therapy.

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Appendix.

Suggested Documentation Template Using Condition-Specific *International Classification of Functioning, Disability and Health* (ICF) Core Sets: The Osteoarthritis Core Set, Brief Version, Is Provided As an Example

Patient's Goal: Long-term goal (LTG): 1, 2, 3 . . . Short-term goal (STG): 1, 2, 3 . . .					Diagnosis:			
Date	[MM-DD-YYYY]						[MM-DD-YYYY]	
	Examination				Intervention + Frequency	Reexamination		
ICF Categories-Intervention Targets <small>(Sample: ICF Core Set for Osteoarthritis^a)</small>	Need to Examine? Yes/No	Test	Test Value	Related to STG/ LTG Number?	Prognosis		Retest Value	Goal Achieved? Yes/No
Body Functions								
b280 Sensation of pain								
b710 Mobility of joint functions								
b730 Muscle power functions								
Body Structures								
s730 Structure of upper extremity								
s750 Structure of lower extremity								
s770 Additional musculoskeletal structures related to movement								
Activities and Participation								
d445 Hand and arm use								
d450 Walking								
d540 Dressing								
Environmental Factors								
e115 Products and technology for personal use in daily living								
e150 Design, construction, and building products and technology of buildings for public use								
e310 Immediate family								
e580 Health services								
Other Categories:								
Personal Factors (Pf)	Influence							
	Positive	Negative						
Pf (eg, coping)								
Pf (eg, acceptance of disease)								
Evaluation and Overall Prognosis:								
Discharge Plan:								
Other Notes:								

^a Brief Core Set (n=13) for osteoarthritis.