



ICF CORE SETS

Manual for
Clinical
Practice

Edited by | Jerome Bickenbach · Alarcos Cieza
Alexandra Rauch · Gerold Stucki

ICF Research Branch
in cooperation with the WHO Collaborating Centre for the
Family of International Classifications in Germany (at DIMDI)

HOGREFE



ICF Core Sets

About the Authors

Jerome Bickenbach, PhD, LLB, is a steering committee member of the ICF Research Branch and was involved in the development of the ICF at the WHO and is a member of the Functioning and Disability Reference Group (FDRG) at WHO.

Alarcos Cieza, Psychologist, PhD, MPH, is a steering committee member of the ICF Research Branch. She has led the development process of several ICF Core Sets since 2001. She has also led the development of the ICF e-learning tool of WHO and participated in the development of other training materials and of the ICF Core Set-based documentation tools. She is a member of the Functioning and Disability Reference Group (FDRG) of WHO and has contributed to the ICF update and has led the measurement group.

Todd E. Davenport, PT, DPT, OCS, has applied the ICF and ICF Core Sets to physical therapy in the care of individuals with musculoskeletal health conditions.

Reuben Escorpizo, PT MSc, DPT, led the development of the ICF Core Set for Vocational Rehabilitation and has also collaborated on the validation of ICF Core Sets.

Monika Finger, PT MSc, participated in the development of the ICF Core Set for Vocational Rehabilitation and the development and validation of an ICF Core Set based questionnaire for vocational rehabilitation.

Andrea Glässer, PT BSc, MSc Neuroreha, MPH, participated in the development and validation of several ICF Core Sets. She provides ICF training in different health professional degree programs.

Miriam Lückenkemper, MA Psychology/Communication science, was involved in the development and validation of ICF-based measurements, manuals, and ICF Core Sets for Vocational Rehabilitation.

Pavel Ptyushkin, MD, MPH, worked for the ICF-focused Multidisciplinary Research Network on Health and Disability in Europe (MURINET) and participated in the development and validation of the ICF Core Sets for Traumatic Brain Injury and Bipolar Disorder. He has given ICF training workshops.

Alexandra Rauch, PT, Health scientist BSc, MPH, participated in the development and validation of several ICF Core Sets, ICF Core Set-based documentation tools and various ICF training materials. Leader of ICF training workshops.

Sean D. Rundell, PT MS, DPT, OCS, has applied the ICF Model and ICF Core Sets to physical therapy in the care of individuals with musculoskeletal health conditions.

Melissa Selb, (Vocational) Rehabilitation Counselor, MSc, is the Coordinator of the ICF Research Branch and has been a member of the organizational team of several ICF Core Set consensus conferences. She has given ICF training workshops.

Gerold Stucki, MD, MS, is Professor and Chair of the Department of Health Sciences and Health Policy at the University of Lucerne, Director of Swiss Paraplegic Research (SPF) and Director of the ICF Research Branch. As Co-Chair of the Functioning and Disability Reference Group (FDRG) of the WHO Family of International Classifications (WHO-FIC) Network and President of the International Society of Physical and Rehabilitation Medicine (ISPRM), he is promoting the implementation of the ICF in medicine, rehabilitation, and the health sector at large. Towards this goal he initiated the ICF Core Set project and has guided their development as a member of the steering committee.

ICF Core Sets

Manual for Clinical Practice

Editors

Jerome Bickenbach

Alarcos Cieza

Alexandra Rauch

Gerold Stucki

ICF Research Branch

in cooperation with the WHO Collaborating Centre for the
Family of International Classifications in Germany (at DIMDI)

HOGREFE 

This document is for personal use only. Reproduction or distribution is not permitted.
From J. Bickenbach, A. Cieza, A. Rauch, & G. Stucki: *ICF Core Sets* (ISBN 9781616764319) © 2012 Hogrefe Publishing.

Library of Congress Cataloging information for the print version of this book is available via the Library of Congress Marc Database

Cataloging data available from Library and Archives Canada

© 2012 by Hogrefe Publishing
<http://www.hogrefe.com>

PUBLISHING OFFICES

USA: Hogrefe Publishing, 875 Massachusetts Avenue, 7th Floor, Cambridge, MA 02139
Phone (866) 823-4726, Fax (617) 354-6875;
E-mail customerservice@hogrefe-publishing.com
EUROPE: Hogrefe Publishing, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950-0, Fax +49 551 99950-425,
E-mail publishing@hogrefe.com

SALES & DISTRIBUTION

USA: Hogrefe Publishing, Customer Services Department,
30 Amberwood Parkway, Ashland, OH 44805
Phone (800) 228-3749, Fax (419) 281-6883,
E-mail customerservice@hogrefe.com
UK : Hogrefe Publishing c/o Marston Book Services Ltd, PO Box 269,
Abingdon, OX14 4YN, UK
Phone +44 1235 465577, Fax +44 1235 465556,
E-mail direct.orders@marston.co.uk
EUROPE: Hogrefe Publishing, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950-0, Fax +49 551 99950-425,
E-mail publishing@hogrefe.com

Copyright Information

The e-book, including all its individual chapters, is protected under international copyright law. The unauthorized use or distribution of copyrighted or proprietary content is illegal and could subject the purchaser to substantial damages. The user agrees to recognize and uphold the copyright.

License Agreement

The purchaser is granted a single, nontransferable license for the personal use of the e-book and all related files.

Making copies or printouts and storing a backup copy of the e-book on another device is permitted for private, personal use only.

Other than as stated in this License Agreement, you may not copy, print, modify, remove, delete, augment, add to, publish, transmit, sell, resell, create derivative works from, or in any way exploit any of the e-book's content, in whole or in part, and you may not aid or permit others to do so. You shall not: (1) rent, assign, timeshare, distribute, or transfer all or part of the e-book or any rights granted by this License Agreement to any other person; (2) duplicate the e-book, except for reasonable backup copies; (3) remove any proprietary or copyright notices, digital watermarks, labels, or other marks from the e-book or its contents; (4) transfer or sublicense title to the e-book to any other party.

These conditions are also applicable to any audio or other files belonging to the e-book.

Format: PDF

ISBN 978-1-61676-431-9

Table of Contents

Table of Contents	v
Preface	vii
<i>Gerold Stucki</i>	
1 What Is Functioning and Why Is It Important	1
<i>Jerome Bickenbach</i>	
2 Introduction to the International Classification of Functioning, Disability and Health	4
<i>Alexandra Rauch, Miriam Lückenkemper and Alarcos Cieza</i>	
2.1. The Integrative Model of Functioning, Disability and Health	5
2.2. The Structure and Codes of the ICF Classification	6
2.3. ICF Qualifiers	9
3 ICF Core Sets	14
<i>Pavel Ptyushkin, Melissa Selb and Alarcos Cieza</i>	
3.1. ICF Core Sets Development Process	15
3.2. Available ICF Core Sets	16
3.3. Types of ICF Core Sets	19
4 Use of ICF Core Sets in Clinical Practice	22
<i>Alexandra Rauch, Miriam Lückenkemper and Alarcos Cieza</i>	
4.1. The Selection of ICF Core Sets (“What to Describe”)	22
4.2. The Description of the Level of Functioning (“How to Describe”)	27
4.3. The Documentation Form	31
5 Use Cases	38
5.1. Use Case 1: Applying the ICF Core Set for Musculoskeletal Conditions in Acute Care	39
<i>Alexandra Rauch</i>	

5.2.	Use Case 2: Applying the Comprehensive ICF Core Set for Spinal Cord Injury in Post-Acute Care	55
	<i>Alexandra Rauch</i>	
5.3.	Use Case 3: Applying the ICF Core Set for Multiple Sclerosis in Long-Term Care	71
	<i>Andrea Glässer and Miriam Lückenkemper</i>	
5.4.	Use Case 4: Applying the ICF Core Set for Vocational Rehabilitation in Long-Term Care	84
	<i>Monika Finger and Miriam Lückenkemper</i>	
5.5.	Use Case 5: Applying the ICF Core Set for Low Back Pain in Long-Term Care	98
	<i>Todd Davenport, Sean Rundell and Reuben Escorpizo</i>	
6	References	117
7	Acknowledgements	125
8	Key Terms	139
9	Contents of Enclosed CD	140

The documentation form to create a functioning profile mentioned in this manual is also available in an open access interactive web-based format www.icf-core-sets.org

Preface

Gerold Stucki

The diagnosis of health conditions and the assessment of an individual's functioning are at the core of clinical practice. For the diagnosis and classification of health conditions, health professionals have relied for more than 100 years on the World Health Organization's (WHO) *International Classification of Diseases* (ICD), whose 11th edition is currently under way. For the assessment and description of functioning, health professionals have been able to turn to the ICD's companion volume, the *International Classification of Functioning, Disability and Health* (ICF) for the past 10 years. The ICD and the ICF are currently used for health statistics so that mortality, morbidity and disability data can be collected in a uniform and internationally comparable fashion. There are a variety of other uses for these classifications, such as programme eligibility and reimbursement. Most importantly, however, the ICF has great potential for enhancing clinical practice by providing a standardized description of functioning by means of ICF-based tools, such as those described here. This information is central for all features of clinical practice: these data structure the clinical assessment of functioning, the assignment to health services and health interventions and the management of services and interventions, including outcome evaluation. In this manual we focus on the description of functioning for which standardization is of crucial importance, both for consistent practice and for comparable health outcomes.

When the ICF was endorsed by the World Health Assembly in 2001, it represented the outcome of a unique international collaborative exercise that produced not only a paradigm shift in our understanding of functioning and disability, but also a complete classificatory tool that, for the first time, made health and disability information comparable around the globe. Yet, by constructing an exhaustive classification, it was clear that the ICF was not directly usable as a practical tool since, in daily practice, clinicians need only a fraction of the categories found in the ICF. Responding to the need for practical ICF-based tools for clinical practice, the ICF Core Set project was begun soon after in 2001.¹⁻²

The ICF Core Sets provide health professionals with invaluable tools tailored for specific health care areas. In this manual, health professionals will find practical guidance on how to apply ICF Core Sets in their clinical practice in order to structure the clinical description and assessment of functioning. Although ICF Core Sets

are intended for all health practitioners, the emphasis in this manual is on the needs of health professionals who apply the ICF Core Sets in the context of rehabilitation. The manual is inherently multi-professional and may be used not only by practitioners working in different settings but also by students in the health professions, their teachers and their mentors.

To facilitate the use of the manual, each chapter can be read on its own. The manual starts with an introduction to the concept of functioning as the lived experience of health. It then provides an introduction to the ICF and the process and scope of the development of the ICF Core Sets. A theoretical chapter outlining the principals that govern the use of the ICF Core Sets in practice is followed by a series of use cases illustrating how to apply the ICF Core Sets in different contexts. To facilitate the use of the ICF Core Sets in clinical practice, the manual also includes a CD containing over 1,400 pages of documentation forms.

The editors and authors of this manual are enthusiastic about the enormous potential that the implementation of the ICF and the ICF Core Sets has to better understand patients' problems and how to best address their needs. We recognize that this manual would not have been possible without the outstanding effort of health professionals around the world and the excellent support provided by the Classification, Terminology and Standards Team at WHO, led by Dr. Bedirhan Üstün and coordinated by Nenad Kostanjsek. We wish to commend everyone who has contributed to this outstanding and valuable practical tool.

The ICF and the ICF Core Sets are still new and their use in clinical practice is still challenging. We would therefore like to encourage users of this manual to become involved in the further development of the ICF and the ICF Core Sets by collaborating with the ICF Research Branch in cooperation with the WHO Collaboration Centre for the Family of International Classifications in Germany (at DIMDI), www.icf-research-branch.org. Let's learn from each other!

1 What Is Functioning and Why Is It Important

Jerome Bickenbach

Everyone knows what health is, although we are all a bit vague about it. A researcher who had spent years defining health gave up saying that “it seems to be impossible to devise a concept of health which is rich enough to be nutritious and yet not so rich as to be indigestible”.³ Although the World Health Organization’s definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” is famous, when it comes to collecting information about people’s health, assessing patients, planning health interventions and describing the outcomes we want, no one actually uses this definition. To be practical about health information, we need a more concrete notion of “health”. We need to focus on what matters about one’s health. Longevity certainly matters, but for most of us, our health is more about what we can do or not do in our lives. Health, in short, is about how we function in our day to day lives. In order to denote this positive and practical aspect of health, WHO used the term “functioning”, which is the foundation for the *International Classification of Functioning, Disability and Health* (ICF).

What does the WHO mean by functioning? Firstly, the WHO notion is both narrower and broader than the ordinary English term “functioning”. It is narrower because it only applies to humans, but far broader because it captures all body functions and body structures and everything that people do (actions, tasks, skills) as well as all the things they are or aspire to be (parents, workers, voters). In the following chapters, the specific details of how the WHO concept of functioning operates in the ICF will be carefully set out, since these details are crucial for

Why should the notion of functioning matter to health professionals? First and foremost, functioning is what matters to the health professionals' patients. Patients are not so much concerned to know medical facts; they want to know if they will be able to walk or see their friends across the street or get a job. All of us think of health as important because of how our health affects everything that we do in our lives. Secondly, there is no better description of outcomes of health interventions than improvements in functioning. Finally, we know that problems in functioning can predict both the objective need for health services and the subjective desire for these services. Administratively, therefore, health-system planning depends on good information about functioning.

In actual clinical and public health, uses of the WHO notion of functioning meet the challenges of descriptive data collection and analysis. At both the individual and the population levels, functioning describes the outcome of the four main public health strategies: prevention, cure, rehabilitation and support. We seek to improve functioning, either as a primary outcome (cure and rehabilitation) or as a related outcome (prevention and support).⁴ Functioning is also valuable for the clinical assessment of individuals. As we shall show in the following chapters, the ICF functioning framework offers a common terminology and conceptual model for the improvement of clinical and patient-oriented assessment instruments. Thus, for example, the international network OMERACT (Outcome Measures in Rheumatology) has adopted the ICF as the reference model to understand what to measure when thinking about the lived experience of rheumatoid arthritis.⁵ The ICF is also the basis for the ICF Core Sets for which this manual provides guidance for use in practice.

2 Introduction to the International Classification of Functioning, Disability and Health

Alexandra Rauch, Miriam Lückenkemper and Alarcos Cieza

In May 2001, the *International Classification of Functioning, Disability and Health* (ICF)⁶ of the WHO was endorsed by the World Health Assembly. The ICF provides a comprehensive and standardized framework and language for the description of *functioning* and *disability*. As introduced in Chapter 1, functioning is the lived experience of health. To better understand functioning, the ICF offers a multidimensional approach based on the interaction of components of the person and the person's environment. As a classification, the ICF systematically classifies and groups components of functioning and environmental factors, each of which is composed of domains (chapters and blocks) and categories. Qualifiers are provided to describe the extent of the problems in functioning, that is, the extent of disability denoted in each domain and category. This chapter provides an introduction to the basic concepts of the ICF.

2.1. The Integrative Model of Functioning, Disability and Health

Functioning is the umbrella term for Body Functions, Body Structures and Activities and Participation. Disability refers to impairments in Body Functions and Body Structures, limitations in Activities and restrictions in Participation (the definitions of all these components are presented in Table 1). Most importantly, although functioning is associated with a health condition (which includes diseases, disorders and injuries), it is not conceptualized as the direct consequence of a health condition but rather the result of the interaction between a health condition and contextual factors (Environmental and Personal Factors). The interaction among these components is dynamic and bidirectional; changes in one component may influence one or more of the other components. This understanding is depicted by the integrative biopsychosocial model of the ICF in Figure 2.

The ICF model, as depicted in Figure 2, illustrates the essential role of Environmental and Personal Factors for a person's level of functioning and disability. Environmental Factors can act as *barriers* (producing or increasing the severity of a disability) or as *facilitators* (improving or even eliminating a disability). For this reason, Environmental Factors must always be taken into account when describing a person's level of functioning.

With this model, the ICF contributes to a better understanding of functioning and disability and so offers a better approach to describing the lived experience of health. This model also serves as the basis for the classification of functioning.

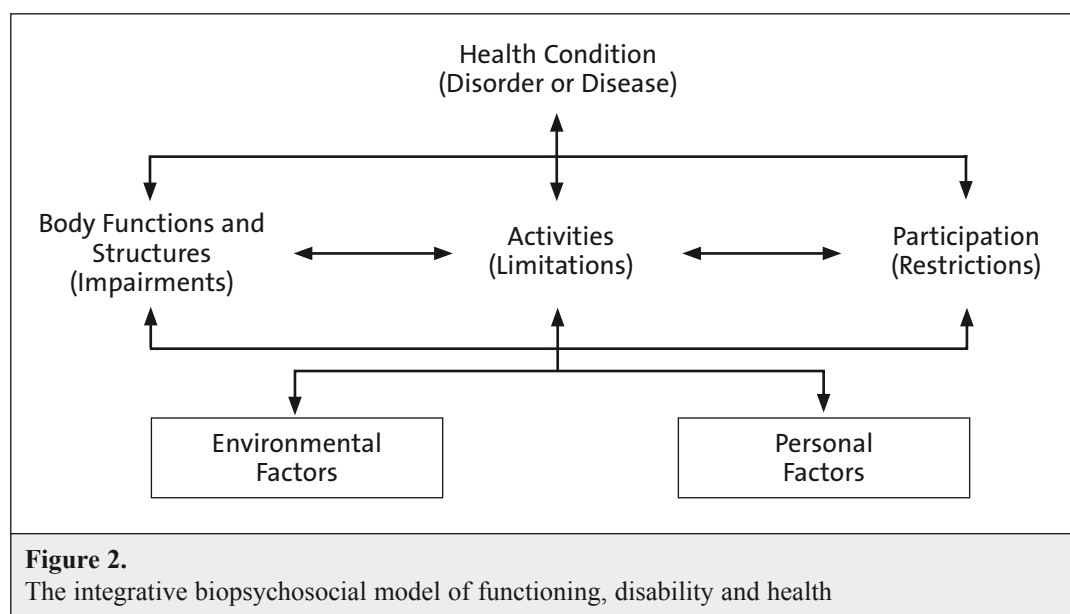


Table 1.

Definitions of the components of the model of functioning and disability

Positive	Negative
Body Functions are the physiological functions of body systems (including psychological functions)	Impairments are problems in body functions or structures such as significant deviation or loss
Body Structures are anatomical parts of the body such as organs, limbs and their components	
Activity is the execution of a task or action by an individual	Activity limitations are difficulties an individual may have in executing activities
Participation is involvement in a life situation	Participation restrictions are problems an individual may experience in involvement in life situations
Facilitators	Barriers
Environmental Factors make up the physical, social and attitudinal environment in which people live and conduct their lives and can act as facilitators or barriers	
Personal Factors are the particular background of an individual's life and living and comprise features of the individual that are not part of a health condition or health state	

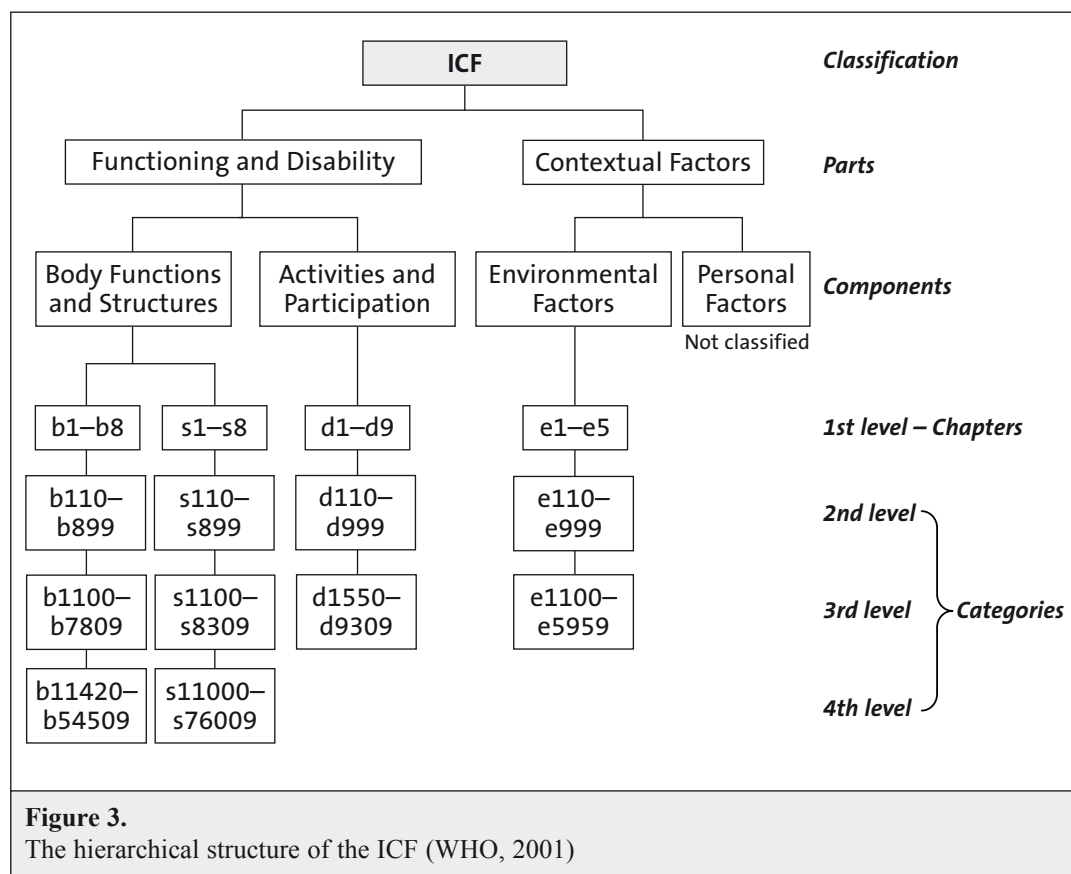
Like all standard classifications in the WHO's *Family of International Classifications* (WHOFIC)⁷, the ICF provides a standard language for the description of functioning by classifying all relevant components of functioning and the environmental factors. Health conditions (disorders or diseases) are a component of the integrative model of functioning, disability and health and can be classified using the *International Classification of Diseases* (ICD).⁸ Since the ICD and the ICF are thus complementary, users are advised to use them together to describe both the health condition and its impact on a person's functioning.

2.2. The Structure and Codes of the ICF Classification

The classification of the ICF is arranged hierarchically (Figure 3). Overall, the classification consists of two parts: (1) "functioning and disability" and (2) "contextual

This document is for personal use only. Reproduction or distribution is not permitted.

From J. Bickenbach, A. Cieza, A. Rauch, & G. Stucki: *ICF Core Sets* (ISBN 9781616764319) © 2012 Hogrefe Publishing.



factors”, each with two *components*: Part 1 consists of “Body Functions and Body Structures” and “Activities and Participation”, and Part 2 consists of “Environmental Factors” and “Personal Factors”. Although Personal Factors are included in the integrative model of functioning, disability and health, they are not as yet classified in the ICF.

In all of the classified components, *chapters* represent the 1st level of the classification. For coding, each chapter is subdivided into the basic elements of the classification, called *categories*, which are organized in hierarchically arranged 2nd, 3rd and 4th levels.

The codes of chapters and categories constitute the common classificatory language that can be applied unequivocally across countries, languages, cultures and professions for data collection and comparison. ICF codes are composed of a prefix (**b** for Body Functions, **s** for Body Structure, **d** for Activity and Participation and **e** for Environmental Factors) followed by a numeric code that consists of one digit for the 1st or chapter level, three digits for the 2nd, four for the 3rd and five for the 4th level, as in the example below.

b2 Sensory functions and pain	1st level chapter
b280 Sensation of pain	2nd level category
b2801 Pain in body part	3rd level category
b28010 Pain in head and neck	} 4th level categories
b28011 Pain in chest	
b28012 Pain in stomach or abdomen	
b28013 Pain in back	
b28014 Pain in upper limb	
b28015 Pain in lower limb	
b28016 Pain in joints	

The hierarchical organization of the classification allows users to choose either a broader description (e.g. by using a 1st level chapter or a 2nd level category) or a more detailed description (e.g. by using a 3rd or 4th level category) of an area of functioning. The level of specificity increases with each lower level as the example above shows. The hierarchical organization allows users to choose the level of specificity required for their needs.

For all categories, except those in Body Structures, definitions and inclusions and exclusions are provided as shown in the following example:

d510 Washing oneself

Washing and drying one's whole body or body parts, using water and appropriate cleaning and drying materials or methods, such as bathing, showering, washing hands and feet, face and hair, and drying with a towel.

Inclusions: washing body parts, the whole body; and drying oneself

Exclusions: caring for body parts (d520); toileting (d530)

The definitions and inclusions provide a detailed description of the meaning of the category and help practitioners use the ICF. The exclusions help to differentiate between related ICF categories.

To provide a convenient structure to the classification, chapters are often subdivided into *blocks* of categories. Blocks organize categories into common themes, as for example the block *Muscle functions* (b730–b749) comprising *b730 Muscle power functions*, *b735 Muscle tone functions*, *b740 Muscle endurance functions* and *b749 Muscle functions, other specified and unspecified*; or the block *Household tasks* (d630–d649) comprising *d630 Preparing meals*, *d640 Doing housework* and *d649 Household tasks, other specified and unspecified*. Blocks are not part of the structure of the classification and usually are not used for coding purposes.

While the categories of functioning classified in the ICF provide health and health-related domains it is essential to use the ICF qualifiers to capture all of the information for describing the extent of problems in functioning or disability. Although Personal Factors are not classified, users may assess and describe them in a manner that is suitable for their use.

2.3. ICF Qualifiers

In all the components of functioning (Body Functions, Body Structures, Activities and Participation), the first qualifier describes the extent of a problem in functioning – more precisely, it denotes the range from full functioning (no problem) to complete disability (complete problem), including the intermediate levels of mild, moderate and severe disability. “No problem” in functioning is used to denote the absence of a problem, understood to include optimal, full or even outstanding functioning. In the Environmental Factors, the first qualifier denotes the amount of positive (facilitator) or negative (barrier) impact of the Environmental Factor on functioning. An Environmental Factor is rated as a barrier because of its negative impact on functioning (e.g. the impact of bad air quality on respiration) or its absence (e.g. the impact of lack of support on performing housework). In some situations, the description of functioning or levels of disability or the impact of the environment is not possible due to a lack of information or the inapplicability of an ICF category. In these situations, the codes **.8** and **.9** are used. For all components, the description of functioning or levels of disability uses the following *generic scale* (Table 2).

To be meaningful, an ICF code requires at least one qualifier. Hence, an ICF code (composed of the letter and numeric code) is completed by at least the first qualifier placed after a dot following the numeric code, e.g. b28016.**3** (severe impairment in pain in joints). In the case of an environmental facilitator, the dot alone denotes a barrier and the plus (+) sign denotes a facilitator, e.g. e310+**4** (complete facilitator in the area of immediate family).

Other qualifiers are available for all components, except Body Functions (Table 3). Body Structures may be qualified with three qualifiers (first qualifier = extent of impairment, second qualifier = nature of impairment, third qualifier = location of impairment). For example, the ICF code **s7501.412** describes a complete impairment (**4**) due to total absence (**1**) of the left (**2**) lower leg (s7501).

For Activities and Participation, two qualifiers are required. The first qualifier records the level of performance of the area of Activities and Participation and the second the person’s capacity. Performance describes what an individual actually does in his or her current environment in light of the positive or negative impact of

Table 2.

Generic scale of the ICF qualifiers

First Qualifiers for Body Functions, Body Structures, and Activities and Participation:		
xxx.0 NO problem	(none, absent, negligible,...)	0–4%
xxx.1 MILD problem	(slight, low,...)	5–24%
xxx.2 MODERATE problem	(medium, fair,...)	25–49%
xxx.3 SEVERE problem	(high, extreme,...)	50–95%
xxx.4 COMPLETE problem	(total,...)	96–100%
xxx.8 not specified (used when there is insufficient information for the description of the extent of the problem)		
xxx.9 not applicable (used when the category is applicable, e.g. in ‘b650 Menstruation functions’ for men)		
Qualifiers for Environmental Factors:		
xxx.0 NO barrier	xxx+0 NO facilitator	
xxx.1 MILD barrier	xxx+1 MILD facilitator	
xxx.2 MODERATE barrier	xxx+2 MODERATE facilitator	
xxx.3 SEVERE barrier	xxx+3 SUBSTANTIAL facilitator	
xxx.4 COMPLETE barrier	xxx+4 COMPLETE facilitator	
xxx.8 barrier, not specified	xxx+8 facilitator, not specified	
xxx.9 not applicable	xxx.9 not applicable	

Environmental Factors (including all aspects of the physical, social and attitudinal world). Capacity, by contrast, describes an individual’s inherent or intrinsic ability to perform a task or an action. To describe a person’s true capacity, the second qualifier describes capacity, the intrinsic ability of the person, without assistive devices, personal assistance or any other Environmental Factor acting as a facilitator or barrier. A neutralized environment, e.g. a test setting, is arguably the best suitable environment to obtain information about capacity. The difference between performance and capacity reflects the impact of Environmental Factors on functioning in the individual’s environment. For example, the ICF code d450.13 describes a person’s capacity to walk as severely limited (3 = severe problem in capacity) but the 1 (= mild problem with performance) indicates that the limitation in capacity is compensated by some Environmental Factor, for example a walking assistive device. More detailed information can be added with two optional qualifiers: a third qualifier to describe capacity with assistance and a fourth qualifier to describe performance without assistance.

Environmental Factors are quantified by only one qualifier. The impact on functioning or levels of disability can be positive when the factor is a facilitator or

Table 3.

Overview of qualifiers for the components of functioning and Environmental Factors

Component	1st Qualifier	2nd Qualifier	3rd Qualifier
Body Functions	Extent of impairment 0 = NO impairment 1 = MILD impairment 2 = MODERATE impairment 3 = SEVERE impairment 4 = COMPLETE impairment 8 = not specified 9 = not applicable	–	–
Body Structures	Extent of impairment 0 = NO impairment 1 = MILD impairment 2 = MODERATE impairment 3 = SEVERE impairment 4 = COMPLETE impairment 8 = not specified 9 = not applicable	Nature of impairment 0 = no change in structure 1 = total absence 2 = partial absence 3 = additional part 4 = aberrant dimension 5 = discontinuity 6 = deviating position 7 = qualitative changes in structure, including accumulation of fluid 8 = not specified 9 = not applicable	Location of impairment 0 = more than one region 1 = right 2 = left 3 = both sides 4 = front 5 = back 6 = proximal 7 = distal 8 = not specified 9 = not applicable
Activities and Participation	Extent of difficulty in performance 0 = NO difficulty 1 = MILD difficulty 2 = MODERATE difficulty 3 = SEVERE difficulty 4 = COMPLETE difficulty 8 = not specified 9 = not applicable	Extent of difficulty in capacity 0 = NO difficulty 1 = MILD difficulty 2 = MODERATE difficulty 3 = SEVERE difficulty 4 = COMPLETE difficulty 8 = not specified 9 = not applicable	

Table 3. Continued

Component	1st Qualifier	2nd Qualifier	3rd Qualifier
Environmental Factors	Extent of the impact of the environment 0 = NO barrier 1 = MILD barrier 2 = MODERATE barrier 3 = SEVERE barrier 4 = COMPLETE barrier 8 = barrier, not specified 9 = not applicable or +0 = NO facilitator +1 = MILD facilitator +2 = MODERATE facilitator +3 = SUBSTANTIAL facilitator +4 = COMPLETE facilitator +8 = facilitator, not specified 9 = not applicable	—	—

negative when it is a barrier. To denote this difference, a facilitator is marked with a plus sign instead of the dot (+X) and a barrier follows the dot (.X), hence e310+2 means moderate facilitator “Immediate family” and e310.2 means moderate barrier “Immediate family”.

Qualifiers complete an ICF code and provide the full description of a person’s functioning or level of disability. If standardized instruments or other sources of information are used to assess the level of functioning in a category, the results of the measure can be “translated” into a qualifier. Thus, using qualifiers facilitates a common understanding of the description of a person’s level of functioning. Furthermore, the use of qualifiers makes it possible to develop functioning profiles as illustrated by the use cases in Chapter 5.

The ICF is an international classification standard and scientific tool for the description of functioning and disability. The application of the ICF contributes to the standardization of data and facilitates data collection and comparison. Since the ICF is a complete and exhaustive classification, however, it may be impracti-