



Poster Booklet

WHO-FIC Network
Annual Meeting 8-12 October **2016**

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

WHO Family of International Classifications Network Annual Meeting
Tokyo, Japan 8-12 October 2016





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In reply please
refer to:

Lucilla Frattura
Classification Area, General Directorate
Regional Central Health Directorate
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Your reference:

31 May 2016

Dear Dr Frattura,

**WHO Family of International Classifications Network Annual Meeting
and ICD Revision Conference
Tokyo, Japan 8-14 October 2016**

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, and ICD Revision Conference which will take place in Tokyo, Japan, from Saturday 8 to Friday 14 October 2016.

The meeting will be hosted by the Japan Ministry of Health, Labour and Welfare (MHLW) as well as the Japan Hospital Association (JHA). The Secretariat function will be carried out by the WHO HQ Health Data Standards and Informatics unit.

“**Health Information in the New Era: ICD Revision Conference**” has been identified as the main theme for the meeting this year.

Please find attached the provisional timetable. This 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 website: www.who.int/classifications/network/meeting2016.

There will be two meeting venues; the Jikei University Medical School on Saturday and Sunday, 8 and 9 October, followed by the Tokyo International Forum from Monday through Friday, 10 - 14 October.

The website for the coordination of meeting registration 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 may be accessed via hyperlink from the WHO website listed above.

Registration for the meeting is mandatory and must be made through the meeting web site. Participation is by invitation, only.

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 delegation 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 Hernan Velasquez (velasquezh@who.int) no later than 31 July 2016, and complete their registration through the web site by 31 August 2016, at the latest.

As per established practice, we understand that all participation costs for you and your delegation 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.

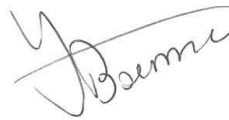
We would like to request each WHO Collaborating Centre to submit a poster presenting the annual report from your centre. We will use the same platform as in 2015 for the submission and collection of the posters for 2016. The link is available on the WHO website and on the meeting website. This applies to all posters, for plenary poster sessions, and for presentation in the Committees or Reference Groups

The deadline for poster abstracts is 15 June 2016 and the deadline for the submission of final posters is 5 August 2016. Please do inform your delegation accordingly.

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

We are looking forward to hearing from you and seeing you in Tokyo

Yours Sincerely,



Dr Ties Boerma
Director
Information, Evidence and Research



Italian WHO-FIC CC annual report

Lucilla Frattura on behalf of the Italian WHO-FIC CC's research network
Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, Italy

Abstract The aim of this work is to present the annual report of the Italian WHO-FIC CC.

Table 1– The new TORs 2015-2019

Introduction

In July 2015, the Central Health Directorate – Classification Area – Friuli Venezia Giulia Region was redesignated for the third time as a WHO-FIC Collaborating Centre. After the first eight years of supporting WHO in developing, maintaining, and implementing the WHO-FIC, the new quadriennium started under redefined TORs (Table 1). Lucilla Frattura was confirmed as Center Head. Nenad Kostanjsek was confirmed as the responsible officer for WHO.

Tor 1 Assisting WHO in developing, maintaining and revising the WHO Family of International Classifications, Terminologies and Standards (WHO-FIC), in particular the International Classification of Diseases (ICD), the International Classification of Functioning, Disability and Health (ICF), the International Classification of Health Interventions (ICHI), and relevant terminological and ontological aspects.

TOR 2 Supporting global work with active participation to Committees, as for Implementation & Education, Update & Revision, Electronic Tools & Terminology, and Family Development and Reference Groups, as for Mortality, Morbidity, Functioning & Disability that assist WHO in the development, testing, implementation, use, improvement, updating and revision of members of the WHO-FIC.

TOR 3 Collaborating with local and regional users of classifications by networking and providing support, disseminating information about the WHO-FIC and other health-related classifications, regarding the availability, suitability and applicability of the classifications for different purposes, as reporting and coding, availability of tools for implementation, data analysis, and interpretation, in coordination with WHO.

TOR 4 Promoting use of the WHO-FIC, developing, formulating and sharing teaching materials, organizing and conducting local, regional and global training courses and translating international WHO-FIC materials to the relevant language for local use, in coordination with WHO.

TOR 5 Improving the level and quality of implementation of WHO classifications, supporting quality assurance procedures of the WHO-FIC regarding mechanisms, norms and standards of classification use, data collection, and data analysis, in coordination with WHO.

Figure 1 – The Tokyo Map of the Italian WHO-FIC CC 2015-2016 activities (the stations are the 2016 WHO-FIC Network Meeting posters)



Methods & Materials

Taking into account the new 2015-2019 (TORs), 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 first year (21 July 2015-21 July 2016), the Italian WHO-FIC CC was active on five lines of work: (i) Revision of the International Classification of Diseases (ICD-11); ii) Management of the ICD-10 and ICF

update process; iii) ICHI development; (iv) IT and Ontological developments for WHO-FIC; (v) National work on WHO-FIC.

In the last year, Italian CC members served as co-chairs of ITC, FDRG, and MRG. The URC Secretariat for ICD and ICF was provided by the Italian Center. The centre also participated in ICF and ICD update process with two voting members. The Italian FDRG co-chair also served as member of the SEG and as coordinator of the «Functioning interventions» in the ICHI development process. In order to support ICD-11 field trials, a web-based system (ICDfit) has been designed and developed according to WHO requirements. New contracts were signed to monitor ICF implementation in Italy, and to support local use of

ICD-10 and ICF. Research partners were involved in collaborative projects to collect data using ICF.

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 funding.

References

Italian WHO-FIC annual report, Udine July. 2016

Acknowledgements

1. All activities carried out by the Italian Centre were possible thanks to the deep understanding and funding by Friuli Venezia Giulia Regional Administration, national and other regional institutions and authorities.
2. Agreement between Italian Ministry of Health and Friuli Venezia Giulia Region, 2010-2012; 2013-2016



Update and Revision Committee (URC) Annual Report

Vogel U.¹, Jelsma J.², Simoncello A.³, Tonel P.³

¹German Institute of Medical Documentation and Information (DIMDI) - URC ICD Co-chair; ²University of Cape Town - Department of Health and Rehabilitation Sciences - URC ICF Co-chair; ³Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC - URC ICD and ICF secretariat

Abstract This poster includes an outline of the purpose and strategic plan of the Update and Revision Committee and presents a preliminary annual report of the work of the Committee for 2016.

Introduction

The 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 include 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 Classification.

Methods & Materials

The URC work is mainly conducted through the update and revision platforms for ICD-10 and ICF, which are workflow engines designed to facilitate communication within expert workgroups and ensure transparency of the processes. Work and communications are also carried out via e-mail, conference calls and meetings, including an annual meeting during the WHO-FIC Annual Meeting. Key deliverables of the URC work include the lists of updates for WHO-FIC member classifications.

Product/Deliverable	Activities	Start Date	Planned End Date	%
Annual updates to ICD-10	Submission, review, decision and implementation of update proposals for ICD-10.	nov-16	Oct 2016 - end of annual submission process	0.5
Transition strategy from ICD-11 revision process to URC update process	WHO draft for comments	Oct 14	Oct 16	0.3
Realize a Foundation ICF implementation of ICF proposals	Submission, review, decision and implementation of ICF-related update proposals for ICF. Due to the difference in submission process and lack of supporting rationale additional work is required.	nov-10	Oct 2016	0.9
Provide annual updates to ICF	Submission, review, decision and implementation of update proposals for ICF.	nov-14	Oct 2016	0.5
Overall coordination of the update process	Secretariat: Participation in the works, meetings and teleconferences of Initial Review Group and FDRG.	nov-16	Oct 16	0.5
i) A PDF file which incorporates all the amendments passed by the URC from 2006-2014 available on the web-site. ii) An updated ICF Browser available on the WHO-FIC web site reflecting all these amendments. iii) An updated ICF Browser available on the ICF Update Platform reflecting all these amendments.	Secretariat: Integrating all the amendments into a single electronic version of the ICF. Publishing this on the web-site as a PDF file. Updating the ICF Browsers, both on the WHO-FIC web site and in the ICF Update Platform.	Oct 14	Nov 2016	0.1

Table 1 – The URC relevant part of the WHO-FIC SWP (May 3, 2016 v, simplified):

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

Results

The URC ratified 60 recommendations at the 2015 WHO-FIC Network annual meeting held in Manchester, United Kingdom, for updating the ICD-10 and 20 recommendations for updating the ICF (Fig. 1 and 2).

Instruction	Tabular list entries	Source	Approv. Date	Major/Minor	Sugg. Impl. Date
Revise exclusion	Chapter I Certain infectious and parasitic diseases (A00-B99) <i>Incl.:</i> diseases generally recognized as communicable or transmissible <i>Use additional code (U03-U84), if desired, to identify resistance to antimicrobial drugs</i> <i>Excl.:</i> carrier or suspected carrier of infectious disease (Z22.-) certain localized infections - see body system-related chapters infectious and parasitic diseases complicating pregnancy, childbirth and the puerperium (except obstetrical tetanus) (O98.-) infectious and parasitic diseases specific to the perinatal period (except tetanus neonatorum, whooping cough, congenital syphilis, perinatal gonococcal infection and perinatal human immunodeficiency virus (HIV) disease) (P15-P19) influenza and other acute respiratory infections (J00-J22)	2135 MBG	October 2015	Minor	January 2017
Delete title code, revise and add inclusions	A06.51 Amoebic lung abscess (A06.8*) Amoebic abscess of lung (and liver) (J99.8*) Amoebic abscess of lung (and liver), with pneumonia (J17.1-*)	2150 Canada	October 2015	Minor	January 2017
Revise code title and add inclusion	A08.1 Acute gastroenteropathy due to <i>Nonalkaligenes</i> <i>Nonalkaligenes</i> Small round structured virus enteritis	2157 Australia	October 2015	Minor	January 2017

Figure 1 – Screenshot from the ICD annual updates approved in 2015

Proposal ID & update type	Affected Code	Original version	Update version
Major: Addition of new codes at the second and third level	8750-8759 Movement functions		h761 Spontaneous movements Functions associated with frequency, fluency and complexity of total and individual body-part movements such as inflex spontaneous movements and patterns of movement. <i>Note: This code should be applied only to inflex activities than completed ages months.</i> <i>Exclusions: motor reflex functions (h760); intention movement (action functions) (h751); involuntary movement functions (h762)</i> h7610 General movements Frequency and quality of age-specific general spontaneous movements such as "arching" movements and "idiotic" movements in early life. h7611 Specific spontaneous movements Frequency and quality of other spontaneous movements normally present in the first postnatal months, such as arm and leg movements, head rolling, finger movements and kicking. h7618 Spontaneous movements, other specified h7619 Spontaneous movements, unspecified
D # 149 Minor: Change in note at the third level	0570 Looking after one's health	05702 Maintaining one's health Caring for oneself by being aware of the need and doing what is required to look after one's health, both to respond to risks to health and to prevent ill-health, such as by seeking assistance (professional and non-professional), following medical and other health advice, and avoiding risks to health such as physical injury, communicable disease, drug-taking and sexually transmitted diseases.	05702 Maintaining one's health Caring for oneself by being aware of the need and doing what is required to look after one's health, both to respond to risks to health and to prevent ill-health, such as by seeking assistance (professional and non-professional), following medical and other health advice, and avoiding risks to health such as physical injury, communicable disease, drug-taking and sexually transmitted diseases.

Figure 2 – Screenshot from the ICF annual updates approved in 2015

At present, in 2016, 104 proposals have been moderated for ICD-10 and put to vote by URC members. With regard to ICF, 25 proposals have been reviewed by the FDRG and 20 of them have been put to vote by URC members. Functions, activities and completeness of deliverables are represented in the latest version of the Strategic Work Plan submitted to the WHO-FIC Council.

Conclusions

The achievements of the Committee are made possible by the generous efforts of members and relative institutions. The increasing number of ICD proposals being processed, the synchronization from one ICD revision to the other, and the realization of a foundation ICF with the implementation of the classification items coming from the ICF-CY, require an increasing engagement of the Collaborating Centers in the Committee's work.

Acknowledgements

Members of the Committee:
A.H. Almborg, R. Anderson, S. Bang, H. Brear, A. Brooke, S. Cherkasov, L. Clarke, T. Crawford, M. Cuenot, H. Di Nubila, A. Elsworthy, L. Frattura, K. Giannangelo, F. Grippo, O. Guye, L. Hanmer, J. Hargreaves, J. Hough, D. Hoyte, R. Jakob, L.A. Johansson, Y. Kyoo Kang, S. Maart, K. Mabon, R. Madden, N. Melin, D. Meshkov, J. Millar, J. Miller, D. Murphy, H. Nishimoto, H. Ogata, E. Oikawa, D. Pickett, M.M. Robinson Nicole, H. Rocha Sanchez, J. Rust, E. Sauls, K. Seo, A. Shoshmin, O. Steinum, D. Suvupan, C. Sykes, H. Ten Napel, U. Trinks, C. Van Gool, M. Virtanen, M. Watari, P. Wood.

References

- Terms of Reference for WHO FIC Update and Revision Committee (URC) version Dec 2012
- URC SWP, May 3, 2016
- The WHO Updating & Revision Committee <http://www.who.int/classifications/committees/URC.pdf>
- The ICD update platform <https://extranet.who.int/icdrevison/nr/login.aspx?ReturnUrl=%2Ficdrevison%2FDefault.aspx>
- The ICF update platform <https://extranet.who.int/icfrevision/nr/loginICF.aspx>



INFORMATICS AND TERMINOLOGY COMMITTEE – ANNUAL REPORT

8-12 October 2016
Tokyo, Japan

C105

Karen Carvell¹, Vincenzo Della Mea²

¹North American Collaborating Center;

²University of Udine, Italy and Italian Collaborating Center

Abstract This poster presents the annual report of the Informatics and Terminology Committee (ITC), highlighting activities of since the Manchester meeting in October 2015.

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.

Over the past six years, the ITC has continued managing and supporting the design and development of software tools used inside the WHO-FIC network and work related to the linkage between WHO classifications and other terminologies.

Administration

Ad-hoc meetings of the co-chairs, Karen Carvell and Vincenzo Della Mea as well as WHO liaison Can Celik and Secretary Jun Nakaya have been held throughout the year. A face to face mid-year meeting was not held. Jun Nakaya from the Japanese Collaborating Center accepted the role of ITC secretary at the Manchester meeting. This is viewed as a positive move to transition the work of ITC to the new co-chairs next year when existing co-chairs complete their terms in 2016.

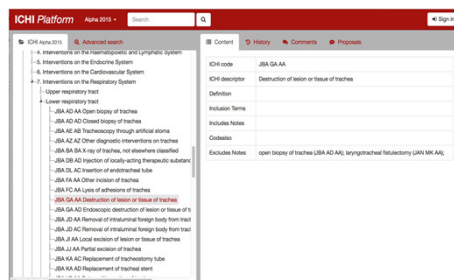
Classifications and Revision Platforms

WHO headquarters and collaborating centres work to enable standardized maintenance, update and revision of WHO classifications. Work has continued on the classification update platforms and on the ICD Revision Platform:

Coding tool – This was developed to enable searching for codes in the ICD-11 Mortality and Morbidity Statistics using natural language expressions. This tool has been continuously revised and enhanced during the last year.

ICD-11 coding exercises tool (ICD-Fit) - Formal technical testing was completed on the tool. This involved 8 raters coding from case summaries to test the capabilities of the tool. A multi-language version of the web-based system is now available to support ICD-11 coding exercises.

ICHI Platform- Over the past years an ICHI browser was developed to enable access to the Alpha version of the ICHI classification. During the ICHI meeting in Trieste (January 2016) and the FDC mid-year meeting in Conegliano (May 2016), sessions on this topic were held with participation of ITC members. The result was a long-term work plan for the expansion of the browser to become a more comprehensive platform for the creation, revision and maintenance of ICHI. The platform will allow comments, proposals, history of modifications, three privilege levels for users, and linkages to other classifications in the family.



Standards

Technical standards are developed to enable the electronic exchange of WHO classifications. During the last year, work has been carried out in the following directions:

URI API: URIs (Uniform Resource Identifiers) are standard identifiers for ICD entities, with a corresponding Application Program Interface (API) platform for software to access information about the classifications. Experimentations have been started on the coding API, based on the coding tool software, to enable code search also on third party software.

ClaML (Classifications Markup Language) ClaML is the WHO recommended format to exchange classifications between developers and users. It is an ISO standard used worldwide. In 2015 the standard started to undergo revision in the ISO process. Its result will be ClaML 3.0 with a target of completion in 2018. The WHO-FIC-Network is actively involved in the revision through the ITC. It will try to ensure that emerging classification needs for the exchange standard will be considered.

Formal Knowledge Representation

A small working group, lead by ITC began preliminary steps toward an **ICF ontology**. A survey of FDRG members on ICF uses had been conducted to inform the preparatory work for an ICF ontology. A meeting was held in the spring to discuss the next steps to create ICF category structures which will provide a better understanding of the components of ICF and their logical relationships. An output of the meeting was an action plan based on previous work by H. Ten Napel on a categorical structure for ICDH as well as the results of the ICF Ontology workshop held in Venice in 2009. This will give new life to the formalization of ICF. Some work has been completed on the meaning of ICF components, but not yet with an overall framework of reference. The first step will be the scoping of ICF, i.e. discovering and deciding on the meaning of the terms as represented by the terminology in the classification.

Relation types

- **Has feature:** a certain element means that thing (Consciousness has feature of continuity)
- **Acts on:** describe the orientation of a process
 - aural pressure: b2405 sensations related to the ear:
 - Sensation
 - Acts on: pressure
 - Is function of: ear
 - Has feature: elevated (qualifier)
- **Has temporal marker:** describe the timing
 - b1351 Sleep onset within sleep functions but also detect all other categories on which onset could be applied
 - This could be seen as a form of **temporal is part of**
- **Is function of:** relation between anatomy and physiology
 - E.g. Blinking: b2151 functions of eyelid – body process
 - Is function of: eyelid
 - Has function: protecting the cornea
 - Has feature: voluntary
- **Is part of:** to describe categories that are making up bigger categories

Other Activities

The web site for poster submissions has been maintained the 2016 WHO-FIC meeting.

Some members of ITC are members of the ICD-11 MMS Task Force, where they have collaborated to define ITC related aspects of the ICD-11 Reference Guide.

Acknowledgements

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



Mortality Reference Group Annual Report, 2015-2016

8-12 October 2016
Tokyo, Japan

C106

DL Hoyert¹, F Grippo², LA Johansson³

(1) NCHS, (2) ISTAT, (3) Norwegian Directorate of Health, Oslo

Abstract The MRG is a component of the International Classification of Diseases (ICD) updating process. Comprised of members from Collaborating Centres and regional offices, the MRG reviews problems faced in the application of ICD to mortality. In its 18th year, the MRG deliberated about 150 issues related to both updates to ICD-10 and development of the ICD-11 revision and made recommendations to the Update and Revision Committee for further action.

Introduction

This is the 18th annual report of the Mortality Reference Group (MRG), established at the 1997 meeting of the Centre Heads as part of an updating mechanism for ICD-10.

The MRG has dealt with hundreds of issues related to updating and clarifying ICD-10 as it applies to mortality classification and coding. The MRG has settled more than 600 issues selected largely from the Mortality Forum (an international mortality classification discussion network) and submitted 399 recommendations to the Update and Revision Committee (URC) for consideration.

This report describes the background of the MRG and the issues decided in the 18th year.

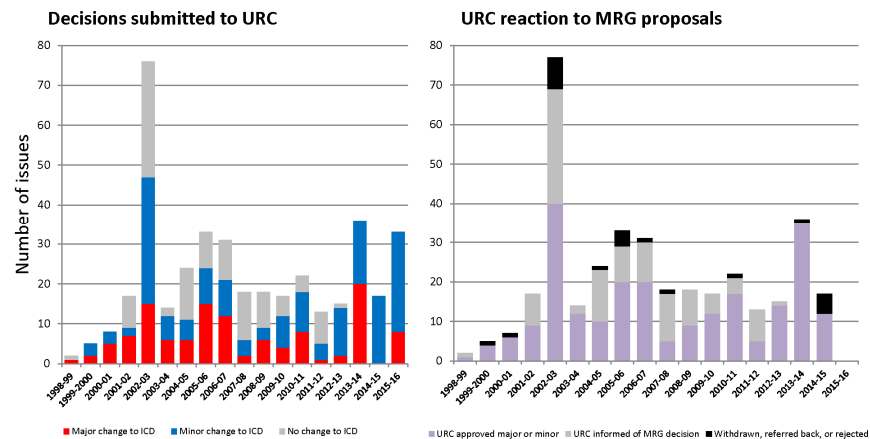


Basis for the MRG

Provisions for the MRG are described in two documents: the WHO long-term strategy document (WHO/HST/ICD/C/97.39) and the Centre Heads' Report for 1997 (WHO/HST/ICD/C/97.65). Briefly, for updating ICD-10, WHO - working with the Centre Heads - established two separate bodies: the MRG and URC. The MRG discusses issues raised in the Mortality Forum or those referred from other sources including the Centre Heads and WHO. The MRG can make decisions regarding the application and interpretation of ICD to mortality and submit a subset as recommendations to the URC for a vote on ICD updates and changes. The decisions requiring no change in the ICD are forwarded for the URC's information and for documentation.

Decisions during the full 18 years

Summary of MRG decisions by work year



In the 18 years (1998-2016), the MRG reached more than 600 decisions. The left panel of the chart shows the subset of the decisions that were sent on to the URC for information as well as for voting. The MRG forwarded 399 decisions to the URC: 288 recommendations for changes in the ICD and 111 decisions requiring no change in the ICD. The total number of issues either withdrawn by the MRG, referred back by the URC for additional work, or rejected by the URC during the first 18 years was 24 and is shown in the right panel of the chart.

Decisions during the 18th year

The MRG met in Washington, DC, March 15-16, and in Tokyo, Japan, October 8, 2016. A smaller table group also met around then to work through issues concerning the decision tables where MRG decisions left details open.

The MRG reviewed about 150 issues, and submitted 33 recommendations (8 major and 25 minor) to the URC (see Table).

Table. Decisions made in 2015-2016

Year Discussed and Issue
<i>Minor change submitted to URC in 2016</i>
2014-2016: Malnutrition and diabetes
2014-2016: Dementia note vol 2 section 4.2.5
2014-2016: Failure to thrive in adults
2015-2016: Default code needed for infectious hepatitis
2010-2016: Complications of invasive medical procedures other than surgery
2015-2016: Code for metabolic syndrome
2014-2016: Epilepsy and status epilepticus
2014-2016: Preference of active vs sequelae of stroke
2015-2016: Hypertension and aortic aneurysm
2014-2016: Senile heart disease indexing
2012-2016: Phrase communicable diseases in mortality rules
2015-2016: Note on R65 in volume 1
2014-2016: Special instruction on in situ neoplasms
2014-2016: Expand list of conditions unlikely to cause death
2014-2016: Linkages between G45 and F01 and F03
2015-2016: Mortality instructions on U82-U85 codes
2015-2016: Linkages for I70 and I42
2015-2016: Change in type of linkage for K85-K86 and F10
2015-2016: J45 instructions for mortality
2016: Coding pathological fractures
2016: Main injury priority
2015-2016: Indeterminate colitis and colitis of unspecified origin
2015-2016: Consistency between sex of patient and diagnosis
2015-2016: Additions to Annex 7.8
2015-2016: Series of editorial and typographical changes for volume 2
<i>Major change submitted to URC in 2016</i>
2008-2016: Carbon monoxide sources
2014-2016: Ammonia encephalopathy code
2014-2016: Unspecified effects of other external causes
2014-2016: Pulseless electrical activity
2015-2016: Cervical schwannomatosis coding
2015-2016: Carcinomatosis and other metastatic cancer
2015-2016: O80-O84 note in volume 2
2015-2016: Ampullary carcinoma

Conclusions

In the 18th year, the MRG met in March and in October, communicated by e-mail, posted proposals and comments on the ICD-10+ Platform, did considerable work on a number of issues outside the committee meetings, circulated documentation for issues under consideration; and comprehensively documented all activities. During the eighteenth year, a total of about 150 issues were reviewed by the MRG and the MRG's Table Group. Closure was reached for many of these and 33 decisions were submitted to the URC in 2016. Eight of these were recommendations for major change and 25 for minor change.



Annual report FDRG 2015-16

8-12 October 2016
Tokyo, Japan

C107

Catherine Sykes^{1,2}; Andrea Martinuzzi³

*1World Confederation for Physical Therapy, UK; 2University of Sydney, Australia
3E. Medea Institute, Research Branch of the Italian Collaborating Centre, Italy*

Abstract This poster describes the activities of the Functioning and Disability Reference Group in the 12 months from October 2015 to October 2016. Four main streams of work are reported; 1 ICF updates, 2 ICF education, 3 ICF Ontology development, 4 Harmonisation.

Background

The items on the FDRG component of the WHO-FIC strategic plan are reported below. The co-chairs met monthly by teleconference with the Molly Meri Robinson Nicol, WHO liaison, and secretariat Stefanus Snyman and Heidi Anttila.

FDRG members and collaborators were informed of progress on the projects during the year and met by teleconference in March and September.

A mid-year meeting was held on 4-5 June 2016 in Bangkok, Thailand attended by 31 members and collaborators from 16 countries. In conjunction with the FDRG meeting were meetings spent making progress on the mICF; a one day meeting with the Education and Implementation Committee (EIC) and a meeting of the Asia Pacific Network at which Andrea Martinuzzi presented in introduction to the ICF and Catherine Sykes chaired an open discussion session.

1 ICF updates

In 2015-2016 there were 31 proposals that were still under consideration, of which 6 were new proposals. 11 remained in the Open Layer as no clear consensus had been reached. 20 were moved to the Closed Layer for voting. Of these 8 were rejected and 9 were approved and 3 were returned to the platform for further discussion. The final number of proposals for further review on the Platform was thus 14.

In 2016 there has been a concerted effort to enhance the Environmental Factors component with new updates.

Jennifer Jelsma and Janice Millar are thanked for their tireless efforts in the running of the ICF updates process. Jennifer will be stepping down from the position of URC Co-chair at the 2016 annual meeting. A volunteer to replace her is required.

The number of FDRG members contributing to this essential task is low. The FDRG co-chairs would like to see higher priority given to ensuring that ICF is fit for purpose.



2 ICF education

The **ICF Practical Manual** was subject to some changes in referencing which has delayed its progress through the WHO publications process.

The **ICF e-Learning introductory module** continues to await finalisation through WHO processes. The timeline developed after the October meeting was revised at the mid-year meeting. At the time of writing there has been no progress.

ICF Education.org portal for education materials has 43 items in Albanian, Portuguese, Danish, Italian, Spanish, English, French, German and Finnish. The majority of the items are presentations, also included are webinars, exercises, special editions of journals and manuals. There are 413 users of the portal. Since the portal was opened in September 2015 there have been more than 12,000 views



ICFEducation.org: Views per month
September 2015-August 2016

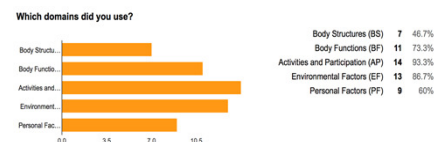
A set of criteria for defining **ICF advisors and educators** for inclusion on a database was agreed. The database is intended to facilitate the matching of ICF expertise with requests for assistance.

A draft set of questions was prepared and pilot tested. The questions were revised with input from ICD educators to see if a single WHO-FIC database could be developed. A draft was reviewed at the mid-year meeting. Further discussion will take place at the annual meeting.

3 Informing ICF Ontology

A survey investigating how ICF qualifiers and categories have been used in real life has been designed and circulated to FDRG members and collaborators. The survey was launched online on August 2015.

Preliminary results were reported at the mid-year meeting. See separate poster.



Further responses are expected before the annual meeting. To participate: <http://tinyurl.com/ICFquestionnaire>

4 Harmonisation

- FDRG members and collaborators continue to work with the Family Development Committee (FDC) on the development of the International Classification of Health Interventions. See separate poster.
- FDRG continues to be represented on the functioning Technical Advisory Group (ftAG) informing the ICD-11 development. Specifically there has been input to the text for the ICD-11 Reference guide regarding Functioning Properties. See separate poster.

Acknowledgements

The Co-chairs would like to thank Stefanus Snyman and Heidi Anttila who have supported them with secretariat services; Molly Meri Robinson as WHO Liaison and all the FDRG members and collaborators who have provided input to the tasks on the WHO-FIC strategic plan and supported them in their co-chairing roles over the past four years. Best wishes are offered to the incoming Co-chairs.

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Identification and coding of the main condition using ICD-10 for case mix purposes: comparison of national modifications.

8-12 October 2016
Tokyo, Japan

C406

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Abstract Statistics using ICD codes tend to collect cases with similar codes together into categories of interest useful to measure variation over time and between settings. DRGs do the same for the particular use case of measuring hospital products. Examples are shown of differences between versions of ICD (ICD-9-CM, ICD-10 CM, ICD-10 WHO, ICD-11) which raise questions about differences in practice, ie in coding the main condition. Cardiovascular diseases are considered.

Introduction

Since 1996, prospective payment systems (PPS) based on diagnosis related groups (DRGs) has been introduced in Italy. DRGs are secondary patient classification systems based on primary classified medical data, in which single events of care are grouped into larger, economically and medically consistent groups. The main primary classified medical data are diagnoses and interventions codes. The current lists of health conditions that guide the DRG assignment in Italy are composed of single ICD-9-CM codes, as in the US DRGs system. The conversion of these lists in ICD-10 WHO might pose the issue of combined codes for the «primary (and secondary) diagnosis». The dagger-asterisk system has not been implemented by the ICD-10-CM, which solves the issue with new children in the ICD hierarchy, and with some «shortcuts» compared to WHO original version (i.e. the deletion of the asterisk). In order to study the impact of that national modification on possible new ICD-10 lists for DRGs assignment in Italy, we analyzed the conversion problems with the ICD-9-CM codes which should convert to ICD-10 dagger-asterisk codes.

Methods & Materials

As an example, we considered ICD-9-CM codes (2007 version, currently used in Italy) of MDC 5 (cardiovascular diseases) which convert to ICD-10-WHO dagger-asterisk code combinations. We verified how

the ICD-10-CM operated in these cases (1). We also considered how ICD-11 classifies the same entities. The complete description of ICD-9-CM codes was considered, especially when the rule was "to code first underlying disease". We considered this rule as equivalent to the dagger-asterisk system in ICD-10.

Results

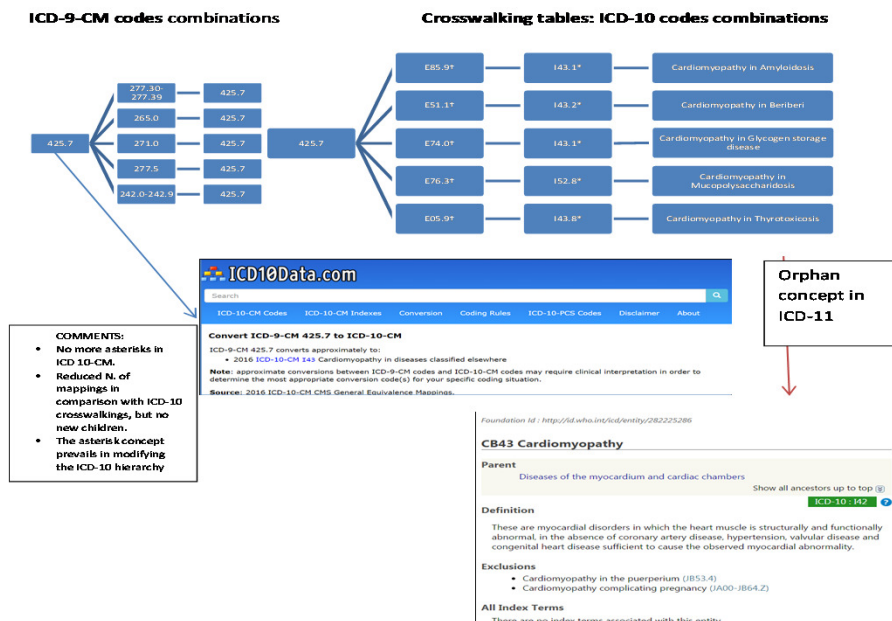
39 ICD-9-CM codes of MDC 5 out 471 were transcoded by the Authors into 89 dagger-asterisk codes according to ICD-10-WHO. Volumes 1 and 3, and the full description of each ICD-10-WHO entity were considered. Figure 1 shows an example of how one of the 39 ICD-9-CM code crosswalks to different ICD versions, including ICD-11. A specific crosswalking table was created with different conversion solutions. Four-digit ICD-9-CM codes were differentiated from five-digit ICD-9-CM codes.

Table 1 shows a summary. The US Modification provides 61 non homogeneous solutions in comparison with 89 dagger-asterisk codes. In particular, we detected four different ways to classify the health conditions examined:
a) detailed specific five-digit codes that clearly identify the health condition (i.e. diphtheritic cardiomyopathy);
b) three-digit codes that refer to groups of conditions with specifications in the inclusions (e.g. cardiomyopathy in diseases classified elsewhere);
c) detailed five-digit codes that specify the site within the inclusions (e.g. heart gonococcal infection includes endocarditis, myocarditis and pericarditis);
d) mix between a) and b);
e) combined codes that describe organ manifestations with the underlying disease (e.g. histoplasmal endocarditis and pericarditis).

Table 1: Comparison of coding solutions using different ICD versions.

ICD-9-CM		ICD-10 WHO	ICD-10-CM
Type	N.		
4 digits (i.e. 425.7, 421.1, 422.0)	10	49 dagger-asterisk codes	- 5 single codes - Choice between two couples of codes in four different cases - Choice among 5 single codes in one case
5 digits (i.e. 098.83, 098.84, 098.85)	29	40 dagger-asterisk codes	- 21 single codes - 6 couples of single codes ("with") - Choice among 3 single codes in one case - Choice among 13 single codes in one case

Figure 1: An example of crosswalk to different ICD versions



Conclusions

The case-mix requires to cluster the health conditions in homogeneous groups according to the absorption of resources. Specifically, coding multiple conditions following ICD-10-WHO has led to a high degree of accuracy, but also to some redundancy that may appear complex to the coders. ICD-10-CM has changed the hierarchy of ICD-10-WHO making data comparison among countries difficult. It also poses the question of the real limits that a clinical modification should have. On the other hand a new criterion should be considered: health conditions absorbing comparable resources should be grouped in codes which describe clinical manifestations. This could help avoid redundancy. It is desirable that ICD-11 diversify how to code the specificity of detailed codes for the most costly health conditions.

References

(1) <http://www.cdc.gov/nchs/icd/icd10cm.htm>



ICD-10 use in children psychiatry between old approaches and ICD-11.

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WHO-FIC CC, Udine, (2) Bologna Local Health Authority, Emilia Romagna Region

Abstract This poster presents the activities carried out to implement the full use of ICD-10 in the Emilia Romagna region (Italy), where WHO Multiaxial Classification of Child and Adolescent Psychiatric Disorders, version 1996, is currently used for collecting data from child/adolescent neuropsychiatry services in the regional information system.

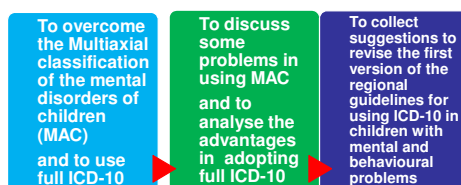
Introduction

Although ICD-10 is not mandatory for morbidity coding in Italy, Italian scientific societies have adopted the derived Multiaxial Classification (MAC) of Child and Adolescent Psychiatric Disorders as a diagnostic tool (1). This has led to two misconceptions on ICD-10: ICD-10 is only a diagnostic tool and is limited to the categories of the MAC (Chapter V, some codes of Chapter XXI, few codes from other Chapters). This paper presents the activities carried out by the Italian WHO-FIC CC (LC) to implement the full use of ICD-10 in the Emilia Romagna region (Italy), where MAC is used for collecting data from child/adolescent neuropsychiatry services.

Methods & Materials

LF provided the Emilia Romagna region with support in the training of professionals for implementing regional ICD-10 guidelines, jointly with LB, scientific coordinator of the regional training programme (Figure 1). The ICD-10 training was organized in 7 training plenary sessions (duration: 7 hours) and a feedback report (duration: 4 hours) at the central level, in 6 different locations in Emilia Romagna (Bologna, Modena, Rimini, Parma, Ferrara, Forlì). The professionals involved in morbidity coding in the Children psychiatric services were invited. The programme duration was 7 months, from September 2015 to March 2016. Each training session was divided into two parts: introduction to regional coding guidelines and updates on ICD-10; clinical case discussion with the active participation of the trainees (Figure 2). A preliminary regional data analysis was carried out to verify the current use of multiple coding. A final report was scheduled with a list of FAQ.

Figure 2: Three aims of the training programme



Results

310 professionals (clinicians, psychologists, rehabilitators operating in the public community-based services for children with neuro-psychiatric problems) attended the 7-day training programme. 24 clinical cases were collected and 14 were analyzed.

Figure 1: The administrative map of the Emilia Romagna region



Topics discussed:

- Differences between full ICD-10 and Multiaxial classification (MAC).
- Distinction between making a diagnosis and coding health conditions using a standard coding system.
- Differences between using ICD-10 for diagnostic purposes and using ICD-10 for coding health conditions according to the WHO coding rules
- The added value to code signs and symptoms using full ICD-10 (this is not possible using MAC).
- New possibilities in ICD-10 Z codes and the mistakes in MAC Axis 5.
- Coding issues.
- How to browse ICD-10 online through the Italian Portal of Health Classifications (3) and to print the three volumes in pdf format using the Portal.
- Problems in different Italian translations of the same ICD-10 parts (in particular Chapter V), realized by different translators.
- Obsolescence of MAC in general and in particular with respect to Axis 6 (Functioning).
- The new ICD-11 hierarchy and the new Chapters of Mental and Behavioural Problems.
- Epidemiological consequences in coding multiple conditions according to MAC and the comorbidity artefact.

Conclusions

An appropriate use of ICD-10 allows users to keep the classification as a diagnostic tool and to fully code all conditions and reasons for encountering health services. The experience is the second initiative in Italy involving the Italian WHO-FIC CC aimed at the implementation of full ICD-10 for morbidity coding in children with mental and behavioural disorders and problems (2).

New educational materials were developed; coding errors due to the outdated translation of the MAC were addressed; wrong coding habits were corrected.

The distinction between diagnosis and coding of a health condition was made clear. At the end of the programme, trainees were seamlessly switching from the use of the outdated MAC to the use of the full ICD-10.

Some issues remained open:

- a) How to implement functioning description using ICF, in order to collect and store comprehensive data by information systems.
- b) ICD-10 limits for coding health conditions under Chapter V in 0-3 year children.
- c) Type and duration of an "episode of care" in community mental health services: when should morbidity be coded, if an episode of care has a very long duration?
- d) The risk of labelling children using ICD-10 coding.

References

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Acknowledgements or Notes

The authors thank all the professionals who attended the training programme; Paolo Soli, Michela Cappai e Alessio Saponaro for cooperating in course management and data analysis; Marisa Marchesini and Elisabetta Iacovone for administrative support.



ICF implementation in Italy: regional policies and national needs.

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Abstract The poster presents some observations on the first attempt to monitor ICF implementation on a national basis.

Introduction

ICF has been used in Italy for more than a decade, without any specific case use. The few national regulations state that Regions are responsible for ICF implementation, but they do not provide implementation guidelines. The current Italian Action Plan in favour of persons with disabilities asks to reform the disability assessment criteria. ICF is considered a standard but few data are available to reach a consensus on how to proceed. The WHO FIC implementation database poses some problems taking into account the multifaceted Italian situation.

Methods & Materials

In March 2015, a one year national project funded by the Italian Ministry of Health was started in order to: collect data on how the Italian regions are using ICF in health, social, education and labour policies; review the way to collect ICF-based data and report on them; study the advantages of introducing a common data set to standardize data collection for national purposes; study if and how an ICF data collection and analysis might be at the basis of new ways to determine disability in Italy. The Italian WHO-FIC CC was the project coordinator (1).

Results

Data were collected on laws, regulations, assessment tools and programs in which ICF was the conceptual framework and the basis for the collection of coded information at individual level. Only two regions collect data through information systems and are able to analyse them in order to publish reports. Some of the regions use ICF to individuate target populations for different purposes: to distribute social services or social benefits (using different eligibility criteria); to assess the functioning status for school inclusion; to support work inclusion. Only one region (Friuli Venezia Giulia) has developed a method to use ICF at the basis of a new information system, to open an individual biopsychosocial record and assess the outcomes of integrated care plans. Different national initiatives have been planned to introduce ICF,

Table 1: Some answers to the questions of the WHO FIC implementation database with comments

ICF Implementation

ICF is partially and fully implemented. It is used heterogeneously at Regional and local level on the basis of different regulations, laws, and tools.

Tools

ICF Checklist, WHO-DAS 2.0, ICF Core Sets are available in Italian, but the prevalent ways by which ICF is used do not match with these tools. Many regions have developed ad hoc ICF sections within multidisciplinary assessment tools. Other regions have developed new specific ICF tools. The great problem is misinterpretation of basic concepts and coding rules. Different Ministries have regulated ICF use in different ways and for different purposes.

Electronic Tools

Different electronic tools have been developed for the recording, collection, processing, or storing of functioning or disability data. Some of them are for sale.

For example:

- the Local Health Authorities in the Friuli Venezia Giulia Region use the VilmaFABER system – a public system not for sale. This tool collects, codes in ICF and processes data on functioning and disability of patients of any age (<http://www.vilmafaber.eu>)
- the Local Health Authorities in the Veneto Region use a section on the Ati@nte web system – a private system for sale. This tool processes the ICF data collected by the «SVAMDI tool» in adults with disabilities (<http://www.sistemafante.it/ICF.aspx?id=58>)
- some schools use the SOFIA tool developed by Centro Studi Erikson – a tool for sale – for planning individual educational plans for pupils with special educational needs. It integrates an ICF-CY browser, but it does not collect ICF data for statistics (<http://digital.erikson.it/per-le-scuole/sofia-pei-online-pdp-icf-compilazione-guidata>)
- Some schools use OpenICF (<http://www.openicf.it/openicf/Index?me=standard>)
- Some schools use tools developed in specific projects funded by the Ministry of Education or developed by schools themselves.

Purpose

ICF is used for several purposes, but without a common governance:

Clinical care including rehabilitation

Legislation
Health and disability statistics
Administrative data, including health records
Policy development or planning
Measurement or assessment
Research
Education
Labour

What aspects of ICF are implemented in **clinical care including rehabilitation**?

Coding (e.g. ICF concepts or terms WITH codes)

What aspects of ICF are implemented in **legislation**?

ICF Conceptual Framework Definition

What aspects of ICF are implemented in **health and disability statistics**?

ICF Conceptual Framework Definition

Documentation (e.g. ICF concepts or terms WITHOUT codes)

What aspects of ICF are implemented in **administrative data, including health records**?

ICF Conceptual Framework Definition

Documentation (e.g. ICF concepts or terms WITHOUT codes)

What aspects of ICF are implemented in **policy development or planning**?

ICF Conceptual Framework Definition

Documentation (e.g. ICF concepts or terms WITHOUT codes)

What aspects of ICF are implemented in **measurement or assessment**?

ICF Conceptual Framework Definition

Documentation (e.g. ICF concepts or terms WITHOUT codes)

What aspects of ICF are implemented in **research**?

ICF Conceptual Framework Definition

Documentation (e.g. ICF concepts or terms WITHOUT codes)

What aspects of ICF are implemented in **education**?

ICF Conceptual Framework Definition

Documentation (e.g. ICF concepts or terms WITHOUT codes)

What aspects of ICF are implemented in **labour**?

ICF Conceptual Framework Definition

Documentation (e.g. ICF concepts or terms WITHOUT codes)

Translation

ICF is used in Italian.

Maintenance

Since 2010, the Italian WHO-FIC CC is responsible for maintaining the translation in Italian, without any specific agreement with WHO and no new published version.

The Italian WHO-FIC CC is also responsible for ICF maintenance. It is aware of ICF updates done by WHO, it participates in WHO update process, and since 2010 has served as the URC ICF Secretariat.

The available printed Italian translations (2001 for ICF and 2007 for ICF-CY) were done by a group of experts and published by a publisher, before the existence of the Italian WHO-FIC CC.

ICF has not been adopted by the Italian Ministry of Health. The Italian Ministry of Health has not defined rules, mandatory requirements or a data flow in national health information system regarding ICF.

An institution's cycle for incorporating the updates is not defined. The Italian WHO-FIC CC translates the WHO updates on an annual basis and publishes them on the Italian Portal of Health Classifications (www.reteclassification.it). The last update was done and published on the Portal in 2015, but it was not adopted on a national basis or incorporated in the version printed by Erikson edizioni.

The Italian WHO-FIC CC is currently and de facto responsible for disseminating ICF updates in Italy.

The current update process meets the needs of the Italian WHO-FIC CC, but the users are not fully aware of the process.

Education

Educational materials and activities are available in Italy, but it is impossible to provide specification and full references because an «educational headquarter» does not exist. This represents one of the great ICF open issues in Italy. The WHO-FIC CC provides training on the basis of specific agreements. In general it provides training for public bodies in health, social, labour and education sectors. Educational materials and activities of WHO-FIC CC are tailored on specific implementation needs and mainly focus on how to collect data to be coded using ICF. At the same time, subjects unknown to the WHO-FIC CC train professionals in different sectors without supervision or monitoring by WHO-FIC CC. There is a training business lacking quality control. This happens because of the lack of a national implementation strategy.

Certification requirements

Certification or training requirements for users of ICF are currently absent in Italy.

with an intermittent interministerial coordination. Table 1 shows some answers to the questions of the WHOFIC implementation database, with comments. Great problems were found in answering questions about disability statistics. ICF is considered as a framework for questions in surveys on “functional limitations” according to Eurostat. An authority for assuring the quality of ICF use is not present.

A task force is necessary to monitor ICF implementation; a minimum data set should be defined to minimize the interregional differences; a large amount of solid data are necessary to reform any policy. The WHO FIC Implementation database seems to consider the implementation as a linear process. The Italian multifaceted reality is difficult to represent. An attempt was made by using the comment sections.

Conclusions

ICF use in Italy is widely heterogeneous.

References

- (1) Frattura L. et al. WHOFIC Network Annual Meeting, 2015



Five-year programme for using ICF at school to include children with special educational needs: the dandelion way for ICF learning and teaching.

**8-12 October 2016
Tokyo, Japan**

C516

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 (2) Giuseppe Mazzini Primary School - Terni (Umbria Region)
 (3) Montecastrilli Primary and Secondary Schools (Umbria Region)

Abstract The poster presents the five-year training programme set up in the Umbria Region, Terni province, aimed at using ICF to better include children with special educational needs at school.

Introduction

The ICF Project targeted to networks of schools was launched at national level in 2010 by the Italian Ministry of Education, University and Research (MEUR) (1). The network set up in Umbria to implement the local winning project has been continuing in a local programme for implementing knowledge and tools developed under the MEUR programme. The original network of schools was led by MEM and SC, with LF as ICF expert, trainer and supervisor.

Methods & Materials

The programme target was a network of 10 schools out of 34 operating in 7 different municipalities, supported by the WHO-FIC Italian collaborating centre. A scientific board of 13 teachers was defined. Different groups of teachers (and some health professionals) were involved over the years in different steps, using the training of trainees approach. In 2016 a set of webinars were organized (Table 1).




ICF case use: individual educational plan, containing an ICF-based assessment for guiding the decision on how to modify the baseline. A&P component was used in conjunction with EFs. A specific analysis was realized to expand the ICF EF categories referred to teachers, educational methods and strategies, and educational products. Specific case studies were set up to train teachers to describe functioning at school, to read the functioning profile and understand its meaning. Both narrative description and coding were provided in order to verify the coding quality.

Results

More than 880 teachers were involved, 40% of them dedicated to special educational needs. More than 100 new teachers expert in inclusive education were involved in webinars made in 2016.

Current use of the new tools: in all the schools of the network, the ICF-based tools are used to define and evaluate the individual educational plans for children with special educational needs.

Table 1 – Steps of the training and implementation programme

	Introducing ICF	School year 2011-2012	10 primary schools operating in 7 different municipalities About 90 teachers attending the training programme	Training: face to face, group work. One course for each school.
	Focusing on ICF and planning assessment tools	School year 2012-2013	10 primary schools (the same as above) 13 teachers (scientific board) 3 health professionals from Local Health Authority 2 delegates from the main municipality in the District	Training: face to face
	Implementing ICF-based tools and approach in the school network	School year 2013-2014	9 schools (8 from the original group) About 100 Special Educational Needs (SEN) teachers approaching ICF structure and ICF tools	Training: face to face, group work. One course for each school.
		School year 2014-2015	9 schools (8 from the original group) About 100 SEN teachers approaching ICF structure and using the ICF tools to define the individual educational plan. About 180 non SEN teachers approaching ICF structure and tools.	Training: face to face, group work. One course for each school led by the members of the network scientific board
		School year 2015-2016	9 schools About 100 SEN teachers using the ICF tools to define the individual educational plan, collaborating with non SEN teachers. About 400 non SEN teachers approaching ICF structure and ICF tools.	Peer to peer training. Training: face to face, group work. One course for each school led by the members of the network scientific board
	Implementing ICF in all schools in the District and in schools from other regional and extra-regional Districts	School year 2013-2014	SEN and non SEN teachers working in the different areas of the Terni District or in other regional districts.	Training: face to face, group work for each area of the District
School year 2015-2016		46 teachers, coordinators for the inclusion plan in each District school	Mixed training: webinars and tutorials via web and workshops	
		School year 2015-2016	Starting with June 2016, the school network will give a training course via web, to each Italian teacher willing to attend it	Webinars and tutorials via web

Conclusions

ICF is a training challenge. The shift from the theory of the red book to the practice in children assessment required a great effort for defining how to collect information to code using ICF. The need to expand the EFs referred to school shows the descriptive limits of the ICF.

Describing how the school operates for inclusion instead of paying attention to children problems was a practical revolution.

References

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ICF and inclusive education in Italy: monitoring how the users implement regional guidelines.

8-12 October 2016
Tokyo, Japan

C517

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WHO-FIC CC, Udine (2) Local Health Authority CN 1, Savigliano, Piedmont Region

Abstract Although ICF is not mandatory for disability statistics in Italy, several Italian Regions have adopted it for assessment purposes. This paper presents some results of the in itinere monitoring activities in the Piedmont region (Italy), where ICF is used as defined by regional rules and forms for disability determination of children in order to give indications to schools for defining individual educational plans.

Introduction

This paper presents some results of the in itinere monitoring activities in the Piedmont region (Italy), where ICF is used as defined by regional rules and forms for disability determination of children in order to define individual educational plans (see also Frattura & Malara, 2016).

Methods & Materials

In January 2016 two different online questionnaires were designed in order to collect information by different users. One aimed at describing how health professionals and teachers use the ICF, and the other at investigating how the forensic clinicians take into account the sections of the regional forms filled by health professionals for the disability determination of children. A selection of forms filled by the teachers involved in inclusive educational planning was analyzed in a qualitative way; two focus groups were also organized with teachers and the Authors.

Results

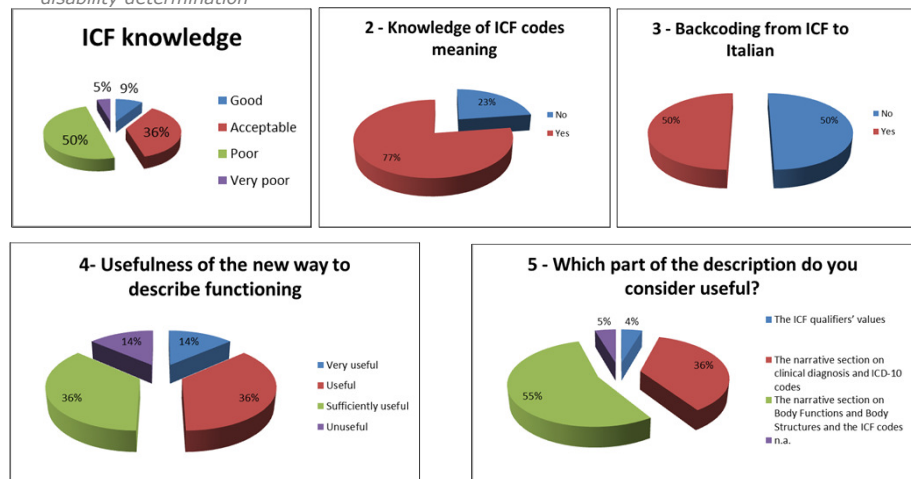
At the end of February 2016, 135 online questionnaires were collected and analyzed; 22 forensic clinicians answered the specific questionnaire (Figures 1, 2). Data showed heterogeneity in ICF use, partial knowledge of the regional rules, non-homogeneous competences in using the ICF model of functioning. The forensic clinicians continued to use the narrative sentences, thinking that ICF codes did not add any added value to their judgement. The qualitative analysis of the documents showed different ways to use the regional forms. ICF was useful to organize description but the comparison between the narrative text and the codes showed that, in some cases, the two texts had different meanings. Many teachers were not specifically trained to use ICF for educational purposes. Most of the attention was on the children's problems instead of on capacity of the teachers (considered as Environmental Factors) to solve the children's problems using educational methods and strategies (other Environmental Factors).

References

Table 1: Questionnaire for forensic physicians involved in children disability determination, Piedmont Region

Personal information	age	<input type="radio"/> 20-30 <input type="radio"/> 30-40 <input type="radio"/> 40-50 <input type="radio"/> 50-60 <input type="radio"/> 60-70
	professional profile	
	affiliation	
1) How would you describe your knowledge of ICF?		<input type="radio"/> Very poor <input type="radio"/> Poor <input type="radio"/> Acceptable <input type="radio"/> Good <input type="radio"/> Very good
2) Do you know the meaning of the ICF alphanumeric coding?		<input type="radio"/> Yes <input type="radio"/> No
3) Do you backcode from ICF to Italian?		<input type="radio"/> Yes <input type="radio"/> No
4) Do you think that the information written by children psychiatrists in the regional form - Annex B part 1 "Descriptive functioning profile – health aspects", aimed at supporting you in the assessment of pupils with a condition of disability, are...		<input type="radio"/> Absolutely useless <input type="radio"/> Unuseful <input type="radio"/> Sufficiently useful <input type="radio"/> Useful <input type="radio"/> Very useful
5) Which parts of Annex B part 1 "Descriptive functioning profile – health aspects" do you consider useful for decisional purposes?		<input type="radio"/> The narrative section on clinical diagnosis and ICD-10 codes <input type="radio"/> The narrative section on Body Functions and Body Structures and the ICF codes <input type="radio"/> The ICF qualifiers' values
6) Annex B part 1 "Descriptive functioning profile – health aspects" provides you with more information useful for determining the degree of disability in comparison with previous clinical documents:		<input type="radio"/> Totally agree <input type="radio"/> Agree <input type="radio"/> Slightly agree <input type="radio"/> Disagree <input type="radio"/> Strongly disagree
7) If you were asked your opinion on Annex B part 1 "Descriptive functioning profile – health aspects", what would you say about it?		<input type="radio"/> I would maintain it as it is <input type="radio"/> I would suggest to stop its use <input type="radio"/> I would change it, specify.....

Table 2: Answers to the questionnaire by a group of forensic physicians involved in children disability determination



Conclusions

In the past eight years, Piedmont Region has organized a massive ICF training programme, introduced new forms to assess children using ICF, but has not monitored their implementation. The lack of a database with ICF data was considered a weakness of these policies. This first attempt to monitor how the professionals use the new tools provided a lot of suggestions for better using ICF in practice. A new awareness has emerged about the need to better understand the difference between using ICF and

collecting information for ICF coding. The regional forms, similarly to many other available in Italy, are about ICF and do not guide the collection of information in "natural language". The variety of Environmental factors and their roles have to become more central in the assessment. A possibility exists to use the assessment system developed by the WHO team directed by LF. This system automatizes the coding, and guides the evaluators to explore the relationships among a lot of environmental factors and individuals with a health condition. It also creates a database, which allows to compare functioning profiles at individual and cohort levels.



The relevance of functioning indicators in distinguishing clusters of outpatients.

8-12 October 2016
Tokyo, Japan

C518

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Abstract 490 outpatients under the care of community-based mental health services (N= 133), community-based services for children with disabilities (N= 173) and community-based services for adults with disabilities (N=184) in Friuli Venezia Giulia Region were assessed in order to describe the mix of resources invested in their functioning. The data of the three groups are shown in order to compare the corresponding mix of resources and the associated functioning results. The database was made by ICF data collected using the ICF based assessment system developed by the Italian WHO-FIC CC experts. Five clusters were created according to the Cumulative Functioning Ratio (CFR) values.

Introduction

The study aims were:

- to describe the distribution of the mix of resources invested in individual functioning outcomes (health services, social security interventions, general social support interventions, professional carers, non-professional carers and relationships, products and technologies, material and immaterial goods)
- to describe the usefulness of the investment in individual functioning using the infographic Family of Functioning Indicators.

Materials and Methods

Cross-walking tables from lay language to ICF and algorithms made by the Italian CC were used by an ad hoc developed software to automatically code in ICF and to calculate the Cumulative Functioning Ratio (1) at individual level. The data were shown as distribution of values by ID.

Four examples in each table (Tables 1-3) are shown in which blue lines connect the investment in health and CFR values relating to the same ID.

Results

490 outpatients under the care of community-based mental health services (N= 133), community-based services for children with disabilities (N= 173) and community-based services for adults with disabilities (N=184) were assessed in order to describe the mix of resources invested in their functioning. The data for the three groups are shown in order to compare the corresponding mix of resources and the associated functioning results.

Adults under the care of community-based mental health services showed better functioning outcomes than the other two groups (CFR > 0.86). Investments in functioning were different among the three groups, and, inside each group, among three different clusters.

The community-based approach to functioning and health was the same for all assessed persons. Nevertheless the obtained functioning results were not equally distributed.

Conclusions

CFR allows to distinguish individual functioning profiles. It clarifies the role of EF in functioning and shows that results in functioning do not directly depend on the amount of investments.

Investments in health (collected in lay language and automatically coded by the software using ICF EF)

CFR values and VilmaFABER EcoLabel (automatically calculated by the software using specific algorithms)

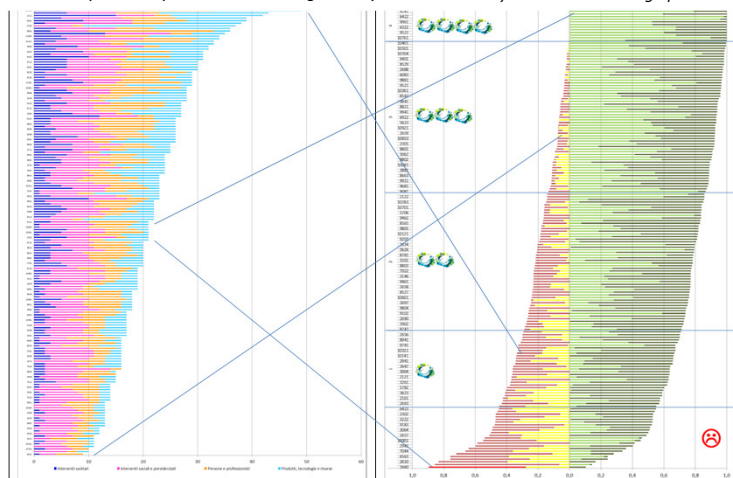


Table 1 - Investments and results in outpatients < 18 years by patient ID and functioning indicators (N=173) - Community based services for adults with disabilities

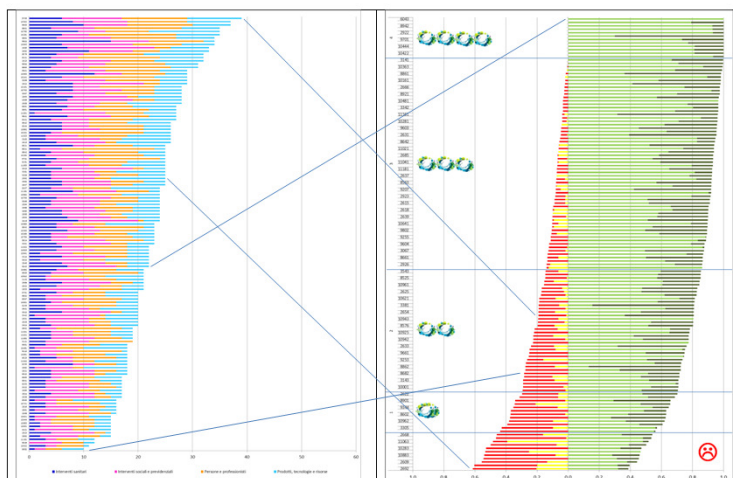


Table 2 - Investments and results in outpatients > 18 ys by patient ID and functioning indicators - Mental health community-based services (N = 133)

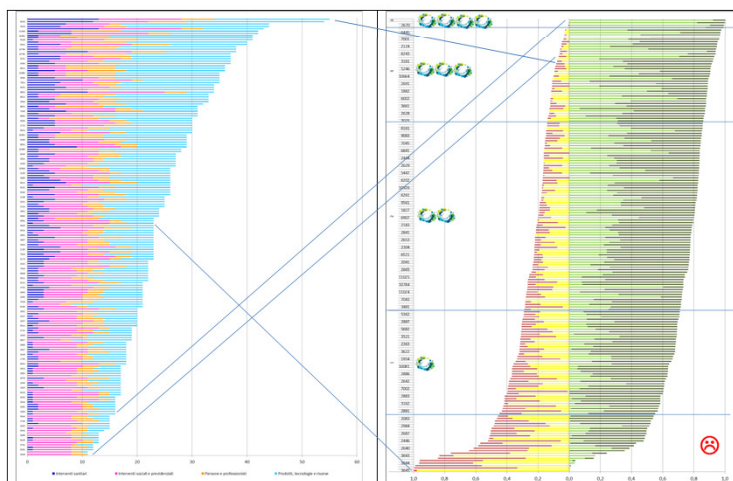


Table 3- Investments and results in outpatients > 18 ys by patient ID and functioning indicators - Community-based services for adults with chronic conditions (N= 184)

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(1) Frattura L. et al. The infographic Family of Functioning Indicators (FaFI). WHO-FIC Network Annual Meeting 2015

(2) Frattura L. et al. Disability/functioning balance and levels of disability: some evidences for continuum, WHO-FIC Network Annual Meeting 2016



Disability/functioning balance and levels of disability: some evidences of a continuum.

8-12 October 2016
Tokyo, Japan

C519

Lucilla Frattura, Giovanni Bassi, Giulio Castelpietra, Andrea Simoncello
Central Health Directorate, Classification Area, Friuli Venezia Giulia Region,
IT WHO-FIC CC

Abstract The conceptualization of "severe disability" for eligibility or statistical purposes was re-formulated taking into account ICF semantics and syntax. ICF data were collected, analysed and presented using the method and tools defined by the Italian WHO-FIC CC. Results are shown on 490 outpatients assessed in the Friuli Venezia Giulia region in order to describe the prevalence of persons with disabilities according the ICF definitions of functioning and disability.

Introduction

Understanding the prevalence of disability is important for public health programs to be able to address the needs of persons with disabilities. Nevertheless the majority of data available are about the "classical" problems in mobility, seeing, and self-care. The ICF is able to support the collection of a new generation of data.

Methods and Materials

The ICF definition of "disability" as the negative aspects of the interaction between an individual with a health condition and his/her contextual factors was operationalized and different algorithms were defined for distinguishing positive and negative aspects in a single functioning profile. The performance qualifier value .1 was used as cutoff. The presence of EFs was also considered to distinguish "environment-free" interactions from "environment-related" interactions (Figure 1). Each profile was visualized using four different colors: yellow and red mean disability (environment-free and environment-related) and light and dark green mean functioning (environment-free and environment-related). The data show Cumulative Functioning Ratio (CFR) distributions in shades of red and green according to the VilmaFABER EcoLabel (Fig. 2).

Results

Data on 490 outpatients recruited in the Friuli Venezia Giulia Region are shown according to four different aspects in functioning profiles. Five different levels of functioning/disability balance were created, taking into account the Cumulative Functioning Ratio (CFR). The outpatients were grouped by age and health service in order to show the differences across settings. Nearly 11.6% of the overall sample showed more "disability" than "functioning" in the functioning profile (N. = 57). Nearly 7.5% of the overall sample (N. = 37) showed only "functioning" (Fig. 3, 4). Outpatients cared by community mental-health services showed the highest CFR values (74 cases, 55%).

Conclusions

It was possible to show how the balance between functioning and disability was distributed in a continuum in a single profile and in a cohort. The common thinking of the correspondence between a spectrum of diseases (i.e. severe mental disorders) and disability seems to be invalidated. The severe disability as measured by CFR <0.55 represented a very small minority in the evaluated cohort. It will be necessary to collect data on a larger sample to confirm these results. The design of a world disability survey could be supported by our understanding on how to collect and analyze ICF coded data. The burden of disability could be recalculated.

Figure 3 Distribution of 490 outpatients by age, health service and CFR value.

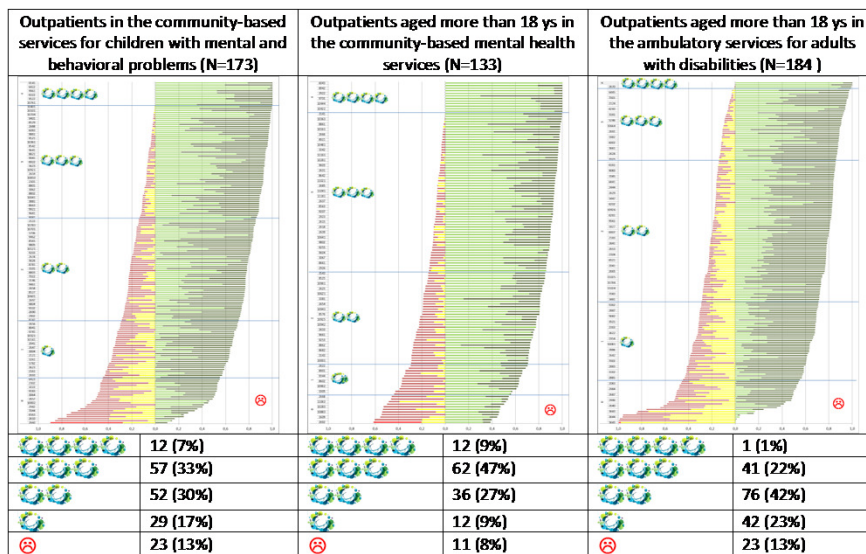


Figure 4 Distribution of 57 outpatients by age, health service and CFR value < 0.55

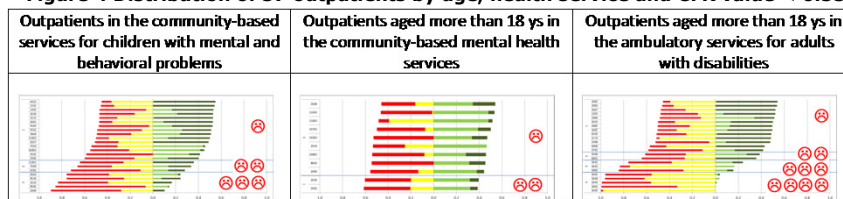


Figure 1 Disability and Functioning operationalization

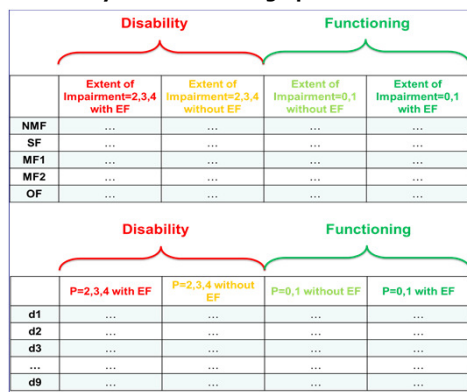


Figure 2 - The VilmaFABER EcoLabel

Number of "world spheres"	CFR values	Number of red emotions	CFR values
5 (all green)	CFR = 1	0	0.55 < CFR < 0.80
4 (3 green, 1 red)	1 < CFR < 0.86	1	0.48 < CFR < 0.25
3 (2 green, 1 red)	0.86 < CFR < 0.71	2	0.25 < CFR < 0.18
2 (1 green, 1 red)	0.71 < CFR < 0.55	3	0.18 < CFR < 0.08

Acknowledgements

Part of this analysis was supported by the CCM project - Central Actions (funded by the Italian Ministry of Health) for verifying the possibility to use ICF for disability determination in Italy.

References

Frattura L. et al. The infographic Family of Functioning Indicators (FaFi). WHO-FIC Network annual meeting 2015



Use case for ICF: three Italian online surveys for encouraging the ontological work

8-12 October 2016
Tokyo, Japan

C520

Lucilla Frattura, Giovanni Bassi

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Abstract In order to collect specific information on ICF use cases, a questionnaire was designed by the authors and three online surveys were launched in Italy in February 2016. We modified the FDRG grid used in 2015 to gather information on the use of ICF in some implementation areas: Clinic, Education, Statistics, Epidemiology, Eligibility. 302 respondents participated. Some results are shown.

Introduction

During the FDRG mid-year meeting 2015 in Helsinki a small group of FDRG members from various countries compiled a list of ongoing ICF implementations and a provisional list of modalities by which the classification was used. The grid was used to gather information on the use of ICF in some areas of implementation: Clinic, Education, Statistics, Epidemiology, and Eligibility. Few respondents were active on the first round. Data were presented at the Manchester Network meeting (1) and in the Bangkok FDRG mid-year meeting, in 2016. In order to collect more information, a new form was designed by the authors and three online surveys were launched in Italy in 2016.

Methods & Materials

We used the first FDRG grid to design an online survey aimed to detail the use cases in Italy. The original questions were slightly modified and overall 30 questions were defined (Table 1). Three surveys were launched in February 2016 and closed by the end of the same month. One survey was launched in the Piedmont region, one in the Veneto region and the third through the Italian Portal of Health Classifications. Some general information was also collected to describe the respondents. The data were analyzed by the authors considering the answers to all the three surveys (Figure 1).

Table 1: The list of questions in the ICF implementation questionnaire

1. Which is the ICF use case you refer to in answering the questions?
2. Which sector does your ICF use case refer to?
3. Do you use ICF or ICF-CY?
4. How do you collect information to be coded using ICF?
5. Which is the source of the information you collect in order to code it using ICF?
6. Which ICF components do you use?
7. How do you use the Body Functions component?
8. How do you use the Body Structures component?
9. How do you use the Activities and Participation component?
10. How do you use the Environmental Factors component?
11. How many ICF categories do you use?
12. At which level do you use ICF categories?
13. Do you use the ICF qualifiers?
14. In which component do you use qualifiers?
15. Which values do you use for the Body Functions qualifier?
15 bis. If you use an alternative score, please describe it
16. How do you assess Body Functions?
17. Which qualifiers do you use for Body Structures?
18. Which qualifiers do you use for Activities and Participation?
19. In which environment do you assess performance?
20. How do you assess performance?
21. Which values do you use for the Performance qualifier?
21 bis. If you use an alternative score, please describe it
22. In which environment do you assess capacity?
23. How do you assess Capacity?
24. Which values do you use for the Capacity qualifier?
24 bis. If you use an alternative score, please describe it
25. Do you describe the Environmental Factors' effect?
26. In which environment do you assess the facilitators and barriers?
27. Do you use the ICF qualifiers to distinguish Functioning and Disability?
28. Which qualifiers do you use to distinguish Functioning and Disability?
29. Please, cross the threshold value you use to distinguish Functioning and Disability.
30. How do you represent the Functioning/Disability individual profile?

Results

We chose to show only some results (Table 2) in relation to similar data presented in WHO meetings. The distinction between Activities and Participation (AP) did not exist in practice. The Environmental Factors were used jointly to AP, but also to many components. 68% of respondents used restricted lists of categories suggesting an ICF redundancy. The Capacity concept and its assessment (question Number 23) are critical issues. This was confirmed by the fact that respondents were able to assess Performance, but not Capacity and a lot of them calculated the Capacity values «subtracting the role of EF from performance». The answers to the questions 28, 29, 30 were difficult to analyze, suggesting that the issue of the distinction between functioning and disability in a descriptive profile is not clearly addressed in ICF.

Figure 1: Distribution of the 302 respondents by Administrative Region



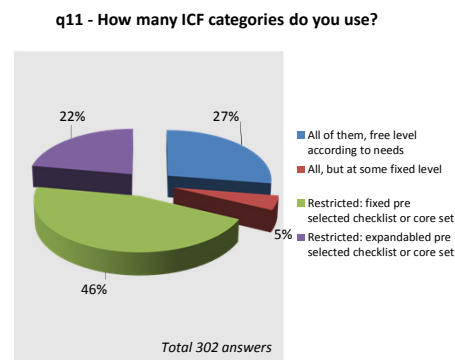
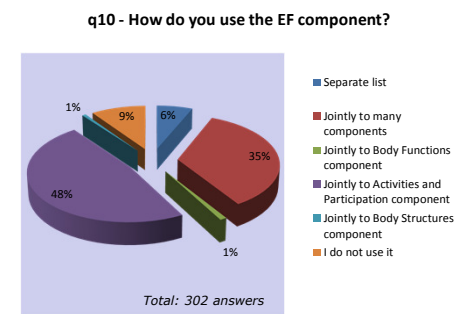
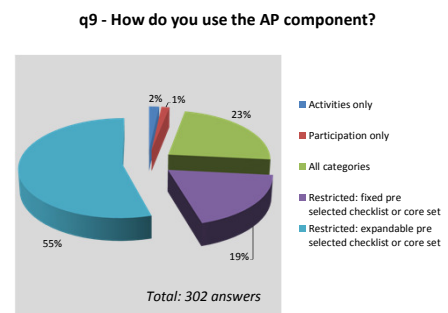
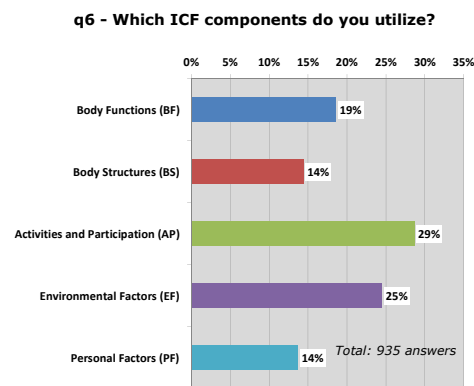
Conclusions

1. More responses in respect to those collected on the first round with FDRG grid (N=22).
2. Participation of users in all areas explored by the ICF practical manual.
3. The overall results might be used in ICF ontological work.
4. The new questionnaire in English could be revised and used in a new online survey.

References

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Table 2 - Distribution of some answers to the ICF implementation online questionnaire by 302 Italian respondents





ICF ontology: from theory to practice. The journey continues

8-12 October 2016
Tokyo, Japan

c521

Andrea Martinuzzi¹, Vincenzo Della Mea¹, Huib Ten Napel²

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2) Netherlands WHO-FIC CC

Abstract An ontological analysis of ICF has been recognised as a much needed step to address the problems that along these years of ICF use and ICF updates have arisen. The present poster provides an update on activities carried out in the last year on this topic.

Introduction

An ontological analysis of ICF has been recognised as a much needed step to address the problems that along these years of ICF use and ICF updates have arisen.

Informal meetings have been carried out by the co-chairs of FDRG and ITC involved in this task, plus also a short meeting involving all poster coAuthors during FDC mid year meeting.

As initial actions to start such analysis two approaches have been identified:

- a bottom-up approach of studying the way in which ICF is used across the world by a survey of use cases,
- a top-down approach starting from the existing ICF categories and relations seen through ontologizing tools.

First action: Survey

The first action started in summer 2015 and produced a first yield of responses that highlighted some key issues that may inform future work: the full or partial representation of components, the relation between activity and participation and the way in which they are represented, the relationship between part I (the person) and part 2 (the context), the use of the qualifiers.

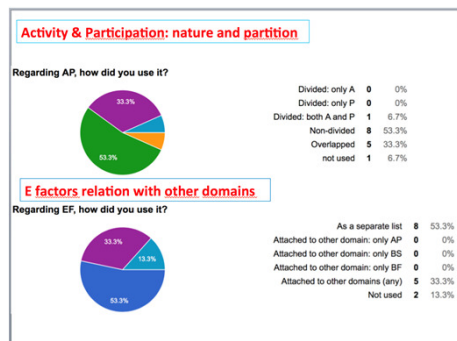
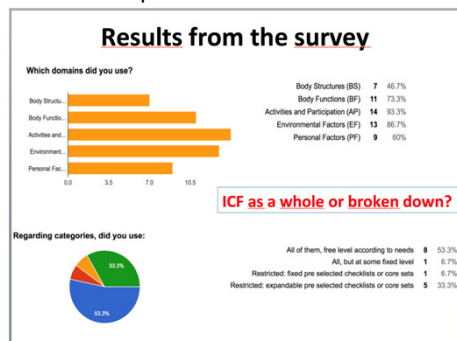


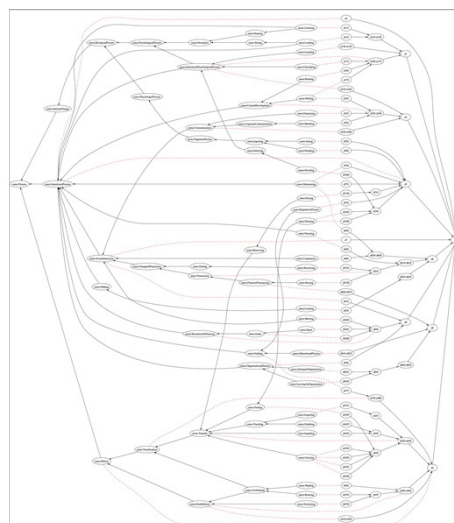
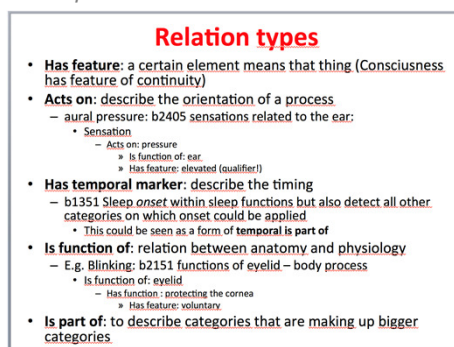
Figure 1 and 2: excerpt of Survey results

Second action: Scoping of ICF

During the FDC mid year meeting in Conegliano, a short meeting of the ICF Ontology Small Working Group has been carried out with the aim of designing further steps of the work, given also the scarcity of resources that, at present, can be devoted to this topic.

The agreed second action starts from previous work by H. Ten Napel on a categorial structure for ICIDH and from the results of the ICF Ontology workshop held in Venice in 2009, to give new life to the formalization of ICF. In fact, work has been already made on the meaning of ICF components, but not yet with an overall framework of reference. The first step will be the scoping of ICF, i.e., discovering and deciding on the meaning of the terms as represented by the terminology in the classification.

Figure 3 and 4: examples of previous work that will be reused and reinterpreted.



Conclusions

Regarding the first action, the limited number of responses however prompted further actions aimed at increasing the response rate and at providing more indicative answers to the key points.

To increase participation the thorough revision of the questionnaire text was carried out and is due to be released shortly. The direct solicitation of reactions from authors of published papers describing ICF use is the chosen strategy to increase the number of responses.

In addition, a number of comments and proposals have been recorded at the joint FDC/ITC ICF Ontology session in Manchester 2015 that will provide further input for the work.

Regarding the second action, a number of specific activities have been foreseen:

- Develop a content model that takes into consideration some features considered useful for maintenance (e.g., relevant time of life: CY, elderly, etc);
 - From the examples go systematically to the whole texts and the additional terms coming out for use cases;
 - Model ICF in Protegè in an ongoing process of refinement, while the formal model is being developed;
 - Establish a proof of concept for feasibility of this methodology.
- The resources available for these actions are students and volunteering members from FDRG/ITC/FDC.

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Disability management and need for assessment in neuro-oncological patients and their caregivers: a longitudinal study based on ICF model

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On behalf of Neurology and Neurosurgery Disability management group of Besta

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Abstract Neuro-oncological patients and their caregivers have specific needs related to the different phases of disease and treatment. Aim of this study is to identify neuro-oncological patients' needs during the hospitalization at the Neurological Institute C. Besta of Milan (INNCB) and after some months from the discharge and their caregivers' burden. Patients' protocol was composed of the Need Evaluation Questionnaire (NEQ) while the caregivers' protocol was composed of Caregiver Needs Assessment (CNA) and Family Strain Questionnaire (FSQ). Preliminary results show the presence of profiles characterized by high level of needs among neuro-oncological patients as well as high levels of needs and burden among their caregivers, despite the high variability of questionnaires' scores during the hospitalization. In general, patients and caregivers' needs and burden decrease after some months from the discharge. On the basis of these results, it will be possible to identify future strategies and actions of disability management to meet the reported needs.

Introduction

Neuro-oncological patients and their caregivers have specific needs related to the different phases of disease and treatment that can develop and change during the hospitalization and the transition from hospital to home. Neuro-oncological patients usually report a need for information related to the side effects of tumour and treatment and to the changes in the personality, cognitive functions and working abilities. The experience of their caregivers is characterized by rapid changes at the time of diagnosis and throughout patients' illness and their need for practical information to better support patients. Aim of this study is **to identify neuro-oncological patients' needs during the hospitalization at the INNCB and after discharge and their caregivers' burden**. The knowledge of these needs will allow the identification of possible actions for the **Disability Manager**, a professional able to meet patients and caregivers' reported needs using a bio-psychosocial approach to health and disability. The Disability Manager is able to support patients and their caregivers and act as an interlocutor between patient and local institutions facilitating the hospital-to-home transition.

Methods & Materials

This is an observational longitudinal study on adult patients with neuro-oncological diseases and their caregivers. Patients underwent brain or spinal surgery and had cancer therapy for different periods after surgery. Patients and caregivers were consecutively enrolled at INNCB and completed ad hoc questionnaires before the discharge (T0) and after 4 months from the discharge (T1).

The protocol:

The protocols were the following:

Patient's Questionnaire T0: questions on their knowledge of Institute's services; **Need Evaluation Questionnaire (NEQ).**

Caregivers' Questionnaire T0: questions on assistance, economical situation, their knowledge of Institute's services; **Family Strain Questionnaire (FSQ); Caregiver Needs Assessment (CNA).**

Patients' Questionnaire T1: questions on further treatments and territorial services; **NEQ.**

Caregivers' Questionnaire T1: questions on assistance, further treatments and territorial services; **FSQ; CNA.**

Data analyses:

Descriptive statistics were performed to illustrate the prevalence of patients' needs and their caregivers' needs and burden at T0 and T1.

Results

Results:

A total of 103 patients and their caregivers were enrolled: most of the patients had a tumour of Grade 1 and their caregivers were mainly their spouses or partners. Complete questionnaires at T0 and T1 were available for 68 patients and caregivers.

The preliminary results show the presence of profiles characterized by high level of needs among neuro-oncological patients and high levels of needs and burden among their caregivers despite the high variability of questionnaires' scores at T0. In particular, need for information seems to be the highest. In general, patients and caregivers' needs and burden tend to decrease at T1.

Future perspective:

On the basis of these results, it will be possible to identify future strategies and actions to meet patients and caregivers' needs and to improve the Institute's services describing the potential role of the Disability Manager. It will be possible to implement corrective actions in the following areas:

- **Improvement of the admission process of neuro-oncological patients;**
- **Facilitation of the hospital-to-home transition;**
- **Psychological support for weak patients and their caregivers;**
- **Structuring a network between hospital and territory.**

Conclusions

Our study reports unmet supportive care and need for information in neuro-oncological patients during the different phases of disease and treatment. Unmet needs and burden were also observed in neuro-oncological patients' caregivers since they suddenly had to play this role after the diagnosis. Patients and caregivers' needs seem to be higher during the hospitalization rather than after some months from surgery. Since it is important to consider environmental factors when evaluating patients, caregiver's burden and needs should be also taken into account in order to support caregivers in critical situations and allow them to play their crucial role as facilitators in patient's life. Patient's diagnosis changes their role, consequently they have to learn how to be a caregiver and how to reorganize their relationships. The identification of patients and caregivers' needs allow to develop specific actions and strategies to meet their needs. The Disability Manager could play this role: he/she is a professional able to facilitate the interaction between patients and Institute and the patient's transition from hospital to home, and to support caregivers. In addition, the Disability Manager could support health care workers and medical staff who usually receive a lot of requests from patients and caregivers. This approach is based on the bio-psychosocial model since the interventions involve both individuals and their environment.

Acknowledgements or Notes

We are grateful to all patients, caregivers and health professionals who are participating in our study.

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Determinants of health and disability in the Italian ageing population: the IDAGIT National Study

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- 4) Prodest Consulting, Via A. Boito 12, Monza, Italy

Abstract Aging in population is influenced by medical, economic and social changes, which make people live longer, in particular in the European Countries where the percentage of citizens aged 60+ will rise from 20.3% to 28.8% between 2000 and 2025 (WHO). The **IDAGIT Project (Identification of Determinants of Healthy Aging in Italy)** aims to provide valid and reliable information on determinants of health and disability in the Italian aging population. To achieve this goal, IDAGIT researchers will use tailored instruments to acknowledge the role of environmental factors on health status of ageing people and in particular the role of built environment and social networks.

Introduction

The aging of the Italian population is one of the most rapid among European Countries and the percentage of citizens aged 60+ will rise from 24% to 34% between 2000 and 2025 (WHO). At population level, individuals' health condition is hardly modifiable, but **disability, intended as the interaction of health conditions with environmental factors, can be decreased acting on more changeable environmental factors** such as built environment and social networks. Preliminary results from COURAGE in Europe project showed that it is possible to calculate a general Social Network Index and specific indexes for all the different features of the (built) environment. Our hypothesis is that social networks and features of built environment may be determinants of disability and predict outcomes such as quality of life and well being, and also independent of the presence of non-modifiable factors such as comorbidities, age, gender and educational level.

Aims, Methods & Materials

IDAGIT project aims are:

- 1-To provide valid and reliable information on ageing and on determinants of health and disability in an Italian population aged 18-49 and 50+ enrolled in North, Centre and South Italian areas.
- 2- To validate a research protocol, derived from WHO studies, useful for an Italian research on ageing.
- 3-To produce comparative analysis of health and disability trajectories, by linking-up IDAGIT data with other international information derived from other international projects.

IDAGIT project is a Cross-sectional study with probabilistic sampling design, stratified by age and gender, and involving individuals aged ≥ 18 years old.

Research duration is 36 months (from November 2014 to November 2017).

Methodology: The validation process of the research protocol in the Italian context will be based on two different approaches. Classical Test Theory including: test-retest to evaluate protocol stability; Cronbach's Alpha coefficient to evaluate its reliability; Split-half and Cograduation coefficient to evaluate its internal consistency and to assess the capacity of the protocol in predicting the evolution of the phenomenon being measured. Moreover, Item Response Theory approach will be taken to assess item equivalence across population. The project will also incorporate methods to calibrate and to adjust self report responses for reporting biases: in particular the IRT approach and the Hierarchical Ordered Probit Models (HOPIT) will be used to correct for biases in cut-points in rating scales.

Results

IDAGIT is expected to identify which factors act as determinants of health and disability in aging populations, among those related to health state and contextual factors, that can be modified through public health interventions aimed to increase active and healthy ageing. Understanding the complex relationship between subjects' inner health condition, outcomes such as disability and QoL, the network of social relationships that are available to subject and the way in which they interact with the environment is the best way to provide recommendations that define interventions to be carried out to promote active and healthy ageing. These interventions should be designed to maximize participation of elderly subjects, be cost-effective and have an impact towards improvement of social networks and improve person-environment interaction. At the same time, interventions should be effective in reducing physical barriers and thus reducing disability and increase active and healthy aging.

Conclusions

IDAGIT validated protocol could be considered a guideline protocol for the data collection on ageing based on WHO-International Classification of Functioning and Disability. Considering that health state is hardly modifiable in aging population, public health actions will be fundamental to decrease environmental barriers and increase social cohesion. **Understanding future ageing scenarios and their determinants is, thus, particular important for planning health and social policies.**

IDAGIT data will be compared to data from other international projects, such as EU COURAGE in Europe (Collaborative Research on Aging in Europe) and WHO SAGE (Study on Global Ageing and Adult Health) researches. Results will also be shared and discussed with relevant stakeholders in the field of policy development for disability as well as for active and healthy ageing.



Acknowledgements or Notes

We are grateful to all people who are participating in the IDAGIT study.

The IDAGIT Project is funded by the Italian Ministry of Health and is coordinated by Neurological Institute C. Besta IRCCS Foundation of Milan (Italy).





Updates on ISO9999 mapped to ICF

Giovanni Bassi, Lucilla Frattura

Central health Directorate / Classification Area- Friuli Venezia Giulia Region, ITWHO-FIC CC

Abstract The first attempt to map ICF, Environmental factors Chapter 1, into ISO 9999 was done using the 1998 Italian version of ISO 9999 and the ICF-CY. The reason is that in Italy the 1998 version is, today, the official nomenclature on which are classified the technical aids that The Health National System provide to person with disability. In this poster we present an update of this mapping due to the other versions of ISO 9999 until the last version 2011.

Introduction

Since 1998, the content and the structure of ISO 9999 has been greatly modified. Some classes have been removed, other classes have a different place in the classification, some new classes have been created, many classes have changed with regard to codes and titles. ICF has been also modified, including Chapter 1 of Environmental Factors (EFs), when it was decided not to update the ICF-CY any longer (WHO-FIC resolution "Merger of ICF-CY into ICF" - 2012). This poster presents the results of an update work on the mapping of ICF to ISO 9999:1998, presented at the WHO-FIC Annual Meeting in Brasilia. The update work considered all subsequent versions of ISO 9999 up to 2011 version (1) We present the final results of the comparison between ISO 9999:1998 and ISO 9999:2011.

Methods & Materials

The method previously used to map ISO 9999 to ICF second-level categories of Chapter e1 mainly followed semantic rules. The titles of ISO 9999 classes were compared with the semantic content of the titles and definitions (including inclusions and exclusions) of ICF categories. In case of ambiguity of the contents of ISO 9999 classes, the subclasses and divisions were considered. Another rule was that of assigning one single ICF category to one single division of ISO 9999. For the present work, we chose to keep the original association we made between ICF categories and ISO 9999:1998 divisions ("persistence" rule), even when these, in the subsequent ISO 9999 versions (2002 v. - 2011 v.), have been modified; for example, when ISO 9999 divisions have been added to or grouped in a different subclass or moved from a class to another.

With regard to new classes / subclasses / divisions added in the versions following ISO 9999:1998, the mapping rules were the same used in the first work.

Reference

(1) Bassi G., Frattura L. WHO FIC Annual Meeting 2012

Results

1. The relationship "one to one" found in ISO 9999:2011 is present in half of the classes (N = 6), in 4 cases the mapping is to category e115 "Products and technology for personal use in daily living". The relationship "one to many" in the remaining classes differed quantitatively and qualitatively from class to class. In some classes it was "weak" (classes 04, 05, 22, 24), in other classes it was "strong" (classes 18 and 28).
2. The application of the "persistence" rule until the ISO 9999:2011 generated some "weak" "one to many" relationships, which could be easily dealt with.
3. The comparison of ISO 9999:1998 and ISO 9999:2011 versions shows a difference in the number of ISO 9999 divisions associated with the ICF categories considered. This is due to the changes made to

ISO 9999 over the years. It should be noted that e115 was still the most used category. Mapping to category e125 was less frequent due to the grouping of different codes. Mapping to some categories was more frequent: e140, due to the addition of new divisions to class 30; e135, in the new 2011 version a specific class for assistive devices for the work environment has been added; e150 and e155, due to the addition of new categories.

Conclusions

- The more frequent mappings related to built environment suggest a specific revision of this sector of EFs in both classifications.
- ISO9999 is a "dynamic" classification.
- ICF should better specify the contents of Chapter e1, at least those of category e115.

Table 1: The differences in mapping different ISO 9999 versions into ICF

ISO 9999 1998	ISO Classes	ICF Categories (e1)		Relation
Aids for therapy and training	03	e115	e130	"one to many"
Orthoses and prostheses	06	e115		"one to one"
Aids for personal care and protection	09	e115		"one to one"
Aids for personal mobility	12	e120		"one to one"
Aids for housekeeping	15	e115		"one to one"
Furnishings and adaptations to homes and other premises	18	e115	e120 e150 e155	"one to many"
Aids for communication, information and signalling	21	e115	e125	"one to many"
Aids for handling products and goods	24	e115	e135	"one to many"
Aids and equipment for environmental improvement, tools and machines	27	e115		"one to one"
Aids for recreation	30	e115	e140	"one to many"

ISO 9999 2011	ISO Classes	ICF Categories (e1)		Relation
Assistive products for personal medical treatment	04	e115	e130	"one to many"
Assistive products for training in skills	05	e115	e130	"one to many"
Orthoses and prostheses	06	e115		"one to one"
Assistive products for personal care and protection	09	e115		"one to one"
Assistive products for personal mobility	12	e120		"one to one"
Assistive products for housekeeping	15	e115		"one to one"
Furnishings and adaptations to homes and other premises	18	e115	e120 e150 e155	"one to many"
Assistive products for communication and information	22	e115	e125	"one to many"
Assistive products for handling objects and devices	24	e115	e125	"one to many"
Assistive products for environmental improvement and assessment	27	e115		"one to one"
Assistive products for employment and vocational training	28	e115	e130 e135 e150 e155	"one to many"
Assistive products for recreation	30	e140		"one to one"

Table 2: ISO 9999, 1998 and 2011 versions divisions into ICF

ICF Categories		ISO 9999 1998 (Divisions into ICF)		ISO 9999 2011 (Divisions into ICF)	
		N	%	N	%
Products and technology for personal use in daily living	e115	421	59,6	454	58,4
Products and technology for personal indoor and outdoor mobility and transportation	e120	83	11,8	107	13,8
Products and technology for communication	e125	110	15,6	84	10,8
Products and technology for education	e130	54	7,6	55	7,1
Products and technology for employment	e135	10	1,4	24	3,1
Products and technology for culture, recreation and sport	e140	12	1,7	26	3,3
Design, construction and building products and technology of buildings for public (and private) use	e150 e155	16	2,3	28	3,6
Total		706		778	



ICHI Alpha 2016 - Development

8-12 October 2016
Tokyo, Japan

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C601

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Abstract Content development for ICHI Alpha 2016 has progressed since the 2015 annual WHO-FIC meeting in Manchester. Three chapters within Section 1 'Interventions on Body Systems and Functions', have been reviewed externally, with some changes being made to code hierarchy, inclusions and exclusions to better reflect the classification structure in these chapters. The Functioning Technical Working Group (FTWG) continues to further develop content relating to Section 2 'Interventions on Activities and Participation Domains' and Section 3 'Interventions to Improve the Environment and Health-related Behaviour'.

Work has progressed on reviewing and updating the existing extension codes for use with ICHI, and new extension codes have been included for therapeutic and assistive products and technologies, as well as medical substances.

There has been further development of the 'ICHI Platform', which will be used as the basis for ongoing updates and review of ICHI as we move towards a Beta version and ICHI completion.

This poster highlights recent work on ICHI content development and extension codes.

Introduction

Content development for the International Classification of Health Interventions (ICHI) has continued to progress during 2015-2016. The 2016 ICHI Alpha version will contain more than 6000 interventions across three sections: Interventions on Body Systems and Functions, Interventions on Activities and Participation Domains and Interventions to Improve the Environment and Health-related Behaviours.

This poster describes the refinements made to ICHI content and axes to develop the 2016 version.

Methods & Materials

First versions of the ICHI axes for targets, actions and means were published in 2008 and still constitute the base of the current axes system. Some revisions to the axes for the 2016 version to support required additions and revisions of codes in the Tabular list. Most changes have affected the 'Health-related Behaviour' group within the target axis, as described in a separate poster. The residual categories in the Action axis has also been revised with corresponding changes reflected in the Tabular list.

Three chapters from within Section 1, Interventions on Body Systems and Functions, have undergone external review:

- 1 Interventions on the Nervous System and Mental Functions
- 3 Interventions on the Ear
- 5 Interventions on the Endocrine System

This process involved reviewing the current ICHI Alpha 2015 interventions in these chapters, resulting in proposed changes to the code hierarchy, new and revised interventions, and inclusion/exclusion terms.

During the 2016 midyear meeting working groups also provided input on new and revised antenatal, obstetrics, postnatal and wound interventions.

Extension codes continue to be developed for use with ICHI. Work has progressed on developing extension codes for therapeutic and assistive products and technologies as well as medicaments.

Much work has also continued to improve the textual descriptions (titles, definitions, includes and exclusions), across the classification.

Work has progressed on the development of the ICHI Platform in collaboration with the Italian Collaborating Centre which will now host the ICHI Alpha 2016 content and be used as the basis for ongoing updates and review of ICHI as we move towards a Beta version and ICHI completion.

Results

Section 1 Interventions on Body Systems and Functions

Of the three chapters reviewed from ICHI Alpha 2015 comments were received from the following external reviewers: in Australia, Canada, South Africa, Japan and Korea. Reviewers made proposals concerning modifications to code titles, inclusion/exclusion terms, and addition or deletion of interventions. The table below indicates the total number of changes proposed for each chapter reviewed.

Number of Interventions	Ch 1 Nervous (n=647)	Ch 3 Ear (n=300)	Ch 5 Endocrine (n=510)
Modified	58	23	7
Deleted	14	8	10
New	18	5	3
TOTAL	90	36	20

ICHI Extensions

Many of the existing extension codes, including Topology, Temporality and Detailed Anatomy have been reviewed for ICHI 2016 and now better reflect extensions appropriate for medical/surgical, functioning, and public health interventions.

New extension codes for therapeutic products have been included following a review of CPT and the Canadian Classification of Interventions (CCI). The Functioning Technical Working Group (FTWG) have developed a list of assistive products and technologies, refer separate poster. The table below indicates the number of products codes proposed to date for ICHI 2016.

Therapeutic and assistive products and technologies codes in ICHI 2016

Therapeutic products	165
Assistive products and technologies	84
TOTAL	249

Examples of therapeutic products included are seen in the table below:

Body system	Therapeutic product	Inclusion terms
Cardiovascular	Cardiac lead, defibrillator	Cardiac resynchronization therapy (CRT) lead
	Intraaortic balloon pump	IABP
	Loop recorder, implantable	Cardiac event recorder

The current substance and anatomy extensions included in ICD-11 are also to be used as extension codes in ICHI Alpha 2016.

Conclusions

Active review and development of ICHI content continues. Feedback will be sought from many sources across countries and specialties over the coming months. The completeness of ICHI content will be tested during this process.

Acknowledgements or Notes

The Medical/Surgical TWG, the Functioning TWG, the ICHI Development Team, WHO-FIC Collaborating Centres, and a range of independent experts are thanked.



ICHI Alpha 2016 - focusing on Interventions to improve the Environment and Health-related Behaviour

8-12 October 2016
Tokyo, Japan

C602

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Abstract Since the 2105 annual WHO-FIC meeting in Manchester the ICHI Alpha 2015 has been reviewed. This poster highlights three areas in which important progress has been made: Section 3: Interventions to Improve Environment and Health-related Behaviour; Interventions related to community-based case-management and the development of a list of assistive products and technology for use as extension code.

Introduction

The ICHI Alpha 2015 included approximately 6000 interventions. These interventions were distributed across three sections:

1. Interventions on Body systems and functions
2. Interventions on Activities and Participation Domains
3. Interventions to Improve the Environment and Health-related Behaviour

This poster provides an overview of improvements made to:

- Section 3: Interventions to Improve the Environment and Health-related Behaviour
- Interventions related to community-based case-management
- A list of assistive products and technology for use as an extension code has been developed.

Methods & Materials

Work during the last year has focused on further developing and refining ICHI content, and has been achieved with input from members of the Functioning TWG and ICHI development team, experts from the WHO-FIC Collaborating Centres, as well as other experts in the field.

Two meetings, which provided important opportunities for face-to-face discussions, have been held:

- meeting in Trieste, Italy focusing on mental health interventions
- midyear meeting (FDC and ICHI) in Conegliano, Italy.

The work has also included further development of editorial and coding guidelines and review of the Target codes to show a hierarchical structure.

Information on content development focusing on other aspects of ICHI – including mental health interventions; birthing, obstetric and gynecological interventions; and nursing interventions – is provided in other posters.

Results

Section 3: Interventions to Improve Environment and Health-related Behaviour

The list of health-related behaviour Targets has been revised and expanded, and definitions for all behaviour Targets have been developed.

ICHI Alpha 2016 contains 29 behaviour Targets and ≈ 415 corresponding interventions for delivering at individual and population level. Definitions are now supplied for all of these interventions, and inclusions and exclusions have been added to guide users and ensure mutual exclusivity. The six new Targets account for 96 interventions:

ICHI target	n
Parenting behaviours	14
Self-harm behaviours	15
Family and partner violence behaviours	17
Community violence behaviours	15
Gambling behaviours	19
Digital technology use behaviours	16

The Action 'Infection control measures' has been revised and four new interventions have been added: Separation of a person for infection control; Population quarantine measures; Health care infection control measures and Animal infection control measures.

There has also been a complete review of Section 3 to identify and remedy errors, gaps, overlaps, and redundancies.

Interventions related to community-based case-management

Following a proposal submitted to the ICHI development team a set of codes has been developed to capture interventions related to community-based case-management: Advocating for a person; Navigating the service system; Case coordination and Individualized planning.

This work involved adding two new Actions - Planning (TB) and Navigating (TC), and making changes to the three existing Actions - Collaborating (TD), Advocacy (TA) and Preparation (SI).

List of assistive products and technology for use as extension code

A new ICHI extension code has been developed, comprising a list of 84 assistive products and technologies. The list consists of eight headings based on the categories in ICF Environmental Factors Chapter 1, 'Products and technology'. Under each of these headings subcategories have been added to describe assistive products and technology in more detail.

Assistive products and technology	n
Assistive products and technology for personal use in daily living (e1151)	22
Assistive products and technology for personal indoor and outdoor mobility and transportation (e1201)	18
Assistive products and technology for communication (e1251)	9
Assistive products and technology for education (e1301)	8
Assistive products and technology for employment (e1351)	9
Assistive products and technology for culture, recreation, and sport and play (e1401)	10
Assistive products and technology for the practice of religion or spirituality (e1451)	1
Design, construction and building products and technology of buildings for private or public use (e150, e155)	7

The list of products was reviewed against the WHO's priority list of assistive devices to ensure adequate coverage in all areas.

Conclusions

The program of work conducted over 2015/16 has resulted in substantial enhancements to the classification, including more comprehensive coverage in the tabular list, removal of overlaps and redundancies, the addition of inclusion and exclusion notes to improve clarity, a more complete set of definitions for axis categories and interventions, and further development of editorial and coding guidelines.

Acknowledgements

The Functioning TWG together with the ICHI Development team, Collaborating Centres as well as other contributors to ICHI content and development are gratefully acknowledged.

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Perinatal ("birthing") interventions: a multifaceted approach to an underexploited area of ICHI

8-12 October 2016
Tokyo, Japan

C604

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Abstract

Perinatal care and birthing interventions have changed in recent decades the epidemiology of perinatal mortality and morbidity. However, in most intervention lists and classifications used across the world the number of interventions specifically occurring in the perinatal period is limited. ICHI content model, once the relevant targets are identified, allows the composition of new intervention codes by assembling the proper action and mean. ICHI alpha 2015 was revised with special attention to this group of interventions with the aim of ensuring proper representation of current perinatal care. A group of experts involved both in the pre-natal care, the delivery and the immediate post-natal care met to enrich the present ICHI list of birthing interventions. The revision consisted in systematically matching current practice at an Ob/Gyn/neonatology department with the codes already present in ICHI, and adding new codes when matching was not possible. The presence of structure targets like "fetus", "uterus" and "placenta" as well as the body function targets like "procreation functions" or "lactation" allows the precise description of all relevant pre-natal and delivery associated interventions. For post-natal interventions using extension codes detailing temporality could solve the problem of distinguishing interventions carried on an infant from interventions carried on a grown up person.

The enriched list of birthing interventions will be presented. The reduction of maternal and newborn mortality are two of the sustainable development goals. Richer representation of interventions in this very important time in life will be instrumental in monitoring advances in this field.

Introduction

The perinatal period is a very critical and important time in which very specific and timely health interventions cluster. Perinatal care has considerably changed across the last decades, modifying the outcome of maternal and child health. The improvement in maternal health and the reductions of child mortality are two of the UN Millennium Development Goals. To implement and monitor the advancement towards these goals it is important to have detailed and updated annotation of all health interventions targeting this time of mother and child life. For this reason a special attention was devoted to intervention listing in the current ICHI draft and a formal revision of the existing list was launched with the active involvement of professionals in this field.

Methods & Materials

The fTWG agreed to call for a workshop to address the capture of current perinatal interventions. The workshop was open to experts in ObGyn, midwives, neonatologists. Two complementary strategies were followed:

- 1) Revision of existing interventions and check for their current applicability and appropriateness of definitions/Inclusions/exclusions
- 2) Systematic listing of all currently performed routine interventions starting from the pregnant female to the end of the early neonatal period and check form their presence in ICHI

Results

1) Target axis was examined for items that would be used to describe perinatal interventions.

Nine targets were identified: NME-Uterus, NMF-cervix, NMH-vagina, NMI-vulva, NMM-placenta-amnion-cord, NMR-fetal & embryonic structures, NMZ-female genital system NTJ-procreation functions NTX-functions related to fertility NTL-functions related to pregnancy SRL-parent-child relationship 59 Interventions currently listed in ICHI have these targets and are relevant to the perinatal period. One of these (arteriography of placenta) was deleted because obsolete.

Codes	NM	NT-SR	PZA
Existing	49	10	1
Deleted	1	-	-
Proposed	14	-	4

2) The systematic survey of current practice identified one missing target (body of uterus) and 14 missing interventions:

- 3 missing interventions on Uterus
- 2 missing interventions on the cervix
- 2 missing interventions on genital system
- 2 missing interventions on placenta
- 5 missing interventions on foetus

The interventions on the neonate will use necessarily the same targets as grown up children and adults, but the temporality extension code will highlight them. In spite of this, some procedures typically performed on the neonate such as identification, screening tests, heel prick, routine prophylactic manoeuvres needed 4 new appropriate codes.

Conclusions

Involvement of dedicated professionals in specific fields has been the strategy to enrich and check ICHI content. This same procedure was followed for the revision of the interventions performed during the perinatal period (birthing). The dual approach of checking existing codes and reviewing current practice to create missing ones was applied with success to birthing interventions. Some of the discussion stemmed during the workshop may be relevant to fields other than perinatal care. The need to add a new anatomical target code (uterus body) or to revise the action code for screening and prophylaxis are examples. Some points of discussion such as the need to specify interventions carried on pre-term infants called into play the complementary use of the WHO classifications (in this case ICF & ICHI). Field testing when launched will be the real benchmarking for the revised ICHI draft. Attention will be needed to include in such testing professionals and units caring for the mother and the new born, given the sensitivity of these fields also in face of the MDGs.

Acknowledgements or Notes

The help and assistance of the ICHI fTWG is acknowledged.



Classification of interventions in mental health care: the ICHI way

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Abstract This poster describes progress in the development of a comprehensive classification of mental health interventions within ICHI. The availability of a standard classification of mental health interventions as part of a broader international classification of health interventions will be valuable in ensuring that mental health care is visible in health information systems. The content developed may be helpful in improving existing national classifications of health interventions, and will provide a sound basis for describing mental health care in all countries.

Introduction

The demand for an international standard classification of mental health interventions is growing, as this is necessary to support data collection and electronic health records for care monitoring, health logistics, management, planning, financing and research purposes. There is currently limited systematization and categorization of mental health care, at either national or international level. The International Classification of Health Interventions (ICHI) can provide an international standard for collecting and reporting data on mental health interventions. This poster describes progress in the development of a comprehensive classification of mental health interventions within ICHI.

Methods & Materials

In 2011, first steps towards a classification of mental health interventions within ICHI were taken in a workshop in Sydney, Australia. Since 2011, work has continued to progressively expand the coverage of mental health interventions in ICHI. In February 2016, a meeting focused on mental health, involving 10 experts from Italy, Sweden and Australia, was held in Trieste, Italy. During the FDC-ICHI mid-year meeting, held in May 2016 in Conegliano, Italy, there were further discussions, involving participants from three WHO regions.

Table 1: Main results regarding the improvement in mental health classification

Interventions targeting 'Mental functions'
The following decisions were made concerning use of codes with 'Mental functions' targets. Corresponding coding guidance will be provided to ensure consistent use of codes for describing mental health interventions
<ul style="list-style-type: none"> Interventions used in mental health should utilize the Targets: <ul style="list-style-type: none"> AT1 'Mental functions' (ICF chapter-level) AT2 'Global mental functions' (ICF block-level) AU2 'Specific mental functions' (ICF block-level) More detailed Targets at ICF third level should not be utilized in mental health. Existing intervention codes with more specific 'mental functions' targets will remain in the classification where they are needed to describe interventions typically delivered by nurses or allied health professionals (e.g., 'Assessment of consciousness function') More specific targets can be recorded for mental health interventions using an extension code added to the classification for this purpose, if greater detail is required
Interventions targeting 'Health-related behaviours'
<ul style="list-style-type: none"> New Targets needed for describing interventions within mental health care were added: Self-harm, Family and partner violence, Community violence, Gambling, and Digital technology use Sets of intervention codes for existing health-related behaviour Targets were reviewed to ensure comprehensive coverage of mental health interventions
Actions: Seclusion, Restrain and 'stabilizing'
<ul style="list-style-type: none"> Action categories 'Seclusion' and 'Restrain', and the interventions 'Seclusion in order to avoid self-harm' and 'Applying restraint to a person' were deleted A new Action, 'Stabilizing', was agreed for use in describing mental health interventions such as pharmacological stabilization by compulsory treatment order
Peer support interventions
<ul style="list-style-type: none"> Peer support (FA) has been added to the Means axis, to be used together with the Action 'Provision' to describe interventions in which a health provider establishes a peer-support network or links a patient with a peer-support person 'Peer support' is defined as 'Emotional, social and practical assistance given by a person/group who possesses experiential knowledge of a specific behaviour or stressor' A set of new 'peer support' codes for mental health and public health interventions are included in ICHI Alpha 2016, e.g., VEJ RD FA 'Provision of peer support for parenting behaviours'

Over the course of this year there has been substantial review and enhancement of ICHI content from a mental health perspective.

Table 2: Examples of Target definitions in 'Health-related behaviour' section

Alcohol use behaviours	Behaviour concerning patterns of alcohol consumption
Digital technology use behaviours	Behaviour concerning patterns of use of screen-based technology Including: Digital technology overuse, digital technology addiction, internet addiction
Illicit drug use behaviours	Behaviour concerning patterns of non-medical use of drugs that are prohibited by law, including where and how such drugs are obtained and consumed Including: injecting drug use
Self-harm behaviours	A range of behaviours that include attempting suicide, any intentional self-inflicted harm, intentional risk-taking, and thinking about or planning for suicide and self-harm (ideation) Including: Intentional self-inflicted poisoning or injury
Family and partner violence behaviours	Behaviour relating to the intentional use of physical force or power, threatened or actual, against another person, largely between family members and intimate partners Including: Sexual violence towards a partner or family member
Gambling behaviours	Behaviour concerning patterns of placing bets or playing at games of chance for money or other stakes Including: online gambling

Results

In ICHI, codes for describing mental health interventions are found principally among those that target Mental functions (based on ICF categories in Chapter b1), Activity and Participation domains (based on ICF Chapters d1 to d9), and Health-related behaviours.

Key changes agreed for ICHI 2016 to improve coverage of mental health interventions are summarised in Table 1. An important change was deletion of the Action categories 'Restrain' and 'Seclusion'. WHO recommends outlawing the improper use of these actions, and the UN report A/HRC/22/53 states that they "may constitute torture and ill-treatment", if used as standard practice in persons with disabilities. Changes made to the classification were informed by reference to current scientific literature concerning mental health interventions. Thus 'Peer support' was agreed as a new Means category, and a set of peer support intervention codes has been added to the tabular list. Definitions for all 'Health-related behaviour' Targets have been developed, and new Targets needed for describing interventions within mental health care have been added. Examples are provided in Table 2.

Conclusions

These changes to axis categories, and corresponding revision of the tabular list of intervention codes in ICHI Alpha 2016, will enable more comprehensive representation of mental health interventions, so that ICHI is better able to meet clinical and statistical information needs.

The availability of a standard classification of mental health interventions as part of a broader international classification of health interventions will be valuable in ensuring that mental health care is visible in health information systems. The content developed may be helpful in improving existing national classifications of health interventions, and will provide a sound basis for describing mental health care in all countries.