REGIONE AUTONOMA FRIULI VENEZIA GIULIA
direzione centrale salute, integrazione socio sanitaria, politiche sociali e famiglia

Azienda per i Servizi Sanitari n. 5 "BASSA FRIULANA"
AREA DELLE CLASSIFICAZIONI

WHO-FIC Network I ANNUAL MEETING
Barcelona
11-17 October

I CONTRIBUTI

del Centro Collaboratore italiano
dell'Organizzazione Mondiale della Sanità
per la Famiglia delle Classificazioni Internazionali

Barcelona, 11-17 October 2014

WHO-FIC Annual Network Meeting

Driving improvement in healthcare: from data to eHealth tools

www.reteclassificazioni.it

Centro Collaboratore italiano dell'Organizzazione Mondiale della Sanità per la Famiglia delle Classificazioni Internazionali
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In reply please refer to: WHO FIC 2014

Your reference: WHO-FIC 2014

Lucilla Frattura
Head, WHO-FIC Collaborating Centre
Regional Health Administration Via
Pozzuolo, 330
33100 Udine
Italy

25 June 2014

Dear Dr Frattura,

WHO Family of International Classifications Network Annual Meeting
Barcelona, Spain, 11-17 October 2014

I take great pleasure in inviting you and the delegation from your centre to the next annual meeting of the World Health Organization Family of International Classifications (WHO-FIC) Network, which will take place in Barcelona, Spain, from Saturday 11 to Friday 17 October 2014.

The meeting will be hosted by the Agency for Health Quality and Assessment of Catalonia (AQuAS), the Catalan Ministry of Health, the Office of Health of the Barcelona City Council and Fundació TicSalut. The Secretariat function will be carried out by the WHO HQ Classifications, Terminology and Standards unit.

"Driving improvement in healthcare: from data to eHealth tools " has been identified as the main theme for the meeting this year.

Please find attached the provisional timetable and a tentative list of participants. These will be updated in line with comments from the Small Executive Group (SEG) and yourselves after review by the Secretariat. Updates will be posted on the WHO web site:
http://www.who.int/classifications/network/meeting2014/en/index.html

The meeting venue is the CCIB, the Barcelona International Convention Centre.

The website for the coordination of meeting registrations and accommodation reservations developed by our hosts will provide all the details regarding general orientation and meeting facilities, as well as accommodation and social program reservation forms and procedures. The website will be accessed via hyperlink from the WHO FIC website.

Registration for the meeting is mandatory and must be made through the meeting web site.

Each WHO Collaborating Centre is to be represented by two main delegates and as many alternates as you deem appropriate. However, we would like you to restrict the size of each team to no more than 5 members, unless responsibilities for the work program warrant a higher number. Please send an updated list of your delegation with full individual details (including email address) to Eva Foust (fouste@who.int) no later than 31 July 2014, and complete their registration through the web site by 22 September 2014 at the latest.

As per established practice, we understand that all participation costs for you and your team will be borne by yourself or your organization.

This invitation is sent to you by e-mail. Should you require a hard copy, please inform us and we will send one for you and your team members accordingly.

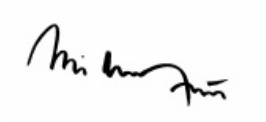
We would like to request each WHO Collaborating Centre to submit a poster presenting the annual report from your centre. We will use the same platform as in 2013 for the submission and collection of the posters for 2014. The link is available on the WHO website and on the meeting website. This applies for all posters, for plenary poster sessions and for presentation in the Committees or Reference Groups

The deadline for poster abstracts is 15 July 2014 and the deadline for the submission of final posters is 5 September 2014.

If you require any further information regarding the meeting please do not hesitate to contact me and the members of the WHO-CTS Team.

I am looking forward to meeting you in Beijing.

Sincerely,



(Electronic signature)

Dr T. Bedirhan Üstün
Coordinator
Classifications, Terminologies and Standards
Department of Health Statistics and Informatics

ENCLS.
Draft Timetable
Draft List of Participants

Barcelona, 11-17 October 2014

WHO-FIC Annual Network Meeting

Driving improvement in healthcare: from data to eHealth tools

Composizione della delegazione 2014

Lucilla Frattura

Italian WHO-FIC Collaborating Centre Head, Council (voting member), Update and Revision Committee (ICF voting member), Education and Implementation Committee (voting member), Functioning and Disability Reference Group (member)

Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC, Udine

Vincenzo Della Mea

Informatics and Terminology Committee (co-chair)

University of Udine, Dept Mathematics and Informatics

Andrea Martinuzzi

Functioning and Disability Reference Group (co-chair)

"E. Medea" Scientific Institute, Conegliano Research Centre

Matilde Leonardi

Education and Implementation Committee (voting member) , Functioning and Disability Reference Group (member)

Neurological Institute Carlo Besta IRCCS Foundation - Neurology, Public Health and Disability Unit, Milan

Francesco Grippo

Mortality Reference Group (voting member)

Italian National Institute of Statistics, Rome

Andrea Simoncello

Informatics and Terminology Committee (voting member)

Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC, Udine

Paula Tonel

Update and Revision Committee (ICF secretariat)

Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC, Udine

Giovanni Bassi

Observer

Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC, Udine

Giulio Castelpietra

Observer

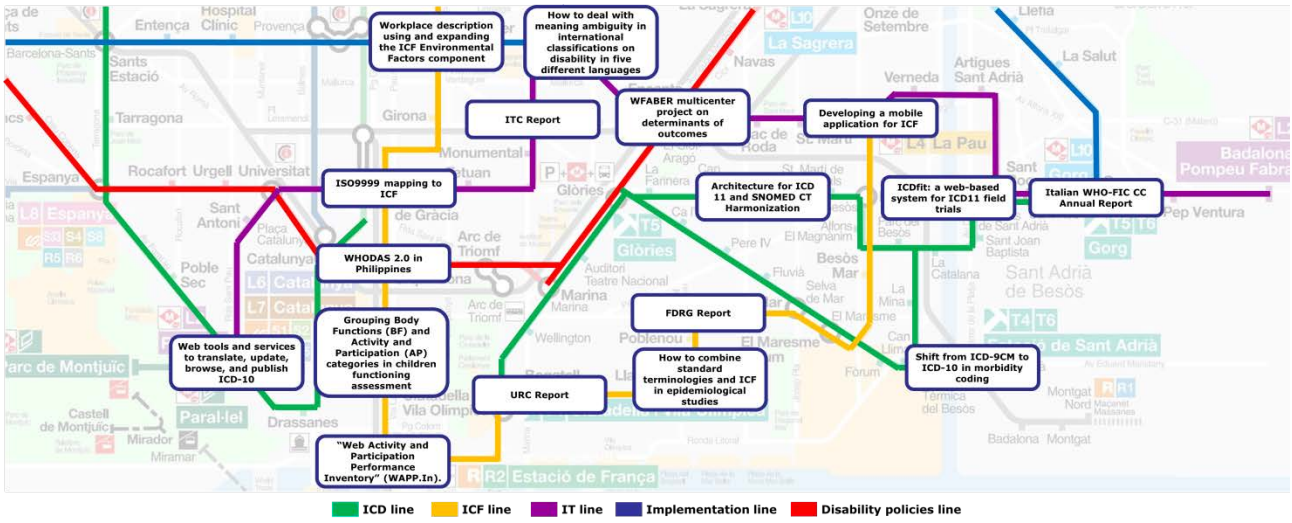
Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC, Udine

Barcelona, 11-17 October 2014

WHO-FIC Annual Network Meeting

Driving improvement in healthcare: from data to eHealth tools

The Barcelona Subway Interactive Map of the Italian WHO-FIC CC 2013-2014 activities (each station is a downloadable WHO-FIC 2014 Meeting poster)

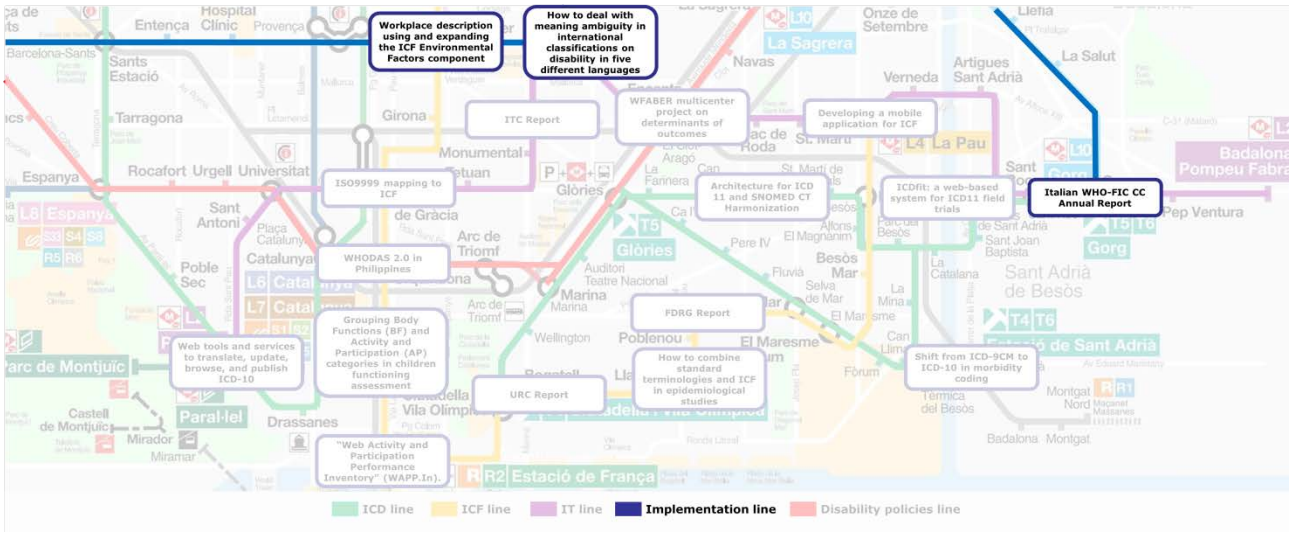


Barcelona, 11-17 October 2014

WHO-FIC Annual Network Meeting

Driving improvement in healthcare: from data to eHealth tools

Implementation Line



- *Bassi G., Frattura L., Simoncello A.* How to describe the workplace using and expanding the Environmental Factors component of the ICF: the first version of the “Workplace assessment schedule”.
- *Rodrigues J.M., Frattura L., Cuenot M.* How to deal with meaning ambiguity in international classifications on disability in five different languages.
- *Frattura L.* Updates on the performance monitoring plan of the Italian WHO-FIC Collaborating Centre: a new reporting way on annual activities.

How to describe the workplace using and expanding the Environmental Factors component of the ICF: the first version of the "Workplace assessment schedule"

11-17 October 2014
Barcelona, Spain

C526

Bassi G.[1], Frattura L.[1], Simoncello A.[1], Paolone D.[2], Gorini G.[2]
[1]Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC; [2]Italia Lavoro, Ministry of Labour, Rome

Abstract On the basis of a specific agreement, the WHOFIC Italian CC supported Italia Lavoro in the review and development of specific ICF-based assessment tools. During this cooperation, a first version of a "Workplace assessment schedule" was developed, taking into account ICF and its limits regarding the Environmental Factors component.

Introduction

In 2013, a new national programme was launched on the evaluation of functioning/disability of persons with disability in order to support their inclusion in the labour market by Italia Lavoro, the governmental body responsible for the programme on behalf of the Italian Ministry of Labour. On the basis of a specific agreement, the WHOFIC Italian CC supported Italia Lavoro in the review and development of specific ICF-based assessment tools (Figure 1, blue-written labels). During this cooperation, a first version of a "Workplace assessment schedule" was developed, taking into account ICF and its limits regarding the Environmental Factors component.

Methods & Materials

The starting point was a previous version of the assessment schedule and the areas it assessed (1, 2). The characteristics of the workplace to describe are shown in Figure 2.

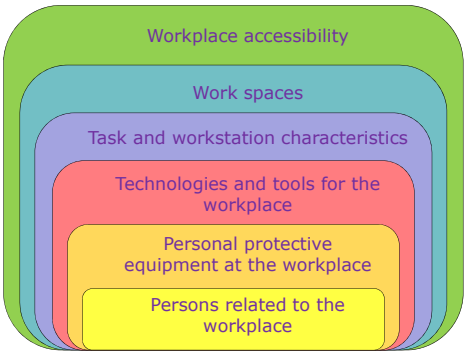
The possibility to use other standard terminologies to expand the ICF categories used was also considered.
It was found that only categories from domain e1 could be expanded using a more specific standard terminology.
The standard used was ISO9999.
The expansion of the other ICF-EF categories was done using the general terminology already present in the assessment tool.

Results

The tool foresaw the assessment of 89 items, in the 6 aspects mentioned above.
The 89 items were mapped using 12 ICF categories (Tables 1 e 2) from the following domains:

- 3 categories from e1: e120, e135, e150
- 3 categories from e2: e225, e240, e250
- 4 categories from e3: e325, e330, e340, e345
- 2 categories from e5: e540, e590.

Figure 2 – What to describe in the workplace

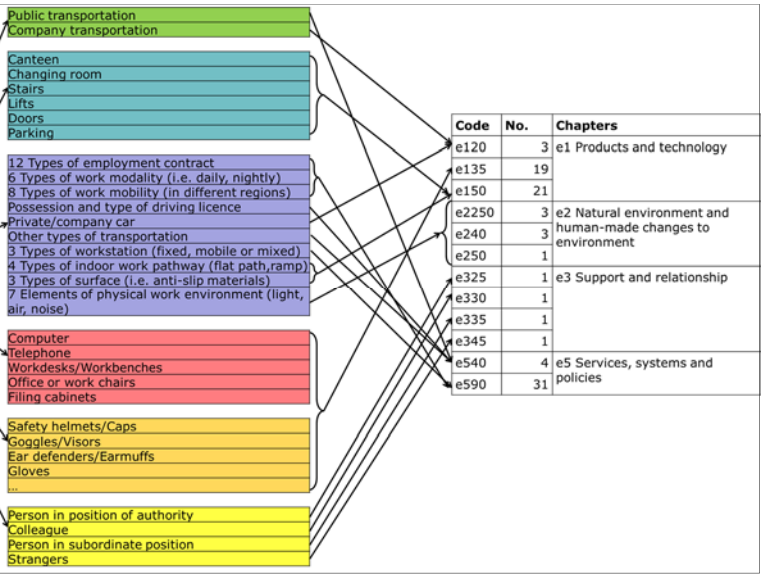


Conclusions

It is possible to expand ICF to describe a workplace.
The list of expanded ICF-EF terms can be used to describe a worker functioning profile in a workplace described using the new tool.
This new tool will be used jointly to a "Questionnaire on the employer's expectations 1.0", which was also defined. This other questionnaire, through the exploration of 8 AP chapters and 54 items, will be useful to match the professional functioning profile requested by the employer with the functioning profile of the candidate. Field trials were planned to verify their feasibility.

Table 1 – Structure of the Assessment schedule and count of items

Assessment Areas		Sections	No.
1	General workplace characteristics	Workplace accessibility	2
		Work spaces	14
2	Specific workplace characteristics	Task and workstation characteristics	50
		Technologies and tools for the workplace	11
		Personal protective equipment at the workplace	8
		Persons related to the workplace	4
	Total		**89**



The information foreseen by the assessment tool was mapped to ICF using a semantic and/or conceptual similarity method.

Figure 1 – New ICF based tools for labour system

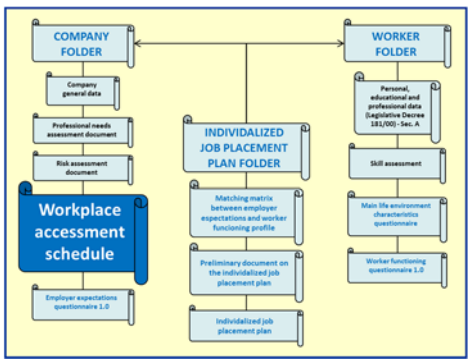


Table 2 – Number of items mapped to ICF EF Chapters

Items to map No.	ICF EF Chapters	ICF categories used to map workplace items
3	**e1** Products and technology	e120
19		e135
21		e150
3	**e2** Natural environment and human-made changes to environment	e2250
3		e240
1		e250
1	**e3** Support and relationships	e325
1		e330
1		e335
1		e345
4	**e5** Services, systems and policies	e540
31		e590
89	**Total**	

References

1. Frattura L., Conclave M., Gorini, G. ICF implementation in targeted employment of persons with disabilities: the Italian work in progress. WHO-FIC Network Annual Meeting Cape Town 2011
2. Conclave M, et al. The ICF and Labour Policies Project: the first Italian nationwide experience of ICF implementation in the labour sector, D&R, 2009; 31 (S1): S16-S21

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How to deal with meaning ambiguity in international classifications on disability in five different languages

11-17 October 2014
Barcelona, Spain

C515

Rodrigues J.-M.[1], Frattura L.[2], Cuenot M.[3]

[1] Inserm U1142, LIMICS, UPMC UJM (France), [2] Central Health Directorate, Classification Area, Friuli Venezia Giulia Region (Italy), [3] French National School of Public Health (France)

Abstract From ICIDH to ICF, knowledge on disability has evolved and the wording has changed in the different languages without a clear relation with Ontology. The authors compare the different meanings of the same word disability, in five languages, across standard classifications and UN Convention on the Rights of Persons with Disabilities (CRPD) and propose an ontology perspective. One of us has proposed to use an acronym to overcome the linguistic barrier with the translation in national languages. The discussion is open to consider the risk not to face the use of the same English terms without referring to a semantic definition before translation.

Introduction

From the International Classification of Impairments, Disabilities, Handicaps (ICIDH, WHO, 1980) to the International Classification of Functioning, Disability and Health (ICF, WHO, 2001), knowledge on disability has evolved and the wording has changed in the different languages without a clear relation with Ontology. The authors compare the different meanings of the same word disability across standard classifications and the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and propose an ontology perspective.

Methods & Materials

Three different meanings of the same English term disability in three different standard terminologies were analysed (ICIDH, ICF, UNCRPD) then the translation of these three different meanings in five languages were considered.

Results

ICIDH Disability is defined as: The inability to perform an activity in a normal manner due to an impairment.
ICF Disability is defined as: "An umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual and that individual's contextual factors". In the same classification, WHO provides a definition for Functioning, in such a way specular, used for describing the positive interaction between an individual and that individual's contextual factors.
On the other hand UNO has approved and defined a **UN CRPD which defines persons with Disabilities** as Persons "who have long-term physical, mental, intellectual or sensory impairments which in interaction …may hinder their full and effective participation in society on an equal basis with others". Such a definition allows us to outline the concept of disability, which, without questioning the physical/mental impairment (seen as a precondition), focuses on the consequences that people with disabilities face in their daily life because of the presence of barriers. The consequences, according to the UN definition, are negative and they regard the restriction to participation in life. Thus, the definition of the UN, although it does not explicitly define what disability is, suggests that disability is the negative consequence of an interaction between a person with impairments and the environment. On the other hand, the issue about what is a positive interaction and what is a negative one is not faced in the " ICF red book". The schema suggested in Annex 2 (ICF, pag. 223) is not sufficient to solve the problem on how to distinguish positive from negative interactions.

Table 1 - The table shows the results of the semantic comparison

Language	ICIDH	ICF	UNCRPD
English	Disability	Disability	Disability
French	Incapacité	Handicap	Handicap
Italian	Disabilità	Disabilità	Disabilità
Portuguese	Incapacidade	Incapacidade	Deficiência
Spanish (Castillano)	Discapacidad	Discapacidad	Discapacidad
Unique Semantic Identifier (USI)	USI 01 The inability to perform an activity in a normal manner due to an impairment.	USI 02 An umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual and that individual's contextual factors.	USI 03 …who have long-term physical, mental, intellectual or sensory impairments which in interaction …may hinder their full and effective participation in society on an equal basis with others.

Figure 2 – The "disability semantic" cloud

Conclusions

The different national languages addresses the change in meaning differently making comparisons of words misleading.
One of us [1] has proposed to use an acronym to overcome the linguistic barrier with the translation in national languages. In the era of Ontology an alternative proposal may be to associate to the words (e.g Disability) in each language a Unique Semantic Identifier (USI) which explicits the definition of the word allowing not to confuse it with the same word with another meaning in another context. The discussion is open to consider the risk not to face the use of the same English terms without referring to a semantic definition before translation. The positive side of the disability coin is "functioning" and we need to identify it too in an appropriate ontological way .

References

1. Frattura L. , Griffo G. **Updating Annex 5: ICF, people with disabilities and UN CRPD: implications for statistics and policies monitoring.** *WHOFIC2011 / D002 Cape Town, South Africa 29 October - 4 November 2011*

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Updates on the performance monitoring plan of the Italian WHO-FIC Collaborating Centre: a new reporting way on annual activities

11-17 October 2014
Barcelona, Spain

C206

Frattura L. on behalf ot the WHO-FIC Italian collaborating centre network
Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC

Abstract Moving from the 2011-2015 terms of reference (TORs) of the Italian WHO-FIC CC, a performance monitoring plan was defined to yearly assess the CC's performance. The aim of this work is to present the third-year results of the performance monitoring plan of the Italian WHO-FIC Collaborating Centre (CC).

Introduction

The aim of this work is to present the third-year results of the performance monitoring plan of the Italian WHO-FIC Collaborating Centre (CC) using the content of the CC annual report [1] and the Italian posters submitted at Barcelona Annual meeting.

Methods & Materials

Moving from the 2011-2015 terms of reference (TORs) of the Italian WHO-FIC CC, a performance monitoring plan was defined to yearly assess the CC's performance. Five main criteria were used: (i) adherence to the relevant lines of work of the WHO-FIC Strategic Work Plan (SWP); (ii) outcomes of the activities; (iii) new partnerships; (iv) communication power; and (v) resource consumption.

Results

In the third year (21 July 2013-21 July 2014), the Italian WHO-FIC CC was active on five lines of work at international, national and regional level: (i) revision of the International Classification of Diseases; (ii) IT and ontological development for WHO FIC; (iii) coordination and management of the ICD-10 and ICF update process; (iv) national work on WHO-FIC; and (v) awareness building and implementation support of WHO-FIC in WHO regions. Some results are presented in an interactive map (QR accessible) that allows browsing through all the posters presented by the CC at the 2014 WHO-FIC annual meeting (Figure 1).
New projects inside the WHO-FIC network: launch of the WFABER project; coordination of and active participation in mICF; involvement in SNOMED-CT and ICF common ontology efforts; ISO9999 mapping to ICF; translation into Italian of the WHODAS 2.0 Manual; translation into Italian of the ICD-10 Training tool; translation into Italian the ICD-10 1996-2013 cumulative updates; transcoding administrative discharge data from ICD9-CM to ICD-10 using a new software, developed by the Italian WHO-FIC CC. Updates at national level: the CC is formally engaged, as leader of the ICD-10-related line of work, in the national project of revision of the Italian case-mix system (IT-DRG project); ICD-10 cumulative updates were translated into Italian and the relevant ClaML file was maintained both in English and Italian through the Italian Portal of Classifications, which was restyled. Updates at regional level: a third VilmaFABER field trial was carried out in the Friuli Venezia Giulia Region and a fourth field test was started in the Liguria Region. VilmaFABER has been published on the web (Figure 2) [2].
The communication power was evaluated considering presentations, seminar and meeting organization, and active users of the Italian Portal of Classifications (Figure 3).

Figure 3 – The new Italian Portal of Classifications as a strategic communication tool of the Italian CC

Figure 1 – The Barcelona Subway Interactive Map of the Italian WHO-FIC CC 2013-2014 activities (each station is a downloadable WHO-FIC 2014 Meeting poster)

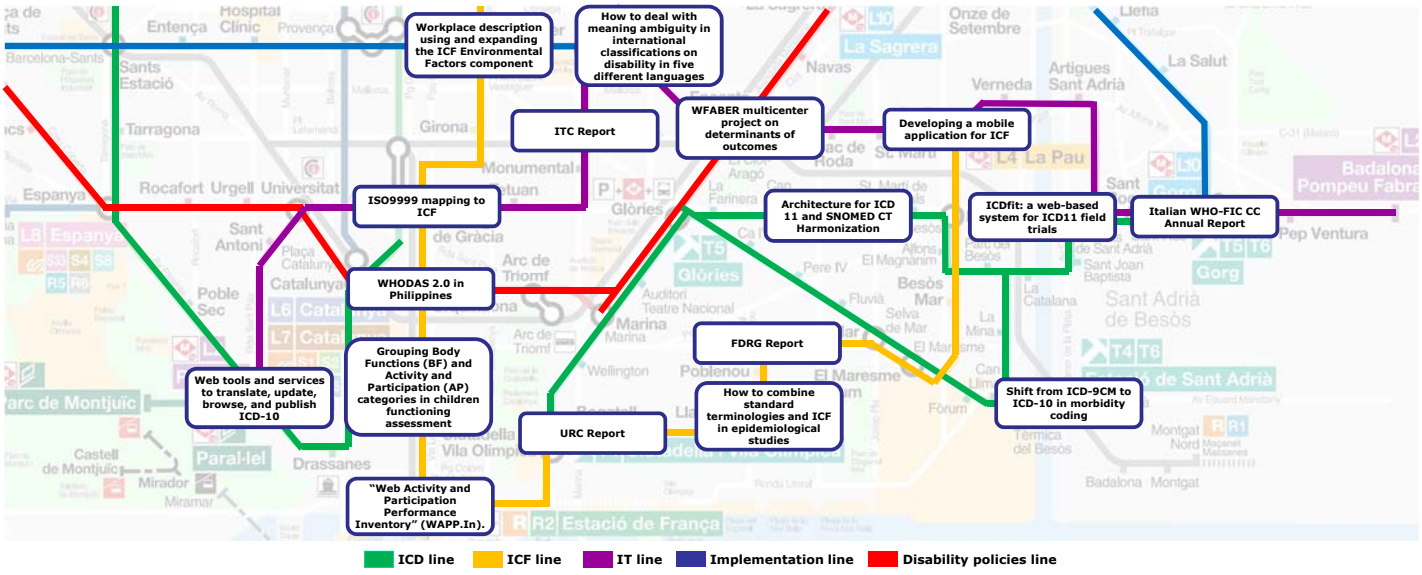

Figure 2 – The VilmaFABER logo

vilma FABER Friendly.Alimenting.Biopsychosocial.Electronic.Record

Conclusions

The activities of the Italian Collaborating Centre are linked to the relevant lines of work of the WHO-FIC SWP according to the CC's TORs. All activities of the Centre were made possible thanks to regional and national funding.

Acknowledgements

All activities carried out by the Centre were possible thanks to the deep understanding and concrete funding by Friuli Venezia Giulia Regional Administration, national and other regional institutions and authorities.
1. Agreement between Italian Ministry of Health and Friuli Venezia Giulia Region, 2010-2012; 2013-2015
2. "Progetto It.DRG", founded by National Health Service 2004 to realize strategical objectives under the National Haalth Plan, accortding to art. 1, comma 34, Law n. 662/1996 (CIPE Decision 23 March 2012 for assigning to the Emilia Romagna region the amount allocated for the realization of the "It.Drg Project").

References

1. Italian WHO-FIC annual report, Udine 3 Sept. 2014
2. www.vilmafaber.eu

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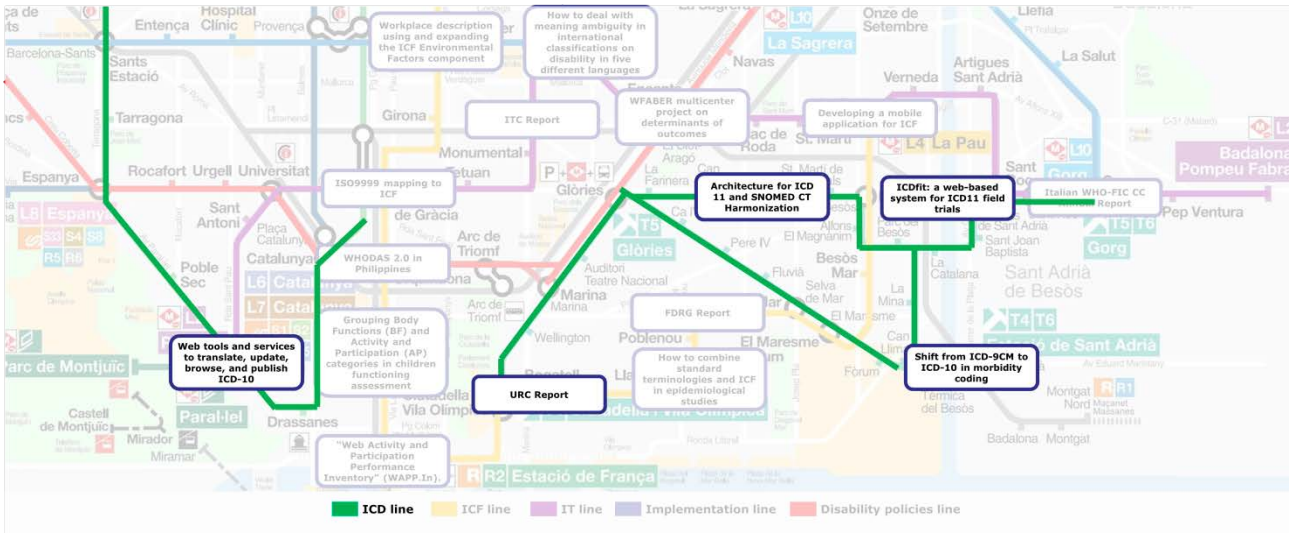
Barcelona, 11-17 October 2014

WHO-FIC Annual Network Meeting

Driving improvement in healthcare: from data to eHealth tools

ICD Line



- *Frattura L., Grippo F., Frova L.* The collaborative effort to implement updated classifications: the lesson learned in developing and using web tools and services to translate, update, browse, and publish ICD-10.
- *Gongolo F., Vogel U., Moskal L.* URC Annual Report.
- *Brand-Persson K., Campbell J., Chute C. et al* Architecture for ICD 11 and SNOMED CT Harmonization.
- *Frattura L., Della Mea V., Vuattolo O. et al* The shift from ICD9-CM to ICD-10 in coding health conditions in Italy: preliminary data on morbidity statistics effects.
- *Della Mea V., Donada M., Celik C et al* ICDfit: a web-based system for ICD11 field trials.

The collaborative effort to implement updated classifications: the lesson learned in developing and using web tools and services to translate, update, browse, and publish ICD-10.

11-17 October 2014
Barcelona, Spain

C428

Frattura L.[1], Grippo F.[2], Frova L.[2], Alicandro G.[2], Tonel P.[1], Simoncello A.[1], Munari F.[1], Castelpietra G.[1], Terreni S.[3], Veos C.[3]
[1]Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC; [2]Italian National Institute of Statistics (Istat), Rome; [3]Insiel, Trieste

Abstract Web tools were developed to ensure translation consistency and publication of complete, searchable online versions of WHO-FIC, starting from ICD-10. The AVATARC translation environment as well as the files of updated ICD-10 volumes (2013 as a basis) that the Italian CC has prepared could be used by other countries. The publication rights of the online versions for implementation and update purposes need to be regulated with/by WHO.

Introduction

The translation of classification updates is a necessary implementation step for non – English speaking countries. During the translation process, several problems may arise that should be considered in the classification implementation.
These may be due to differences in language structure, or to differences between updates and official classification versions, or they may concern the position of updated terms/sentences within the text, or the choice of a lead term when the English term is an adjective, or the consistency with previous translations.

Methods & Materials

Considering the flowchart shown in Figure 1, ICD-10 cumulative updates 1996-2013 were translated. They were divided into two groups (1996-2009 updates and 2000-2013 updates), and the implementation years were taken into account, according to ISTAT needs for mortality coding purposes. The second group of updates was translated using a collaborative approach thanks to the support of web services available in the Italian Classification Portal. Volume 1 updates were loaded into a specific web platform (AVATARC) where both the English text to be translated and the proposed Italian translation were present (Figure 2). Comments on and proposals of translation modification were collected. After agreement on all translations was reached, the English updates was prepared. Specific questions were submitted to the secretariat of the ICD-10 update process.

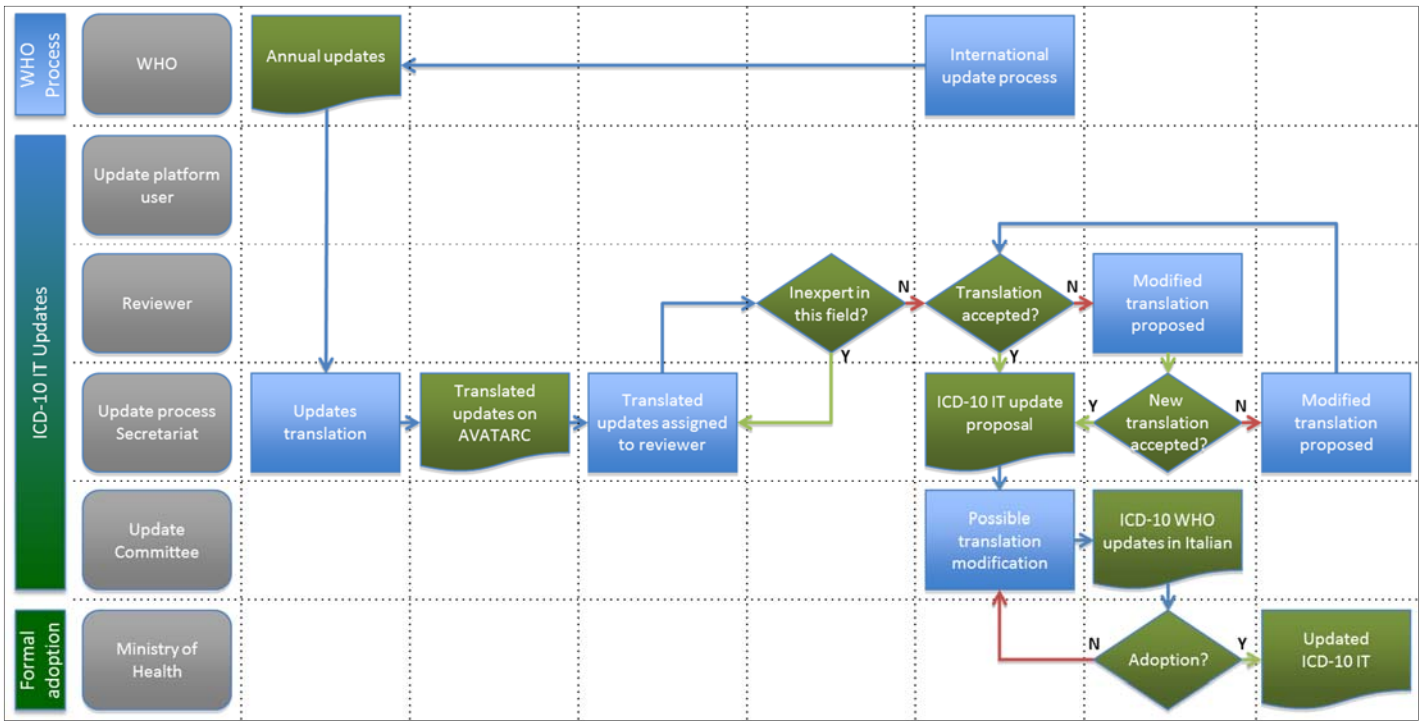
Results

Volume 1 ClaML file was updated in both languages (www.reteclassificazioni.it). Translation of Volumes 2 and 3 updates was done starting from DOC files. Translation of terms and definitions were verified and checked for consistency with previous translations by using the English and Italian ClaML files (2000, 2009 and 2013).

ICD-10 Volume 1 ClaML file was updated both in English and in Italian. The ICD-10 browser was consequently updated in both languages. Similarly, Volumes 2 and 3 DOC files were updated. A list of problems with the previous Italian translation and with

Figure 2 – Italian Classification Portal – AVATARC, view for users with REVISION grants

Figure 1 – «Inspirational» flowchart regarding the translation and approval of the ICD-10 updates: ICD-10 Italian implementation«rehearsal».



Conclusions

The classifications updates translation is a challenge that requires the definition of rigorous criteria.
Those who translate need to have available the different updated versions of the English ClaML files, for reference, in the same environment where the translation is shared. The AVATARC translation environment as well as the files of the updated ICD-10 volumes English version that the Italian CC has prepared could be used by other countries. It would be desirable to consider these issues as well as publication rights of the online versions for implementation and update purposes.

Acknowledgements

1. Agreement between Italian Ministry of Health and Friuli Venezia Giulia Region, 2010-2012; 2013-2015
2. "Progetto It.DRG", funded by National Health Service 2004 to realize strategical objectives under the National Health Plan, according to art. 1, comma 34, Law n. 662/1996 (CIPE Decision 23 March 2012 for assigning to the Emilia Romagna region the amount allocated for the realization of the "It.Drg Project").

References

1. Gongolo F., Simoncello A., Francescutti C. **New tools for translation in a collaborative web environment.** *WHO-FIC Network Annual meeting 16-22 October 2010, Toronto, Canada*
2. Capezzuoli A., Grippo F., Saccoccio T. et al. **ICD10 Online in Italian: new perspectives for users, epidemiologists and coders.** *WHO-FIC Network Annual meeting 12-18 October 2013, Beijing, China*

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URC Annual Report

11-17 October 2014
Barcelona, Spain

C105

Gongolo F.[1], Vogel U.[2], Moskal L.[3]
[1] Central Health Directorate of Friuli Venezia Giulia Region – Italian WHO-FIC Collaborating Centre URC Co-chair; [2]German Institute of Medical Documentation and Information (DIMDI) German WHO-FIC Collaborating Centre – URC Co-chair; [3]Canadian Institute for Health Information (CIHI) – North American WHO-FIC Collaborating Centre, URC Secretariat.

Abstract This poster represents the Update and Revision Committee (URC) 2014 annual report as submitted September 5, 2014 for the Barcelona WHO-FIC annual meeting.

Introduction

Purpose of the Update and Revision Committee (URC) is to support WHO and WHO-FIC Network in keeping the WHO Family of International Classifications "Reference Classifications" up to date in line with current knowledge. The functions of the URC are the development of Update policies, Update coordination & decision making and the participation in the revision work in order to ensure synchronization from one revision to the other and consistency within the members of Family of International Classifications.

Methods & Materials

The URC work currently focuses on the 10th Revision of the International Classification of Diseases (ICD-10) and the International Classification of Functioning Disability and Health (ICF) and is mainly conducted through the update and revision platforms. These platforms are workflow engines designed to facilitate communication within expert workgroups and ensure transparency of the processes. Work and communication is also carried out via e-mail, conference calls and meetings, including an annual meeting during the WHO-FIC Annual Meeting. The key deliverable of the URC work is the lists of annual updates for WHO-FIC member classifications.

Deliverable	Activities	Start Date	End Date (plan)	%
Annual updates to ICD-10	Submission, review, decision and implementation of update proposals for ICD-10.	nov-13	oct-14	0,8
Realize a Foundation ICF implementation of ICF proposals	Submission, review, decision and implementation of ICF-CY related update proposals for ICF. Due to the difference in submission process and lack of supporting rationale additional work is required.	nov-10	oct-12	0,8
Provide annual updates to ICF	Submission, review, decision and implementation of update proposals for ICF.	nov-12	oct-13	0,8
Overall coordination of the update process	Secretariat. Participation in the works, meetings and teleconferences of Initial Review Group and FDRG.	nov-12	oct-13	0,8

Tab. 1 – The URC relevant part of the WHO-FIC SWP (August 22,2013 v, simplified):

ICD-10 related items
ICD-11 related items
ICF related items
overall coordination

Results

Annual updates: the URC ratified 121 recommendations at the WHO-FIC Network 2013 Annual Meeting held in Beijing, China for updating the ICD-10 and 40 recommendations for updating the ICF (Fig. 1 and 2). At the moment, in 2014, 74 proposals have been moderated for ICD and 48 proposals have been reviewed and put to vote for ICF. Functions, activities and completeness of deliverables are represented in the latest version of the Strategic Work Plan submitted to the WHO-FIC Council (Tab 1).
An intensive restructuring of the content of the ICF update platform was carried out in coordination with FDRG. Using the features of the ICF update platform, all the proposals in the Open Discussion Layer were checked for consistency and then clustered together according to the relevant topic/block. Under every cluster, all the comments related to the different proposals were compiled and edited thus greatly simplifying the work of updating ICF carried out by the URC.

Instruction	Tabular list entries	Source URC #	Appr. Date	Major / Minor	Sugg. impl. Date
Revise list of three character categories	**Arthropod-borne viral fevers and viral haemorrhagic fevers (~~A90~~A92-A99)** ~~A90 Dengue fever [classical dengue]~~ ~~A91 Dengue haemorrhagic fever~~ A97 Dengue	1971 WHO	October 2013	Major	January 2016
Revise list of three character categories	**Exposure to inanimate mechanical forces (W20-W49)** ... **W26 Contact with ~~knife, sword or dagger~~ other sharp objects**	2001 Australia	October 2013	Major	January 2016
Delete categories at chapter level	**Arthropod-borne viral fevers and viral haemorrhagic fevers (~~A90~~A92-A99)** ~~A90 Dengue fever [classical dengue]~~ ~~Excl.: dengue haemorrhagic fever (A91)~~ ~~A91 Dengue haemorrhagic fever~~	1971 WHO	October 2013	Major	January 2016
Add categories, codes and text Revise code in excludes note	**A97 Dengue** Dengue is a viral disease transmitted by bite of mosquito infected by dengue viruses. It is one disease entity with different clinical presentations and often with unpredictable clinical evolution and outcome. Most patients recover following a self-limiting non severe clinical course like nausea, vomiting, rash, aches and pains, but a small proportion progress to severe disease, mostly characterized by plasma leakage with or without haemorrhage, although severe haemorrhages or severe organ impairment can occur, with or without dengue shock. **A97.0 Dengue without warning signs** Dengue fever (DF)Dengue haemorrhagic fever Grades 1 and 2 Dengue haemorrhagic fever without warning signs **A97.1 Dengue with warning signs** Clinical warning signs are: abdominal pain or tenderness, mucosal bleeding, lethargy and /or restlessness, rapid decrease in platelet count, increase in hematocrit. Other signs can include: persistent vomiting, visible fluid accumulation, liver enlargement more than 2 cm. Dengue haemorrhagic fever with warning signs **A97.2 Severe Dengue** Clinical signs include: 1. Severe plasma leakage leading to shock (Dengue shock syndrome - DSS) and/or fluid accumulation with respiratory distress; 2. Severe bleeding as evaluated by clinician; 3. Severe organ involvement: Liver AST or ALT >=1000, CNS: impaired consciousness (encephalitis), involvement of other organs, as myocarditis or nephritis Severe Dengue fever Severe Dengue haemorrhagic fever **A98 Other viral haemorrhagic fevers, not elsewhere classified** ***Excl.:*** chikungunya haemorrhagic fever (A92.0) dengue haemorrhagic fever (~~A91~~,A97.-)	1971 WHO	October 2013	Major	January 2016

Fig. 2 – Snap shot from the ICD annual updates document v. 2014

Proposal ID & update type	Affected Code	Original version	Update version
ID # 55 Major: Addition of a new code and addition of exclusion	b114 Orientation functions	**b1565 Visuospatial perception** Mental function involved in distinguishing by sight the relative position of objects in the environment or in relation to oneself.	**b1143 Orientation to objects** Mental functions that produce awareness of objects or features of objects. **b1565 Visuospatial perception** Mental function involved in distinguishing by sight the relative position of objects in the environment or in relation to oneself. Exclusion: orientation to objects (b1143)
ID # 56 Major: Addition of a new code	b114 Orientation functions		**b1144 Orientation to space** Mental functions that produce awareness of one's body in relation to the immediate physical space.
ID # 64 Major: Addition of a new code	b1670 Reception of language		**b16703 Reception of body language** Mental functions of decoding messages in body gestures made by hands and other movements, in order to obtain their meaning.
ID # 65 Major: Addition of a new code	b1671 Expression of language		**b16713 Expression of body language** Mental functions necessary to produce messages using body gestures made by hands and other movements.

Fig. 2 – Snap shot from the ICF annual updates document v. 2014

Conclusions

The achievements of the Committee, made possible by the generous efforts of members and relative institutions, show an increasing engagement of the Collaborating Centres both in maintaining the ICD-10, particularly in view of the synchronization from one revision to the other, and in realizing a foundation ICF, with the implementation of the update proposals coming from the ICF-CY.

Acknowledgements

Members of the Committee:
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1. Terms of Reference for WHO FIC Update and Revision Committee (URC) version Dec 2012
2. URC SWP, March 4, 2013
3. The WHO Updating & Revision Committee http://www.who.int/classifications/committees/URC.pdf
4. The ICD update platform https://extranet.who.int/icdrevision/nr/login.aspx?ReturnUrl=%2Ficdrevision%2FDefault.aspx
5. The ICF update platform https://extranet.who.int/icfrevision/nr/loginICF.aspx

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Architecture for ICD 11 and SNOMED CT Harmonization

11-17 October 2014
Barcelona, Spain

C318

Kristina Brand-Persson, James R Campbell, Christopher G Chute, Monica Harry, Sukil Kim, Vincenzo Della Mea, Alan Rector, Molly Meri Robinson Nicol, Jean Marie Rodrigues, Stefan Schulz, Harold Solbrig, Kent Spackman, Jane Millar, Bedirhan Üstün

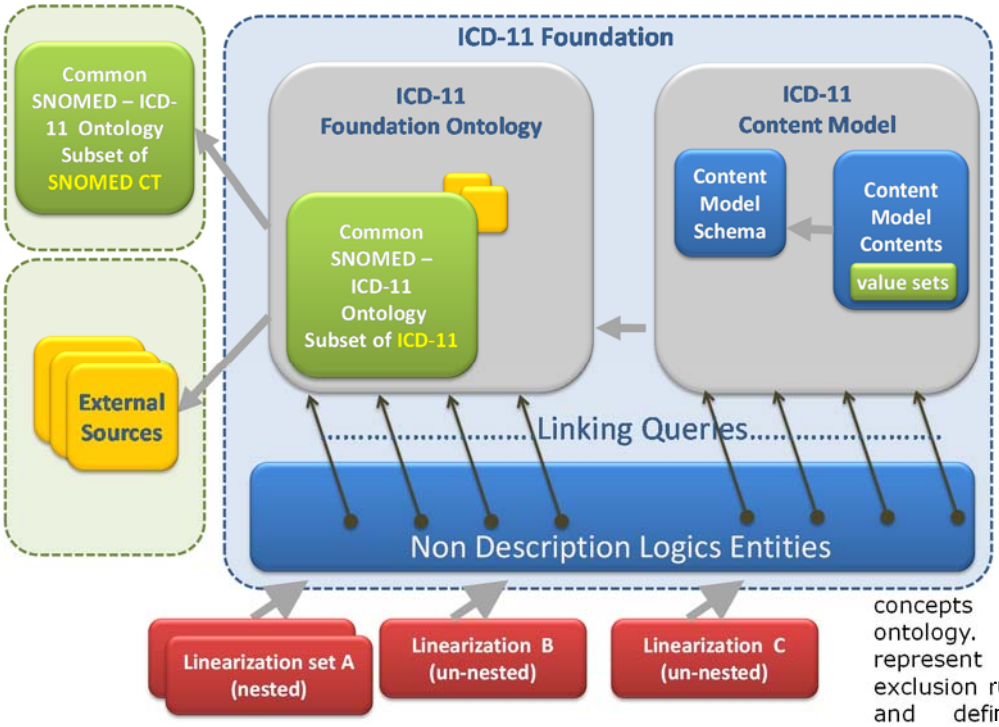
Common Ontology Working Group of the IHTSDO – WHO Joint Advisory Group (JAG)

Based on agreed principles for a Common Ontology for ICD 11 and SNOMED CT, an architecture has been elaborated. It is being used to help characterize what is ICD-11 and owned by WHO, what is SNOMED CT and owned by IHTSDO, and what are the Collaborative Work Products, which are jointly owned. The architecture distinguishes the components available for the end user (linearizations) from their background repository (foundation). It furthermore distinguishes the representational status of different artefacts: from context-free, pure ontological content of a SNOMED CT subset to purpose-specific monohierarchical arrangements of codes. It is finally supplemented by medical knowledge provided by the content model and by a rich collection of multilingual names, definitions and interface terms.

SNOMED CT is a standardized terminology for health records, based on principles of formal ontology using description logics. Here, a subset is extracted, the **Common Ontology**, mostly consisting of concepts and axioms from the highly polyhierarchical "Finding / Disorder" branch. They denote "situations", i.e. life periods of a patient having a given clinical condition. This common ontology will provide most of the entities of meaning that are necessary to represent the content of ICD-11.

External sources cover content that is outside the scope of SNOMED CT but considered necessary for the common ontology, e.g. gene names or new content needed for ICD-11 but still in the submission process for SNOMED CT.

The **ICD Foundation Ontology** contains the ontological content, mostly SNOMED CT, apart from the external sources. It is a multi-hierarchical taxonomy and takes additional description logics axioms from SNOMED CT. Its entities of meaning describe what is universally true for the concepts covered.



The **ICD Content model** provides multilingual names, sets of interface terms (**value sets**) and definitions, together with supportive knowledge about the ICD classes to be represented in the linearizations, e.g. diagnostic criteria, body sites, causal mechanisms, all of them linked to the common ontology. Furthermore the content model provides rules that guide the building of linearization classes, such as exclusions, which ensure the disjointness of linerarization classes.

A collection of **Non-Description Logics Entities** constitutes the repository for all linearizations. They are linked via queries to the concepts in the common ontology. These queries represent the numerous exclusion rules in linearizations and define non-ontological groupers (headings).

Linearizations are those releases of ICD-11 which address specific use cases like mortality, morbidity, primary care, reimbursement or classifications for medical specialties. They are familiar to the user, as they incorporate the classical classification principles (single hierarchy, non-overlapping classes, exhaustive partitions). They are expressed as queries on the common ontology, and incorporate additional knowledge from the ICD-11 content model. Residuals (NEC – not elsewhere classified, NOS – not otherwise specified) are automatically generated at all hierarchical levels. That linearizations are expressed by queries highlights their status as a special kind of terminological artefacts, which are not ontologies but whose content can be traced back to a principled ontology, viz. the **Foundation Ontology**. The hierarchical makeup may differ between linearizations, as they reflect pragmatic preferences in the arrangement of classification codes. Linearizations can also be nested.

The shift from ICD9-CM to ICD-10 in coding health conditions in Italy: preliminary data on morbidity statistics effects

11-17 October 2014
Barcelona, Spain

C402

Frattura L.[1], Della Mea V.[2], Vuattolo O.[2], Munari F.[1], Verdini E.[3] , Zanier L.[4], Arcangeli L.[5], Carle F.[5]

[1]Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC; [2]University of Udine; [3]Health Information System Service, Emilia Romagna Region; [4]Central Health Directorate, Health Information System Service, Friuli Venezia Giulia Region; [5]Ministry of Health, VI Office, Rome

Abstract Data are presented in order to evaluate the impact of the introduction in Italy of ICD-10 on morbidity statistics, by transcoding ICD9-CM codes in administrative Hospital Discharged Form database to ICD-10 2013 Italian version codes, by a specifically developed web tool named TransIT, under the "IT-DRG Project".

Introduction

In Italy, ICD9-CM is currently used for coding health conditions at hospital discharge. In order to introduce ICD-10 in morbidity coding and revise the overall case mix classification system, since 2010 a national project has been founded led by the Italian Ministry of Health and Emilia Romagna Region ("IT-DRG Project"). It involves the Friuli Venezia Giulia Region (as Italian WHO-FIC CC) to update ICD-10 and the Lombardia Region to update the interventions and procedures classification. In order to evaluate the impact of ICD-10 introduction in Italy, the Italian WHO-FIC CC has been active on the translation of ICD updates, the update of ClaML files [1] and development of web tools and services. The ICD-10 2013 Italian version was used as the reference version to transcode administrative hospital discharge data by a specifically developed web tool named TransIT. This was developed to make the transition easier for coders that already know ICD9-CM.

Methods & Materials

A subset of the Hospital Discharge Form (SDO) database was provided by the Italian Ministry of Health, including data from 3 Regions (Emilia Romagna, Veneto, Friuli Venezia Giulia) for 2011 and 2012. TransIT was used to transcode SDO ICD9-CM codes from the available database. TransIT transcoding rules were obtained initially by processing the original American ICD9-CM to ICD10-CM transcoding rules (http://www.cdc.gov/nchs/data/icd/DiagnosisGEMs_2007.zip), complemented by rules identified by classification experts to take into account the differences between ICD9-CM and ICD-10 (in particular, the dagger/asterisk convention). The outputs of TransIT can be a single exact ICD-10 code, a single approximate code, a set of codes ("composite"), or even a number of codes or composites among which to choose. The developed software can be used either online, through a web browser, or embedded in SDO compilation software as a transcoding table or as a web service.

Table 1 – Sample of the Italian Hospital Disharge Forms considered for transcoding

Region	Year	Total records (N)	Main conditions (N)	Other conditions (N)
Friuli Venezia Giulia	2011	197,664	197,663	235,566
	2012	198,225	198,224	240,074
Veneto	2011	729,748	728,210	596,233
	2012	697,020	696,991	587,969
Emilia-Romagna	2011	787,152	787,142	1,023,630
	2012	764,514	764,511	1,006,775
Total		**3,374,323**	**3,372,741**	**3,690,247**

Database source: Ministry of Health 2014

Figure 2 – TransIT user interface

Results

A total of 3,374,323 SDOs were analysed, of which 3,372,741 contained a main condition, with a total of 3,690,247 secondary conditions. The number of different ICD9-CM codes used was 10987 (88.4% on a total of 12,435). Looking at both main and secondary conditions, a large number of SDOs ICD9-CM codes (86.36%) was transcoded automatically, that is, transcoding provided just one option, either exact (35.86%), approximate (50.18%) or composite (0.32%).

Table 2 – Transcoding ICD9-CM to ICD-10 by TransIT in a sample of the Italian Hospital Disharge Forms by Region and Year

Region	Year	Single exact ICD-10 code (N)	Single Approximate ICD-10 code (N)	Composite ICD-10 codes (N)	Multiple ICD-10 codes choice (N)	Not trans-coded (N)
Friuli Venezia Giulia	2011	161,524	212,018	1,951	54,308	0
	2012	163,131	215,795	1,971	53,911	0
Veneto	2011	473,204	659,351	4,613	177,388	199
	2012	457,646	642,714	4,977	170,545	201
Emilia-Romagna	2011	644,378	919,009	4,468	228,357	1
	2012	632,884	895,487	4,812	223,810	0
Total (N)		**2,532,767**	**3,544,374**	**22,792**	**908,319**	**401**
%		**35,86%**	**50,18%**	**0,32%**	**12,86%**	**0,006%**

Database source: Ministry of Health 2014

Table 3 – The most used ICD9-CM/ICD-10 categories in the SDO sample

ICD9-CM	Mapping type	ICD-10	Count (N)	Frequency (%)	Cumulative (%)
427.31	exact	I48.0	160,051	2	2
401.1	approximate	I10	154,454	2	4
V30.00	approximate	Z38.0	119,093	2	6
250.00	approximate	E11	99,086	1	8
401.9	exact	I10	72,246	1	9
V58.11	approximate	Z51.1	67,694	1	10

I48.0 Paroxysmal atrial fibrillation
I10 Essential (primary) hypertension
Z38.0 Singleton, born in hospital
E11 Non-insulin-dependent diabetes mellitus
Z51.1 Chemotherapy session for neoplasm

The remaining 12.86% of SDO ICD9-CM codes needed manual intervention, since transcoding provided more than one option. 401 codes could not be transcoded (0.006%). When examining the 100 most used ICD9-CM codes, which covered 42% of SDOs, 44 were coded exactly, 46 approximately, and 10 with multiple choices. When analyzing details of codes that could not be transcoded, a number of coding mistakes were found (mostly: intermediate level categories and groups that cannot be used for SDOs coding conditions according to coding rules).

Conclusions

The transition from ICD9-CM to ICD-10, based on these preliminary data analysis, could be less difficult than supposed, because a large number of ICD9-CM codes can be easily transcoded to one single ICD-10 code, leaving a manageable 10% of codes to be chosen by coders among a small set of options. However, training is needed for coders to understand the differences between the two ICD versions, in particular when involving the dagger/asterisk mechanism, which is not present in ICD9-CM. The lack of the E codes in current SDO coding rules is another issue to address in ICD-10 V-W-X-Y codes implementation in Italy.

References

1. Frattura L., Grippo F., Frova L. The collaborative effort to implement updated classifications: the lesson learned in developing and using web tools and services to translate, update, browse, and publish ICD-10. WHO-FIC Network Annual Meeting, Barcelona 2014, submitted

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1. Dept of Mathematics, University of Udine was founded by the Region Friuli Venezia Giulia, to support the research activities on WHO classifications use, 2014-2016
2. Agreement between Italian Ministry of Health and Friuli Venezia Giulia Region, 2010-2012; 2013-2015 to support National Health Service in implementing WHO classifications
3. "Progetto It.DRG", founded by National Health Service 2004 to realize strategical objectives under the National Health Plan, according to art. 1, comma 34, Law n. 662/1996 (CIPE Decision 23 March 2012 for assigning to the Emilia Romagna region the amount allocated for the realization of the "It.Drg Project")

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ICDfit: a web-based system for ICD-11 field trials

11-17 October 2014
Barcelona, Spain

C305

Authors: Vincenzo Della Mea[1], Marc Donada[1], Can Celik[2], Nenad Kostanjsek[2]
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Abstract In order to support the implementation of of ICD-11 Field Trial core study protocols, a web-based system (ICDfit) has been designed and developed with a number of functionalities to replicate the organizational structure of the ICD11 field trials, and help to collect data in a form ready to be analyzed.

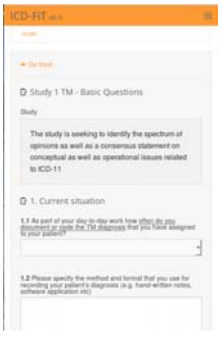
Introduction

In order to support the implementation of of ICD-11 Field Trial core study protocols, a web-based system (ICDfit) has been designed and developed with a number of functionalities, including:
- Computer Assisted Personal Interviews (CAPIs) for three field trial instruments;
- support in creating other language versions of the instruments and administering them in these languages;
- user access and policy mechanisms that will be enforced in the user interface, in particular the field trial organization is replicated: WHO coordination, Field Trial Center, Field Trial Site, raters and key informants.
- built-in extensibility to enable further studies.

The present poster illustrates the current prototype of the system.

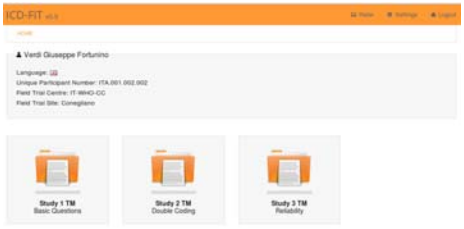
Methods & Materials

The ICDfit system has been developed using PHP5, MySQL, Apache, on a Linux server.
The system implements the organization structure of field trials (FT), based on WHO coordination, FT centers (FTC) and FT sites (FTS).
Users can belong to different categories: FTC Coordinator, FTS coordinator, Rater and Key Informant.
The three main FT instruments have been developed in both Western and Traditional Medicine version.
Collected data can be exported in CSV format for further processing by means of statistical software.
The system can be easily updated to include future studies.
The web interface has been developed using a responsive template in order to be accessible from tablets and smartphones too, like in figure.



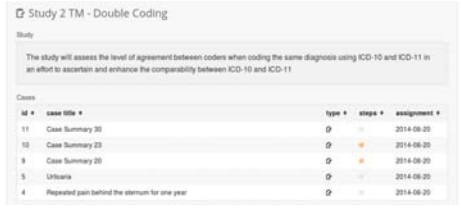
Raters, key Informants, studies

Users are enabled to the system through an invitation mechanism, after which they register to the system by filling a Participant Information Form. They can then access the system through a login page, that brings them to a web page personalised depending on user category. In the next figure you can see a typical Rater page.

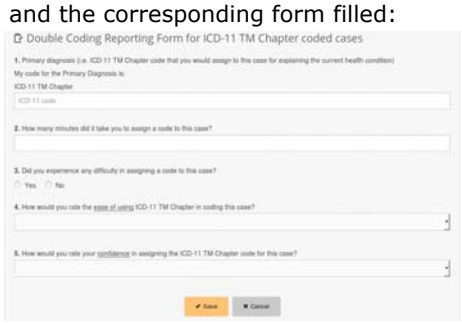


Key Informants will only see the Study 1 icon.
The Study 1 (Basic questions) is not based on case rating, so there are only questions to be answered:

Study 2 and 3 consist in rating a number of cases, that are shown as a list when clicking on their icons, as shown in the next screenshot:



A case summary can be then viewed and the corresponding form filled:



Coordinators

An FTS coordinator is able to invite and manage raters:

An FTC coordinator may assign new field trial sites in their country, and manages also key informants:

Sites can be defined by assigning a site name and inviting a coordinator:

Cases are assigned by selecting the raters and choosing the cases:

Finally, each coordinator has also a dashboard to check FT status:

Conclusions

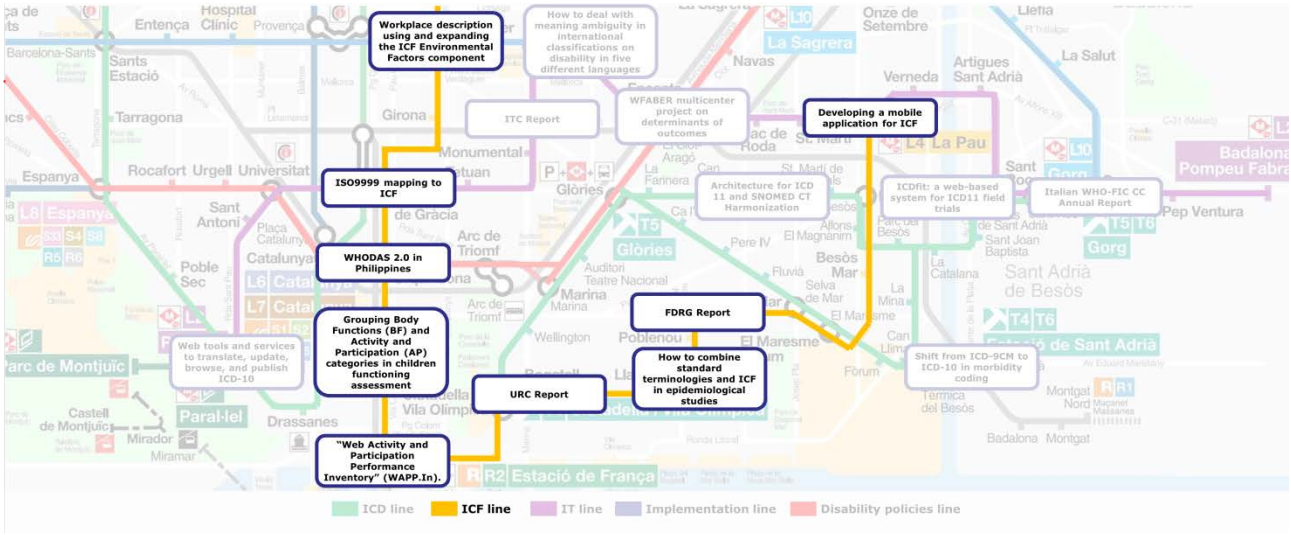
The prototype is up and running, and also a demo site for testing and training is available.
A preliminary technical testing has been planned from August 2014 onwards to verify functionality and interface issues.

Barcelona, 11-17 October 2014

WHO-FIC Annual Network Meeting

Driving improvement in healthcare: from data to eHealth tools

ICF Line



- *Bassi G., Simoncello A., Castelpietra G.* How to expand ICF Environmental Factors (EF) starting from ISO-9999 Classification: toward a "hybrid" standard terminology?
- *Leonardi M., Kostanjsek N.F., Chatterji S.* Measuring Disability and Health in Emergencies: implementing a disability survey using WHODAS 2.0 in the Typhoon Yolanda affected areas of the Philippines.
- *Frattura L., Bassi G., Simoncello A. et al* Grouping Body Functions (BF) and Activity and Participation (AP) categories in children functioning assessment: a new core set or some ontologic suggestions?.
- *Frattura L., Bassi G., Simoncello A.* How to ask questions about performance while considering facilitators and barriers: the first web version of the "Web Activity and Participation Performance Inventory" (WAPP.In).
- *Castelpietra G., Bassi G., Frattura L.* To kill two birds with one stone: how to automatically combine standard terminologies and nomenclatures with ICF Environmental Factors in epidemiological studies.
- *Sykes C., Martinuzzi A.* FDRG Annual Report.

Incrocio con **Implementation Line**

- *G Bassi G., Frattura L., Simoncello A.* How to describe the workplace using and expanding the Environmental Factors component of the ICF: the first version of the "Workplace assessment schedule".

Incrocio con **ICD Line**

- *Gongolo F., Vogel U., Moskal L.* URC Annual Report.

How to expand ICF Environmental Factors (EF) starting from ISO-9999 Classification: toward a "hybrid" standard terminology?

11-17 October 2014
Barcelona, Spain

C528

Bassi G., Simoncello A., Castelpietra G., Frattura L.
Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC

Abstract VilmaFABER assessment system uses a ICF-ISO9999 "hybrid" standard terminology, developed by the Italian WHO-FIC CC to overcome the poor descriptive power of ICF Environmental Factors component. It was used to describe care and living environment in different samples of Italian outpatients. It has shown a positive answer from professionals and persons evaluated. A validation is kindly suggested in the context of the WHO-FIC network. It should be useful to consider new candidates for updating the ICF EF list of categories.

Introduction

As ISO-9999 classification is a related member of the WHO-FIC since 2003 [1] and it was suggested as a more specific and a more detailed classification in addition to the Environmental Factors (EF) listed in ICF, it seems reasonable to combine the two classifications in order to ensure a more precise description of the care and living environment [2]. The aim was to develop some expanded ICF-EF e1 categories by combining ICF categories with ISO-9999 terms, useful to implement web tools in order to better describe patients [3] and suggest ICF updates too.

Methods & Materials

ISO-9999 classes [4-7] were mapped to three digit categories of ICF-EF, Chapter 1, and compared with the semantic content of the titles and definitions (including inclusions and exclusions) of the ICF categories. If an ISO-9999 class was mapped to more than one ICF category, its subclasses were considered. Combined terms were created (Expanded ICF-EF terms), with the ICF code in first coding position and the ISO-9999 code in second coding position, for example: "e120 Wheelchairs (ISO 12 21)" or "e115 Aspirators (ISO 03 03 21)". This expansion was tested in a sample of outpatients (N=213) from Friuli Venezia Giulia Region. Detailed information on the field trial sampling procedure and results are shown elsewhere [8].

Results

Eight hundred forty-one ISO-9999 (ISO) classes were found to fit with 8 ICF categories. The distribution of ISO classes within the ICF categories was the following:

- 500 ISO classes fitted with ICF - e115,
- 98 ISO classes fitted with ICF - e120,
- 125 ISO classes fitted with ICF - e125,
- 64 ISO classes fitted with ICF - e130,
- 13 ISO classes fitted with ICF - e135,
- 21 ISO classes fitted with ICF - e140,
- 20 ISO classes fitted with both ICF - e150 and ICF - e155.

A total of 841 expanded ICF-EF terms out of 8 ICF-EF categories was thus obtained.

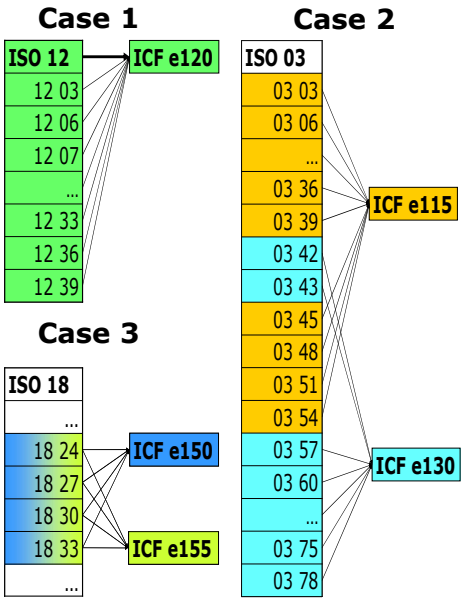
Table 1 – Results of mapping ISO9999 to ICF EF chapter 1

ICF category	*ISO 9999 classes*	*Number (%) of overall ISO codes*
e115	03, 06, 09, 15, 18, 21, 24, 27, 30	500 (59,5)
e120	12, 18	98 (11,7)
e125	21	125 (14,9)
e130	03	64 (7,6)
e135	24, 27	13 (1,5)
e140	30	21 (2,5)
e150 e155	18	20 (2,4)
Total N=8	**Total N=17**	**841 (100)**

Table 2 – Examples of the VilmaFABER expanded ICF-EF categories

e115 Assistive products for administering medicines (**ISO 03 18**)
e120 Wheelchairs (**ISO 12 21**)
e125 Assistive products for seeing (**ISO 21 03**)
e130 Assistive products for training in the arts (**ISO 03 69**)
e135 Industrial transportation vehicles (**ISO 24 39**)
e140 Musical instruments (**ISO 30 12**)
e150 Assistive products for vertical accessibility (**ISO 18 30**)
e155 Construction elements in the home and other premises (**ISO 18 24**)

Figure 1 – Examples of mapping of ISO codes to ICF categories



The distribution of ISO classes within the ICF categories, when applied to the field trial sample, was the following:

- 30 ISO classes fitted with ICF – e115
- 11 ISO classes fitted with ICF – e120
- 9 ISO classes fitted with ICF – e125
- 1 ISO classes fitted with ICF – e130
- 1 ISO classes fitted with ICF – e135
- 3 ISO classes fitted with ICF – e140
- 1 ISO classes fitted with ICF – e150

A total of 56 expanded ICF-EF terms out of 7 ICF-EF categories was thus obtained at population level [8].

Table 3 – Results of mapping ISO9999 to ICF in the first VilmaFABER field trial

ICF category	*ISO 9999 classes*	*Number (%) of overall ISO codes*
e115	03, 06, 09, 15, 18, 24, 27, 30	30 (53,6)
e120	12, 18	11 (19,6)
e125	21	9 (16,1)
e130	03	1 (1,8)
e135	24, 27	1(1,8)
e140	30	3 (5,3)
e150	18	1 (1,8)
Total N=7	**Total N=16**	**56 (100)**

Conclusions

Our findings highlight the importance of expanding the granularity of ICF-EF categories in order to describe more accurately the EF involved in the individuals' functioning and disability.
The expanded ICF-e1 terms may be considered a new hybrid standard terminology and may be a useful solution instead of updating all e1 categories. The reliability of this methodology was further supported by the evidences obtained from the field trial. Furthermore, the mapping has to be revised using the ISO-9999 updated version. A validation of our mapping is kindly suggested in the context of the WHO-FIC network. This, may enrich the debate on the actualization of the WHO health classifications, particularly concerning the ICHI development. It should be also useful to consider new candidates to update ICF EF list of categories.

Acknowledgements

vilma FABER Friendly.Alimenting.Biopsychosocial.Electronic.Record

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Measuring Disability and Health in Emergencies: implementing a disability survey using WHODAS 2.0 in the Typhoon Yolanda affected areas of the Philippines

11-17 October 2014
Barcelona, Spain

C534

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Abstract Typhoon Yolanda was one of the strongest tropical cyclones ever recorded that struck the Philippines on November 8, 2013. A survey on the populations' disability and health profiles was conducted after this disaster using a protocol composed of socio-demographic schedule, household questionnaire and WHODAS 2.0 Disability Assessment Schedule. This survey will allow us to report the affected populations' health and disability problems and to validate the WHODAS 2.0 in an emergency situation so that for future emergency health and disability evaluation could be performed with WHODAS 2.0 as part of the general emergency situation.

Introduction

Typhoon Yolanda struck the Philippines on November 8, 2013 with strong winds of over 300 km/h. It was one of the strongest tropical cyclones ever recorded. The death toll has reached 6.300 and many provinces were affected, as showed in the figure 1.
In response to this massive devastation, the WHO Regional Office for the Western Pacific, in consultation with the UN Humanitarian Inter-Cluster Coordination Group decided to conduct a survey on post-typhoon disability and health profiles of people affected.
The main aim of this survey is to provide detailed information on affected populations' ongoing health and disability problems as well as to provide a broader base for humanitarian support to people affected.

Methods & Materials

The Survey Protocol includes socio-demographic questionnaire, household questionnaire and WHODAS 2.0 Disability Assessment Schedule.
Whodas 2.0 was provided by WHO HQ, and modified for field application by WHO Regional Office, the Social Development Research Center (SDRC) of De La Salle University, Inclusive Development and Empowerment Agenda (IDEA) and Neurological Institute Besta of Milan.
A field training was prepared by Besta Insitute and performed by a WHO expert in the area of disability studies and by researchers of SDRC and IDEA.
Data collection was conducted from May 25 to June 30, 2014 and July 17-18, 2014 after a pilot study on 100 cases. A further survery will be repeated 9 months to one year later.
Figure 2 shows the specific questions on typhoon of the Household questionnaire as an example.

Results

A sample of 2000 adult people has been interviewed by researchers of the Social Development Research Center (SDRC) of De La Salle University and the Inclusive Development and Empowerment Agenda (IDEA). The interviewers were 40, men and woman from Tacloban area, Leyte island, and some had previous experiences on surveys. There were teachers, social workers, phychologists, nurses and community workers among the field staff.
People interviewed came from 12 different Barangays.
Data will be analysed by Besta Institute, WHO of Geneve and WHO of Manila and they will be available soon.

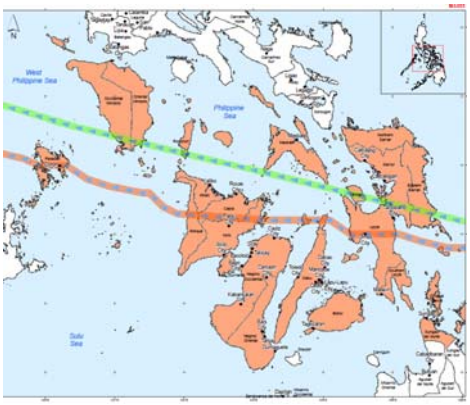

Figure 1:Affected provinces in red

QD+21	Was there any loss of life(s) among your first degree members in your household as a result of Typhoon Yolanda?	1 Yes 2 No ..... →	QD+24
QD+22	How many life(s) were lost?		
QD+23	Please circle the type of relationship of the household members deceased.	1. SPOUSE 2. MOTHER 3. FATHER 4. SISTER 5. BROTHER 6. GRAND MOTHER 7. GRAND FATHER 8. CHILD/CHILDREN N: 9. GRAND-CHILD / GRAND-CHILDREN N:	
QD+24	Where do you live now?	1 In YOUR HOUSE 2 In a TENT 3 In a TRANSITION AL HOUSE 4 In a BRICK HOUSE 5 HOSTED 6 OTHER	
QD+25	Was your home damaged by Typhoon Yolanda?	1 Yes 2 No ..... →	QD+28
QD+26	What type of damage had your house?	1 COMPLETE DESTRUCTION 2 PARTIAL DESTRUCTION	
QD+27	Did you receive any assistance to repair or rebuild your house? (circle all applicable)	1 No 2 Yes, CASH 3 Yes, TOOLS AND/OR MATERIAL	
QD+27	Has Yolanda affected the livelihoods of your household?	1 Yes 2 No ..... →	QD+29
QD+28	If yes, in which livelihood area(s)?	1 INFORMAL SECTOR 2 FISHERY 3 FARMING 4 SMALL BUSINESS 5 LABOR 6 OTHER _____	
QD+29	Did you receive any assistance to improve your household's livelihood ? (circle all applicable)	1 No 2 Yes, CASH GRANT 3 Yes, CASH FOR WORK 7 OTHER, SPECIFY: _____	

Figure 2: Questions on typhoon of the Household questionnaire

Conclusions

It was the first time ever that – within the context of an UN lead humanitarian response effort - disability was officially recognized as key outcome indicator and WHO committed to do a disability survey in the areas affected by Yolanda.
This innovative approach that considers functioning and disability profiles together with tailored socio demographic information, allows better public health planning and improvement in policies and interventions.
At the end of data analysis we will be able to report the health of people affected. Furthermore this survey will allow us to validate the WHODAS 2.0 in an emergency situation so that for future emergency health and disability evaluation could be performed with WHODAS 2.0 as part of the general emergency situation.

Photo: Typhoon Yolanda

Acknowledgements or Notes

Authors thank all the interviewers that participated to data collection.

Grouping Body Functions (BF) and Activity and Participation (AP) categories in children functioning assessment: a new core set or some ontologic suggestions?

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Barcelona, Spain

C530

Frattura L.[1], Bassi G.[1], Simoncello A.[1], Terreni S.[2], Veos C.[2]
[1]Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC; [2]Insiel, Trieste

Abstract Results are shown on the contents of a web tool to facilitate the description of the individual functioning/disability balance in children. BF and AP categories were combined according to specific assessment criteria, taking into account the EF role.

Introduction

There are no automated tools to describe functioning and disability in children that take into account the need to collect information on impairments, limitations and restrictions, and consider explicitly the Environmental Factors (EF) role.
Aim: to define a web tool to facilitate the description of the individual functioning/disability balance in children, which combines BF and AP categories according to specific assessment criteria, and takes into account the EF role.

Methods & Materials

The starting points were the Italian administrative rules for school inclusion of children with disabilities and specific educational needs (1). These rules suggest to assess children in 9 areas: cognitive, relational, communication, linguistic, sensorial, movement, neuropsychological, social and personal autonomy, and learning.

Figure 1 – 5 W for exploring children functioning

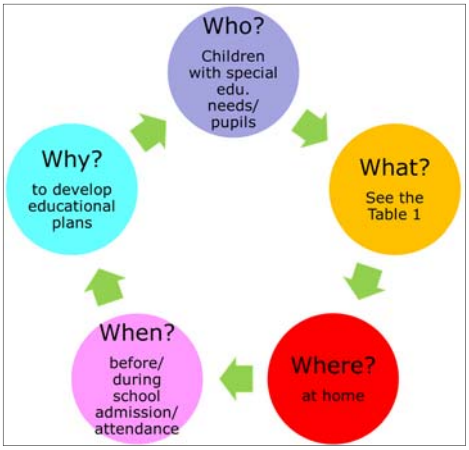
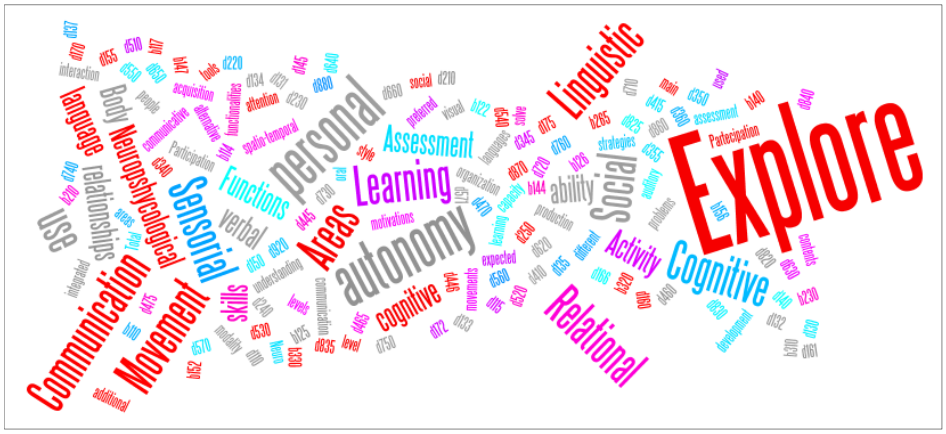


Table 1 – What to explore, according to the administrative rules?

	Area	What to explore?
1	**Cognitive**	Explore the levels of cognitive development achieved; the strategies used to solve tasks or problems; cognitive style; the ability to use different skills in an integrated way.
2	**Relational**	Explore the level of self-esteem; the relationships with other people; the motivations of the relationships.
3	**Communication**	Explore the interaction modality; the main contents of communication; the preferred tools.
4	**Linguistic**	Explore the ability to understand oral language; the verbal production and the communicative use of verbal language; the use of alternative or additional languages.
5	**Sensorial**	Explore the visual, auditory, tactile functionalities.
6	**Movement**	Explore the fine and gross movements.
7	**Neuro pshycological**	Explore the mnestic and attention abilities; the intellectual ability; the spatio-temporal organization.
8	**Social and personal autonomy**	Explore the personal and social autonomy.
9	**Learning**	Explore the acquisition of the skills expected for the age.

Figure 1 – The semantic STORM in children assessment



Thirty professionals were selected among those who had taken part in the VilmaFABER field trial during 2013 and who had a specific background on neurological and psychiatric problems of children. Formal assessment documents prepared by the professionals were collected and information on functioning, written in natural language, was backcoded to ICF.
A list of BF and AP ICF categories was thus created, moving from a semantic storm (Figure 2). The professionals were then asked to group the information mapped to these categories into the 9 suggested assessment areas, avoiding to put a category in more than one assessment area.

Table 2 – The CALM after the storm

Assessment Areas	BF (N)	BF categories	A&P (N)	A&P categories
Cognitive	5	b117; b160; b163; b164; b167	5	d131; d132; d137; d155; d175
Relational	6	b110; b122; b125; b126; b152; b180	11	d240; d250; d660; d710; d720; d730; d740; d750; d760; d880; d920
Communication	-	-	7	d134; d315; d335; d345; d350; d355; d360
Linguistic	3	b310; b320; b330	6	d133; d310; d320; d325; d330; d340
Sensorial	3	b210; b230; b265	-	-
Movement	2	b147; b176	11	d410; d415; d420; d435; d440; d445; d446; d450; d455; d460; d465
Neuro pshycological	4	b114; b140; b144; b156	5	d110; d115; d135; d160; d161
Social and personal autonomy	-	-	21	d210; d220; d230; d470; d475; d510; d520; d530; d540; d550; d560; d570; d571; d620; d630; d640; d650; d835; d840; d860; d870
Learning	1	b172	11	d130; d140; d145; d150; d166; d170; d172; d815; d820; d825; d830

Results

A web children and youth core set was created as a part of the Vilma-FABER system, which foresaw the assessment of 101 categories, 24 from BF Chapters 1-3 and 77 from all 9 AP Chapters (Table 2). After grouping the items in the 9 suggested assessment areas, taking into account the professionals' suggestions, and after three rounds of consultations, a final combination of categories was approved.

The VilmaFABER system was updated with this new core set. An automated output was designed in order to release a specific valid document, written in both natural and ICF language. This new document describes the individual functioning/disability balance, according to the threshold between functioning and disability which VilmaFABER system was using (2). Field trials were planned to test the core set in selected samples in order to reduce the number of the chosen dimensions to assess and to verify how the information on the EF role for each category changes the meaning of the sentences written in natural language. The combination of BF and A&P categories describing 9 assessment areas may be helpful on the ICF ontological revision.

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WHO - FAMILY OF INTERNATIONAL CLASSIFICATIONS NETWORK ANNUAL MEETING 2014

WHO-FIC Network
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C527

How to ask questions about performance while considering facilitators and barriers: the first web version of the "Web Activity and Participation Performance Inventory" (WAPP.In).

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Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC

Abstract WAPP.In was developed to be a web questionnaire to facilitate the description of ICF performance, facilitators and barriers for any selection of ICF AP categories. It does not use ICF sentences and definitions to question someone about his or her life in the past 30 days, but its contents fit completely with ICF constructs. A field test is ongoing in a clinical setting.

Introduction

It is difficult to collect information about performance while explicitly taking into account the Environmental Factors (EF) role, for each activity considered, whatever the subset of categories considered. Moreover, it results particularly difficult to collect information about barriers. Available tools have not been developed to take into account the different kinds of environmental aspects. On the other hand, ICF as a language, which classifies Environmental Factors, may result difficult to use. Aim: to define a web questionnaire to facilitate the description of ICF performance, facilitators and barriers for any selection of ICF AP categories, without using ICF sentences and definition to question someone about his or her life in the past 30 days.

Methods & Materials

The starting point was a previous VilmaFABER selection of AP categories and the way they were analysed jointly with EF. At the current stage of development, VilmaFABER may be considered as a system for coding information on functioning that supposes a method to collect biopsychosocial information. To overcome some methodological and practical issues on how the biopsychosocial information has to be collected, WHODAS 2.0 and other tools that had dealt with the problem of performance description were analysed.

Figure 1 – Comparison between WHODAS 2.0 and WAPP.In flashcards

WHODAS 2.0	WAPP.In
-	**Flashcard 1: The role of Environmental Factors** When answering, use this scale which describes the role of environmental factors in the activities that we are going to explore. The role of the environmental factors can be "negative" (Barrier Effect: "they hindered me in doing the activity") or "positive" (Facilitator effect: "they helped me to do the activity). When answering, think about natural environment – climate or land forms; human built environment - drugs, devices, furniture, built environment; people; institutions – services, organizations, rules – and, in general, everything that influences you in doing the activity. Effect BARRIER: N – NO hindrance; L – LOW hindrance; M – MODERATE hindrance; S – SEVERE hindrance; C – COMPLETE hindrance Effect FACILITATOR: N – NO help; L – LOW help; M – MODERATE help; S – SEVERE help; C – COMPLETE help
Flashcard #1: Meaning of health condition and difficulty By health condition I mean diseases or illnesses, or other health problems that may be short or long lasting; injuries; mental or emotional problems; and problems with alcohol or drugs. Remember to keep all of your health problems in mind as you answer the questions. When I ask you about difficulties in doing an activity think about ... Health conditions: • Diseases, illnesses or other health problems • Injuries • Mental or emotional problems • Problems with alcohol • Problems with drugs Having difficulty with an activity means: • Increased effort • Discomfort or pain • Slowness • Changes in the way you do the activity Think about the past 30 days only	**Flashcard 2: Meaning of difficulty** "Difficulty in doing an activity or in participating in a life situation" means: • Increased effort • Discomfort or pain • Slowness • Changes in the way you do the activity or participate.
Flashcard #2: Level of difficulty When answering, I'd like you to think back over the past 30 days. I would also like you to answer these questions thinking about how much difficulty you have had, on average, over the past 30 days, while doing the activity as you usually do it. 1 None; 2 Mild; 3 Moderate; 4 Severe; 5 Extreme or cannot do	**Flashcard 3: Level of difficulty** When answering, I'd like you to think back over the past 30 days. I would also like you to answer these questions thinking about how much difficulty you have had, on average, over the past 30 days, in doing the activity considering people closed to you or people you have to deal with, devices you are using or drugs you are taking and, in general, everything that influence you while doing the activity (natural environment, services/organizations, rules etc.). When answering, use this scale which describes how much difficulty you had in doing the activity or in participating. NONE difficulty; MILD difficulty; MODERATE difficulty; SEVERE difficulty; EXTREME difficulty

Figure 2 – How WAPP.In asks about doing activities: an example

I am now going to ask you some questions about:

d510	*Washing oneself:* **Washing and drying one's whole body, or body parts, such as bathing, showering**

In the past 30 days did you do this activity? ☐ **Yes** *(Go to 1)* ☐ **No** *(Go to A)*

A) Did you not do the activity because you were hindered by someone? ☐ **Yes** *(Go to 2-2a)* ☐ **No** *(Go to B)*	*(Ongoing intervention project: Professionals in charge of the patient and people close to the patient)* **2) Could you tell me who?**	**1) Did any of the professionals in charge of your health or any of the people close to you hinder you in doing this activity?** ☐ **Yes** *(Go to 2-2a)* ☐ **No** *(Go to 3)* **2a) How much did he/she hinder you?** N L M S C N L M S C *(Go to 3)*	**3) Did any of the professionals in charge of your health or any of the people close to you help you do this activity?** ☐ **Yes** *(Go to 2-2b)* ☐ **No** *(Go to 4)* **2b) How much did he/she help you?** N L M S C N L M S C *(Go to 4)*
B) Did you not do the activity because you were hindered by something? ☐ **Yes** *(Go to 5-5a)* ☐ **No** *(Go to C)*	*(Ongoing intervention project: Products and technologies used)* **5) Could you tell me what?**	**4) Did any product or technology you are using hinder you in doing this activity?** ☐ **Yes** *(Go to 5-5a)* ☐ **No** *(Go to 6)* **5a) How much did it hinder you?** N L M S C N L M S C *(Go to 6)*	**6) Did any product or technology you are using help you do this activity?** ☐ **Yes** *(Go to 5-5b)* ☐ **No** *(Go to 7)* **5b) How much did it help you?** N L M S C N L M S C *(Go to 7)*
C) Did you not do the activity because health services hindered you ? ☐ **Yes** *(Go to 8-8a)* ☐ **No** *(Go to D)*	*(Ongoing intervention project: health interventions/policies)* **8) Could you tell me which services?**	**7) Did the health interventions you received hinder you in doing this activity?** ☐ **Yes** *(Go to 8-8a)* ☐ **No** *(Go to 9)* **8a) How much did they hinder you?** N L M S C N L M S C *(Go to 9)*	**9) Did the health interventions you received help you do this activity?** ☐ **Yes** *(Go to 8-8b)* ☐ **No** *(Go to 10)* **8b) How much did they help you?** N L M S C N L M S C *(Go to 10)*
D) Did you not do the activity because other services/organizations hindered you? ☐ **Yes** *(Go to 11-11a)* ☐ **No** *(Go to E)*	*(Ongoing intervention project: social, welfare, education, labour interventions/policies)* **11) Could you tell me which services/organizations?**	**10) Did the interventions you received hinder you in doing this activity?** ☐ **Yes** *(Go to 11-11a)* ☐ **No** *(Go to 12)* **11a) How much did they hinder you?** N L M S C N L M S C *(Go to 12)*	**12) Did the interventions you received help you do this activity?** ☐ **Yes** *(Go to 11-11b)* ☐ **No** *(Go to 13)* **11b) How much did they help you?** N L M S C N L M S C *(Go to 13)*

E) Did you decide not to do the activity?
☐ **Yes** *(Go to next activity)*
☐ **No** *(Go to 1)*

13) In the past 30 days *(considering everything that helped and/or hindered you)* **how much difficulty did you have in doing this activity?**

None	Mild	Moderate	Severe	Extreme

The aim was to allow to collect information in natural language and to allow VilmaFABER to code them in ICF language.

Results

A new questionnaire was developed, temporarily named WAPP.In. It considered 63 items from the 9 Activity and Participation chapters, and explored the EF role, starting from the list of expanded ICF-EF terms which VilmaFABER releases at the end of the first step of the individual functioning assessment, available in a drop-down menu. WAPP.In collects information on facilitators, barriers and performance in natural language and uses a unique question structure. The answers were collected using a five-level Likert scale to explore the level of difficulty in doing activities and the level of facilitator and/or barrier effects. Each level of the Likert scale corresponds to an ICF qualifier value (0 to 4).
An automated ICF coding was developed and an instruction manual was written to administer WAPP.In. A special attention was given to self-determination, in order to distinguish activities which cannot be performed because of barriers from activities that are not performed because of the individual's will. A version for children was studied.

Conclusions

It is possible to explicitly collect information on performance, facilitators and barriers using the WAPP.In. It is also possible to ask questions using natural language, stressing the necessity to collect good information on the EF role to explain difficulties in doing an activity. Coding in ICF may be a subsequent, automatic step in the process of standardization of the information collected using natural language. A first field test is ongoing to test the questionnaire in selected samples.

Figure 3 – A WHODAS 2.0 question example

Domain 3 Self-care

I am now going to ask you about difficulties in taking care of yourself.

Show flashcards #1 and #2

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
D3.1	Washing your whole body?	1	2	3	4	5
D3.2	Getting dressed?	1	2	3	4	5
D3.3	Eating?	1	2	3	4	5
D3.4	Staying by yourself for a few days?	1	2	3	4	5

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WHO - FAMILY OF INTERNATIONAL CLASSIFICATIONS NETWORK ANNUAL MEETING 2014

To kill two birds with one stone: how to automatically combine standard terminologies and nomenclatures with ICF Environmental Factors in epidemiological studies

11-17 October 2014
Barcelona, Spain

C524

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Abstract The distribution of expanded ICF-EF terms was analyzed in a sample of 213 outpatients from Region Friuli Venezia Giulia, Italy. Outpatients were selected according to the main healthcare service involved. Almost 200 expanded ICF-EF terms were found (corresponding to 17 ICF-EF items). The distribution of expanded ICF-EF terms in the three groups was different, suggesting a different pattern of the "functioning/disability balance" in these groups. Expanded ICF-EF terms may be useful for epidemiological and statistical purposes.

Introduction

The ICF provides a functioning descriptive model useful to describe the interactions between an individual with a health condition and his/her contextual factors. A great novelty is its Environmental Factors (EF) component. Unfortunately, the poor granularity of the EF component of ICF compared to other standard terminologies may discourage its use by those who look for more accuracy or, on the contrary, may facilitate its use by those who need less accuracy. However, standard terminologies do not cover all factors classified by the ICF.
Aims: (1) to build expanded ICF-EF terms; (2) to study the distribution of expanded ICF-EF terms in a selected outpatient sample; (3) to suggest the use of expanded ICF-EF terms in epidemiological studies.

Table 1: Distribution of the main uncoded Environmental Factors (EF) defining subjects that provide support, assistance and relationships to the patients, in different groups (G), according to the electronic ICF-based individual record. Data are presented as number of items coded and percentages (%) on the total number of ICF items.

Uncoded "Support and Relationships" EF	G1	G2	G3	Tot	*Expanded ICF-EF*	ICF codes	G1	G2	G3	Tot
Spouse	0	2	9	11						
%		0.6	2.5	3.1						
Partner	0	4	2	6	e310 Spouse					
%		1.1	0.6	1.7						
Father and/or mother	92	33	102	227	e310 Father and/or mother					
%	25.6	9.2	28.4	63.2						
Sibling	5	25	35	65	e310 Sibling					
%	1.4	7.0	9.7	18.1						
Children	0	4	15	19	e310 Children					
%		1.1	4.2	5.3						
Foster/adoptive parent	7	1	5	13	e310 Foster/adoptive parent					
%	1.9	0.3	1.4	3.6						
Grandparent	13	0	5	18	e310 Grandparent					
%	3.6		1.4	5.0						
Medical Doctor	0	7	0	7	e355 Medical Doctor					
%		22.6		22.6						
Psychotarapist	0	3	0	3	e355 Psychotarapist					
%		9.7		9.7						
Speech therapist	1	0	0	1	e355 Speach therapist					
%	3.2			3.2						
Occupational therapist	1	5	0	6	e355 Occupational therapist					
%	3.2	16.1		19.4						
Nurse	0	13	1	14	e355 Nurse					
%		41.9	3.2	45.2						
Lawyer	0	0	2	2	e360 Lawyer					
%			0.1	0.1						
Social worker	0	16	4	20	e360 Social worker					
%		72.7	18.2	90.9						
Trustee	0	8	10	18	e330 Trustee					
%		28.6	35.7	64.3						
Employer	0	0	6	6	e330 Employer					
%			21.4	21.4						
Supervisor	0	3	1	4	e330 Supervisor					
%		10.7	3.6	14.3						
Personal care provider	0	0	4	4	e340 Personal care provider					
%			20.0	20.0						
Personal assitant	0	11	5	16	e340 Personal assitant					
%		55.0	25.0	80.0						
Ex spouse	0	1	0	1	e315 Ex spouse					
%		5.3		5.3						
Cousin	0	4	0	4	e315 Cousin					
%		21.1		21.1						
Nephew/niece	0	1	2	3	e315 Nephew/niece					
%		5.3	10.5	15.8						
Brother in law	0	1	3	4	e315 Brother in law					
%		5.3	15.8	21.1						
Aunt/uncle	0	3	4	7	e315 Aunt/uncle					
%		15.8	21.1	36.8						
Friend	0	8	4	12	e320 Friends					
%		66.7	33.3	100						
Acquaintance	1	1	1	3	e325 Acquaintance					
%	16.7	16.7	16.7	50.0						
Colleague	0	1	0	1	e325 Colleague					
%		16.7		16.7						
Neighbour	0	1	0	1	e325 Neighbour					
%		16.7		16.7						
Community member	0	1	0	1	e325 Community member					
%		16.7		16.7						
Total							120	157	220	497
							24.1	*31.6*	*44.3*	*100*

χ^2 test for the difference in the distribution of ICF codes = 113.4 P < 0.001

Methods & Materials

Specific standard terms concerning care and living environment were collected using international and national nomenclatures and standards (ISO-9999, Italian Essential Levels of Health Care (ELHC), Italian Social Care Services nomenclature) and automatically mapped to ICF. Then, expanded ICF-EF terms were obtained that had the ICF code in first coding position and the standard nomenclature term in second coding position. The expanded ICF-EF terms were then used to collect data on a sample of 213 outpatients selected according to the main healthcare service involved (Child and Adolescent Neuropsychiatry Services, No. = 53; Mental Health Departments, No. = 51; and Healthcare Districts, No. = 109).

Table 2: Distribution ISO-9999 codes and ICF fitted items, in different groups (G), according to the electronic ICF-based individual record. Data are presented as number of items coded and percentages (%) on the total number of ICF codes.

ISO-9999 codes		G1	G2	G3	Tot	*Expanded ICF-EF*	ICF codes	G1	G2	G3	Tot
03 03	Assistive products for respiratory therapy	5	0	4	9	e115 Products and technology for personal use in daily living		78	6	166	250
03 18	Assistive products for administering medicines	2	2	0	4			*31.2*	*2.4*	*66.4*	*100*
03 24	Physical, physiological and biochemical test equipment and materials	0	0	1	1						
03 33	Assistive products for pressure-sore prevention (antidecubitus)	2	0	28	30						
03 39	Assistive products for visual training	0	0	0	0						
03 48	Equipment for movement, strength and balance training	7	0	7	14						
06 03	Spinal orthosis	3	1	2	6						
06 12	Lower limb orthotic systems	15	0	20	35						
06 24	Lower limb prosthetic systems	0	0	1	1						
06 30	Prostheses other than limb prostheses	0	1	2	3						
06 33	Orthopaedic footwear	10	0	18	28						
09 03	Clothes and shoes	1	0	1	2						
09 06	Assistive products for protecting the body (body-worn)	0	0	6	6						
09 12	Assistive products for toileting	0	0	8	8						
09 15	Assistive products for tracheostomy care	1	0	0	1						
09 18	Assistive products for sensory care	1	0	2	3						
09 21	Products for skin protection and skin cleaning	0	1	1	2						
09 24	Urine diversers	0	0	4	4						
09 27	Urine collectors	0	0	3	3						
09 30	Assistive products for absorbing urine and faeces	8	0	20	28						
09 33	Assistive products for washing, bathing and showering	1	0	12	13						
12 03	Assistive products for preparing food and drink	1	0	0	1	e120 Products and technology for personal indoor and outdoor mobility and transportation		42	1	86	129
12 09	Assistive products for eating and drinking	1	0	4	5			*32.5*	*0.8*	*66.6*	*100*
18 03	Tables	1	0	1	2						
18 09	Sitting furniture	12	0	8	20						
18 36	Furniture for storage	0	0	1	1						
24 09	Assistive products for operating and/or controlling devices	0	0	2	2						
24 27	Assistive products for fixation	0	0	1	1						
27 06	Measuring instruments	1	0	0	1						
30 06	Games	1	0	0	1						
12 03	Assistive products for walking, manipulated by one arm	1	1	5	7	e120 12 03					
12 06	Assistive products for walking, manipulated by both arms	10	0	8	18	e120 12 06					
12 07	Accessories for assistive products for walking	0	2	0	2	e120 12 07					
12 12	Car adaptations	2	2	0	5	e120 12 12					
12 18	Cycles	3	1	3	7	e120 12 18					
12 21	Wheelchairs	17	0	42	59	e120 12 21					
12 24	Wheelchair accessories	1	0	6	7	e120 12 24					
12 27	Vehicles	0	0	1	1	e120 12 27					
12 30	Assistive products for transfer and turning	0	0	7	7	e120 12 30					
12 36	Assistive products for lifting	0	0	12	14	e120 12 36					
18 18	Seating devices	0	0	2	2	e120 18 18					
21 03	Assistive products for seeing	10	4	24	38	e125 21 03					
21 09	Input and output devices for computer; typewriters and calculators	1	0	3	4	e125 21 09					
21 12	Computers	0	0	7	7	e125 21 12					
21 15	Typewriters and word processing software	0	0	1	1	e125 21 15					
21 18	Assistive products for calculation	0	0	1	1	e125 21 18					
21 24	Assistive products for drawing and writing	0	0	1	1	e125 21 24					
21 36	Assistive products for telephoning	0	1	0	1	e125 21 36					
21 42	Assistive products for face-to-face communication	2	0	0	2	e125 21 42					
21 45	Assistive products for finance	2	0	3	5	e125 21 45					
03 43	Assistive products for training in alternative and augmentative communication	0	0	3	3	e130 Products and technology for education		0	0	3	3
										100	*100*
27 09	Work furniture	0	0	1	1	e135 Products and technology for employment		0	0	1	1
										100	*100*
30 09	Assistive products for exercise and sports	0	0	1	1	e140 Products and technology for culture, recreation and sport		1	0	2	3
30 12	Musical instruments	0	0	1	1			*33.3*		*66.7*	*100*
30 15	Assistive products for producing photos	0	0	1	1						
18 30	Assistive products for vertical accessibility	1	0	4	5	e150 Design, construction and building products and technology of building for public use		1	0	4	5
								20.0		*80.0*	*100*
Total								137	12	299	448
								30.6	*2.7*	*66.7*	*100*

χ^2 test for the difference in the distribution of ICF codes = 12.6 P = 0.39

Results

Expanded ICF-EF terms related to outpatients sample were almost 200 compared to 17 ICF-EF items.
Twenty-nine ICF-uncoded family members, health and social professionals, trustees, friends and colleagues were found (corresponding to 8 ICF items in e3)[Table 1]. Fifty-six ICF-ISO-9999 codes were found (corresponding to 7 ICF-EF e1 categories) [Table 2].
Twenty-five different ICF-ELHC terms were found (corresponding to ICF code e580) [Table 3]. Eighty ICF-Italian Social Care Services terms were found (corresponding to ICF code e575)[Table 4].

Table 3: Distribution of Essential Levels of Health Care (ELHC) terms and ICF fitted items, in different groups (G), according to the electronic ICF-based individual record. Data are presented as number of items coded and percentages (%) on the total number of ICF e580 code.

ELHC terms		G1	G2	G3	Tot	*Expanded ICF-EF*	ICF code	G1	G2	G3	Tot
1.A-1.E	Services targeted to the population at large and the working community	5	3	3	11	e580 1.	e580 *Health services, systems and policies*	173	209	286	668
	%	*0.7*	*0.4*	*0.4*	*1.6*			*25.9*	*31.3*	*42.8*	*100*
2.	District health care services										
2.A	Basic health care services	24	28	51	103	e580 2.A					
	%	*3.6*	*4.2*	*7.6*	*15.4*						
2.B	Local emergency response	3	2	2	7	e580 2.B					
	%	*0.4*	*0.3*	*0.3*	*1.0*						
2.C	Pharmaceutical services provided through licensed local pharmacies	13	21	45	79	e580 2.C					
	%	*1.9*	*3.1*	*6.7*	*11.8*						
2.D	Supplementary health care support	4	1	6	11	e580 2.D					
	%	*0.6*	*0.1*	*0.9*	*1.6*						
2.E	Specialist day-hospital services	36	24	35	95	e580 2.E					
	%	*5.4*	*3.6*	*5.2*	*14.2*						
2.F	Provision of prostheses	17	0	23	40	e580 2.F					
	%	*2.5*		*3.4*	*6.0*						
2.G	Local day-hospital and home-based services	36	63	58	157	e580 2.G					
	%	*5.4*	*9.4*	*8.7*	*23.5*						
2.H	Local health care services provided in residential and semi-residential support facilities	12	56	52	120	e580 2.H					
	%	*1.8*	*8.4*	*7.8*	*18.0*						
3.A-3.I	Hospital services	21	7	8	36	e580 3.					
	%	*3.1*	*1.0*	*1.2*	*5.4*						
4.	Services targeted to care and rehabilitation of non self-sufficient persons	2	4	3	9	e580 4.					
	%	*0.3*	*0.6*	*0.4*	*1.3*						

*Code 2.1 (Spa water services) was excluded, due to the lack of codes in this category
χ^2 test for the difference in the distribution of ELHC codes = 24.41 P = 0.001

The distribution of expanded ICF-EF codes was statistically different among groups (χ^2 test for the difference in the distribution of ICF codes, ELHC codes and Regional Social Services Information System codes P<0.001), except in Table 2 (χ2 test for the difference in the distribution of ICF codes P=0.39). Outpatients in G2, however, represented only the 2.7% of the total ICF codes in Table 2.

Conclusions

The expanded granularity of ICF-EF items will allow a more detailed description of the EF underlying an individual functioning profile. The fact that almost 200 expanded ICF-EF codes, out of only 17 ICF-EF items, were used, shows the usefulness to expand the ICF.
The different distribution of expanded ICF-EF terms in the three groups suggests a different pattern of the "functioning/ disability balance" in these groups.
Expanded ICF-EF terms may be useful for epidemiological and statistical purposes.

Table 4: Table 7: Distribution of Regional Social Services Information System terms and ICF fitted items, in different groups (G), according to the electronic ICF-based individual record. Data are presented as number of items coded and percentages (%) on the total number of times ICF e575 code is used.

Regional Social Services Information System codes		G1	G2	G3	Tot	*Expanded ICF-EF*	ICF code	G1	G2	G3	Tot
Interventions for access to Social Service [a]		7	0	2	9	e575 Interventions for access to Social Service	e575 *General social support services, system and policies*	42	30	42	114
	%	*6.1*		*1.8*	*7.9*			*36.8*	*26.3*	*36.8*	*100*
Social work [b]		10	4	9	23	e575 Social work					
	%	*8.8*	*3.5*	*7.9*	*20.2*						
Economical support interventions [c]		8	16	11	35	e575 Economical support interventions					
	%	*7.0*	*14.0*	*9.6*	*30.7*						
Residential services [d]		11	6	7	24	e575 Residential services					
	%	*9.6*	*5.3*	*6.1*	*21.1*						
Semi-residential and social skill interventions [e]		5	3	12	20	e575 Semi-residential and social skill interventions					
	%	*4.4*	*2.6*	*10.5*	*17.5*						
Family care and institutional care [f]		1	1	1	3	e575 Family care and institutional care					
	%	*0.9*	*0.9*	*0.9*	*2.6*						

*Housing services and activities supporting the access to employment were excluded, due to the lack of codes in this category

[a] Interventions addressed to the user that are adopted immediately after contact with social services
[b] Services provided by social services professionals
[c] Interventions providing economical support to single users and/or families, based on national and/or regional regulations, and/or absence of or insufficient income, and of evident social difficulties and/or risk of social marginalization
[d] Interventions aimed at ensuring home care, meant as a basic individual right and, more extensively, as a meaningful space. The concept refers to the user's home - place of memory and of material and immaterial objects linked to user and user's family personal history and to his/her routine. This concept may be expanded to social relationships, nature, landscape, culture, community history.
[e] Integrated services provided to families that need specialist support. These interventions provide daily stay in residential facilities (24h care) for elderly, immigrants, disabled people, persons undergo, etc. , daily care centers, and temporary residential facilities providing accommodation, health care, recreational services, etc.
[f] Replacement services addressed to families unable or inadequate to perform, permanently or temporarily, their duties. Interventions providing permanent stay in 24h care facilities, such as residential facilities for self-sufficient persons with social difficulties that cannot be dealt with at home, and community and housing facilities providing social and health care.

χ^2 test for the difference in the distribution of Regional Social Services Information System codes = 20.8 P < 0.001

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FDRG Annual Report

11 – 17 October 2014
Barcelona, Spain

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C106

Abstract
This poster describes the activities of the Functioning and Disability Reference Group in the 12 months from October 2013 to October 2014. Four main streams of work are reported; 1 ICF updates, 2 ICF education, 3 Measurement, 4 Harmonisation and development.

Background

The items on the FDRG component of the WHO-FIC strategic plan are reported on below. The co-chairs met bi-monthly by teleconference. FDRG members and collaborators were informed of progress on the projects during the year and met by teleconference in March, July and September. A mid-year meeting was held from 1-3 May 2014 at the WCPT offices in London, attended by 30 participants from collaborating centres.

ICF Updates

Collaborative work between URC and IRG moderators to cluster 84 proposals to have 26 new proposals, and updates workshops, have been instrumental in the progress on ICF updates. A total of 41 proposals were passed to the URC for voting. Only 11 proposals remain in the Open Discussion Layer.

Summary of ICF updates in 2013-2014

LAYERS	Number of proposals with new review comments in 2014 & 2013	
INITIAL REVIEW LAYER	2014	7/13
	2013	12/12
FDRG LAYER	2014	7/7
	2013	7/7
OPEN DISCUSSION LAYER	2014	33/52
	2013	51/145
		Recommendations before votes
CLOSED DISCUSSION LAYER	2014	41 — 24 for adoption, 17 for rejection
	2013	65

ICF Ontology

Towards a common ontology for ICF
The acknowledgment that work towards an ICF Ontology is needed and that this is the time to act was shared by WHO and by the relevant committees (ITC, FDC).
The effort aims at a more ambitious project towards a common seamless integration of all health information to allow complete representation of health and functioning in the digitalized world.
Building blocks in the project will be:

- Modelling
- Content linkages
- Terminology linkages
- Content development
- Review of qualifiers

•Leadership of the project will sit in WHO, but FDRG will substantially contribute to its realization. Possible initial steps involving FDRG will include:
•shortlisting of ICF use cases
•Stocktake/term beating for functioning relevant terms and concepts
•Contribute to the model development

Measurement

Building on the work of John Hough in 2013, see posters at http://www.who.int/classifications/network/meeting2013/en/ a small group has been working on a paper on the criteria for selecting quality ICF literature. Significant progress was made during the mid-year meeting and is reported in a separate poster. The draft paper will be considered during the annual meeting, after which this project will be dropped from the WHO-FIC strategic work plan. The paper is due to be completed for publication by the end of 2014.

ICF Practical Manual

Comments on the exposure draft of the ICF practical manual were accepted between October 2013 and May 2014. These have been considered and, where practicable without major redrafting, incorporated. Substantial comments have been retained for subsequent editions.
The ICF Practical Manual exposure draft will be remain on the WHO web site until WHO has completed the final internal publications process. There will be no printed copies of the publication.
Collaborating Centres are encouraged to translate the practical manual.
The writing group led by Ros Madden and including Andrea Martinuzzi, Judith Hollenweger, Diane Caulfeild, Jennifer Madans and Mitch Loeb are thanked for their tireless efforts to produce the manual. Thanks also go to those members of FDRG and EIC who commented on drafts and to WHO staff for their input.

Harmonization and development

Education and Implementation Committee (EIC)
A survey intended to find out about the ICF education needs of FDRG members and collaborators was carried out in the first quarter of 2014. The results were reported to EIC and the FRDG mid-year meetings. The results indicate the direction for a future education strategy for ICF.
Interested WHO-FIC delegates are requested to attend the EIC session dedicated to ICF education to work on the strategy. The results of the survey are reported in a separate poster.

ICHI development group
Andrea Martinuzzi chairs the technical working group for functioning interventions. FDRG members and collaborators have contributed to the development of the axes and tabular list of functioning interventions in an updated Alpha 2. New developments in the ICHI project will be reported in separate posters.

Informatics and Terminology Committee (ITC)
In addition to working on ontology development the FDRG is working with ITC on a mobile application, named mICF, for the collection of functional status data. The mICF project will be reported in separate posters.

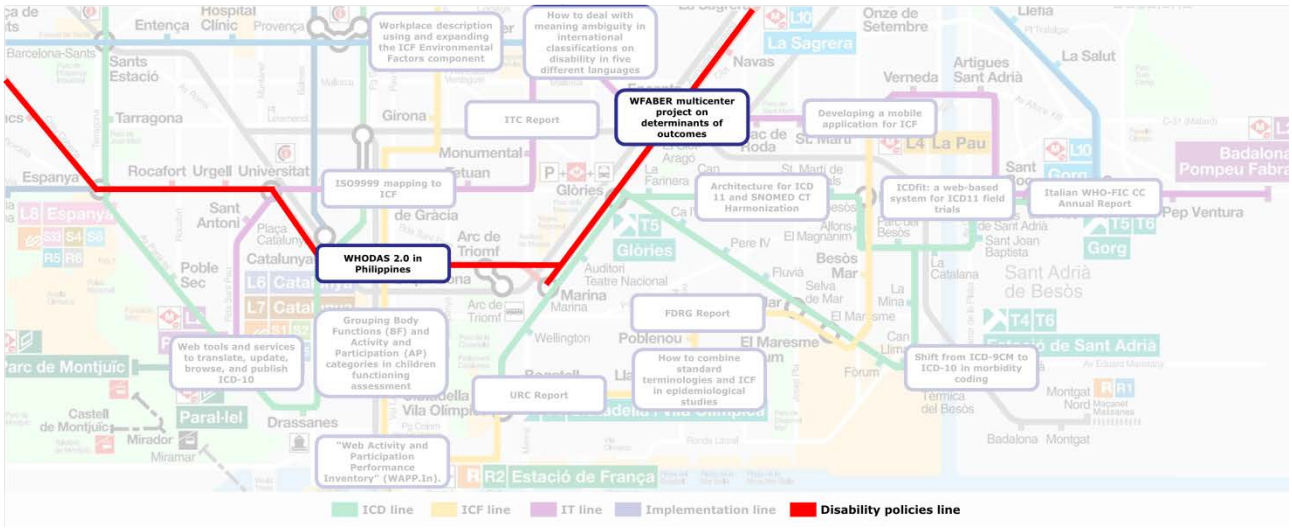
For further information contact the co-chairs: **Andrea Martinuzzi** [andrea.martinuzzi@lanostrafamiglia.it] and **Catherine Sykes** [csykes@wcpt.org] or the Secretariat **Stefanus Snyman** [ssnyman@sun.ac.za].

Barcelona, 11-17 October 2014

WHO-FIC Annual Network Meeting

Driving improvement in healthcare: from data to eHealth tools

Disability policies Line



- *Frattura L., Anttila P., Nurmi-Koikkalainen P.* How to automatically expand ICF-EF in order to better describe care and living environment factors at country level: steps toward a multicenter project on the biopsychosocial determinants of outcomes.

Incrocio con **ICF Line**

- *Leonardi M., Kostanjsek N.F., Chatterji S.* Measuring Disability and Health in Emergencies: implementing a disability survey using WHODAS 2.0 in the Typhoon Yolanda affected areas of the Philippines.

WHO - FAMILY OF INTERNATIONAL CLASSIFICATIONS NETWORK ANNUAL MEETING 2014

How to automatically expand ICF-EF in order to better describe care and living environment factors at country level: steps toward a multicenter project on the biopsychosocial determinants of outcomes

11-17 October 2014
Barcelona, Spain

C525

Frattura L.[1], Anttila P.[2], Nurmi-Koikkalainen P.[2], Snyman S.[3], Green S.(4), Bassi G.[1], Simoncello A.[1], Terreni S.[5], Soranzio A.[5]

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Abstract To launch a cooperation to carry out a WHO-FIC based multicenter naturalistic outcomes study using an international version of VilmaFABER (Friendly Alimenting Biopsychosocial Electronic Record), a web application developed by the Italian WHO-FIC collaborating center. Three countries took part in this preliminary study: Finland, South Africa, and Italy. The WFABER (Worldwide Friendly Alimenting Biopsychosocial Electronic Record) project is open to all other interested WHO-FIC network countries.

Introduction

There are currently no collaborative studies inside the WHO-FIC network on biopsychosocial determinants of outcomes at community level to facilitate decision-making, continuity of care, and welfare planning. The aims of this three-country collaboration are to develop, test and launch a first release of an international version of the web assessment systema named VilmaFABER (1) in a multicenter "naturalistic outcome" study inside the WHO-FIC network.

Figure 1 - WFABER cooperation project: step 1

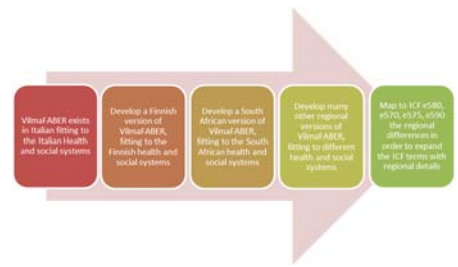

Figure 2- WFABER cooperation project: step 2

Methods & Materials

Three countries took part in this preliminary study: Finland, South Africa and Italy. The FABER application was used. FABER integrates WHO classifications with national terminologies and standards into an individual electronic record. FABER uses the ICF environmental factors (EFs) as "superstandard" terminology. It automatically creates new terms made by an ICF code in the first position and other standard terms (where existing) in second position. This expanded ICF-EF list of terms is used to explore the role (as facilitator or barrier) of the EFs when assessing individual functioning/disability. As there is currently no common international classification of health and social services, great progress was made by the three participating countries to list the country-specific terminologies relating to services in order to provide country-specific expansion of ICF-EF categories e575 (General social support services, systems and policies) and e580 (Health Services, systems and policies).

Results

The FABER information model was enriched with two new country-specific terminologies regarding health and social services and systems, in order to create new expanded ICF-EF terms that can be used in Finland and South Africa. The first part of the collection information form was completed. A prototype of the international FABER was developed. A preliminary draft of the worldwide FABER (WFABER) project was made.

Table 1 - WFABER cooperation project: some examples about the e580 ICF expansion (a new Big Bang?)

Italy *		Finland **		South Africa ***	
Italian Health System	**Italian expanded ICF-EF**	**Finnish Health System**	**Finnish expanded ICF-EF**	**South African Health System**	**South African expanded ICF-EF**
2.A Assistenza sanitaria di base	e580 LEA:2.A - Assistenza sanitaria di base	E Perusterveydenhuollon palvelut	e580 E Perusterveydenhuollon palvelut	2.1.1.1 Primary Healthcare services: Community-based services (CBS)	e580 2.1.1.1 Primary Healthcare services: Community-based services (CBS)
2.B Attività di emergenza sanitaria territoriale	e580 LEA:2.B - Attività di emergenza sanitaria territoriale	A Hätä-, ensiapu- ja päivystyspalvelut	e580 A Hätä-, ensiapu- ja päivystyspalvelut	2.3.5.1 Specialised services: Emergency medical services	e580 2.3.5.1 Specialised services: Emergency medical services
2.C Assistenza farmaceutica erogata attraverso le farmacie territoriali	e580 LEA:2.C - Assistenza farmaceutica erogata attraverso le farmacie territoriali	SI Apteekkipalvelu	e580 SI Apteekkipalvelu	1.8 Essential Drugs Programme (EDP)	e580 1.8 Essential Drugs Programme (EDP)
2.F Assistenza protesica	e580 LEA:2.F - Assistenza protesica	HGA Apuvälinepalvelu	e580 HGA Apuvälinepalvelu	2.3.2.3 Provision of assistive devices	e580 2.3.2.3 Provision of assistive devices
2.G Assistenza territoriale ambulatoriale e domiciliare	e580 LEA:2.G - Assistenza territoriale ambulatoriale e domiciliare	O Kotihoito, kotipalvelut ja omaishoidon tukipalvelut	e580 O Kotihoito, kotipalvelut ja omaishoidon tukipalvelut	2.1.1.1 Home and community-based care	e580 2.1.1.1 Home and community-based care
2.G.3 Attività sanitaria e sociosanitaria rivolta alle persone con problemi psichiatrici e alle loro famiglie	e580 LEA:2.G.3 - Attività sanitaria e sociosanitaria rivolta alle persone con problemi psichiatrici e alle loro famiglie	J Päihde- ja mielenterveyspalvelut	e580 J Päihde- ja mielenterveyspalvelut	2.3.1.1 Mental health & psychiatric service: Community-based service	e580 2.3.1.1 Mental health & psychiatric service: Community-based service
3.A Pronto soccorso	e580 LEA:3.A - Pronto soccorso	AA Hätäkeskuspalvelu	e580 AA Hätäkeskuspalvelu	2.3.5.1 Emergency medical services	e580 2.3.5.1 Emergency medical services
3.B Degenza ordinaria	e580 LEA:3.B - Degenza ordinaria	F Erikoissairaanhoidon palvelut	e580 F Erikoissairaanhoidon palvelut	2.2.1 District hospitals services	e580 2.2.1 District hospitals services

*Source: D.P.C.M. del 29 novembre 2001, "Definizione dei livelli essenziali di assistenza", in GU 8 febbraio 2002, n. 3.
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Table 2 - WFABER cooperation project: some examples about the e575 ICF expansion (a new Big Bang?)

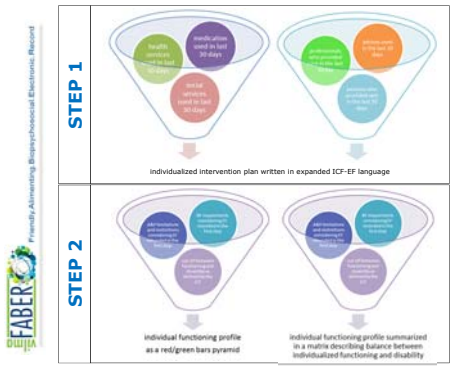
Italy *		Finland **		South Africa ***	
Italian Social Care System	**Italian expanded ICF-EF**	**Finnish Social Care System**	**Finnish expanded ICF-EF**	**South African Social Care System**	**South African expanded ICF-EF**
Attività di Servizio sociale professionale	e575 Attività di Servizio sociale professionale	B Neuvonta - ja ohjauspalvelut	e575 B Neuvonta - ja ohjauspalvelut	Social work with children and families	e575 Social work with children and families
Interventi volti a favorire la domiciliarità	e575 Interventi volti a favorire la domiciliarità	M Asumiseen liittyvät palvelut	e575 M Asumiseen liittyvät palvelut	Home-based care for: Aged; Disabled; Terminally ill people	e575 Home-based care for: Aged; Disabled; Terminally ill people
Trasferimenti in denaro per il pagamento di interventi e servizi	e575 Trasferimenti in denaro per il pagamento di interventi e servizi	I Työllistymisen ja taloudellisen tuen palvelut	e575 I Työllistymisen ja taloudellisen tuen palvelut	Social security	e575 Social security

*Source: Conferenza delle Regioni e delle Province autonome, "Nomenclatore interregionale degli interventi e dei servizi sociali", Documento n. 09/093/CR/C8, 29 ottobre 2009, Roma. **Source: see Table 1 ***Source: see Table 1

Discussion

There are huge differences how the services in the participating countries are named and described in the national contexts. The current ICF-EF terms are not sufficient to describe such diversity, but the new expanded ICF-EF terms are. This preliminary work revealed that it is possible to expand the ICF EF component in order to better describe different health and social systems. The launch of a multicenter outcome study is currently being considered.

Figure 3- VilmaFABER assessment system functions like a concrete mixer



Conclusions

The expanded ICF-EF terms may be considered in the development of ICHI, for ICF-EF ontology and update purposes, and for the mICF development.
The WFABER (Worldwide Friendly Alimenting Biopsychosocial Electronic Record) project is open to all other interested WHO-FIC network countries.

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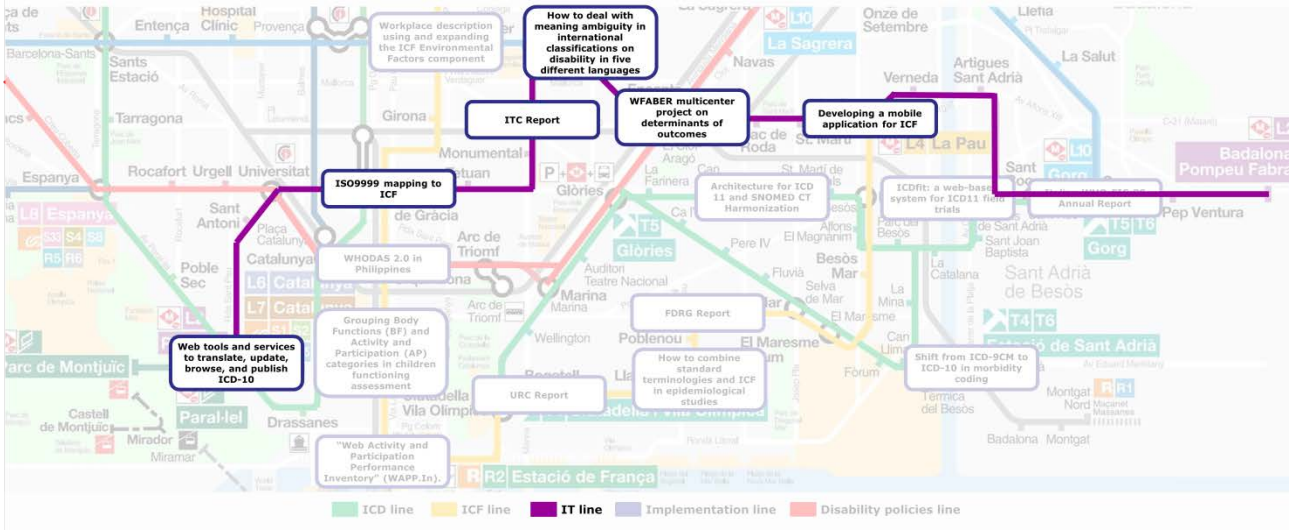

- *Carvell C., Della Mea V.* Informatics and Terminology Committee (ITC) Annual Report.

Incrocio con **ICD Line**

- *Frattura L., Grippo F., Frova L.* The collaborative effort to implement updated classifications: the lesson learned in developing and using web tools and services to translate, update, browse, and publish ICD-10.

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- *Bassi G., Simoncello A., Castelpietra G.* How to expand ICF Environmental Factors (EF) starting from ISO-9999 Classification: toward a “hybrid” standard terminology?

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- *Rodrigues J.M., Frattura L., Cuenot M.* How to deal with meaning ambiguity in international classifications on disability in five different languages.

Incrocio con **Disability policies Line**

- *Frattura L., Anttila P., Nurmi-Koikkalainen P.* How to automatically expand ICF-EF in order to better describe care and living environment factors at country level: steps toward a multicenter project on the biopsychosocial determinants of outcomes.

INFORMATICS AND TERMINOLOGY COMMITTEE - ANNUAL REPORT

11-17 October 2014
Barcelona, Spain

C103

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Abstract

This poster presents annual report of the Informatics and Terminology Committee (ITC), highligting activities of since the Beijing meeting in October 2013.

Introduction

The Informatics and Terminology Committee (ITC) was established in 2010, combining the Electronic Tools Committee and the Terminology Reference Group into one WHO-FIC committee.

Administration

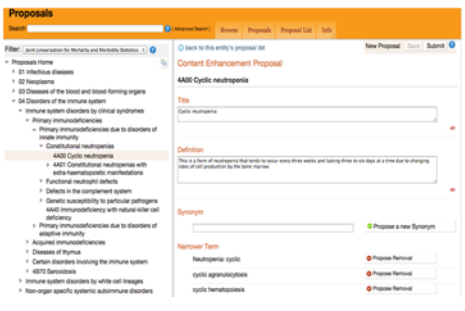
Ad-hoc meetings of the co-chairs have throughout the year; however, due to the lack of resources, no face to face mid-year meeting could be held.

An ITC web page was developed by the Italian Collaborating Centre to contain documents and basic information on the committee such as minutes, membership, reports, etc. This would enhance communication for the committee and other members of the WHO-FIC network. http://mitel.dimi.uniud.it/who-fic-itc . A mailing list for ITC members has also been set up.

The Strategic Workplan was updated following the Beijing meeting to include feedback from Council. This poster highlights work completed in the past year and underway within each of the ITC strategic priorities.

Classifications and Revision Platforms

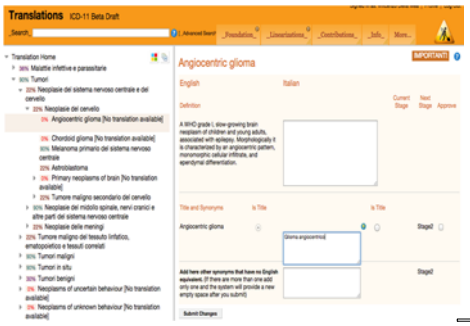
WHO headquarters and collaborating centres work to enable standardized maintenance, update and revision of WHO classifications.
Priorities in this area include maintaining and enhancing browsers for ICD, ICF and ICHI. Work has continued on the classification update platforms and on the ICD Revision Platform, which now provides a section for proposals.



Multilingual Support

A multi-language framework is required to enable the translation of content of WHO classifications.

WHO HQ has developed a tool for this and the seven WHO languages have been loaded into memory. It features a translation memory to track movement in the classification and enables workflow for approval and comment on another person's translation.



In parallel to this effort, the Korean Collaborating Centre continues to work on the translation of ICD-11 to Korean and Chinese.

Standards

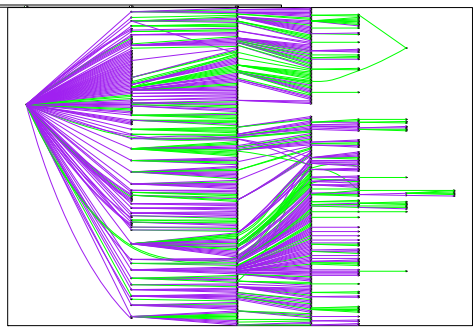
Technical standards are developed to enable the electronic exchange of WH(classifications. In 2013 the WHO developed a Uniform Resource Identifies (URI) scheme to identify ICD-11 entitles and a web interface. The URI API has been further consolidated and now also includes proposals. Correspondingly, the social apps used as a test case for the API have been updated to also publish proposals on Facebook and Twitter.

The German Collaborating Centre has finalized the ICD-O-3 stylesheets and published the German version online. It is also possible to generate pdf, ClaML and Metadata. It is fully implemented in CTK and can be used by other Collaborating Centres, if needed, as well as by WHO.

Formal Knowledge Representation

Another focus of the ITC is to enhance formal knowledge representation of WHO classifications and their linkages to related terminologies. This is a multilateral item requiring coordination with other committees, reference groups, and external participants. There were several activities in the area over the past year:

WHO-IHTSDO harmonization process – A number of ITC members are also members of the WHO-IHTSDO Joint Advisory Group (JAG). During the last year, JAG refined the architecture for harmonization and carried out the mapping of equivalences between ICD11 and SNOMED-CT in the Circulatory System chapter, and then started with a number of other chapters, as a preliminary work towards the Common Ontology.



ICF Ontology – ITC Co Chairs participated in the FDRG mid-year meeting to begin discussions and work on the development of an ontology for ICF.

Other Activities

1. The web site for poster submission has been maintained the 2014 WHO-FIC meeting.
2. During the mid-year FDRG meeting, preliminary work was carried out on the mICF project, aimed at the development of a mobile app for ICF.
3. Work is in progress on a web-based system for the ICD11 field trials.

Acknowledgements

ITC wishes to acknowledge the work of the WHO HQ and collaborating centres for their contributions over the past year.