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EDITORIAL

## Applying the ICF for the acute hospital and early post-acute rehabilitation facilities

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There are many reasons for an acute hospitalization which may range from acute illnesses to injuries. These conditions need complex diagnostic and medical procedures and planned surgical interventions. Common to all hospitalized patients are a number of risks including complications of diagnostic procedures and interventions, such as thrombosis, ulcer and hospital infections to name just a few. Consequently, patients are at risk to experience a significant loss of functioning. Many patients indeed experience a significant loss of functioning and some experience an incomplete recovery. Patient groups such as the elderly, people with a chronic condition and people with disability may even have increased risk of loss of functioning.

Early identification of risks and decrements in functioning should guide early rehabilitation interventions which should complement medical and surgical care [1]. The goals of rehabilitation interventions are to maintain functioning or minimize the loss of functioning, to facilitate recovery and to promote early independence. The ultimate goal of early rehabilitation interventions is to prevent disability becoming permanent.

Early identification and rehabilitation interventions rely on the recognition of patients' needs for rehabilitation care by the staff in the acute hospital. Therefore, physicians, nurses and other health professionals on medical and surgical wards in the acute hospital who are generally not specialized in rehabilitation care provision should be able to briefly assess patients' functioning and to prescribe and initiate appropriate rehabilitation care. In early post-acute rehabilitation facilities [1], physicians, nurses and other health professionals specialized in rehabilitation care provision should be able to comprehensively assess patients' functioning, assign

patients to appropriate rehabilitation programs and interventions, and to manage and evaluate these programs and interventions [2]. Professionals in the acute hospital and in early post-acute rehabilitation facilities should then be able to communicate about patients' functioning and needs within their team or service and when referring patients to other services or facilities. Therefore, all professionals need to share a common understanding of functioning and should be able to communicate about functioning using a language which is shared by physicians, nurses, health professionals and patients alike [2].

The International Classification of Functioning, Disability and Health or ICF approved by the World Health Assembly in May 2001, provides us with a common understanding of functioning. As a classification it can serve as a globally accepted language to communicate about functioning [2–4] at body, person and society levels. With the ICF, functioning becomes a central perspective in medicine with its components body functions and structures, activities and participation. Patients' functioning is now seen as associated with, and not merely as a consequence of a health condition. Also, functioning and health are seen not only in association with an underlying health condition but also in association with personal and environmental factors. Different from the approach of quality of life which has its focus on patient subjective well-being, all aspects of the patient experience including body functions and structures, personal and environmental factors are covered. This bio-psycho-social view is not new to a number of fields in medicine, e.g., rehabilitation and prevention. What is new is that we now have a globally agreed upon etiologically neutral framework and classification for use at both the individual and population levels.

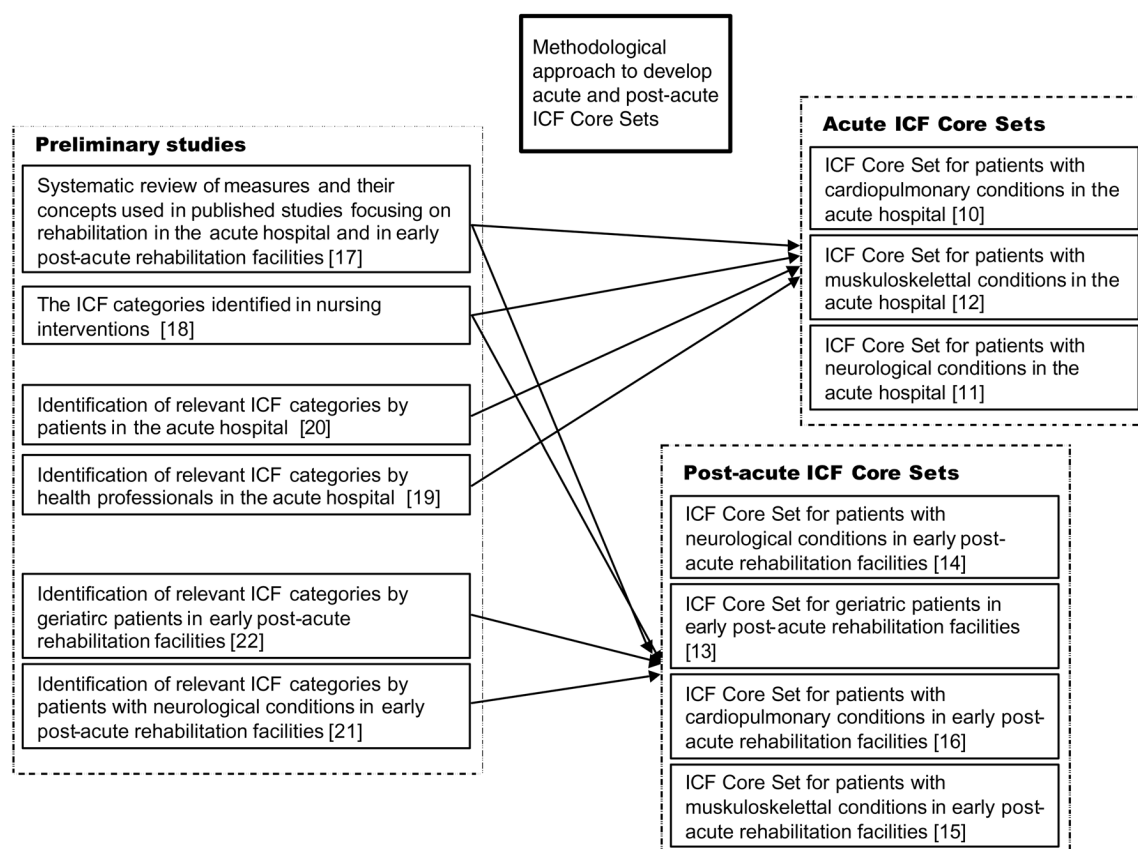


Figure 1.

All member states of WHO are now asked to implement the ICF in the health sector in addition to a number of sectors including education, insurance, labor and legislation. To implement the ICF into medicine and other fields, practical tools need to be developed [2,3]. Considering the length of the classification with around 1500 categories, the main challenge is its use in daily practice. Other challenges include the further operationalization and quantification of the ICF categories and qualifiers and the linkage of the contents of existing measures including clinical tests and health status measures to the ICF categories [5].

Most importantly, ICF-based tools need to be tailored to the need of the users without forgoing the information needed for health statistics and health reporting. To address the issue of feasibility regarding the number of categories to be assessed and the user perspective in medicine which typically takes a condition and or provider perspective, the ICF Core Set project was initiated in 2001.

The ICF Core Set project is a joint project of the ICF Research Branch of the WHO Collaboration Center of the Family of International Classifications (DIMDI) at the Ludwig-Maximilians-University in Munich, Germany, together with the Classification, Assessment and Surveys (CAS) Team at WHO,

partner organizations and associated institutions and individuals.

The goal of the ICF Core Set project is to select sets of categories out of the whole classification which can serve as minimal standards for the assessment and reporting of functioning and health for clinical studies, clinical encounters and multi-professional comprehensive assessment. In a first project, ICF Core Sets have been developed for 12 most burdensome chronic conditions [6–8].

This special issue of *Disability and Rehabilitation* reports on the development of ICF Core Sets for patients in the acute hospital and early post-acute rehabilitation facilities [1,9]. The ICF Core Sets for the acute hospital or Acute ICF Core Sets are intended for use by physicians, nurses, therapists and other health professionals not specialized in rehabilitation care provision. The ICF Core Sets for early post-acute rehabilitation facilities or Post-acute ICF Core Sets are intended for use by physicians, nurses, therapists and other health professionals specialized in rehabilitation care provision.

The first paper in this special issue reviews the rationale and outlines the principles of rehabilitation in the context of an acute injury or illness [1]. The second paper describes the methods used to develop the Acute and Post-acute ICF Core Sets. They

include a formal decision-making and consensus process integrating evidence gathered from preliminary studies and expert opinion [9]. The next seven papers present the results of the consensus process for the three Acute ICF Core Sets [10–12] and the four Post-acute ICF Core Sets [13–16]. These reports are followed by the systematic review of the literature [17] and a study on nursing interventions [18]. Those were preliminary studies relevant to development of all Acute and Post-acute ICF Core Sets. A study on experts' opinion [19] and a cross-sectional study to identify the patients' perspective [20] provided information for the consensus process relevant to the three Acute ICF Core Sets. Two cross-sectional studies to identify the patients' perspective in early post-acute rehabilitation facilities in neurological [21] and geriatric [22] patients provided additional information for the development of the Post-acute ICF Core Sets. Figure 1 shows how this set of publications maps the development process.

The ICF Core Sets presented in this special issue are first versions. They are currently being extensively tested and validated in field studies in Austria, Germany and Switzerland. They will then be tested and validated in different WHO regions. In addition to the empiric data collection in the context of the preliminary studies [20–22] that reflected the patient perspective, the Acute and Post-acute ICF Core Sets will also undergo a close examination and possibly modification by patient and proxy focus groups. The testing and validation studies will be coordinated by the ICF Research Branch in Munich under the auspices of the CAS Team at WHO and in close collaboration with partner organizations.

Comparability of functioning across conditions and settings will be possible with the concurrent definition of generic Acute and Post-acute ICF Core Sets which will be developed and based on the commonalities of the ICF Core Sets presented in this supplement.

We aim that the ICF and the Acute and Post-acute ICF Core Sets will become the standard for describing patients' functioning both in rehabilitation care provision and research. The ICF Core Sets will stimulate research for a better understanding of functioning, disability and health in patients experiencing an acute illness or injury. The practical implementation of the ICF through practical tools such as the ICF Core Sets for the acute hospital and early post-acute rehabilitation facilities will contribute to an increased recognition of patients' rehabilitation needs, an improved rehabilitation care provision and ultimately the prevention of disability in patients suffering from an acute illness or injury requiring hospitalization.

Finally, we would like to congratulate and thank the teams at WHO and at the ICF Research Branch

of the WHO FIC CC (DIMDI) in Munich, the partner organizations and all involved clinicians and scientists for their participation in the development of the ICF Core Sets, a public domain project.

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