

## North American Collaborating Center

### ICF Newsletter

Number 2, 2012

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Click on the hypertext links below to view the ICF topics of interest to you.

- 1) [\*\*\*Psychological Aspects of Functioning, Disability and Health \(2011\): New Book Describes Using ICF with ICD and DSM\*\*\*](#)

ICF pioneer Dr. David Peterson has contributed a useful ICF-oriented textbook designed for Rehabilitation Counselors.

- 2) [\*\*\*Proceedings: "What Is Disability? U.N. Convention on the Rights of Persons with Disabilities, Eligibility Criteria, and the ICF"\*\*\*](#)

The Open Access journal *BMC Public Health* has published a supplement featuring articles on ICF and the U.N. Convention.

- 3) [\*\*\*American Physical Therapy Association Website Provides Impressive and Useful ICF Training Resources\*\*\*](#)

Our colleagues in the APTA Clinical Practice Department have greatly expanded their popular website with ICF training content.

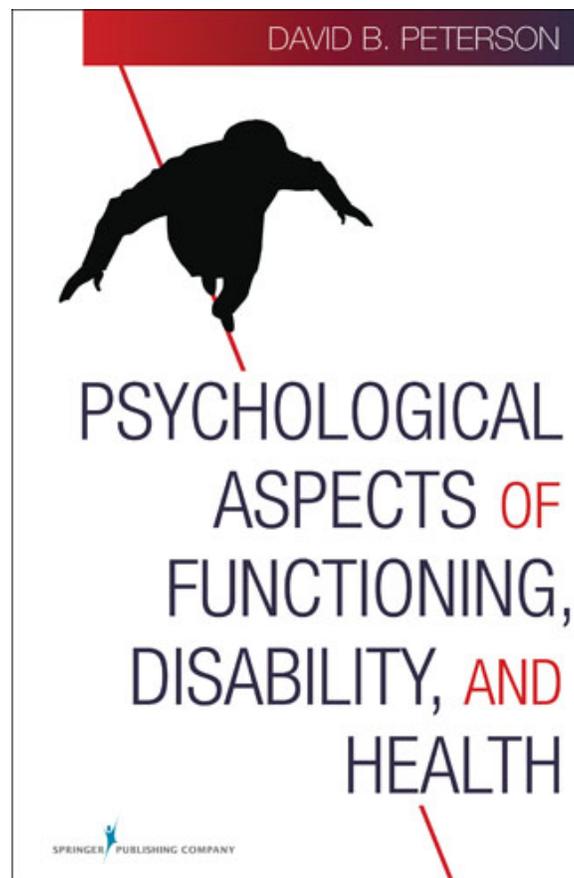
- 4) [\*\*\*Coder's Corner\*\*\*](#)

*Coder's Corner* is our educational feature to help build and enhance your skills as an ICF Coder. In this edition, we feature ICF Environmental Factors in accessible medical offices.

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1) **Psychological Aspects of Functioning, Disability and Health (2011): New Book Describes Using ICF with ICD and DSM**

**ICF pioneer Dr. David Peterson has contributed a useful ICF-oriented textbook designed for Rehabilitation Counselors.**



Readers of this ICF Newsletter will want to take note of an important new textbook authored by ICF pioneer David B. Peterson, Ph.D., from the Charter College of Education, Department of Special Education and Counseling, California State University at Los Angeles.

Professor Peterson's book is entitled *Psychological Aspects of Functioning, Disability and Health*, published by Springer in 2011.

[From the publisher's web page](#), we find this description of the book:

"This textbook focuses on psychopathology as classified in the *DSM-IV-TR*, and discusses how it can be integrated into the *ICF* to assist mental health professionals while diagnosing and treating people with mental disorders. A perfect reference for students, the book serves as a natural bridge between the *DSM-IV-TR* and the *ICF*.

Students will learn the utility of using the *ICF's* biopsychosocial approach for conceptualizing mental health functioning (body functions and structures), disability (activity limitations and participation restrictions), and contextual factors (environmental and personal factors). The *ICF's* collaborative approach presents students with a conceptual framework that guides the selection of appropriate interventions and informs the evaluation of treatment efficacy.

Key Features:

- Develops knowledge and understanding of mental health functioning and disability based on the *ICF* and related diagnoses within the *DSM-IV-TR*;
- Applies the *ICF* conceptual framework to planning mental health assessment and related interventions, and evaluating treatment outcomes; and
- Integrates diagnostic information from the *DSM-IV-TR* with the *ICF's* classification of functioning, disability, and health."

The Table of Contents reveals the breadth of topics covered:

"Part One: The International Classification of Functioning, Disability, and Health (ICF)

I. Introduction: The Development of the ICF

- II. Conceptualizing and Classifying Psychological Functioning: What is Healthy Psychological Functioning?
- III. Conceptualizing Psychological Impairment: Activity Limitations and Participation Restrictions
- IV. Environmental Barriers and Facilitators
- V. Collaborative Assessment: Ethical Tenets of the *ICF*
- VI. Targeting Interventions, Evaluating Treatment Efficacy

Part Two: Cross Walking the *ICF* to the *DSM-IV-TR*

- I. The Multiaxial Diagnostic System of the *DSM-IV-TR* and the Conceptual Framework of the *ICF*
- II. First Priority of Differential Diagnoses
- III. Disorders With Shared Phenomenological Features”

Readers can easily discern, this is an important textbook in the overall implementation of ICF.

Although Professor Peterson and other authors have contributed many publications in the last decade applying the ICF to Rehabilitation Counseling, this represents the first textbook explicitly to join interpretation of the ICF with that of DSM-IV-TR in clinical cases.

In fact, Professor Peterson’s book reads as though it were a helpful crosswalk between the Classification and the DSM, which is innovative.

The new book has been positively reviewed within the Rehabilitation Counseling profession already. [In the journal \*Rehabilitation Counseling Bulletin\*](#), Professor Jan Curtis Case provided affirmative remarks about Professor Peterson’s book, including the following:

“As rehabilitation practitioners continue to faithfully and effectively serve as partners with other professionals, concerns for best practice would strongly urge a common language of functioning, disability and health across professions. The ICF, working in tandem with the DSM-IV-TR, can assist with a more

complete conceptualization of mental health and functioning, the treatment of mental disorders, the evaluation of treatment outcomes, and the promotion of mental health. Combining DSM-IV-TR diagnostic information with the ICF conceptual framework and coding system would seem to give rehabilitation practitioners significant impetus in such aspirations and, thereby, affirm the old adage, ‘Two heads *are* better than one.’” (2012, pg. 127).

Citation: Case JC. Psychological aspects of functioning, disability and health. Book review. *Rehabilitation Counseling Bulletin* 2012 (January); 55:126-127.  
doi:10.1177/0034355211423302

You can read a description of Professor Peterson’s research interests, including his work with the ICF, on this faculty web page:

<http://www.calstatela.edu/faculty/dpeters3/>

You can also read a description of his new book, *Psychological Aspects of Functioning, Disability and Health*, at this web page provided by the publisher:

<http://www.springerpub.com/product/9780826123442>

2) **Proceedings: “What Is Disability? U.N. Convention on the Rights of Persons with Disabilities, Eligibility Criteria, and the ICF”**

**The Open Access journal *BMC Public Health* has published a supplement featuring articles on ICF and the U.N. Convention.**

Readers of this ICF Newsletter will want to take advantage of a set of open access journal articles published in 2011 in the online journal *BMC Public Health*, stemming from an important international conference conducted in Italy during 2010. The subject is the intersection between the ICF and the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

The title of the conference was “What Is Disability? U.N. Convention on the Rights of Persons with Disabilities, Eligibility Criteria, and the International Classification of Functioning, Disability and Health.” It was conducted in Rome on April 19-20, 2010, and the Proceedings were published online in a Supplement in *BMC Public Health* in May, 2011.

The editors were Drs. Carlo Francescutti, Andrea Simoncello, and Luigi Tesio, who also served as article authors. The conference was supported by a generous grant from the Ministry of Labor and Social Policies in the government of the Friuli-Venezia Giulia Region in Italy.

From their Foreword, we learn about the purposes of the conference:

“The Italian Ministry of Health and the Ministry of Labour and Social Policies have supported a three-year research project titled ‘Development of disability evaluation protocols based on the biopsychosocial model of the International Classification of Functioning, Disability and Health – ICF.’

The Project has been led by the Italian WHO Collaborating Centre for the Family of International Classifications - Friuli Venezia Giulia Regional Health Directorate, [with regional collaborators]. . . . The research focus was on defining criteria, methodological principles, instruments and data analysis perspectives oriented to the following main objectives:

- a. To introduce into the Italian legislation the concept of disability as defined by the UN Convention for the Rights of Persons with Disability;
- b. To develop a common technical framework for the evaluation of disability, thus overcoming the current fragmentation in the Italian welfare system;
- c. To test the capability of ICF to serve as a reference descriptive language supporting such disability evaluation framework, as well as providing a frame for the electronic socio-health record of people with disability.

As an integral and crucial part of the discussion of the results achieved, an International seminar was organized in Rome on 19-20 April 2010, aimed to compare different perspectives on the topics and problems addressed by the project.

This volume contains the main papers presented at the workshop and provides an interesting overview of the processes of implementation of ICF in different areas and different social and cultural contexts. We believe that the work presented here can give a contribution to the international debate and suggest innovative insights and research perspectives.” (2011, pg. S1)

The roster of articles, along with their hypertext links to their locations in the Open Access journal, are as follows:

[\*\*UN convention on the rights of persons with disability, eligibility criteria and the International Classification of Functioning Disability and Health\*\*](#)

Carlo Francescutti

*BMC Public Health* 2011, **11**(Suppl 4):S1 (31 May 2011)

[\*\*From codes to language: is the ICF a classification system or a dictionary?\*\*](#)

Luigi Tesio

*BMC Public Health* 2011, **11**(Suppl 4):S2 (31 May 2011)

**Use of The International Classification of Functioning, Disability and Health (ICF) as a conceptual framework and common language for disability statistics and health information systems**

Nenad Kostanjsek

*BMC Public Health* 2011, **11**(Suppl 4):S3 (31 May 2011)

**Measuring disability and monitoring the UN Convention on the Rights of Persons with Disabilities: the work of the Washington Group on Disability Statistics**

Jennifer H. Madans, Mitchell E. Loeb, Barbara M. Altman

*BMC Public Health* 2011, **11**(Suppl 4):S4 (31 May 2011)

**Using the ICF in Ireland**

Anne Good

*BMC Public Health* 2011, **11**(Suppl 4):S5 (31 May 2011)

**Eligibility, the ICF and the UN Convention: Australian perspectives**

Ros Madden, Nick Glozier, Elias Mpofo, Gwynnyth Llewellyn

*BMC Public Health* 2011, **11**(Suppl 4):S6 (31 May 2011)

**Development of an ICF-based eligibility procedure for education in Switzerland**

Judith Hollenweger

*BMC Public Health* 2011, **11**(Suppl 4):S7 (31 May 2011)

**Monitoring the United Nation's Convention on the Rights of Persons with Disabilities: data and the International Classification of Functioning, Disability and Health**

Jerome E. Bickenbach

*BMC Public Health* 2011, **11**(Suppl 4):S8 (31 May 2011)

**The WHO construct of health-related functioning (HrF) and its implications for health policy**

Luis Salvador-Carulla, Carlos Garcia-Gutierrez  
*BMC Public Health* 2011, **11**(Suppl 4):S9 (31 May 2011)

**"Evaluating the model of classification and valuation of disabilities used in Brazil and defining the elaboration and adoption of a unique model for all the country": Brazilian Interministerial Workgroup Task**

Heloisa Di Nubila, Ana Rita de Paula, Miguel Abud Marcelino, Izabel Maior  
*BMC Public Health* 2011, **11**(Suppl 4):S10 (31 May 2011)

**Description of the person-environment interaction: methodological issues and empirical results of an Italian large-scale disability assessment study using an ICF-based protocol**

Carlo Francescutti, Francesco Gongolo, Andrea Simoncello, Lucilla Frattura  
*BMC Public Health* 2011, **11**(Suppl 4):S11 (31 May 2011)

You can read the entire Supplement at the following Open Access website for *BMC Public Health*:

<http://www.biomedcentral.com/bmcpublichealth/supplements/11/S4>

Congratulations to this group of outstanding international authors for conducting the conference and contributing these valuable Proceedings about the ICF.

3) **American Physical Therapy Association Website Provides Impressive and Useful ICF Training Resources**

**Our colleagues in the APTA Clinical Practice Department have greatly expanded their popular website with ICF training content.**

We encourage Readers of this ICF Newsletter to take another look at the recently updated “ICF” web pages hosted by our colleagues at the American Physical Therapy Association (APTA).

The APTA, along with its international counterpart organization the World Confederation of Physical Therapy, have made great strides in their organizational advocacy for implementing both the ICF conceptual framework and ICF coding in the daily practice of Physical Therapy. We commend their efforts and also thank these organization for their scientific and clinical advocacy on behalf of the ICF.

Within APTA, we specifically want to commend our colleagues Justin Moore, P.T., Vice President for Public Policy, Practice and Professional Affairs, and Anita Bemis-Dougherty, P.T., D.P.T., M.A.S., Associate Director of Practice, for their ongoing contributions to expanding knowledge about the ICF within the Physical Therapist community.

The APTA “ICF” page has always had a wealth of information, with specific attention to the [2008 endorsement](#) by the APTA of the ICF conceptual framework for Physical Therapist practice. Moreover, since publication of the ICF, the APTA has been a charter member of the consortium of associations of clinical professionals spearheaded by the American Psychological Association that is developing a “Clinical Manual” for application of the ICF in many allied health professions.

Recently our APTA colleagues added a link to the World Health Organization’s own video description of the ICD-11 revision activities, particularly in relation to ICF and functional status classification within the next generation of the diagnostic classification. That video is from the 2010 WHO “iCamp” event, during which clinician experts from around the world have convened in person and on the Internet to work toward incorporating functional status topics in ICD-11.

That [WHO video](#) from the “iCamp” is itself posted on “YouTube,” hence, the APTA has added a link for its members to the WHO video on YouTube, so that there is transparency about current considerations regarding the ICF in these revision activities. Physical Therapist Catherine Sykes, representing the World Confederation on Physical Therapy, appears in that video to provide a direct relationship between ICD-11 activities and the ICF in daily practice among Physical Therapists.

The APTA ICF web page also directs visitors to review some documents on the “Going Beyond Diagnosis” training initiative spearheaded by the company known as PalmettoGBA, with direct relevance to Physical Therapists’ daily practice.

Finally, the APTA has also expanded its offering of short courses related to the ICF, specifically offered during its annual “Combined Sections Meeting” (CSM) during mid-winter. After their live presentation, the APTA has been able to post either short course documents or video presentations from the continuing education courses offered at the CSM.

For example, the [CSM in February, 2010](#) featured a short course entitled “Application of ICF for Severely Involved Students: Implications for School-Based Therapy.” Then, the [CSM in February, 2012](#) featured a two-part short course entitled “The ICF and Physical Therapy 10 Years Later,” featuring prominent Physical Therapists and other clinicians and scientists describing the first decade’s experience with the classification. If you are a member of APTA, your member privileges will enable you to take advantage of these CSM short courses on the APTA website, and even if you are not a member, you have access to a wide variety of training resources available to anyone.

We encourage all Readers of this ICF Newsletter to visit the APTA’s ICF Training Resources page, at this address:

<http://www.apta.org/ICF/>

4) **Coder's Corner**

**Coder's Corner is our educational feature to help build and enhance your skills as an ICF Coder. In this edition, we feature ICF Environmental Factors in accessible medical offices.**

Welcome back to "Coder's Corner," [a continuing feature in our NACC ICF Newsletter](#) designed to encourage all our Readers to become proficient in ICF coding. Coder's Corner is where we present illustrations appended with ICF coding, to demonstrate the four domains in ICF, and the basic principles of the ICF coding structure. Our goal is to enable each Reader to build and enhance his or her skills as a full-fledged ICF Coder.

Coder's Corner features color photographs, line drawings, or generic clip art representing people with disabilities engaged in everyday activities. Learning about ICF codes and coding rules can be easier when illustrations accompany the actual codes, in addition to text.

An important characteristic of Coder's Corner is the respectfulness with which we approach any given coding example. Even in the abstract, we acknowledge that our coding examples refer to or portray real people who have serious impairments or genuine participation restrictions. We want to see the person first, not the disability.

Our goal is not to accentuate impairments, but to demonstrate that the ICF provides standardization to the description of such cases, by adhering to the ICF coding guidelines. Therefore we approach each example in a non-stigmatizing, humanistic, very respectful manner, and we encourage our Readers to do the same.

In each coding example we present a brief description of the image, one or more representative ICF codes that describe the case in the image, a justification for our selecting those ICF codes, and a short discussion.

Some of our coding examples are simple, others are complicated. Some don't even involve people *per se*, for example in an illustration describing an environmental barrier or facilitator. Some examples utilize

ICF qualifiers, while others are simply expressed at the code-stem level. We acknowledge that some ICF code stems are difficult to apply in practice, too, and we discuss those as well, toward our goal of explaining those codes in a manner that makes them useful to all ICF coders.

[Medical Care for Persons with Mobility-Related Disabilities: ICF Coding for Selected Features of Accessible Medical Offices](#)

Click on any hypertext link below to view specific images in this set of 5 Department of Justice (DoJ) images, or scroll down to review the full set.

- 1st) [An Examination Table That Elevates To Assist Transferring](#)
- 2nd) [Allowing Sufficient Accessible Space To Assist Transferring](#)
- 3rd) [Features of an Accessible Examination Room](#)
- 4th) [Accessible Weight Scales](#)
- 5th) [Accessible Mammography Equipment](#)

For the 5 image examples in this edition of Coder's Corner, we thank our colleagues at the United States Department of Justice, Civil Rights Division, Disability Rights Section, for their publication entitled [Access to Medical Care for Individuals with Mobility Disabilities](#) (2010).

This free 15-page publication had been prepared in collaboration with the U.S. Department of Health and Human Services, Office for Civil Rights, to provide visual and text guidance for physicians and personnel in medical offices about their approaches toward patients with mobility impairments.

Specifically, this technical assistance document had been based on interpretation and potential enforcement of a set of federal statutes in the U.S., including the Americans with Disabilities Act (ADA, 1990, amended 2008), and Section 504 of the Rehabilitation Act of 1973. Hence, this publication gives Technical Assistance and clear instructions to medical

personnel about their roles in providing care for persons with disabilities, particularly mobility impairments, in the context of a specific set of laws, regulations and standards governing that care.

It is a very helpful, interesting publication. It also provides us with many outstanding opportunities to demonstrate ICF coding!

Specifically, the images from this DoJ-DHHS publication enable us to illustrate some ICF codes from the Environmental Factors domain that usually cannot be easily demonstrated. These are the ICF Environmental Factors codes referring to “Services, Systems, and Policies,” and to the “Design, construction, and building products and technology(ies)” that are often considered facilitative when they exist in a person’s environment.

In medical offices, many characteristics of the physical or built environment can affect the delivery and quality of medical care for a wide variety of patients. This is especially true among patients with disabilities, for whom the degree of *accessibility* in turn can affect their *access* to care.

In the U.S. and around the world, many disability advocacy organizations, clinicians, and policy makers are engaged in extensive study about the services, systems and policies that affect health care for persons with disabilities at the actual point of delivering that care --- in clinicians’ offices. It is an important topic within health services research.

Moreover, in the U.S., accessibility can be affected by the degree of compliance with a set of civil rights-oriented laws exhibited in a medical practice or office setting. These civil rights laws, generally under the umbrella of the ADA and Section 504, affect only the United States. A body of federal regulations that implement these laws, and a set of court decisions and legal settlements that serve as precedents, also govern accessibility in medical facilities in the U.S.

Additionally, the regulations that implement the ADA are supported by standards and building codes found in the Americans with Disabilities Act Accessibility Guidelines (the “ADAAG”), with some direct relevance to the design and construction of and within medical offices. These regulations have the force of law. This means that even the type of hardware installed

on doors and the width of corridors in a medical office, among other accessibility features, are governed under the ADA through the ADAAG.

Similar laws in the context of disability rights exist in other countries. Therefore, issues about accessibility in medical offices probably arise in every country, but the laws and regulations described in this edition of Coder's Corner pertain only to compliance with the ADA in the U.S.

From the ICF vantage point, increasing the degree of accessibility in a medical office represents either environmental facilitation or the reduction of environmental barriers. Presumptively, having laws or regulations in place, and requiring compliance in order to enhance overall accessibility of medical offices, would be a good thing. In ICF terms, not having such laws or regulations in place might represent environmental barriers for some persons with disabilities. Having the laws in place, and routinely requiring or enforcing compliance, benefits everyone. That situation constitutes a set of ICF environmental facilitators for many persons with disabilities.

Remember, the Americans with Disabilities Act and the ICF are *not* related. The ADA is a law in only one country, the United States. The ICF is an international classification designed for use around the world. Enactment of the ADA in 1990 preceded the publication of the ICF in 2001. But at their roots, both the ADA and the ICF explicitly recognize the importance of environments among people with disabilities.

For our purposes here, we've taken the images slightly out of their original context, simply to illustrate ICF coding as we do in every edition of Coder's Corner. We encourage readers to find the actual DoJ-DHHS publication on the ADA website, not only to see these selected images in their original context, but also to read this helpful document, toward understanding that compliance with the ADA, and similar statutes around the world, can affect the degree of environmental facilitation experienced by persons with disabilities in medical offices.

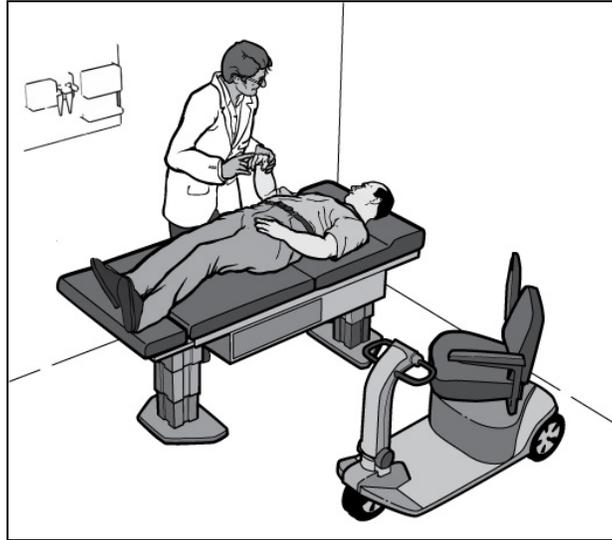
In this edition of Coder's Corner, these images selected from the DoJ-DHHS publication give us some great ICF coding opportunities. We can learn a lot about ICF coding from these accessibility concepts.

Our goal in selecting these drawings, though, is not to describe the legal requirements for accessibility in medical offices. Instead, our goal is to illustrate ICF coding. We will cite the existence of specific parts of the ADA or ADAAG as ICF-oriented “services, systems and policies” that produce greater environmental facilitation. But these images are teaching devices that help us explain ICF coding, rather than explaining the Department of Justice’s Technical Assistance or enforcement of the ADA.

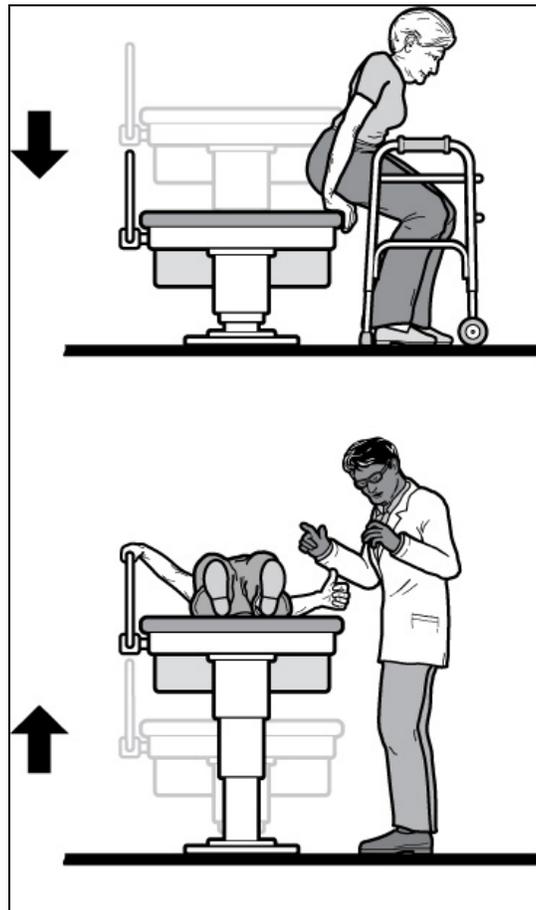
You can find the 15-page .PDF version of the DoJ-DHHS publication at this ADA Technical Assistance website:

[http://www.ada.gov/medicare\\_mobility\\_ta/medcare\\_ta.htm](http://www.ada.gov/medicare_mobility_ta/medcare_ta.htm)

(1A)



(1B)





## Description of the Images

Images (1A) and (1B) show artists' renderings of two patients and two clinicians engaged in utilizing examination tables that can elevate and descend horizontally, with the flip of an electric switch.

This kind of examination table is designed to descend to the level of a conventional wheelchair seat, about 17-19 inches [432 – 482 mm] above the surface of a floor, to enable a seated patient to transfer easily to the examination table at about the same level as their wheelchair. This kind of horizontally-elevating examination table is useful for patients who use other mobility assistive devices, too, including a conventional walker, as shown in Image (1B). Patients of all ages and with many clinical situations can benefit from this type of examination table. Such tables can elevate to a height that is comfortable for the clinician, too, in examining the patient, making this table an invaluable component of an accessible medical office.

Currently there are no ADAAG standards about examination tables in medical offices in the U.S. However, a component of the Patient Protection and Affordable Care Act of 2010 called for the Architectural and Transportation Barriers Compliance Board (also known as the U.S. Access Board) to prepare new regulations pertaining to accessible medical diagnostic equipment. [The Access Board is expected to deliver these standards in 2012.](#) The new standards will probably affect “examination tables and chairs, weight scales, x-ray machines and other radiological equipment, and mammography equipment.” Hence, we can safely predict that horizontally-elevating examination tables and chairs will become more common in the near future, for everyone’s benefit.

These elevating examination tables, and the policies in place that support their broad diffusion among medical offices throughout the U.S. and elsewhere, represent and can be coded as ICF Environmental Factors.

## Justifications for Selecting the ICF Codes

We selected a familiar code from the Activities & Participation domain, **d465**, Moving around using equipment, in both Images (1A) and (1B), but readers will notice that the same ICF code refers to moving

around using different types of equipment, namely a scooter in Image (1A) and a walker in Image (1B). This is perfectly fine from the ICF Coder's viewpoint. [In a previous edition of Coder's Corner](#), we addressed the advantages and disadvantages of using Activities & Participation code **d465**, particularly when also using qualifiers. Here, suffice it to say that **d465** is useful even without qualifier digits, to describe situations in which several different types of assistive mobility devices are used. And frankly, **d465** is among the least interesting ICF codes in Images (1A) and (1B).

Instead, among the more interesting codes would be our first iteration of several in this edition of Coder's Corner of Environmental Factors code **e1501**, representing one in a series of codes about "Design, construction, and building products and technology" in buildings or indoor settings. Here, **e1501** refers to what ICF calls "gaining access to facilities inside buildings," at which point ICF also distinguishes buildings for public use (**e150**) from buildings for private use (**e155**). "Gaining access" is different from "entering and exiting" (**e1500** and **e1550**), and "way finding, path routing, and designation of locations in buildings" (**e1502** and **e1552**).

We also introduce Environmental Factors code **e5801**, for Health systems, in the "Services, Systems and Policies" series. Here, the text in the Descriptive Note for **e5801** is very helpful and shows direct relevance: assigning **e5801** would involve "assistive technology or other adapted equipment, and legislation such as health acts that govern features of a health system such as accessibility."

## Discussion

For many patients with mobility impairments, not having access within their clinicians' offices to an elevating examination table might constitute an environmental barrier. At least, not having such a table available might make transferring from a seated or standing position to the examination table much less comfortable.

Remember, in ICF terms, the lack of facilitation can be considered an environmental barrier. ICF Annex 2 stipulates that "(A)n environmental factor can be a barrier either because of its presence (for example,

negative attitudes towards people with disabilities) *or its absence* (for example, the unavailability of a needed service)” (2001, pg. 233, italics added here). A facilitator reduces or mitigates the effects of a barrier.

Luckily, the Technical Assistance from the DoJ-DHHS publication depicts medical office situations involving this kind of elevating examination tables, which in ICF terms are definitely facilitative.

The “Design, construction, and building products and technology” series of Environmental Factors codes is very useful. These are the ICF coder’s friends for describing a wide variety of environmental barriers and facilitators. The main distinction in this series of codes is between buildings for public use versus buildings for private use. Pertinently, ICF also distinguishes the “Design, construction, and building products and technology” series from the “General products and technology / Assistive products and technology” series, which are immediately adjacent in the coding hierarchy. This means that ICF distinguishes between *products* and *design and construction*, which turns out to be extremely useful for the ICF coder. It means the ICF coder can describe and “tease apart” in a standardized way the environmental effects of helpful products versus the effects of the actual construction of or surrounding a physical setting.

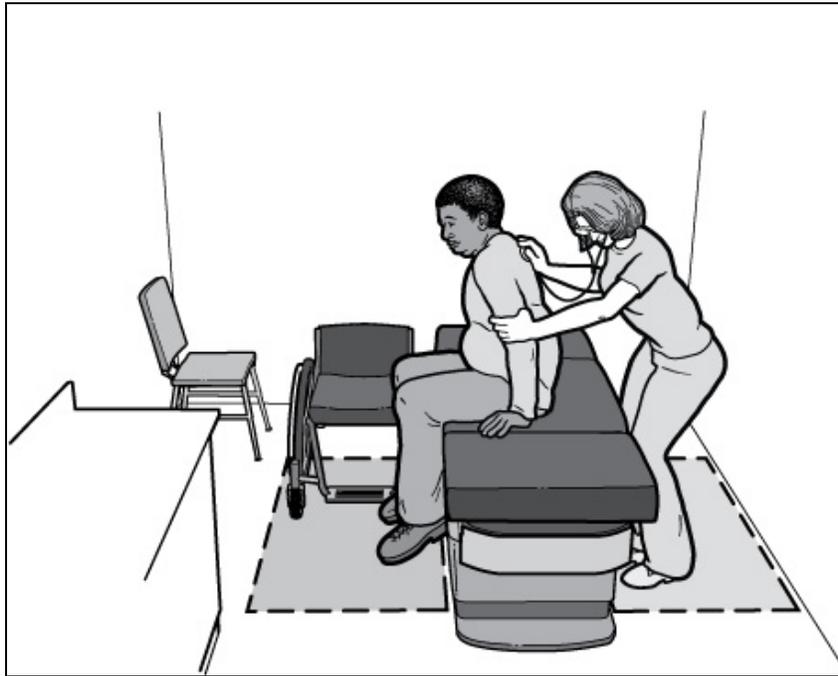
In ICF terms, does an environmental barrier exist because of the lack of a specific type of policy? Or does an environmental facilitator exist because of the motivation provided by a policy that is already in place?

These are important questions for the ICF coder, almost in a “chicken-and-egg” context: does the *policy* that incentivizes and motivates the clinician to purchase this kind of expensive assistive device also create the facilitation, or does the expensive *assistive device* itself create the facilitation? For the ICF coder, this would draw the distinction between **e5801**, Health systems, representing the “policy-facilitation” point of view, versus **e1501**, Design, construction, and building products and technology for gaining access to facilities inside buildings for public use, representing the “assistive device-facilitation” point of view.

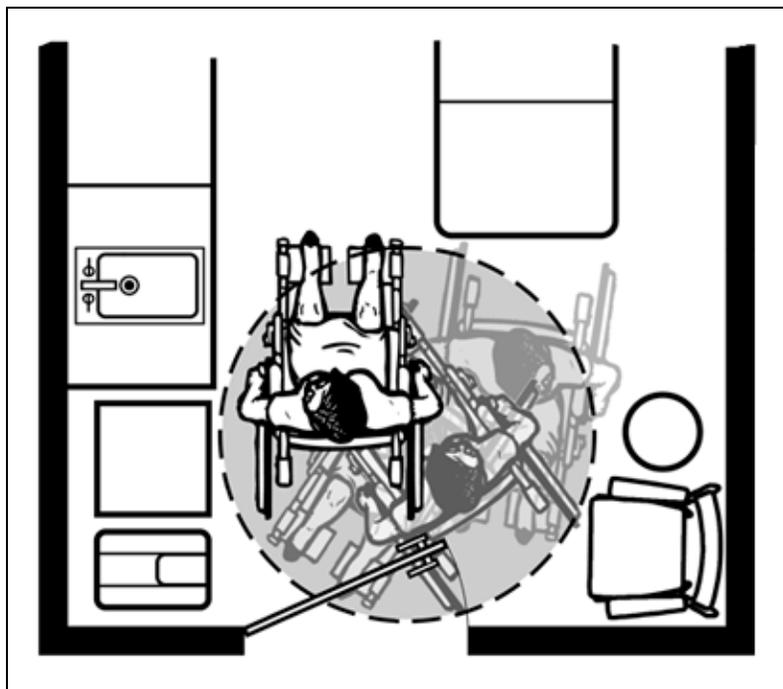
We selected both codes, rather than selecting one or the other, because in Images (1A) and (1B), the examination tables themselves are facilitative, but we also wanted to demonstrate that an existing policy, or in

the U.S. a forthcoming set of policy standards from the U.S. Access Board, might incentivize or motivate clinicians to purchase this expensive type of examination table for their offices, for everyone's benefit. In due course, it should also become "customary," in the context of delivering high-quality medical care, to expect that at least one examination room in a medical practice setting would be equipped with an elevating examination table, even if there were not to be standards in place from the Access Board.

(2A)



(2B)



2nd) Allowing Sufficient Accessible Space To Assist Transferring

Image (2A)

**Activities & Participation**

**d4200.12**                    **Transferring oneself; Mild limitation in Performance with assistance, Moderate restriction in Capacity without assistance**

**Environmental Factors**

**e5152+1**                    **Architecture and construction policies; Mild Facilitator**

Image (2B)

**Activities & Participation**

**d469**                        **Walking and moving, other specified and unspecified. Specification: as in d465, Moving around using equipment, to demonstrate the turning radius necessary for a typical patient using a wheelchair in an examination room.**

**Environmental Factors**

**e5152+1**                    **Architecture and construction policies; Mild Facilitator**

## Description of the Images

Images (2A) and (2B) show the beneficial --- and facilitative --- characteristics of examination rooms with sufficient space.

In Image (2A), the representative patient has easily made the transfer from wheelchair to examination table, in this case because of the facilitative option of being able to make that transfer from either side of the table.

We've all been in medical examination rooms in which the orientation or positioning of the examination table seems to benefit the clinician, rather than the patient. The space in many examination rooms already seems tight or cramped. Imagine if, as a patient with a mobility impairment, it were easier or more comfortable for you to choose the side of your body or your wheelchair from which you would make the transfer to the examination table, rather than being forced to transfer from one side according to the positioning of the examination table. In that situation, the orientation of the examination table would really matter. The positioning of the examination table ought to benefit patients, rather than clinicians, or have flexibility in design and construction to accommodate both patients and clinicians.

Image (2B) demonstrates that patients who use wheelchairs need a clear space in the examination room representing a circle with a diameter width of about 5 feet (~ 1.5 meters), in order to make successful wheelchair turns with the room's door both open and closed. If the space in many examination rooms seems tight and cramped, it would be an environmental barrier if the overall space in the room were insufficient for a patient using a wheelchair. Simply removing stationary chairs and wastebaskets can be a way of adding more space for wheelchair users. In this case, [an ADAAG standard](#) already governs the necessity of providing [sufficient space](#) for wheelchair turning in settings that also require an "[accessible route](#)."

## Justifications for Selecting the ICF Codes

We selected codes in the Activities & Participation and Environmental Factors domains. Image (2A) gives us the opportunity to use **d4200**, Transferring oneself. We assigned qualifiers ".12" although truthfully we

cannot judge this patient's Performance and Capacity in transferring using this simple two-dimensional image; it represents our Coder's judgment.

Perhaps the more important ICF code is **e5152+1**, Architecture and construction policies, Mild Facilitator. The point of the image in the DoJ-DHHS publication is that providing sufficient wheelchair space on both sides of an examination table (whether or not it is also an elevating examination table) enables all patients to choose their preferred side for transferring to that table. For some patients, that's an important choice. Notice that the clinician can utilize the additional space, too.

In Image (2A), there is really no adaptation or device involved: it simply makes common sense for both patient and clinician to have sufficient space and a logical orientation of the examination table. Hence, **e5152**, Architecture and construction policies, represents a good choice in the Environmental Factors domain, because in addition to "building codes," **e5152** refers to "standards," such as safety standards, which broadly interpreted can include the standards set within an individual clinical practice for welcoming and examining patients with mobility impairments. There is no policy requirement in the U.S. to provide wheelchair space on both sides of an examination table, but it represents good practice and courtesy. In ICF terms, it also represents mild facilitation, "+1." Another coding selection might have been **e5158**, Architecture and construction services, systems and policies, other specified, with the Specification being related to providing wheelchair space on all sides of an examination table.

For Image (2B), we selected a rarely-used code in the Activities & Participation domain: **d469**, Walking and moving, other specified and unspecified. The Specification Note would be "Moving around using equipment (**d465**) to demonstrate a 5-foot [1.5 m] diameter width necessary for adequate wheelchair turning space." It's interesting that, by process of elimination, we can usually exhaust all the other mobility-related codes in A&P Chapter 4, Walking and Moving (**d450** – **d469**) to describe mobility abilities or limitations before arriving at **d469**, the important but seldom-used "Other Specified" code. For Image (2B), **d469** really fits well: it is a two-dimensional representation of a person demonstrating a series of sequenced activities, showing the space necessary for a wheelchair user in

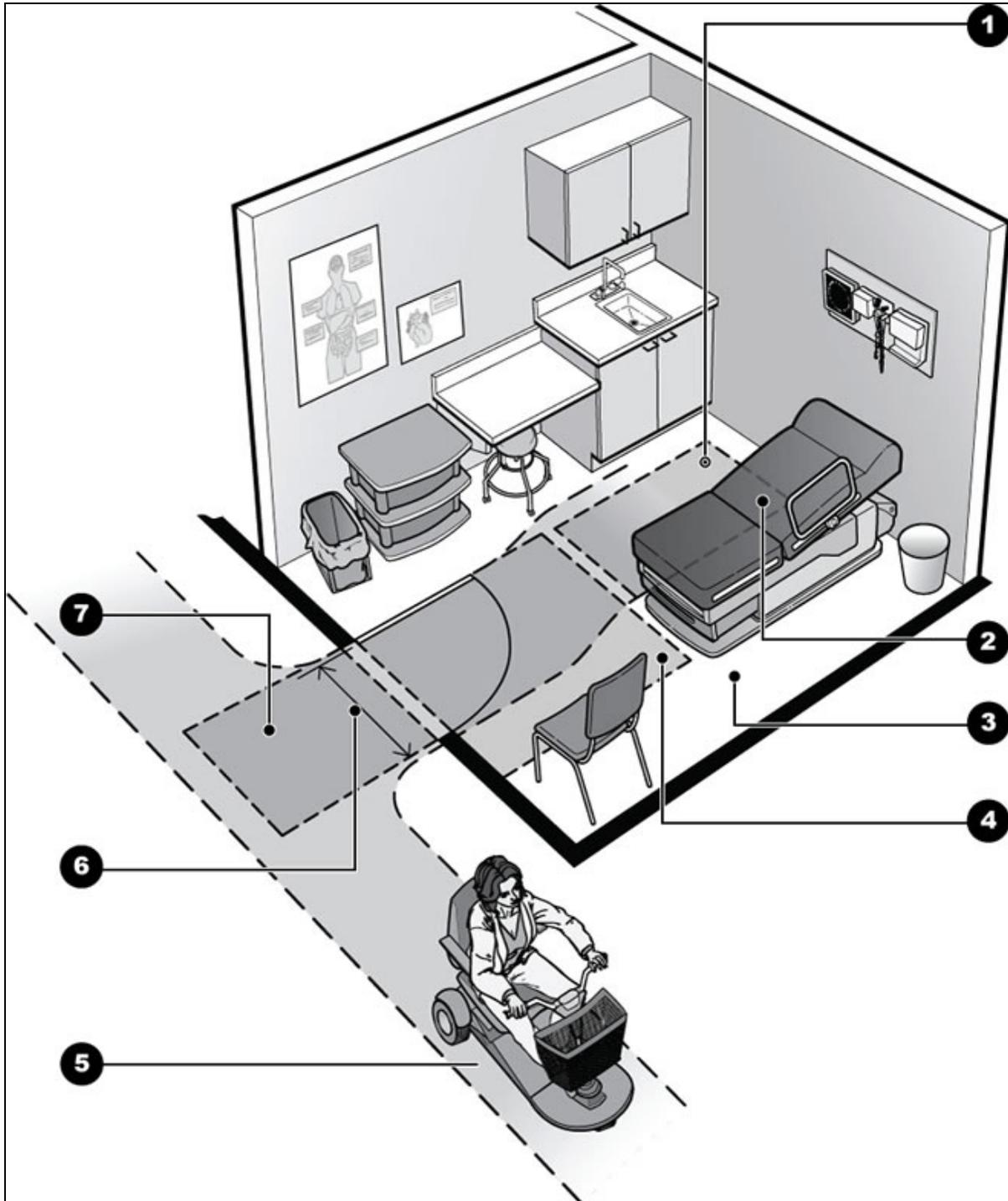
an examination room. We can't and don't need to judge that person's Performance or Capacity, hence, we chose to use **d469** without qualifiers.

## Discussion

One of the primary areas of emphasis in the ADAAG is defining and quantifying the idea of sufficient space for persons with mobility impairments in buildings for public use. There are policies manifested as accessibility standards for wheelchair turning space in the type of [circular area](#) depicted in Image (2B) and in [a T-shaped area](#). The ADAAG also defines the [minimum clear width required for two wheelchairs](#) and the [space necessary for 90-degree turns](#) on an accessible route. Pertinently, though, there are no counterpart ADAAG standards for the same types of accessibility features in buildings for *private* use. The set of current policies is only relevant, and only has motivational properties, in the public sphere.

It's not the purpose of a classification such as the ICF to feature quantifications for policies, though, as we would find in the ADAAG. Instead, the ICF should be used to identify the general Environmental Factors that affect a person's life situation. If those include Services, Systems or Policies, the broad policies themselves should be identified in coding as Facilitators, but more specific information should be provided linking that selected ICF coding to an implementing policy or regulation. In these situations, the ICF "Other Specified" and "Unspecified" codes become the ICF coder's friends: their code stems accurately describe a situation, and the coder's added Specification Note provides the necessary additional information or a link to the policy information.

(3)



### 3rd) Features of an Accessible Examination Room

The bold numbers in parentheses refer to the original numbers on the accompanying composite image of an accessible examination room. The texts are from the DoJ-DHHS publication (2010, pg. 6).

- (1) “A clear floor space, 30 X 48 (inches) [762 - 1,220 mm] minimum, adjacent to the exam table and adjoining accessible route make it possible to do a side transfer.”

#### ICF Coding

#### Environmental Factors

**e1501+1** Design, construction, and building products and technology for gaining access to facilities inside buildings for public use; Mild Facilitator

- (2) “Adjustable height accessible exam table lowers for transfers.”

#### ICF Coding

#### Environmental Factors

**e1501+3** Design, construction, and building products and technology for gaining access to facilities inside buildings for public use; Substantial Facilitator

- (3) “Providing space between table and wall allows staff to assist with patient transfers and positioning. When additional space is provided, transfers may be made from both sides.”

#### ICF Coding

#### Environmental Factors

**e1502+1** Design, construction, and building products and technology for way finding, path routing and designation of locations in buildings for public use; Mild Facilitator

- (4) “Amount of floor space needed beside and at end of exam table will vary depending on method of patient transfer and lift equipment size.”

**ICF Coding**

**Environmental Factors**

**e1508+1** Design, construction, and building products and technology of buildings for public use, other specified; Mild Facilitator. Specification: the amount of floor space needed for optimal mobility accessibility to an examination table will depend on design and construction, or other equipment, in the medical office setting.

- (5) “Accessible route connects to other accessible public and common use spaces.”

**ICF Coding**

**Activities & Participation**

**d465** Moving around using equipment

**Environmental Factors**

**e1502+1** Design, construction, and building products and technology for way finding, path routing and designation of locations in buildings for public use; Mild Facilitator

- (6) “Accessible entry door has 32 (inches) [812 mm] minimum clear opening width with door open 90 degrees.”

**ICF Coding**

**Environmental Factors**

**e1500+3** Design, construction, and building products and technology for entering

**and exiting buildings for public use;  
Substantial Facilitator**

- (7) “Maneuvering clearances are needed at the door to the room.”

**ICF Coding**

**Environmental Factors**

**e1502+1      Design, construction, and building products and technology for way finding, path routing and designation of locations in buildings for public use; Mild Facilitator**

Description of the Image

This composite image shows 7 features of an accessible examination room. For the ICF coder, it is a rich source of Environmental Factors!

The 7 features in this composite image focus on the availability of sufficient space in the medical examination room, primarily to assist with maneuverability for wheelchair users; a scooter user is part of the illustration. The image provides a schematic viewpoint for the features of the examination room that enable a patient with a mobility impairment to enter and exit the room, gain access to features within the room such as the examination table, and comfortably maneuver both their body and their mobility assistive device successfully around the room.

Justifications for Selecting the ICF Codes

To describe the 7 features in ICF coding, we selected four closely-related Environmental Factors codes, from Chapter 1, Products and Technology, pertaining to buildings for public use. These were:

- **e1500**, Design, construction, and building products and technology for entering and exiting buildings for public use;

- **e1501**, Design, construction, and building products and technology for gaining access to facilities inside buildings for public use;
- **e1502**, Design, construction, and building products and technology for way finding, path routing, and designation of locations in buildings for public use; and
- **e1508**, Design, construction, and building products and technology of buildings for public use, other specified.

Of course, the physical features depicted in Image (3) are all adjacent to one another, therefore it's a bit logical that the ICF codes selected to describe those features would be adjacent codes in the ICF hierarchy. We also utilized "Mild Facilitator" as often as "Substantial Facilitator": the degree of facilitation is often up to the Coder's judgment. (Remember, also, that there is a "Facilitator, Not Specified" option in Environmental Factors, i.e., the use of qualifier "+8" when the degree of facilitation cannot be judged efficiently.) The relative similarity among the 7 features enables us to demonstrate three important, subtle distinctions between and among these codes under second-level heading **e150**, Design, construction, and building products and technology of buildings for public use.

First, the basic distinction within the Chapter is important: buildings for public use versus private use. For Image (3), we are only concerned with a coding situation in a building for public use, namely a medical examination room in a clinic or office building. But ICF coders should know that there are identical counterpart codes within both the **e150** series for public-use buildings and the **e155** series for private-use buildings.

Second, the coder should know the ICF distinctions between entering and exiting, gaining access inside a building, and way finding and path routing, which distinguish the third-level codes under both **e150** and **e155**. These seem straightforward, but especially with a composite diagram such as Image (3), it can be hard to determine when "entering and exiting" ends and "gaining access" or "way finding" begins. The distinction between "gaining access" and "way finding" is very subtle, too.

Third, coders using Chapter 1 should remember that ICF distinguishes "general products and technology" from "assistive products

and technology.” “General” products are not adapted, but “assistive” products are specially adapted or designed for an individual patient. Here, ICF treats “general” and “assistive” as adjectives modifying “products and technology.” Then, ICF additionally distinguishes those two from “design, construction, and building products and technology.” With grammatical similarity, here also ICF treats “design,” “construction,” and “building” as adjectives, each modifying the conjoined nouns “products and technology.” Hence, the coder’s challenge is to determine whether a particular product or technology in a coding situation is general, assistive, or associated with the design or construction of the building surrounding that coding situation. It’s not always an easy discrimination. The flexible “8” and “9” codes for “Other Specified” and “Unspecified” can become the ICF coder’s friends!

## Discussion

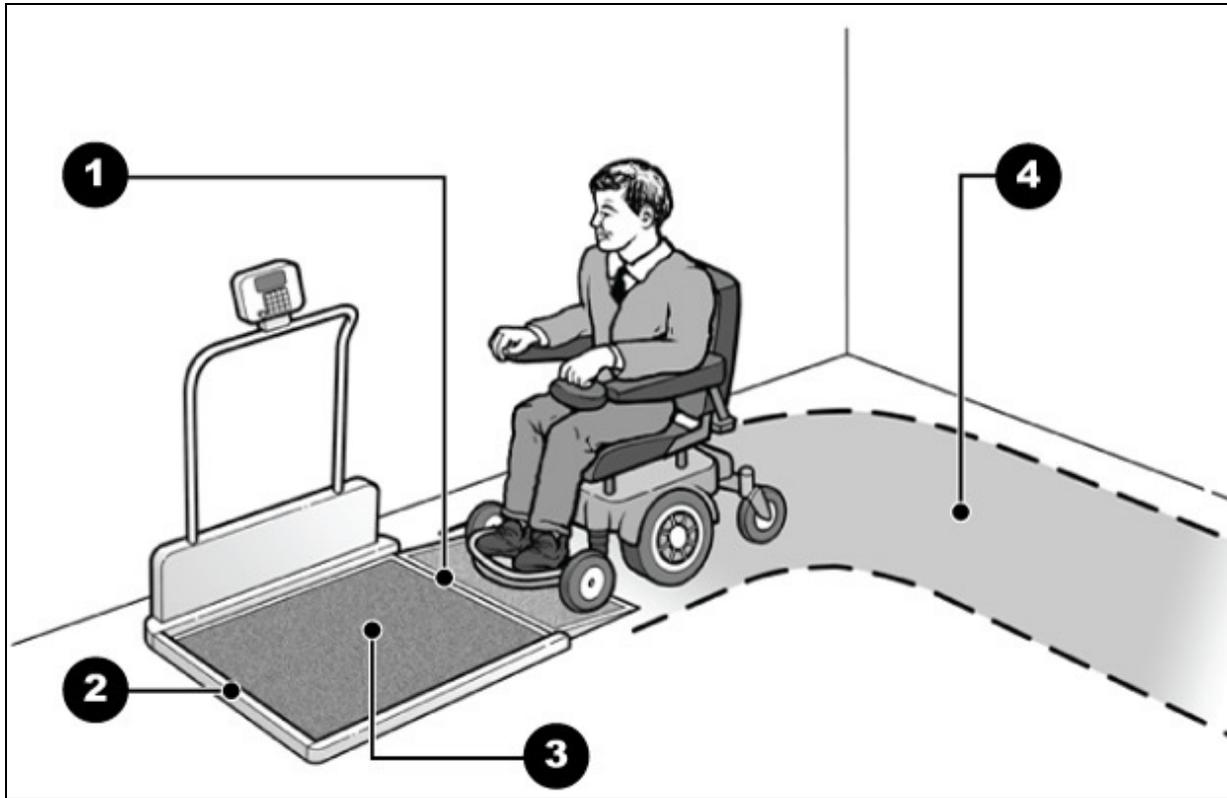
In Image (3), we elected to focus our ICF coding efforts on the “design, construction, and building products and technology” characteristics of the 7 features of an accessible examination room. But “behind the scene,” we might also know that some policies are in place governing some of those features. Which should the ICF coder code --- the facilitative policies, or the facilitative products and technology?

Our answer was to code the facilitative products and technologies, because we had foreknowledge that only a few of the 7 features are currently governed by policies in the U.S., but that other features currently represent “suggestions” or recommendations for good practice and not enforceable under any law. Often, though, those recommendations are very influential, and can yield the same outcomes as a policy with the force of law. For example, if recommendations are produced by professional associations or clinicians’ colleges or academies, they can be highly motivating. In that professional context, the passive goal would be for it to become “customary” for members of that association or academy to incorporate the recommended approach into their clinical practice.

In fact, features numbered **(1)**, **(2)**, **(3)**, and **(4)** do not have corresponding ADAAG standards and are essentially recommendations for good practice, but features numbered **(5)**, **(6)** and **(7)** are strictly governed by ADAAG standards that define and quantify the term “[accessible route](#).”

Even more specifically, the characteristics of feature **(6)** related to [door width](#), and feature **(7)** related to [maneuvering width at doorways](#), have their own very detailed ADAAG standards, which have the force of law.

(4)



#### 4th) Accessible Weight Scales

The bold numbers in parentheses refer to the original numbers on the image above showing an accessible scale for wheelchair users. The texts are from the DoJ-DHHS publication (2010, pg. 13).

- (1) “Sloped surface provides access to scale platform --- no abrupt level changes at floor or platform.”

#### ICF Coding

#### Environmental Factors

**e1501+1 Design, construction, and building products and technology for gaining access to facilities inside buildings for public use; Mild Facilitator**

- (2) “Edge protection at drop off.”

**ICF Coding**

**Environmental Factors**

**e1208+1 Products and technology for personal indoor and outdoor mobility and transportation; Mild Facilitator**

- (3) “Large platform to accommodate various wheelchair sizes.”

**ICF Coding**

**Environmental Factors**

**e1501+2 Design, construction, and building products and technology for gaining access to facilities inside buildings for public use; Moderate Facilitator**

- (4) “Provide maneuvering space to pull onto and off scale.”

**ICF Coding**

**Environmental Factors**

**e1502+1 Design, construction, and building products and technology for way finding, path routing and designation of locations in buildings for public use; Mild Facilitator**

Description of the Image

Image (4) is an artist’s rendering of a typical patient who needs an accessible weight scale as the instrument for determining his weight in the clinical setting, in this case without having to leave his motorized scooter.

There are [many different types](#) of accessible weight scales. This type, illustrating the DoJ-DHHS Technical Assistance publication, is intentionally generic, but even the generic features give us robust opportunities for ICF coding in the Environmental Factors domain.

In this model, the patient can remain seated in their mobility assistive device and move along an ADAAG-defined “accessible route” to the scale. A gently-sloped surface **(1)** takes the patient from the accessible route **(4)** onto the platform for the accessible scale. The computerized scale can compensate for the weight of the patient’s motorized scooter in order to generate an accurate body weight. For safety, there is a protective edge at the end of the platform **(2)**. In this model, it doesn’t appear as though the platform is designed to be large enough to accommodate 180-degree turns by a wheelchair user, hence this patient would simply roll-on forward and roll-off in reverse to and from the active part of the platform.

### Justification for Selecting the ICF Codes

By now, the Environmental Factors codes **e1501** and **e1502** should be familiar, representing “gaining access” and “way finding and path routing” inside buildings for public use, respectively. We utilized these familiar and very useful codes, with either Mild or Moderate Facilitation.

Our most challenging ICF coding situation arose with the feature numbered **(2)**, for the “edge protection” at the end of the scale’s platform. It’s difficult to find an Environmental Factors code that would be “granular” enough to refer to a protective safety edge on a device, but that should be so: ICF is not designed to quantify or depict individual features of any Environmental Factor. The safety edge might be a “design” feature, in which case the code for “gaining access,” **e1501**, might be suitable, on the premise that the accessible scale is similar to “lifts or elevators, [and] escalators” which are design-products of indoor facilities included in the Descriptive Note at **e1501**. Presumably, lifts or elevators and escalators all have common safety features implied within **e1501**, too. Then again, an accessible weight scale without such a common safety feature as a hard-edged platform probably wouldn’t be purchased or used often.

In the end, we settled on the accessible weight scale itself, along with its features such as a safety edge, as being a “product and technology,” and as such, that the accessible scale is a product for personal indoor and outdoor mobility. Hence, we distinguished the scale itself as a product different from being a design-product of the examination room.

Granted, using the mobility product, the scale, is dependent on the design-products, namely the accessible route and the slope-surface edge, being in place. Moreover, the degree of mobility needed by the patient on the accessible scale's platform is minimal; in most cases, including in Image (3), the patient does not even need to complete successful turns to utilize the scale correctly. But for this coding purpose, we needed to distinguish the accessible scale itself from the accessible path to the scale and the sloping surface leading onto the platform. Therefore, for feature **(2)**, we selected ICF code **e1208+1**, Products and technology for personal mobility and transportation, Mild Facilitator. It represents the best "composite" choice for the safety edge.

## Discussion

Accessible weight scales are an important component in the set of standards [under development by the Access Board](#) in cooperation with the [Department of Justice](#). Weight scales were specifically mentioned in the Patient Protection and Affordable Care Act as among the types of medical equipment now requiring ADA standards. In the absence of ADA standards affecting weight scales, the most influential standards have been provided through legal precedents and court settlements.<sup>1</sup>

A patient's weight is essential medical information for diagnosis and treatment. Patients with mobility impairments either cannot stand or would have difficulty standing on conventional weight scales.

To comply with ADA requirements for equal treatment without regard to disability status in medical settings, it will soon become enforceable under the ADA for a clinic to have the ability to weigh all patients accurately.

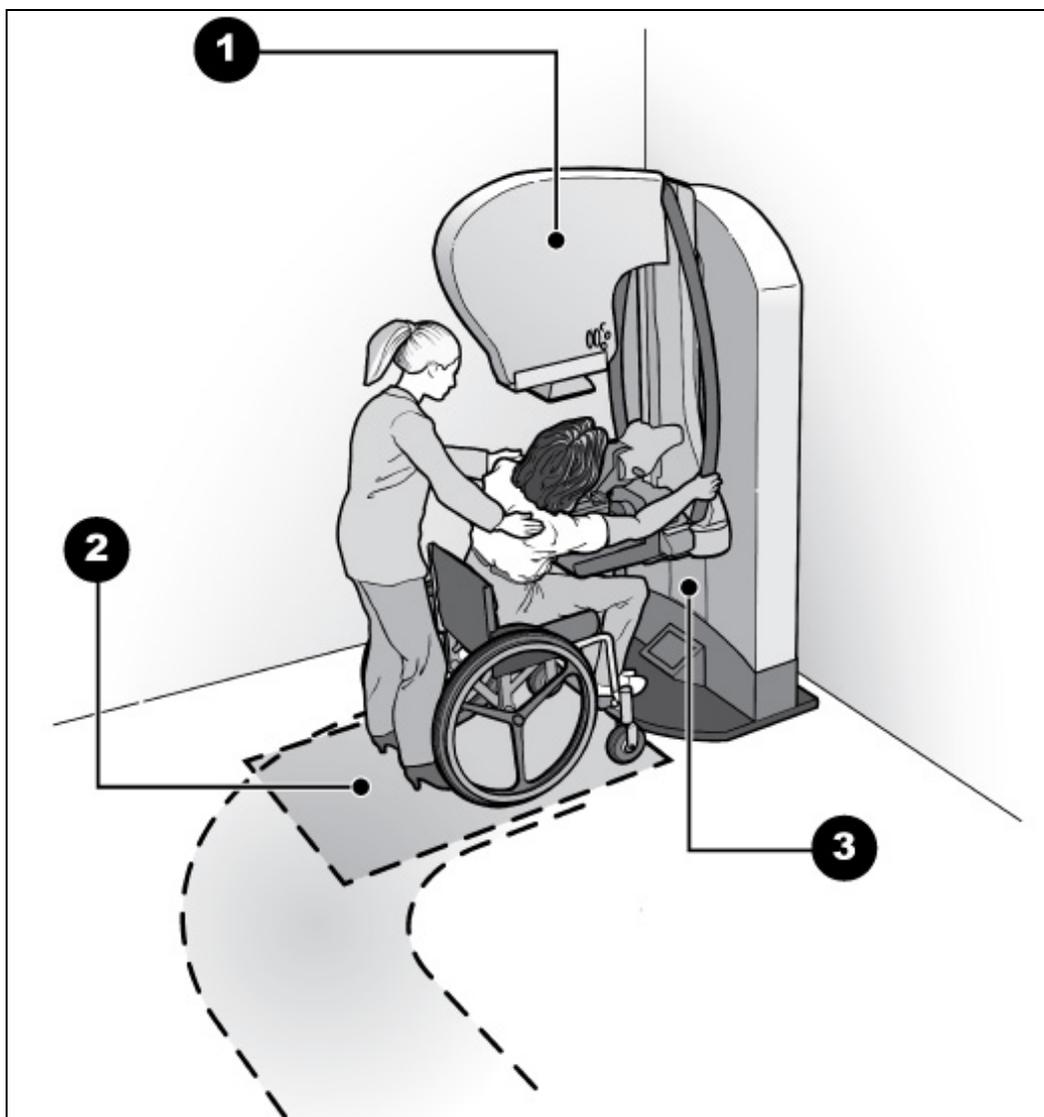
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<sup>1</sup> Relevant settlements affecting accessibility of weight scales for clinical care:

- Metzler, *et al.*, v. Kaiser Foundation Health Plan, Inc., *et al.* (2001)
  - <http://www.dralegal.org/downloads/cases/metzler/settlement.pdf>
- Thompson *et al.* v. Sutter Health *et al.* (2008)
  - [http://dralegal.org/cases/health\\_insurance/Thompson\\_v\\_Sutter.php](http://dralegal.org/cases/health_insurance/Thompson_v_Sutter.php)

One method toward that goal would be to provide the kind of accessible weight scale shown in Image (3) along the examination room's accessible route. In ICF terms, that would represent a policy outcome that removes or mitigates environmental barriers and provides environmental facilitation.

(5)



### 5th) Accessible Mammography Equipment

The bold numbers in parentheses refer to the original numbers on the image above showing an accessible mammography machine. The texts are from the DoJ-DHHS publication (2010, pg. 13).

- (1) “Unit pivots to multiple angles and adjusts in height for seated patients”

**ICF Coding**

**Environmental Factors**

**e1508+3** Design, construction, and building products and technology of buildings for public use, other specified; Substantial Facilitator.  
Specification: A specialized radiographic machine is designed to adjust to the height of a seated patient.

- (2) “It is best to position equipment to allow both front and side approaches; for some patients a side or angled approach may be better for positioning at the camera unit and plate.”

**ICF Coding**

**Environmental Factors**

**e1508+3** Design, construction, and building products and technology of buildings for public use, other specified; Substantial Facilitator.  
Specification: A specialized radiographic machine is designed to accommodate different positions presented by patients according to their degree of comfort.

- (3) “Clearance is needed beneath the camera unit and plate to allow people using wheelchairs and other mobility devices to pull up to the equipment.”

**ICF Coding**

**Environmental Factors**

**e1508+3** Design, construction, and building products and technology of buildings for public use, other specified;

**Substantial Facilitator.  
Specification: A specialized radiographic machine is designed to accommodate mobility equipment underneath the active mechanisms.**

### Description of the Images

Image (5) shows an artist's rendering of a woman who uses a wheelchair being assisted by a clinician to complete a mammography exam. The equipment is part of an accessible route in the examination area. This mammography equipment is designed to be more accessible both in front and on the sides of the active parts of the machine, namely the plate and the camera, to accommodate women with mobility impairments or their mobility assistive devices. It is a tasteful, descriptive illustration.

### Justifications for Selecting the ICF Codes

Generally, we can applaud the broad diffusion of mammography equipment throughout the industrialized world, to the extent that we are now familiar with mobile mammography exam units that bring the technology to patients in their communities. But the diffusion of mammography equipment that is accessible to women with mobility impairments has been much less broad. In the U.S., that might change soon, because accessible mammography equipment is also on the list of medical diagnostic equipment [under review](#) for [standards development](#) by the U.S. Access Board.

In that context, the ICF coder's challenge here might be less about the code stem to select, and more about accurately judging the degree of facilitation. We selected Environmental Factors code **e1508** for all three numbered features: Design, construction, and building products and technology of buildings for public use, other specified, with the separate Specification Notes being related to height adjustability, side positioning, and accommodation of large mobility assistive devices underneath the camera and plate.

The specific features mentioned in Image (3) include pivoting the machine to multiple angles and heights for patients at different levels of seating; enabling side-approaches as well as front-approaches to the camera and plate; and providing adequate clearance underneath the active mechanisms to fit a patient's mobility assistive device, if used.

But just how much facilitation is provided by each of those respective "Other Specified" features? In the absence of policy motivations such as the forthcoming ADAAG standards on mammography equipment, we might judge that having *any* access to accessible mammography equipment is the product of Substantial Facilitation. It would mean that the particular clinical provider had judged, on their own or as a standard of care within their own clinical practice, that having accessible mammography equipment on-site represented either a good business or clinical decision, or both. With these considerations in mind, we judged all three of the numbered features to be components of overall Substantial Facilitation, hence, we added the qualifiers "+3" to all three iterations of code stem **e1508**.

## Discussion

Accessible mammography equipment is essential. The population screened for breast cancer must include women with mobility impairments, for both statistical as well as ethical reasons. The equipment is expensive, though, such that having legal requirements in place augment the statistical and ethical arguments in favor of purchasing the equipment. In ICF terms, that means the policy outcome from developing a set of legal requirements, such as the new ADAAG standards, would represent substantial environmental facilitation, although with both costs and benefits.

Over time, any disparities in access to mammography screening services that might have been exhibited before enactment of new standards would be diminished, and hopefully eliminated. Even though in this Coder's Corner vignette we focused on the ICF codes for the accessibility to mammography equipment itself, the health systems and policy environment could be equally or even more influential, and therefore facilitative, than the equipment. In that case, another ICF coder might have also legitimately selected **e5802+3**, Health policies, Substantial Facilitator, to describe that facilitative health policy environment.

This concludes this edition of *Coder's Corner*. Until next time, ICF Coders, keep on coding!

END OF NEWSLETTER