PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Laying the foundation for a Core Set of the International Classification of Functioning, Disability and Health for community-dwelling older adults in primary care: Relevant categories of their functioning from the research perspective. A scoping review
AUTHORS	Tomandl, Johanna; Heinmüller, Stefan; Selb, Melissa; Graessel, Elmar; Freiberger, Ellen; Kühlein, Thomas; Hueber, Susann; Book, Stephanie; Gotthardt, Susann

VERSION 1 – REVIEW

REVIEWER	Yvonne Heerkens Research Group Occupation & Health, HAN University of Applied Sciences, Nijmegen, the Netherlands
REVIEW RETURNED	15-Feb-2020

GENERAL COMMENTS	The article is well-written. My main concern is the aim of the study and the selection process of included articles. It seems that during that process, new decisions have been made. On page 9 the authors describe that only data on the assessment instruments have been used. My guess is that consequently all qualitative articles (and probably most of the observational articles) are excluded as most qualitative research don't use standardized assessment instruments. Still the authors see it as a strength of this article that qualitative articles are included (page 4 and 19). Although I understand the amount of work involved, I wonder whether the exclusion of the second data set hasn't had a major influence on the outcomes of this search (not mentioned in the discussion). My experience is that especially in qualitative research things as attitudes (now missing; page 18) can be expressed. I think the authors should discuss this. Formal assessment instruments are aways a little bit 'conservative'; it takes a while to include new ideas in instruments. To make the process more transparent, it may be an idea to add to appendix B which articles include one of the assessment instruments in Table 1 or to include only the articles with an assessment instrument. I think this will indicate that most observational and qualitative studies are not included in the results! This dilemma is also visible in the description of the aim of the study; in the abstract the aim is global (finding relevant concepts of functioning within the scientific literature) and at the end of the introduction the aims are: to identify concepts in struments for assessing functioning of older persons and to link these to the ICF. This is strange because when the aim was from the beginning only

	to find instruments than may be the search could have been different. It seems that during the process the aim of the study has been changed. This means: - a consistent description of the aim of the study - more attention in the discussion section about he consequences of using only the first data set - adapting the abstract - rewriting of the 'índicated strength' w.r.t. qualitative studies - changing appendix B. An additional point: in the abstract it is said that the ICF is too detailed. later in the article (page 19) the conclusion is that the ICF is not detailled enough to link properly the concepts found in the literature. My experience is, is that the ICF is often not detailled enough, but that it is sometimes too broad; whole chapters may be irrelevant for certain groups. I would suggest to replace the term too detailled in the abstract (e.g. by the term too broad or too extensive (the term the authors use on page 5)).

REVIEWER	Lisette M. van Leeuwen, Ph.D. Amsterdam UMC, Vrije Universiteit Amsterdam, Otolaryngology-Head and Neck Surgery, Ear & Hearing, Amsterdam Public Health research institute, de Boelelaan 1117, Amsterdam, Netherlands.
REVIEW RETURNED	02-Mar-2020

GENERAL COMMENTS	Review BMJ Open Manuscript bmjopen-2020-037333: “Laying the foundation for an ICF core set for community-dwelling elderly adults in primary care: the research perspective identified by a review of the literature”. General comments: Thank you for the opportunity to review this interesting paper. The study of this manuscript is one of a series of studies to develop an ICF core set for community-dwelling older persons in primary care. The systematic review of the current manuscript captures the perspective of researchers on the health condition. The authors have followed the guidelines of the ICF research branch to conduct this study. In this study, the content of the identified outcome measures was valued. The content of these measures thereby reveal research trends on community-dwelling older persons. Overall it is a well-executed study and a nice manuscript. However, I have a number of larger and smaller comments that I have described below. Marjor comments: - The rationale for developing the core set could be better substantiated. In my opinion, the transition from the problem of multimorbidity and inappropriate polypharmacy (which I understand is the reason for the core set development) to the importance of a holistic approach in these patients could be made more clear. I.e., how could a more holistic approach reduce this problem? For example, that the systematic mapping of a person’s overall functioning leads to an overview of problems, limitations and restrictions and that the (in)effectiveness of medicines can be better estimated? I note that my question is partly answered in the implications of the Discussion section, but I would prefer this to be part of the Introduction section as well. - It is my understanding that the target population are community-dwelling older persons with multimorbidity. In my opinion, the manuscript will improve if this is made more explicit

	and consistent in the various parts of the manuscript (see also minor comments below). - In the Methods section the authors state that they did not include publications focussing solely of body structures although this is a component of functioning as defined by the ICF. I doubt if this was a correct choice, especially considering that the frequency of the various components was calculated and presented. Not taking these publications into account may create an incomplete picture of how health and functioning are normally measured by researchers. In the Discussion section, the authors indicate that categories of the component body structures were infrequently linked which may be due to their exclusion criterion. It therefore may be an invalid conclusion that the component A&P was the most relevant for measuring functioning in older persons. Perhaps I misunderstand the choice not to include publications solely focussing on body structures, but then a better explanation for this choice is needed. - In the Discussion section I miss the link between the results and the rationale for this study. In the current discussion, the results are mainly linked to nursing home placement and not to multimorbidity and the (over)use of medication. In addition, I miss the implications of this study's findings. For example, the study shows infrequent coverage of various ICF categories despite the fact that their importance is supported in the literature, so what kind of consequences would this have in researching functioning of this target population? - The manuscript should be checked on language, consistency in terminology (e.g., bio-psycho-social vs. biopsychosocial/ older persons vs. older adults vs. older patients) and typos. - Please find my specific comments per section below. Minor comments: Abstract - Objective in abstract does not fully correspond with the more specific aim of the study as described in the Introduction section. - "Articles dealing with functioning in the elderly were searched and assessed for eligibility"; please be more specific, in line with the methods described in the main body of the manuscript. Introduction - Page 4 Lines 33-60: Adding numbers to the Introduction would be useful to make the (impact of the) problem described more concrete, e.g., numbers on older patients with multimorbidity and polypharmacy seen by general practitioners; numbers on adverse events of polypharmacy. - Page 5 Line 8: "Functioning limitations", do you mean problems in functioning or maybe disability? Because the ICF is used as a theoretical framework, I suggest to stick to ICF's definitions and terminology. This also applies for example to the definition of functioning (lines 16-22). I think this is important to use this definition, since it is also used in the methods to select publications. - Page 5 Lines 50-55: Two other research groups developed core sets for older patients. Besides the fact that they did not adhere to the standardized process for developing core sets, it may be worth to mention whether there were other reasons, e.g., differences in rationales for the development of the core sets?

	- Lines 5-10: “It is important to capture these different perspectives in the development process in order to gain a holistic understanding of the functioning of people living with a specific health condition”. I am not sure the term “holistic” is appropriate. Should this not be “capture a multiperspective understanding”? Also, please replace “of people living with a specific health condition” with the target population of this series of studies (older persons with multimorbidity). Methods - Page 6 Lines 26-27: typo: two types of reference style. - Page 6 Lines 35-36: “In contrast to other systematic reviews”. Please remove this piece of the sentence. An systematic review can be performed on anything, and depends on its specific purpose. I would therefore only describe the purpose of this review. - Page 6 Lines 35-36: “to operationalize functioning”. Please add “related to community-dwelling older adults” (or something similar), to be more precise. - Page 6 Eligibility criteria, population: was the focus of the study on the target group not an inclusion criterion (see also comment below)?, i.e., community-dwelling older adults with multimorbidity? - Page 6 Lines 59-60: why were participants with dementia excluded? - Page 7 Lines 11-12: “to get a representative picture of the health reality of old adults, studies with participants suffering from one specific health condition were excluded”. I wonder whether this is the correct substantiation. Should it not be because the target population are older patients with multimorbidity (to subsequently also be exposed to the problem of polypharmacy)? - Page 8 Lines 28-29: “The full texts were screened pairwise by four independent researchers”; I do not understand what is meant here, was one half of the full texts screened by two researchers and the other half by the other two researchers? Please clarify. - Page 8 Lines 53-54: “Population: type of sample”; what is meant? Information on diagnosis?/ multimorbodity? Please clarify. - Page 9 Lines 18-31: Two datasets were made. However, the authors only report on the dataset with the linking results on the identified outcome measures. The authors may want to consider not mentioning the other dataset, since nothing is done with it. Subsequently, the authors could sharpen the purpose of this manuscript, by defining the researcher perspective as measurement instruments used in current. - Page 9 Lines 48-49: “two independent researchers”; please include the initials of the researchers. - Page 10 Lines 8-9: typo: type of reference style. Results - Page 10 Lines 35-37: “the study characteristics in Appendix B”; please change into “and the study characteristics are provided in Appendix B”. - Page 11 Table 1: why are the instruments linked to “thematic focus” and not to ICF components? Cognition and mobility are categories of functioning? - Page 13 Lines 5-8: “all 87 ICF categories will serve as candidates for considering during the consensus ..”; Suggest to change into “consideration for inclusion in the core set during the consensus conference”. - Page 16, Lines 58-60: The authors state that concepts linked to ‘not defined in the ICF’ were related to ‘physical activity’

	and ‘activities of daily living’. By defining these in this way I wonder why they could not be linked to the A&P component? Can the authors give examples? Or maybe add a table with these ‘nd’ concepts (possibly in an appendix)? - In order to provide a quick overview of the results, the authors may want to consider to add a table with an overview of the number of concepts per (ICF) component, i.e., including: body structures (number of concepts linked), body functions (number of concepts linked), a&p (number of concepts linked), environmental factors (number of concepts linked), personal factors (number of concepts linked) and ‘nd’ (number of concepts linked). - Appendix B: If I understand correctly that the core set is being developed for community-dwelling people with multimorbidity, it would be interesting to include data on type and/or number of diagnosis/ diseases in the publications identified. Discussion - The authors may want to consider to include a brief summary of the purpose before stating the main findings of the current study. - Page 19 Lines 7-18: The authors mention that the interdisciplinary research team and their interdisciplinary perspective on the topic is a strength of this study. However, the systematic method that was followed (e.g., data extraction and linking procedure) in this study should prevent such a ‘bias’? I think this aspect of interdisciplinary is important in the consensus procedure later in the development process of the core set, and not necessarily in this study. Please clarify. - Page 19 Lines 22-24: The authors mention that publications from other countries may have been missed. However, eligible countries were selected on the basis of predefined inclusion/exclusion criteria? Please clarify.

VERSION 1 – AUTHOR RESPONSE

Reviewer(s)' Comments to Author:

Reviewer: 1
Reviewer Name: Yvonne Heerkens
Institution and Country: Research Group Occupation & Health, HAN University of Applied Sciences, Nijmegen, the Netherlands Please state any competing interests or state ‘None declared’: None declared

Please leave your comments for the authors below The article is well-written.

My main concern is the aim of the study and the selection process of included articles. It seems that during that process, new decisions have been made. On page 9 the authors describe that only data on the assessment instruments have been used. My guess is that consequently all qualitative articles (and probably most of the observational articles) are excluded as most qualitative research don't use standardized assessment instruments. Still the authors see it as a strength of this article that qualitative articles are included (page 4 and 19).
Although I understand the amount of work involved, I wonder whether the exclusion of the second data set hasn't had a major influence on the outcomes of this search (not mentioned in the discussion). My experience is that especially in qualitative research things as attitudes (now missing; page 18) can be expressed. I think the authors should discuss this. Formal assessment instruments

are always a little bit 'conservative'; it takes a while to include new ideas in instruments.
To make the process more transparent, it may be an idea to add to appendix B which articles include one of the assessment instruments in Table 1 or to include only the articles with an assessment instrument. I think this will indicate that most observational and qualitative studies are not included in the results!

This dilemma is also visible in the description of the aim of the study; in the abstract the aim is global (finding relevant concepts of functioning within the scientific literature) and at the end of the introduction the aims are: to identify concepts in instruments for assessing functioning of older persons and to link these to the ICF. This is strange because when the aim was from the beginning only to find instruments than may be the search could have been different. It seems that during the process the aim of the study has been changed.

This means:
- a consistent description of the aim of the study
- more attention in the discussion section about the consequences of using only the first data set
- adapting the abstract
- rewriting of the 'indicated strength' w.r.t. qualitative studies
- changing appendix B.

Thank you for this valuable feedback. The decision to focus on the first data set in this paper was due to the fact that the assessment instruments provide a more standardized and systematic basis for further analysis. Moreover, due to the huge amount of information, it proved difficult to present the results of both data sets within one paper. However, we did not want to reduce the research perspective to only the assessment instruments as we think that the second data is also very important. The categories included in the second data set will thus be considered in addition to the categories included in this first data set for the development of the final core set within the consensus conference. Following your recommendations, we revised

- the aims of the study (please refer to p. 32, l.14-19) to clarify that the focus was on identifying areas of functioning within frequently used assessment instruments in the scientific literature;
- the discussion section (please refer p.43,l.56-60, p.45, l.24-29, p.46, l.16-18) especially concerning the strengths and weaknesses part to be more precise;
- the abstract (please refer to p. 28) especially with respect to the focus of this study;
- the strengths and limitations section especially with respect to the included study designs;
- the Appendix C (former Appendix B) by adding a new column to make transparent which studies have been considered for the first data set.

In addition, we included the references in table 2 to clarify which instruments were used in which studies.
An additional point: in the abstract it is said that the ICF is too detailed. later in the article (page 19) the conclusion is that the ICF is not detailed enough to link properly the concepts found in the literature. My experience is, is that the ICF is often not detailed enough, but that it is sometimes too broad; whole chapters may be irrelevant for certain groups. I would suggest to replace the term too detailed in the abstract (e.g. by the term too broad or too extensive (the term the authors use on page 5)).
We agree with you, that the ICF is to extensive to be used in daily practice, especially in a primary care setting. However, sometimes in our study we experienced that while some categories are described broadly, some are it still not precise enough to describe the concepts found. When revising the abstract, this sentence was deleted, however we added a sentence regarding this discrepancy in the discussion section (please refer to p.46, l.37-41).

Reviewer: 2 *Please find this reviewer's comments attached to this email* Reviewer Name: Lisette M. van Leeuwen, Ph.D.
Institution and Country:
Amsterdam UMC, Vrije Universiteit Amsterdam, Otolaryngology-Head and Neck Surgery, Ear & Hearing, Amsterdam Public Health research institute, de Boelelaan 1117, Amsterdam, Netherlands.
Please state any competing interests or state 'None declared': none declared
Review BMJ Open
Manuscript bmjopen-2020-037333: "Laying the foundation for an ICF core set for community-dwelling elderly adults in primary care: the research perspective identified by a review of the literature".
General comments:
Thank you for the opportunity to review this interesting paper. The study of this manuscript is one of a series of studies to develop an ICF core set for community-dwelling older persons in primary care. The systematic review of the current manuscript captures the perspective of researchers on the health condition. The authors have followed the guidelines of the ICF research branch to conduct this study. In this study, the content of the identified outcome measures was valued. The content of these measures thereby reveals research trends on community-dwelling older persons. Overall, it is a well-executed study and a nice manuscript. However, I have a number of larger and smaller comments that I have described below.
Major comments:
- The rationale for developing the core set could be better substantiated. In my opinion, the transition from the problem of multimorbidity and inappropriate polypharmacy (which I understand is the reason for the core set development) to the importance of a holistic approach in these patients could be made more clear. I.e., how could a more holistic approach reduce this problem? For example, that the systematic mapping of a person's overall functioning leads to an overview of problems, limitations and restrictions and that the (in)effectiveness of medicines can be better estimated? I note that my question is partly answered in the implications of the Discussion section, but I would prefer this to be part of the Introduction section as well.
Thank you for your insightful comment. The idea for developing this core set was threefold: 1. A learning experience in approaching aspects of functioning by developing a feasible instrument for describing it; 2. Thereby when someday having developed the core set and operationalized it as a patient questionnaire to be filled out in the waiting room, to bring aspects of functioning and thereby the patients agenda more strongly into the consultation, and 3. To then test the hypothesis that this might change the consultation, making physicians focus more on psychosocial than on physical goals thereby reducing unnecessary medicine (the overarching topic of the PRO-PRICARE network). We have revised the introduction to clarify the rationale for developing the core set. Please refer to p. 30, l.22-41.
- It is my understanding that the target population are community-dwelling older persons with multimorbidity. In my opinion, the manuscript will improve if this is made more explicit and consistent in the various parts of the manuscript (see also minor comments below).
Thank you for this advice. It has brought light to a possible misunderstanding regarding the study population. The target population of this study is not specifically older adults with multimorbidity, but rather community-dwelling adults aged 75 years and older in general who are largely multimorbid. We mentioned multimorbidity solely to make the argument that due to multimorbidity, there is a tendency for inappropriate polypharmacy, and that to help reverse this tendency, there is a need for new strategies (e. g. including functioning information in the consultation) that consider the complexity of the health of community-dwelling adults 75+ years old. Thus, we added text to the introduction to clarify the connection between the concept of multimorbidity and inappropriate polypharmacy and the idea of introducing new functioning-based strategies as mentioned above. Please refer to p.29, l.52 – p.30, l.30. Furthermore, to avoid possible misunderstanding about the study population, we added the text "community-dwelling adults ≥ 75 years old" where possible and appropriate.
- In the Methods section the authors state that they did not include publications focusing solely of body structures although this is a component of functioning as defined by the ICF. I doubt if this was a

correct choice, especially considering that the frequency of the various components was calculated and presented. Not taking these publications into account may create an incomplete picture of how health and functioning are normally measured by researchers. In the Discussion section, the authors indicate that categories of the component body structures were infrequently linked which may be due to their exclusion criterion. It therefore may be an invalid conclusion that the component A&P was the most relevant for measuring functioning in older persons. Perhaps I misunderstand the choice not to include publications solely focusing on body structures, but then a better explanation for this choice is needed.
The decision was due to the overall aim of this study. By developing a core set we want to provide general practitioners with an easy to handle tool for assessing functioning of their patients so that they get a more holistic view on their patients' health problems. Patients usually tend to report their health problems with regard to body functions, activities or participation; body structures are usually not reported by patients. The link between the reported problems and the underlying body structures is made by the physicians anyway when deciding on a certain ICD or ICPC code. So even without having an ICF core set at hand body structures are always in the focus of physicians. Thus, we decided to exclude studies that solely focus on body structures to ensure that the resulting core set reflects those components of the ICF that are usually not (yet) in the focus of general physicians. The manuscript was revised accordingly to explain this better. Note that the other research groups who developed ICF core sets for primary care and for the geriatric population using a different method also excluded body structures. We referenced the work of these other research groups. Please refer to p.33, l.32-43 and p.44, l.18-26.
- In the Discussion section I miss the link between the results and the rationale for this study. In the current discussion, the results are mainly linked to nursing home placement and not to multimorbidity and the (over)use of medication. In addition, I miss the implications of this study's findings. For example, the study shows infrequent coverage of various ICF categories despite the fact that their importance is supported in the literature, so what kind of consequences would this have in researching functioning of this target population?
More information was added to the discussion to achieve a better link between the results and the rationale for this study. Several aspects of functioning that were identified in this literature review are closely linked to independent living. As there is some evidence that older patients tend to consider problems in functioning that threaten their independent living as most important whereas their physicians focus more on somatic problems and risk it might be warranted to include more psychosocial information in the consultation process in order to better balance medical interventions according to the older patients' needs. Providing physicians with an easy to handle ICF Core Set can be a first step towards achieving this. Please also refer to p.47, l.34-53. Regarding the implications for research we added that some of these infrequently covered ICF categories (i. e. attitudes) might be more in the focus of qualitative research so far, but might be a relevant aspect to also be included in instruments used for assessing functioning. Please also refer to p.45, l.24-33 as well as p.45, l.52-56.
- The manuscript should be checked on language, consistency in terminology (e.g., bio-psycho-social vs. biopsychosocial/ older persons vs. older adults vs. older patients) and typos.
Done.
- Please find my specific comments per section below.

Minor comments:
Abstract
- Objective in abstract does not fully correspond with the more specific aim of the study as described in the Introduction section.
The objective in the introduction was revised. Please refer to p.28, l.6-22.
- "Articles dealing with functioning in the elderly were searched and assessed for eligibility"; please be more specific, in line with the methods described in the main body of the manuscript.

The eligibility criteria (e.g. community-dwelling older adults age 75 and older) as well as the data sources (i.e. assessment instruments) were added to the abstract. Please refer to p.28, l.26-31.
Introduction
- Page 4 Lines 33-60: Adding numbers to the Introduction would be useful to make the (impact of the) problem described more concrete, e.g., numbers on older patients with multimorbidity and polypharmacy seen by general practitioners; numbers on adverse events of polypharmacy.
Thank you for your suggestion. We added text highlighting the prevalence of multimorbidity in patients over the age of 60 as well as of polypharmacy. Please refer to p.29, l.50 -60.
- Page 5 Line 8: “Functioning limitations”, do you mean problems in functioning or maybe disability? Because the ICF is used as a theoretical framework, I suggest to stick to ICF’s definitions and terminology. This also applies for example to the definition of functioning (lines 16-22). I think this is important to use this definition, since it is also used in the methods to select publications.
Done. We changed “functioning limitations” to “problems in functioning.”
- Page 5 Lines 50-55: Two other research groups developed core sets for older patients. Besides the fact that they did not adhere to the standardized process for developing core sets, it may be worth to mention whether there were other reasons, e.g., differences in rationales for the development of the core sets?
To clarify this point, we added more information in the introduction. With regard to the existing ICF Core Set for geriatric patients in early post-acute rehabilitation, the target group and aims of primary care and rehabilitation can differ from each other. Thus, the ICF Core Sets for these settings may also be different. The other two ICF sets (one for primary care and one for geriatric patients) developed by researchers in the Netherlands were developed using other methods; neither examined the perspective of community-dwelling older persons nor involved a systematic or scoping review .To achieve a really multi-perspective understanding we think both perspectives should be considered in the development of the Core Set. When joining the four preliminary Core Sets to a final, comprehensive one, the existing Core Sets will be taken into account. Even if the ICF Core Set developed would turn out to be identical or very similar to one of the existing Core Sets we would still see our work worth doing as we then will have delivered the empiric evidence that it is fit for purpose also in primary care. Please refer to p.31; l.29-46.
- Lines 5-10: “It is important to capture these different perspectives in the development process in order to gain a holistic understanding of the functioning of people living with a specific health condition”. I am not sure the term “holistic” is appropriate. Should this not be “capture a multi-perspective understanding”? Also, please replace “of people living with a specific health condition” with the target population of this series of studies (older persons with multimorbidity).
Thank you. We changed these expressions. Please refer to p.32, l.5.

Methods
- Page 6 Lines 26-27: typo: two types of reference style.
The superscript number is a footnote (please refer to p. 49, l.56ff).
- Page 6 Lines 35-36: “In contrast to other systematic reviews”. Please remove this piece of the sentence. A systematic review can be performed on anything, and depends on its specific purpose. I would therefore only describe the purpose of this review.
Done.
- Page 6 Lines 35-36: “to operationalize functioning”. Please add “related to community-dwelling older adults” (or something similar), to be more precise.
Done.
- Page 6 Eligibility criteria, population: was the focus of the study on the target group not an inclusion criterion (see also comment below)?, i.e., community-dwelling older adults with multimorbidity?
As already mentioned above, your comments regarding the target group helped us realize that there might arise a misunderstanding in our manuscript. The target population of this study is not only older adults with multimorbidity, but community-dwelling adults aged 75 years and above in general. We hope that by having added additional information in the introduction it becomes clearer that we do not

only focus on older adults with multimorbidity. Please also refer to our comment on p.4 in this document.
- Page 6 Lines 59-60: why were participants with dementia excluded?
Dementia is a specific disease. People with dementia have more specific needs than older adults in general. To take this into account we think there should be an independent core set for dementia. Another reason, why we decided to exclude people with dementia is that these persons are no longer fully capable of introspection which is essential also for the validity of the data of two other studies that are part of our development process (qualitative and empirical study). In order to have a comparable sample we decided to also exclude studies with participants with dementia from this literature review.
- Page 7 Lines 11-12: “to get a representative picture of the health reality of old adults, studies with participants suffering from one specific health condition were excluded”. I wonder whether this is the correct substantiation. Should it not be because the target population are older patients with multimorbidity (to subsequently also be exposed to the problem of polypharmacy)?
The target population of this study are not only older adults with multimorbidity, but community-dwelling adults aged 75 years and above in general. Please also refer to our comment on p.4 in this document. As individuals with a certain disease might have very specific needs, we decided to exclude studies with participants suffering from only one specific health condition. We have explained this better now in our manuscript. Please refer to p.33, l.22-24.
- Page 8 Lines 28-29: “The full texts were screened pairwise by four independent researchers”; I do not understand what is meant here, was one half of the full texts screened by two researchers and the other half by the other two researchers? Please clarify.
Exactly, one half was screened by two researchers and the other half by the other two researchers. This was clarified in the manuscript. Please refer to p.34, l.50-52.
- Page 8 Lines 53-54: “Population: type of sample”; what is meant? Information on diagnosis?/multimorbidity? Please clarify.
This refers to the living situation of the participants (e.g. community-dwelling, residents of independent living facilities). To make this clearer, this was added in the manuscript. Please refer to p.35, l.19-21.
- Page 9 Lines 18-31: Two datasets were made. However, the authors only report on the dataset with the linking results on the identified outcome measures. The authors may want to consider not mentioning the other dataset, since nothing is done with it. Subsequently, the authors could sharpen the purpose of this manuscript, by defining the researcher perspective as measurement instruments used in current.
Thank you for this very important feedback. The decision to focus on the first data set in this paper was due to the fact that the assessment instruments provide a more standardized and systematic basis for further analysis. Moreover, it proved difficult to present the results of both data sets within one paper. However, we did not want to reduce the research perspective to only the assessment instruments as we think that the second data set is also very important. It thus will be considered for the development of the final core set within the consensus conference as well. However, we revised the abstract (please refer to p.28) and the aims (please refer to p.32, l.14-19) to sharpen the purpose of this manuscript.
- Page 9 Lines 48-49: “two independent researchers”; please include the initials of the researchers.
Done. Just as the screening process, the linking process was carried out by all in all four researchers, each half by two of them. The wording “two independent researchers” was used to indicate that each concept was linked to an ICF category by two researchers independently of each other. This was now adjusted accordingly in the manuscript. Please refer to p.36, l.16-18.
- Page 10 Lines 8-9: typo: type of reference style.
The superscript number is a footnote (please refer to p. 49, l.56ff).
Results
- Page 10 Lines 35-37: “the study characteristics in Appendix B”; please change into “and the study characteristics are provided in Appendix B”.
Done (p.37, l.3-5).

- Page 11 Table 1: why are the instruments linked to “thematic focus” and not to ICF components? Cognition and mobility are categories of functioning?
The thematic focus was indeed based on the ICF. However, some instruments are too broad (e.g. functioning status and cognition) to be linked to one specific ICF category. Cognition is not an ICF category, but includes different ICF categories (please also refer to Annex 9 of the ICF, where cognition is linked to the categories b140, b144, b164).
- Page 13 Lines 5-8: “all 87 ICF categories will serve as candidates for considering during the consensus …”; Suggest to change into “consideration for inclusion in the core set during the consensus conference”.
Done (p.39, l.37-41).
- Page 16, Lines 58-60: The authors state that concepts linked to ‘not defined in the ICF’ were related to ‘physical activity’ and ‘activities of daily living’. By defining these in this way I wonder why they could not be linked to the A&P component? Can the authors give examples? Or maybe add a table with these ‘nd’ concepts (possibly in an appendix)?
The concepts linked to these two “nd categories” were too broad to be linked to a specific ICF category or a combination of ICF categories. Physical activity was defined in the instrument as e.g. walking, cleaning house, exercise. It might thus have been linked to these corresponding categories, but they would not really have represented what is meant by this concept. It might further have been linked to the category “d5701 Managing diet and fitness” or the category “d9201 Sports”. However physical activity is a much broader concept. It can be defined as any activity that involves some form of physical exertion and voluntary movements. It does not only refer to a specifically planned and structured form of activity that is mostly performed for health purposes (which would probably be linked to d5701); neither is it equitable to sports (usually defined as activities having rules, or goals to train specific skills). Thus, we decided to use the nd code instead. The same applies to activities of daily living. This explanation might go beyond the scope of the manuscript; however, we added a sentence in the manuscript that the concepts were too broad to be linked to one specific ICF category or a combination of ICF categories and in addition added the number of concepts that were linked to each of these “nd categories” to make clear that they were not applied very often. Please refer to p.43, l.31-42.
- In order to provide a quick overview of the results, the authors may want to consider to add a table with an overview of the number of concepts per (ICF) component, i.e., including: body structures (number of concepts linked), body functions (number of concepts linked), a&p (number of concepts linked), environmental factors (number of concepts linked), personal factors (number of concepts linked) and ‘nd’ (number of concepts linked).
Thank you for the good suggestion. Instead of creating an additional table, the number of concepts per ICF component was added in table 2.
- Appendix B: If I understand correctly that the core set is being developed for community-dwelling people with multimorbidity, it would be interesting to include data on type and/or number of diagnosis/ diseases in the publications identified.
Again, the target population of this study are not only older adults with multimorbidity, but community-dwelling adults aged 75 years and above in general. We hope that by having added additional information in the introduction it becomes clearer that we do not only focus on older adults with multimorbidity. Please also refer to our comment above on p.4 in this document. As the focus of this core set is not on diseases, we did not specify the diseases reported in the instruments, but included some information about commonly reported health conditions. Please refer to p.43, l.44-50.
Discussion
- The authors may want to consider to include a brief summary of the purpose before stating the main findings of the current study.
Done (p.43, l.56-69).
- Page 19 Lines 7-18: The authors mention that the interdisciplinary research team and their interdisciplinary perspective on the topic is a strength of this study. However, the systematic method that was followed (e.g., data extraction and linking procedure) in this study should prevent such a

‘bias’? I think this aspect of interdisciplinary is important in the consensus procedure later in the development process of the core set, and not necessarily in this study. Please clarify.
We agree, that the methods used should prevent such a ‘bias’. Still each profession has its very own perspective and might focus on different aspects. Thus, we consider it a strength to have had this interdisciplinary research team as it enabled us to discuss and consider different perspective. This was also helpful in designing the search strategy. Still, we added this fact of the prevention of bias already by the methods used, limiting the multi-professional team as a strength.
- Page 19 Lines 22-24: The authors mention that publications from other countries may have been missed. However, eligible countries were selected on the basis of predefined inclusion/exclusion criteria? Please clarify.
Thank you for this comment. We clarified this in the discussion section. Please refer to p.46, l.22-28. The limitation to specific countries was chosen as the intended ICF core set is meant to be used in primary care practices in Germany or other highly developed and industrialized countries. Thus, it would not make sense to consider research from low- or middle-resource countries with a very different socio-economic and cultural background. The possible loss of publications mentioned in the discussion section now refers to the language restrictions made, rather than to the country selection. As we only included publications written in English or German, other publications that were performed in the selected countries but written in their native language might have been missed.
1

VERSION 2 – REVIEW

REVIEWER	Lisette M van Leeuwen, PhD Amsterdam UMC, Vrije Universiteit Amsterdam, Otolaryngology-Head and Neck Surgery, Ear & Hearing, Amsterdam Public Health research institute, de Boelelaan 1117, Amsterdam, Netherlands.
REVIEW RETURNED	29-Jul-2020

GENERAL COMMENTS	Review BMJ Open, revision Manuscript bmjopen-2020-037333.R1: “Laying the foundation for a Core Set of the International Classification of Functioning, Disability and Health (ICF) for community-dwelling elderly adults in primary care: Relevant categories of their functioning from the research perspective. A scoping review”. General comments Thank you for the opportunity to review a revised version of this manuscript. I thank the authors for addressing my comments and I feel that the manuscript has improved after the revision. My only (bigger) concern and comment are regarding the exclusion of concepts extracted for the included article texts were excluded and the target population. - As part of the data extraction both assessment instruments (1) and concepts extracted from the article text (2) were listed, but only the assessment instruments were used in this study and linked to the ICF. Therefore, as mentioned in my previous review, you may want to consider to omit this part from this manuscript as it now leads to confusion. Moreover, it also would be in line with the objective as stated at the end of the introduction. I agree with the other reviewer that exclusion of the second list may have influenced the outcomes of this study and may also have influenced the search strategy. Moreover, in your rebuttal letter I read that you do want to use the information of the second list for the development of the core set. So then I suggest to include it in current paper or alternatively include this in a separate paper to which you can refer to in this paper? Otherwise,

	a better explanation of not including these concepts in this manuscript is needed in the manuscript. - The target population is defined as 'community-dwelling adults aged 75 years and older'. However, as written in your method section, you did specifically exclude studies with older adults suffering from only one specific health condition. Therefore, I still think the target population 'community-dwelling adults aged 75 years and older with multi morbidity' (which is then defined as having 2 or more conditions) is more appropriate? Also I think the language could still be improved. I am not a native English speaker, but sometimes expressions are used that I do not know if they are appropriate. E.g., 'belong to the universe of the ICF'. Furthermore I have some minor comments, that I listed below. Minor comments - The title is rather long. Also, an abbreviation of the ICF is not needed in the title. Abstract - Objectives – this is a little bit different from the objective stated at the end of the introduction. For example, in the abstract it is 'find concepts of functioning', in introduction it is 'identify aspects of functioning' and 'older adults' vs. 'elderly adults' □ please be consistent in your use of terminology and make sure the objectives are the same (also check the title). - Design – '[..] linked to the ICF using standardized linking rules' Introduction - Line 59, page 4 – add 'The paradigm change from disease-based view to a bio-psychosocial view' or something similar. - Line 3, page 5 – I do not recognize the definition of functioning from the ICF, as mentioned in my previous review I still would recommend to use the definition of the ICF. Also, a reference for this definition is missing. - Line 7-8, page 5 – maybe add one sentence explaining that the ICF is an international standard and classification system for describing functioning and health. - Line 33, page 5 – standardized process of the WHO/ ICF research branch. - Maybe add the purpose of the research perspective as defined by the standardized process, followed by the specific aims of the present study (e.g., 'In the research perspective, the scoping review aims to identify aspects of functioning that are described or evaluation in the scientific related to the health condition of interest (Selb et al., 2015)'. In this paper [..] scientific literature'.) Method - I did not note this is my previous review, sorry, but you may want to add what was done with concepts that could not be linked to the ICF, including the linking to the categories 'not defined'/ 'personal factor'/ 'health condition'. Then the results on these categories follow a little bit more logically. Results - Thank you for your explanation of my previous comment on table 1. The description of the thematic focus of the assessment instruments as presented in Table 1 is not included in the method section. Please include (e.g., under data synthesis), as the results presented in table 1 then will follow more logically.

	- Line 8, page 17 – you may want to add a reference to organ systems and also include the categories/codes (possibly in the method section, see my comment there)? Discussion - Line 3, page 69 – 'From this research perspective, ..' - I did not note this is my previous review, sorry, but is 'relevant' the correct word to use to address the frequency of concepts extracted from the assessment instruments? I doubt you can say that frequency equals relevance. I would suggest to use the word frequency or that some concepts were more dominant or common than others. - Line 12, page 69 – 'With only two ICF categories, 'body structures' [..]; please revise into (or something similar): 'From the content of the assessment instruments, only two ICF categories were linked to the component body structures. Body structures was thereby the least linked component.' - The explanation for not including assessment instruments solely focusing on body structures should be placed in the method section, rather than in the discussion section. - I stick to my previous comment that the multidisciplinary research team is not a strength of this study. It is a strength in the further development of the core set. - Line 37, page 71 – ' while the ICF is too extensive [..]' □ I do not understand the message of this sentence, please revise. - Rather than only pointing this out when discussing the 'attitudes' category, you may want to add a broader discussion point on the study designs of the articles that were included in this study. And then also discuss that qualitative studies were underrepresented and what consequences this has for the results of this study. - Implications for practice □ the sentence 'providing physicians with our comprehensive, but easy to handle ICF-CS' [..]' is a bit premature. Please remove. You can include that this study will complement the other studies, which will be combined to form an IC core set. - Implications for practice □ the sentence 'Considering information on functioning might support general practitioners to better estimate the relevance of medical interventions, and thus avoid unnecessary medical interventions.' comes a bit out of the blue and is unclear to me. Please focus on this study. You may want to address the importance of the researcher perspective, e.g., because assessment instruments that are used influence whether an intervention is seen to be effective or not. Conclusion - 'Despite some limitations experiences in the linking process, the ICF provides a useful reference to identify the concepts of assessment instruments focusing on the functioning of community-dwelling older adults'.

VERSION 2 – AUTHOR RESPONSE

No.	Peer Review comment	Response

		(page and line numbers refer to the document "main manuscript_marked copy")
1	My only (bigger) concern and comment are regarding the exclusion of concepts extracted for the included article texts were excluded and the target population. As part of the data extraction both assessment instruments (1) and concepts extracted from the article text (2) were listed, but only the assessment instruments were used in this study and linked to the ICF. Therefore, as mentioned in my previous review, you may want to consider to omit this part from this manuscript as it now leads to confusion. Moreover, it also would be in line with the objective as stated at the end of the introduction. I agree with the other reviewer that exclusion of the second list may have influenced the outcomes of this study and may also have influenced the search strategy. Moreover, in your rebuttal letter I read that you do want to use the information of the second list for the development of the core set. So then I suggest to include it in current paper or alternatively include this in a separate paper to which you can refer to in this paper? Otherwise, a better explanation of not including these concepts in this manuscript is needed in the manuscript.	We can understand why this explanation as it is now might lead to confusion. As explained in the previous revision, it proved difficult to present the rather complex process and the results (i. e. many ICF categories) of both data sets within one paper. As suggested, we now omitted the part about the concepts of the article text from the manuscript in order to improve readability and avoid confusion. Consequently, we changed the subsection Data extraction, explaining that, following the methodology applied in other ICF-CS development projects, it was decided to focus on assessment instruments, as they provide a standardized and systematic basis for further analysis (please see p.56, l.16-21). As 14 of the initially included 82 studies did not use any assessment instruments, we also changed - the flow chart: these 14 studies are now listed under the exclusion criterion irrelevant outcomes, - Appendix B (references for included articles), - Appendix C (characteristics of included articles) and - the subsection Study characteristics in the results section (please see p.58, l.27-44).
2	- The target population is defined as 'community-dwelling adults aged 75 years and older'. However, as written in your method section, you did specifically exclude studies with older adults suffering from only one specific health condition. Therefore, I still think the target population 'community-dwelling adults aged 75 years and older with multi morbidity' (which is then defined as having 2 or more conditions) is more appropriate?	We are sorry that we insufficiently clarified this issue in the last revision. We excluded studies in which only older adults suffering from one specific health condition were included as these individuals might have very specific needs that do not necessarily represent the needs of other community-dwelling older adults not suffering from the particular disease. Multimorbidity was mentioned in the introduction as it is very common in older people and often accompanied by polypharmacy. Still (as described in the introduction), a blurring between the boundaries of diseases, risk factors and physiological aging processes can be observed in all older individuals, also leading to a tendency for inappropriate polypharmacy. To help reverse this tendency,

		there is a need for new strategies (e. g. including functioning information in the consultation). The participants in the included studies are not necessarily multimorbid. Actually, only one of the studies focuses exclusively on multimorbid patients. What all participants of the included studies have in common is that they are community-dwelling and over the age of 75 years. They might have a certain disease (or also more than one) or they might be completely healthy. Consequently, although this patient population is considered old and it is highly probable that they are multimorbid, we cannot assume that the results of our review can be specifically applied to multimorbid patients. Thus, we feel that 'community-dwelling adults aged 75 years and older with multimorbidity' would not be the correct wording. We feel that most of this explanation is already included in our manuscript, but we realized that there is a possible misunderstanding due to the aforementioned exclusion criterion and tried to clarify this (please see p.54, l.5-14).
3	Also I think the language could still be improved. I am not a native English speaker, but sometimes expressions are used that I do not know if they are appropriate. E.g., 'belong to the universe of the ICF'.	Kindly note that one of the authors is an English native speaker and has revised the manuscript also for language issues. The example you mention ("belong to the universe of the ICF") refers to the terminology used in the article about the ICF linking rules (please also see Cieza et al., 2016. Refinements of the ICF Linking Rules to strengthen their potential for establishing comparability of health information.)
Title		
4	The title is rather long. Also, an abbreviation of the ICF is not needed in the title.	We agree that the title is rather long. In the previous version the title was somewhat shorter. However, we received the feedback from the editor that the title was a little confusing and we were asked to revise it. The first part of the title sets the frame. It corresponds to the whole project, which aims at delivering four preliminary Core Sets as a foundation in the development process of one comprehensive ICF Core Set. The second part of the title was added to clarify what was done in this specific study, also including the

		study type. As we feel that the length of the title is necessary to clarify what the study is about, we prefer to keep it as is. However, as you suggested we deleted the abbreviation of the ICF.
Abstract		
5	Objectives – this is a little bit different from the objective stated at the end of the introduction. For example, in the abstract it is 'find concepts of functioning', in introduction it is 'identify aspects of functioning' and 'older adults' vs. 'elderly adults' → please be consistent in your use of terminology and make sure the objectives are the same (also check the title).	Thank you for this comment. As the objective was indeed to find concepts of functioning (as mentioned in the abstract) we revised the objective in the introduction section in a way that the objective mentioned in the abstract and the introduction section now match each other. As the result of this study is the list of potentially relevant ICF categories for the final ICF Core Set, we kept the term "categories" in the title. As suggested, we now just use the adjective "older" (e.g. older adults, older patients).
6	- Design – '[..] linked to the ICF using standardized linking rules'	Thank you for the suggestion, the sentence was adjusted accordingly.
Introduction		
7	- Line 59, page 4 – add 'The paradigm change from disease-based view to a bio-psychosocial view' or something similar.	Thank you for the suggestion, the sentence was adjusted accordingly (please see p.52, l.9).
8	- Line 3, page 5 – I do not recognize the definition of functioning from the ICF, as mentioned in my previous review I still would recommend to use the definition of the ICF. Also, a reference for this definition is missing.	Thank you for this comment. The definition was based on Stucki et al. (2017). Functioning: the third health indicator in the health system and the key indicator for rehabilitation and the World report on ageing and health published by the World Health Organization in 2015. Unfortunately, the references were deleted unintentionally in the last revision. As suggested, we now cite the definition of functioning that is used in the ICF instead ("Functioning can be defined as the outcome of the interactions between a person's health conditions and contextual factors") and added the corresponding reference (please see p.52, l.12-14).

9	- Line 7-8, page 5 – maybe add one sentence explaining that the ICF is an international standard and classification system for describing functioning and health.	We added "…the international standard and classification system for describing functioning and health …" (please see p.52, l.16-19).
10	- Line 33, page 5 – standardized process of the WHO/ ICF research branch.	Thank you for the suggestion, the sentence was adjusted accordingly (please see p.52, l.46).
11	- Maybe add the purpose of the research perspective as defined by the standardized process, followed by the specific aims of the present study (e.g., 'In the research perspective, the scoping review aims to identify aspects of functioning that are described or evaluation in the scientific related to the health condition of interest (Selb et al., 2015)'. In this paper [..] scientific literature'.)	Thank you for the suggestion, the sentence was added to the introduction (please see p.53, l.3-7).
Methods		
12	- I did not note this in my previous review, sorry, but you may want to add what was done with concepts that could not be linked to the ICF, including the linking to the categories 'not defined'/ 'personal factor'/ 'health condition'. Then the results on these categories follow a little bit more logically.	Thank you for this suggestion. We agree that it might be easier to understand if the linking procedure of these concepts is explained within the methods section. Thus, we added a short paragraph within the subsection Data synthesis, in which we explain what kind of concepts were linked to the categories 'not defined'/ 'personal factor'/ 'health condition' (please see p.57, l.13-31).
Results		
13	- Thank you for your explanation of my previous comment on table 1. The description of the thematic focus of the assessment instruments as presented in Table 1 is not included in the method section. Please include (e.g., under data synthesis), as the results presented in table 1 then will follow more logically.	As suggested, we added a sentence within the subsection Data synthesis: "To give an overview of the identified assessment instruments, they were categorized according to their thematic focus based on the terminology used in the ICF" (please see p.56, l.60-p.57, l.5).
14	- Line 8, page 17 – you may want to add a reference to organ systems and also include	We added a sentence within the subsection Data synthesis explaining that the grouping of the health conditions was based on the structure of

	the categories/codes (possibly in the method section, see my comment there)?	the International Classification of Diseases (please see p.57, l.22-24).
Discussion		
15	- Line 3, page 69 – 'From this research perspective, ..'	Thank you for the suggestion, the sentence was adjusted accordingly.
16	- I did not note this in my previous review, sorry, but is 'relevant' the correct word to use to address the frequency of concepts extracted from the assessment instruments? I doubt you can say that frequency equals relevance. I would suggest to use the word frequency or that some concepts were more dominant or common than others.	Thank you for this insightful comment. However, we assume, following the recommendation of the methodology of the ICF Research Branch, that those aspects of functioning that are frequently assessed in the scientific literature are those that are of particular interest of the scientists investigating persons with a given health condition and can thus be considered being relevant from the perspective of the researchers. Of course, this does not necessarily mean that they are relevant for the patients themselves. To clarify this, we added a short sentence as well as the reference to the subsection Data synthesis (please see p.57, l.45-48). We are of course aware, that these concepts might not necessarily be the same concepts that are relevant to the target population or the health professionals. As described in the manuscript, the concepts that are relevant from their perspectives were investigated in two other studies - the qualitative study and the expert survey.
17	- Line 12, page 69 – 'With only two ICF categories, 'body structures' [..]; please revise into (or something similar): 'From the content of the assessment instruments, only two ICF categories were linked to the component body structures. Body structures was thereby the least linked component.'	We rephrased the sentence to say "From the content of the assessment instruments only four concepts were linked to two ICF categories of the component 'body structures'. Thus, this component was by far the least linked component" (please see p.65, l.26-32).
18	- The explanation for not including assessment instruments solely focusing on body structures should be placed in the method section, rather than in the discussion section.	Kindly note that the explanation is already included in the methods section. We here refer to the subsection Eligibility criteria (Outcomes: […] Publications reporting on studies that solely focused on body structures without considering any other features of functioning were excluded. Since physicians tend to focus on physical aspects of health anyway, and the final ICF-CS is

		meant to complement this traditional emphasis on physical structures and processes with few categories as necessary (for reasons of feasibility), we decided to forego body structures to ensure that the resulting ICF-CS reflects those components of the ICF that are not yet in the focus of general physicians.) Please also see p.54, l.18-31. As this is an important aspect, we believe it is necessary to address it again in the discussion section.
19	- I stick to my previous comment that the multidisciplinary research team is not a strength of this study. It is a strength in the further development of the core set.	We agree that the multidisciplinary team might be the least relevant for this part of the development process; we consequently deleted this sentence from the discussion section (please see. p.67, l.24-30) and from the section Article summary - strengths and limitations (please see. p.51, l.17-19).
20	- Line 37, page 71 – ' while the ICF is too extensive [..]' → I do not understand the message of this sentence, please revise.	What we meant by this is that the ICF is really broad, including more than 1.400 categories, requiring a reduction to the most relevant categories (Core Set) to be used in clinical practice. Still, we were not able to link some concepts of functioning that were really relevant to our study population to one specific ICF category. Sometimes two or more categories were required to describe this concept and still the concept might not be adequately represented (also see the example mentioned in the manuscript). We realized that the sentence might lead to confusions and rephrased it to improve readability and clarify this issue (please see p.67, l.51-54).
21	- Rather than only pointing this out when discussing the 'attitudes' category, you may want to add a broader discussion point on the study designs of the articles that were included in this study. And then also discuss that qualitative studies were underrepresented and what consequences this has for the results of this study.	Due to the limited amount of words available we are not able to discuss this topic in detail. However, we added a sentence to the discussion section explaining that due to the focus on assessment instruments, qualitative studies, which have the potential to analyze participants' feelings, opinions, and experiences in-depth, are underrepresented in this review (please see p.67, l.32-38).
22	- Implications for practice → the sentence 'providing physicians with our comprehensive,	Thank you for your suggestion. We agree that this part might be a bit premature and deleted

	but easy to handle ICF-CS' [..]' is a bit premature. Please remove. You can include that this study will complement the other studies, which will be combined to form an IC core set.	it (please see p.69, l.10-16). Kindly note that the first paragraph of this section already explains that the results of this scoping review andf the three other preparatory studies will be used to develop the comprehensive ICF-CS. Thus, we think there is no need for further explanation.
23	- Implications for practice → the sentence 'Considering information on functioning might support general practitioners to better estimate the relevance of medical interventions, and thus avoid unnecessary medical interventions.' comes a bit out of the blue and is unclear to me. Please focus on this study. You may want to address the importance of the researcher perspective, e.g., because assessment instruments that are used influence whether an intervention is seen to be effective or not.	Thank you for making us aware that there might be some confusion. In combination with your previous comment we now feel that this sentence might also be a bit premature. We thus replaced it with "Defining those aspects of functioning that are relevant from the research perspective seems important to us, because assessment instruments that are frequently used influence whether an intervention is seen to be effective or not. The concepts found therefore will have a strong influence on the final ICF-CS to be developed." (please see p.69, l.3-10).
References		
24	- 'Despite some limitations experienced in the linking process, the ICF provides a useful reference to identify the concepts of assessment instruments focusing on the functioning of community-dwelling older adults'.	Thank you for the suggestion, the sentence was adjusted accordingly (please see p.69, l.30-33).