REGIONE AUTONOMA FRIULI VENEZIA GIULIA
DIREZIONE CENTRALE SALUTE, INTEGRAZIONE SOCIOSANITARIA E POLITICHE SOCIALI

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

WHO-FIC 2017 MÉXICO

Poster Booklet

WHO-FIC Network Annual Meeting 16-21 October 2017

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
Mexico City, Mexico, 16-21 October 2017

Centro Collaboratore dell'Organizzazione Mondiale della Sanità per la Famiglia delle Classificazioni Internazionali
Via Pozzuolo 330 - 33100 UDINE (UD) - tel 0432 805605 - tel 0432 805626 - e-mail: info@reteclassificazioni.it

World Health Organization

20, AVENUE APPIA – CH-1211 GENEVA 27 – SWITZERLAND – TEL CENTRAL +41 22 791 2111 – FAX CENTRAL +41 22 791 3111 – WWW.WHO.INT

Tel. direct: +41 22 791 5877
Fax direct:
E-mail : jakobr@who.int

In reply please refer to:

Your reference: WHO-FIC 2017

Dr Lucilla Frattura
Classification Area, General Directorate
Regional Central Health Directorate
Via Pozzuolo 330
33100 Udine
Italy

23 June 2017

Dear Dr Frattura,

WHO Family of International Classifications Network Annual Meeting
Mexico City, Mexico 16-21 October 2017

I take great pleasure in inviting you and the delegation from your centre to the next annual meeting of the World Health Organization Family of International Classifications (WHO-FIC) Network, which will take place in Mexico, from Monday 16 to Friday 21 October 2017, at the World Trade Center, Mexico City.

The meeting will be hosted by our Collaborating Centre in Mexico, with support by the PAHO/WHO Country Office and WHO Regional Office in the Americas. The Secretariat function will be carried out by the WHO HQ Health Data Standards and Informatics unit.

"Connecting data for Health" has been identified as the main theme for the meeting this year.

Please find attached a provisional timetable. It will be updated in line with comments from the Small Executive Group (SEG) and yourselves, after review of the comments by the Secretariat. Please find relevant documents on the WHO website: www.who.int/classifications/network/meeting2017.

The website for the coordination of the meeting and information about accommodation developed by our hosts will provide all the details regarding general orientation and meeting facilities, as well as accommodation and social program reservation forms and procedures. The website will be accessed via hyperlink from the WHO website listed above, we will inform you about host website availability via email.

Registration for the meeting is mandatory and must be made through the host 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 team to no more than 5 members, unless responsibilities for the work program warrant a higher number. Please send an updated list of your delegation with full individual details (including email address) to Hernan Velasquez (velasquezhe@who.int) by no later than 15 August 2017, and complete their registration through the site by 31 August 2017 at the latest.

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

This invitation is sent to you by e-mail. Should you require a hard copy, please inform us and we will send one for you and your team members accordingly. If one or some of your participants will require visa for Mexico, kindly inform us accordingly with their names and personal addresses in order to send them a personal invitation letter for visa facilities

We would like to request each WHO Collaborating Centre to submit a poster presenting the annual report from your Collaborating Centre. We will use the same platform as in 2016 for the submission and collection of the posters for 2017. The link is available on the WHO website and on the meeting website.
This applies for all posters, for plenary poster sessions, and for presentation in the Committees or Reference Groups

The deadline for poster abstracts is 25 July 2017 and the deadline for the submission of final posters is 10 August 2017. 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 Mexico

Sincerely,

Dr Robert Jakob
Team Leader
Data Standards and Informatics

Italian WHO-FIC CC annual report

16-21 October 2017
Mexico City, Mexico

C208

Frattura L., 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 a summary of the activites carried out over the last year (July 2016-July 2017) by the the Italian WHO-FIC CC.

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.

Table 1: The new TORs 2015-2019

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.

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 second year (21 July 2016-21 July 2017), 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 (until Oct 2016), FDRG (with a change in Oct 2016), MRG, and URC-ICF (from Oct 2016). The Italian Center also provided the URC Secretariat for ICD and ICF and participated in the ICF and ICD update process with two voting members.

The Italian FDRG co-chair also served as member of the SEG (until Oct 2016) and as coordinator of the «Functioning interventions» in the ICHI development process.

New contracts were signed to monitor ICF implementation in Italy and abroad, and to support local use of ICD-10 and ICF.

Here some major activities of the Italian CC are introduced. More details can be found in the posters submitted at this meeting (Figure 1).

Electronic versions of ICF 2017

The Italian CC prepared the electronic version of ICF revision 2017 in order to update both the printed version and the browser.

For the printed version, the Center generated a ClaML version of the most recent ICF version from the one already maintained by the Centre as a support for the Italian translation. For the browser, a script was developed to convert the ClaML version to a CSV file compatible with the browser database schema, under Can Celik guidance.

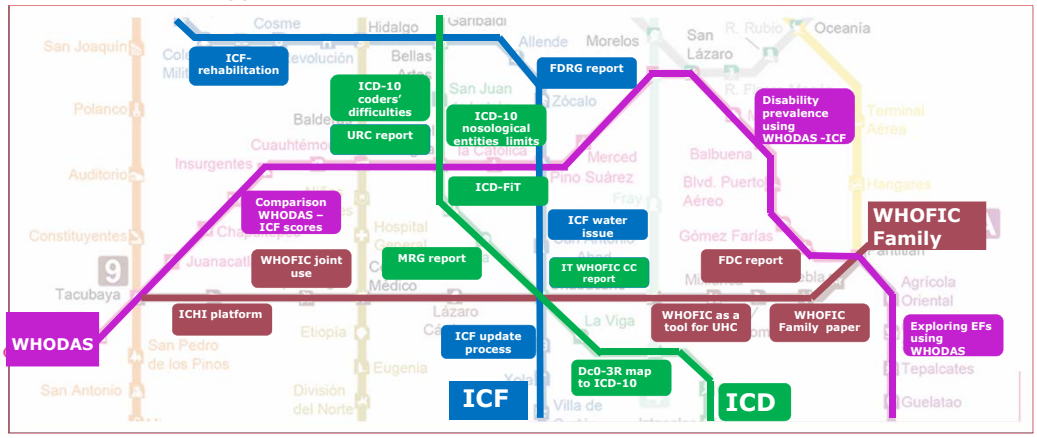
ICD-10 v.2016 Italian translation

The Italian CC will release at the end of 2017 the translation of the three volumes and the online version of ICD-10 v.2016.

ICD-10 Italian modification

The CC is involved in the preparation of the draft of the ICD-10 Italian modification and in its implementation in regional health information system.

Figure 1: The Mexico city Map of some Italian WHO-FIC CC 2016-2017 activities (the stations are the 2017 WHO-FIC Network Meeting posters



ICHI *Platform*

The Italian CC also worked on the renovation of the ICHI Platform, with the support and collaboration of the Australian and Chinese CCs.

The platform was used at the FDC mid-term meeting (June 2017) for working on the ICHI classification. Up to now, there are 66 registered users, and 1543 comments have been produced for ICHI revision.

ICD-FiT

In order to support ICD-11 field trials, a web-based system (ICD-FiT) was designed and developed according to WHO requirements. Since the Tokyo meeting, ICD-FiT has been updated mainly on the dashboard, to help ICD-11 reviewers understand the most frequent coding mistakes made by the raters and thus adjusting ICD-11 where needed.

Support to Albania

The CC is also engaged in implementing the ICD-10 electronic version in Albania.

References

Italian WHO-FIC annual report, Udine, Sept 2017

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

Family Development Committee Annual Report 2017

16-21 October 2017
Mexico City, Mexico

C103

Lyn Hanmer[1], Andrea Martinuzzi[2], Brooke Macpherson[3]
[1]South African Medical Research Council, South African Collaborating Centre and FDC Co-Chair
[2]E. Medea Scientific Institute, Italian Collaborating Centre and FDC Co-Chair
[3]Australian Institute of Health and Welfare, Australian Collaborating Centre and FDC Secretariat

Abstract The Family Development Committee (FDC) aims to develop the World Health Organization's Family of International Classifications (WHO-FIC) as an integrated and comprehensive suite of classifications. It also aims to ensure that the WHO-FIC has a logical structure so that the classifications needed for each component and setting within the health system can be identified. This poster presents a summary of FDC activities from October 2016 to October 2017.

Introduction

The Family Development Committee (FDC) was established in 1999 to ensure that the WHO-FIC has a logical structure so that health classifications needed for each health parameter and setting within the health system can be identified. The Committee assesses potential new member classifications that could fill a gap in the WHO-FIC.

During the year, the FDC met three times; in October 2016 at the Network Annual Meeting in Tokyo, Japan, via teleconference in April 2017, and in June 2017 at the mid-year meeting in Stellenbosch, South Africa.

Figure 1: Attendees of the FDC mid-year meeting in Stellenbosch, South Africa

The mid-year meeting was held in conjunction with meetings of the International Classification of Health Interventions (ICHI) and the Functioning and Disability Reference Group (FDRG).

The FDC co-chairs are Lyn Hanmer (South African Collaborating Centre) and Andrea Martinuzzi (Italian Collaborating Centre). The secretariat function is provided by Brooke Macpherson (Australian Collaborating Centre).

The Strategic Work Plan (SWP) for the FDC is outlined below with progress against each item summarised.

SWP 01: Assist WHO in the development of ICHI

The FDC acts as the focal point for the WHO-FIC Network for the ICHI development work. In order to facilitate communication and co-ordination, FDC and ICHI development meetings have been co-located for several years, including the 2017 mid-year meetings.

The WHO ICHI Task Force was established in 2016. One of the FDC co-chairs is a co-chair of the Task Force, and some members of the Task Force are also members of the FDC.

SWP 02: Integration of the Family

The FDC has been re-drafting the 2007 WHO Family paper, which describes the WHO-FIC, principles of classification and the processes for adding, updating and maintaining classifications in the Family.

At the Tokyo meeting in 2016, a shorter document focused on the reference classifications in the ICD-11 era was tabled for discussion by the FDC. It was anticipated that this document would *complement* the 2007 Family paper.

A writing group has been working since January 2017 to amend and finalise the Family paper, to be presented to the Network in Mexico City in 2017. A revised draft of the Family paper was presented to members at the FDC mid-year meeting, where small groups worked on individual sections. Drafts have also been presented to the ICD-11 MMS Joint Task Force and the WHO-FIC Advisory Council.

The schematic representation of the WHO-FIC is being revised to reflect new developments in classifications. Figure 2 below was developed by the FDC during its 2017 mid-year meeting. Further modifications are under consideration.

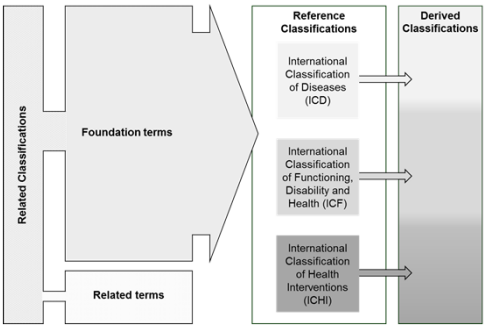


Figure 2: Proposed schematic representation of the WHO-FIC for the revised Family paper. Developed during the 2017 FDC mid-year meeting

SWP 03: Applications of the WHO-FIC: Joint use of reference classifications

Major outcomes of discussions at the 2017 mid-year meeting:

- A template for canvassing case examples of joint use of the WHO-FIC reference classifications will be deployed to the Network.
- IT requirements and tools to support joint use will be investigated in collaboration with the ITC.
- Common concepts across WHO-FIC reference classifications will be investigated.

SWP 04: WHO-FIC support for UHC and the SDGs

The FDC has been assessing how the WHO-FIC can potentially be used to support measuring progress towards the WHO's Universal Health Coverage (UHC) initiative. Since the 2016 Network meeting in Tokyo, this item has been expanded to include the Sustainable Development Goals (SDGs).

SDG3, Health, contains UHC as one of its thirteen targets. UHC in this context represents an influential factor where success in UHC could propel the achievement of the other set targets and, indirectly, other SDGs.

Previous mapping exercises by the FDC have assessed which reference classifications could be useful to monitor the UHC indicators and the 13 targets of the Health SDG. This year the FDC expanded the mapping to include the *100 Core Health Indicators* identified by WHO, which contain indicators for health status, risk factors, service coverage and health systems – all seen as vital elements that contribute to UHC. Each reference classification has a role to play in the monitoring of these indicators.

The FDC will continue to pursue this topic at its 2018 mid-year meeting, with a focus on ensuring alignment with other WHO activities related to UHC.

SWP 05: Assess the need for additional members of the Family

There is a need for further engagement with the FDRG on personal factors in the WHO-FIC. This topic will be included in the agenda for the FDC 2017 annual meeting.

SWP 06: Alignment of members of the Family

The 2017 mid-year meeting concluded that this activity could encompass reviewing the reference classifications for multiple representations of concepts, and ensuring that their meanings are consistent.

This topic will be discussed at the FDC annual meeting in Mexico in October 2017, for possible inclusion in the agenda for the 2018 mid-year meeting.

Acknowledgements

The FDC co-chairs thank the FDC members for their contributions to the FDC work plan activities during the year, and the South African Collaborating Centre for hosting the mid-year meeting.

Update and Revision Committee (URC) Annual Report

16-21 October 2017
Mexico City, Mexico

C105

Hargreaves J.[1], Frattura L.[2], Tonel P.[2]

[1]Australian Institute of Health and Welfare, Australia - URC ICD Co-chair; [2]Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC - URC ICF Co-chair; [2]Central 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 2017.

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 (FIC) "Reference Classifications" up to date in line with current knowledge (1). 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 Classifications .

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 (2,3). Work and communications are also carried out via e-mail, conference calls and meetings, including an annual meeting during the WHO-FIC Annual Meeting. Activities and deliverables of URC in the WHO-FIC Strategic Work Plan are shown here below (Table 1) (4).
In order to update the ICF URC membership list, the Head of the Collaborating Centres were contacted and WHO was asked to update the lists on the ICF update platform.

Table 1 – The URC relevant part of the WHO-FIC SWP

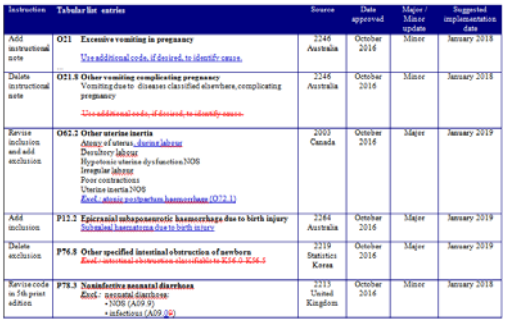
Product/Deliverable	Activities
Annual updates to ICD-10	Submission, review, decision and implementation of update proposals for ICD-10.
Transition strategy from ICD-11 revision process to URC update process	WHO draft for comments
Realize a Foundation ICF implementation of ICF proposals	Submission, review, decision and implementation of ICF-CY related update proposals for ICF. Due to the difference in submission process and lack of supporting rationale additional work is required.
Provide annual updates to ICF	Submission, review, decision and implementation of update proposals for ICF.
Overall coordination of the update process	Secretariat. Participation in the works, meetings and teleconferences of Initial Review Group and FDRG
i) A PDF file which incorporates all the amendments passed by the URC from 2000-2014 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

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

Results

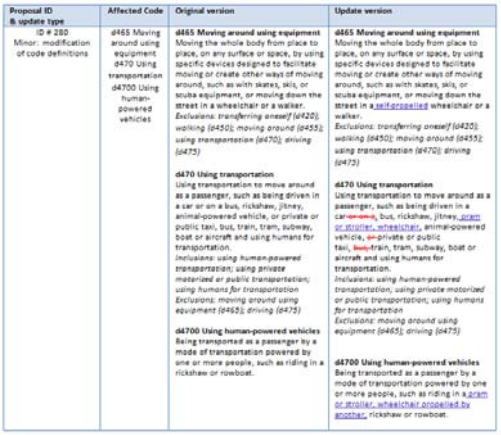
At the 2016 WHO-FIC Network annual meeting held in Tokyo, Japan, the URC ratified 104 recommendations for updating the ICD-10 and 20 recommendations for updating the ICF (Figs. 1 and 2). The annual and cumulative update documents for ICD-10 and the annual update documents for ICF were prepared and delivered to WHO. ICD-10 changes were finalised for the major update of ICD-10 for January 2019.
The analysis of update proposals coming from ICF-CY to be included in ICF was completed.
An updated ClaML version of ICF including all amendments approved by the URC from 2000 to 2016 was prepared. A ClaML-based electronic version of ICF to be used by WHO to update the ICF browser was also prepared. The updated ICF online version can seen at http://apps.who.int/classifications/icfbrowser/ (Fig. 3).
URC participated (by teleconference) in the FDRG mid-year meeting 2017 to address some ICF issues.
At present, in 2017, 88 proposals have been moderated for ICD-10 and put to vote by URC members. With regard to ICF, 24 proposals have been moderated and put to vote by URC members.

Figure 1 – Screenshot from the ICD annual updates approved in 2016



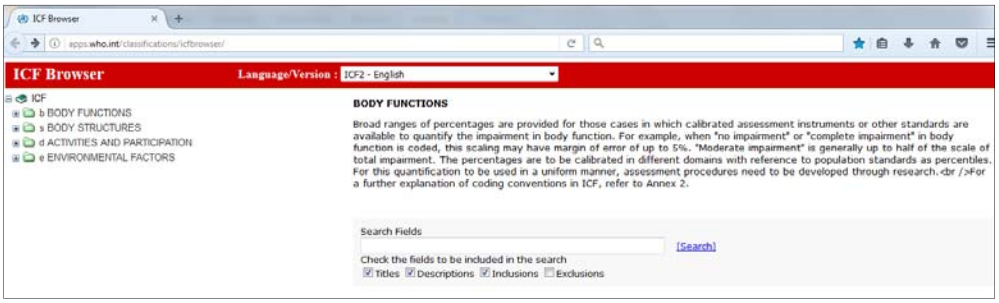
Instruction	Tabular list entries	Source	Date approved	Major / Minor update	Suggested implementation date
Add instructional note	O21 Excessive vomiting in pregnancy Use additional code, if desired, to identify cause.	2246 Australia	October 2016	Minor	January 2018
Delete instructional note	O21.8 Other vomiting complicating pregnancy Vomiting due to diseases classified elsewhere, complicating pregnancy ~~Use additional code, if desired, to identify cause.~~	2246 Australia	October 2016	Minor	January 2018
Revise inclusion and add exclusion	O62.2 Other uterine inertia Atony of uterus, during labour Dystocy: labour Hypotonic uterine dysfunction NOS Irregular labour Poor contractions Uterine inertia NOS Excl.: atonic postpartum haemorrhage (O72.1)	2003 Canada	October 2016	Major	January 2019
Add inclusion	P15.2 Epicranial subaponeurotic haemorrhage due to birth injury Subgaleal haematoma due to birth injury	2264 Australia	October 2016	Major	January 2019
Delete exclusion	P76.8 Other specified intestinal obstruction of newborn ~~Excl.: intestinal obstruction classifiable to P76.0-P76.1~~	2219 Statistics Korea	October 2016	Major	January 2019
Revise code in 5th-print edition	P78.3 Noninfective neonatal diarrhoea Excl.: neonatal diarrhoea: • NOS (A09.9) • infectious (A09.0)	2213 United Kingdom	October 2016	Minor	January 2018

Figure 2 – Screenshot from the ICF annual updates approved in 2016



Proposal ID & update type	Affected Code	Original version	Update version
ID # 280 Minor: modification of code definitions	d465 Moving around using equipment d470 Using transportation d4700 Using human-powered vehicles	**d465 Moving around using equipment** Moving the whole body from place to place, on any surface or space, by using specific devices designed to facilitate moving or create other ways of moving around, such as with skates, skis, or scuba equipment, or moving down the street in a wheelchair or a walker. *Exclusions: transferring oneself (d420); walking (d450); moving around (d455); using transportation (d470); driving (d475)* **d470 Using transportation** Using transportation to move around as a passenger, such as being driven in a car or on a bus, rickshaw, jitney, animal-powered vehicle, or private or public taxi, bus, train, tram, subway, boat or aircraft and using humans for transportation. *Inclusions: using human-powered transportation; using private motorized or public transportation; using humans for transportation* *Exclusions: moving around using equipment (d465); driving (d475)* **d4700 Using human-powered vehicles** Being transported as a passenger by a mode of transportation powered by one or more people, such as riding in a rickshaw or rowboat.	**d465 Moving around using equipment** Moving the whole body from place to place, on any surface or space, by using specific devices designed to facilitate moving or create other ways of moving around, such as with skates, skis, or scuba equipment, or moving down the street in a self-propelled wheelchair or a walker. *Exclusions: transferring oneself (d420); walking (d450); moving around (d455); using transportation (d470); driving (d475)* **d470 Using transportation** Using transportation to move around as a passenger, such as being driven in a car or van, bus, rickshaw, jitney, pram or stroller, wheelchair, animal-powered vehicle, or private or public taxi, bus, train, tram, subway, boat or aircraft and using humans for transportation. *Inclusions: using human-powered transportation; using private motorized or public transportation; using humans for transportation* *Exclusions: moving around using equipment (d465); driving (d475)* **d4700 Using human-powered vehicles** Being transported as a passenger by a mode of transportation powered by one or more people, such as riding in a pram or stroller, wheelchair propelled by another, rickshaw or rowboat.

Figure 3 - The updated ICF online version



Conclusions

The achievements of the Committee are made possible by the generous efforts of URC members and relative institutions.
The realization of a foundation ICF with the implementation of the classification items coming from the ICF-CY was concluded. An increasing engagement of the Collaborating Centers in the Committee's work will ensure a new phase in the ICF update process (5).

References

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http://www.who.int/classifications/committees/URC.pdf
2. The ICD update platform
https://extranet.who.int/icdrevision/nr/login.aspx?ReturnUrl=%2Ficdrevision%2FDefault.aspx
3. The ICF update platform
https://extranet.who.int/icfrevision/nr/loginICF.aspx
4. Terms of Reference for WHO FIC Update and Revision Committee (URC) version Dec 2012
5. Frattura L., Tonel P. The ICF update process: suggestions for improving outcomes. WHOFIC Network Annual Meeting 2017

Acknowledgements

The authors thank URC members for their contributions over the past year. Special thanks to Janice Miller.

Mortality Reference Group
Annual Report, 2016-2017

DL Hoyert[1], F Grippo[2], K Nakayama[3]
(1) NCHS, (2) ISTAT, (3) Japan ICD Office, MHLW

16-21 October 2017
Mexico City, Mexico

C106

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 19th year, the MRG deliberated about 108 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 19th 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 about a thousand issues related to updating and clarifying ICD-10 as it applies to mortality classification and coding. The MRG has settled more than 650 issues selected largely from the Mortality Forum (an international mortality classification discussion network) and submitted 428 recommendations to the Update and Revision Committee (URC) for consideration.

This report describes the background of the MRG and the issues decided in the 19th year.

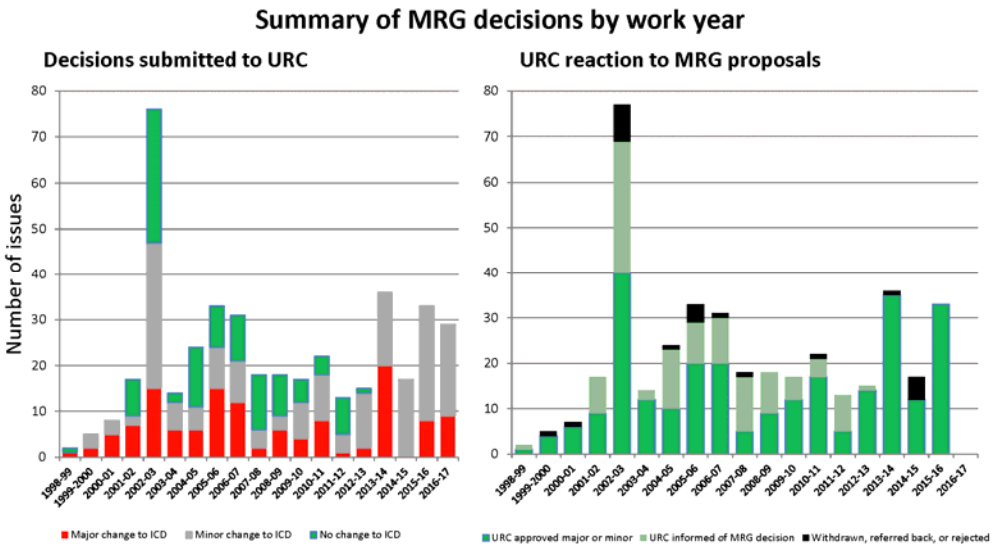
MRG meeting locations, 1998-2017

Basis for the MRG

Provision 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 19 years

In the 19 years (1998-2017), the MRG reached more than 650 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 428 decisions to the URC: 317 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 19th year

The MRG met in Raleigh, NC on March 23-24 and 27-28, and in Mexico City, Mexico on October 16-17, 2017. A smaller table group also met in March to work through issues concerning the decision tables where MRG decisions left details open. The MRG reviewed about 108 issues, and submitted 29 recommendations (9 major and 20 minor) to the URC (see Table).

Table. Decisions made in 2016-2017

Year Discussed and Issue
Minor change submitted to URC in 2017
2016-2017: Addition to Annex 7.4
2016-2016: Index discrepancies involving O10
2016-2017: Rheumatic fever and tonsillitis
2016-2017: Victim of extreme weather (X37-X38)
2015-2017: Term reported as sudden infant death but age is over 1 year
2014-2017: Infections specific to perinatal period
2015-2017: P95 usage notes
2016-2017: Neoplasm instructions in section 4.3.5 A
2014-2017: Correction to URC 2184
2016-2017: Clarification of instructions for diabetes
2016-2017: Congenital conditions
2017-2017: Neonatal diarrhea
2015-2016: Hypertension issues
2015-2017: Adding codes in some of neoplasm instructions section 4.3.5
2015-2017: Move more related to old perinatal certificate to end
2016-2017: Conflict in linkage instructions
2016-2017: Cognitive impairment
2016-2017: Check for modifications of the starting point example
2016-2017: Graphic illustration of coding instructions for mortality
2017: Error correction in vol 2 4.3.7 c
Major change submitted to URC in 2017
2014-2017: Note on I46.9
2014-2017: Unspecified effects of other external causes
2015-2017: Code for hyperbilirubinemia
2016-2017: Appropriate code for hypoproteinemia
2016-2017: Restore missing index entry
2015-2017: Neoplasm instructions modifications related to metastatic
2015-2017: 4.3.7 instructions on rheumatic disease
2016-2017: Chylothorax
2015-2017: Respiratory nos

Conclusions

In the 19th 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 nineteenth year, a total of about 108 issues were reviewed by the MRG and the MRG's Table Group. Closure was reached for many of these and 29 decisions were submitted to the URC in 2017. Nine of these were recommendations for major change and 20 for minor change.
As the updating of ICD-10 is phasing out, current ICD-10 update proposal are also reviewed in terms of their relevance for ICD-11.

ICDfit: current status

16-21 October 2017
Mexico City, Mexico

C311

M.Donada[1], N.Kostanjsek[2], C.Celik[2], V.Della Mea[1], R.Jakob[2]
1 University of Udine and Italian WHO-FIC Collaborating Centre, Udine, Italy
2 WHO, Geneva, Switzerland

Abstract The web-based system developed to support field testing of ICD-11 has been further enhanced during the last year, and many studies have been started on it. The present poster visually describes its current status, with data on its usage.

Introduction

The ICDfit web application has been developed to support the systematic testing of ICD-11 in different settings, across the world.
In 2016/17 ICDfit was used in the line coding pilot testing of ICD-11 MMS.

Based on the pilot test experience the ICDfit functionality has been further enhanced in order to support the following testing activities in 2017:

- Generic line coding (morbidity)
- Generic case coding (morbidity)
- Specialty specific line and case coding (e.g. International Association for the Study of Pain, Traditional Medicine, German Medical Societies etc.)
- Mortality line- and underlying cause coding

The interface used in line and case coding are shown in Figure 1 & 2. Some of the analytical visualization features of ICDfit are displayed in Figure 3-5.

Future plans for ICDfit include the transformation into an ICD-11 coding training, testing and (self-) assessment platform which will form part of an ICD-11 implementation package.

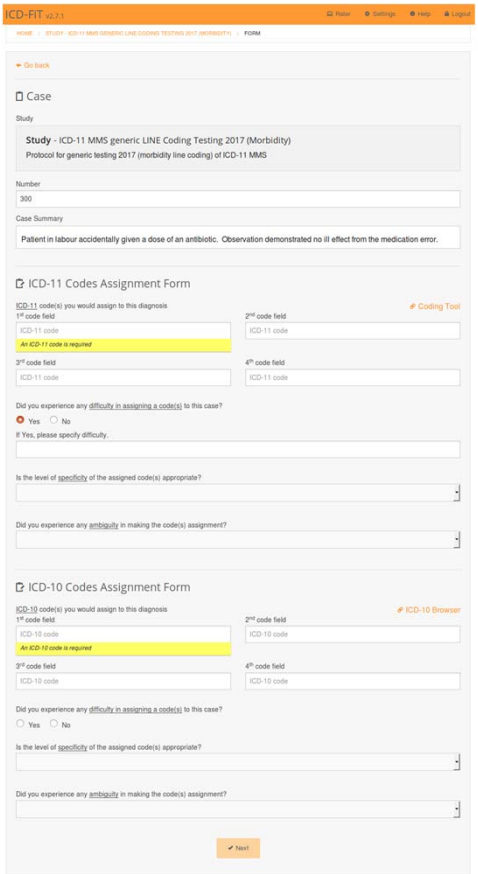


Figure 1 – line coding interface

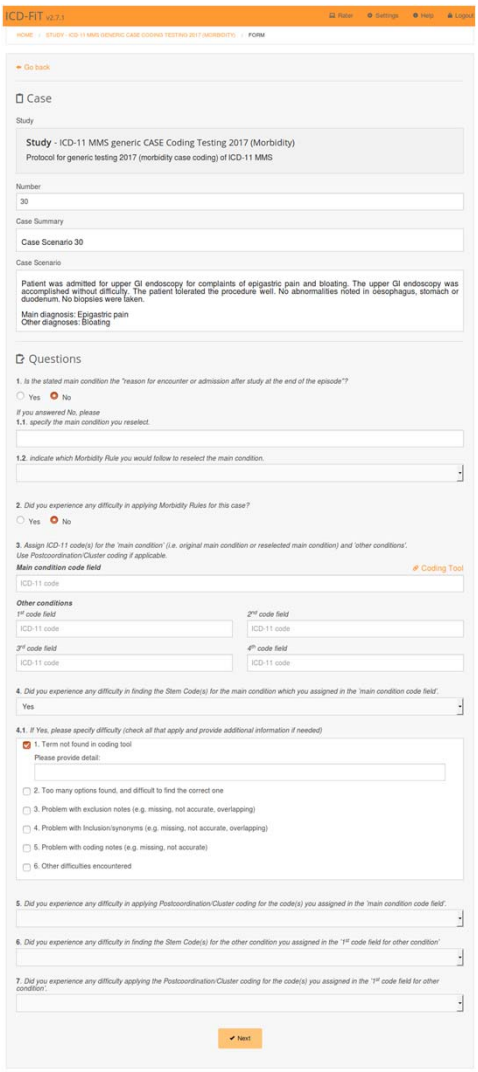


Figure 2 – case summary interface

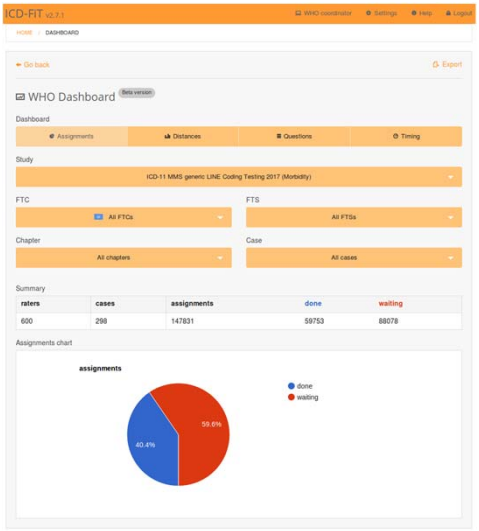


Figure 3 – Coordinator dashboard: main screen

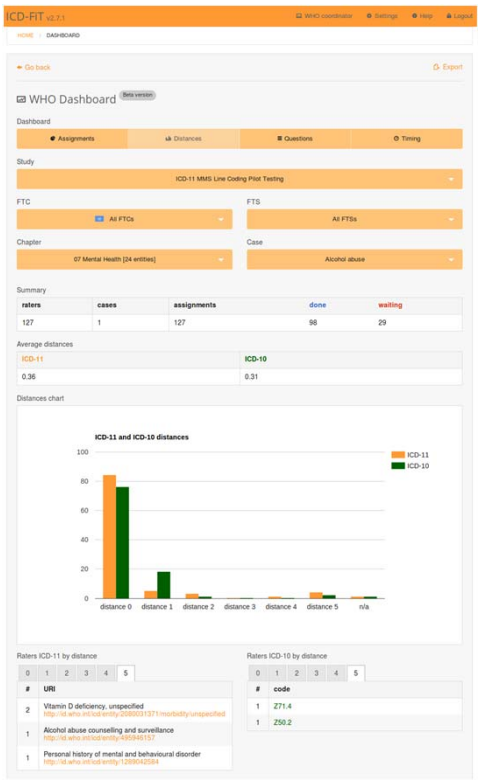


Figure 4 – dashboard: list of rater codes for a case, by distance

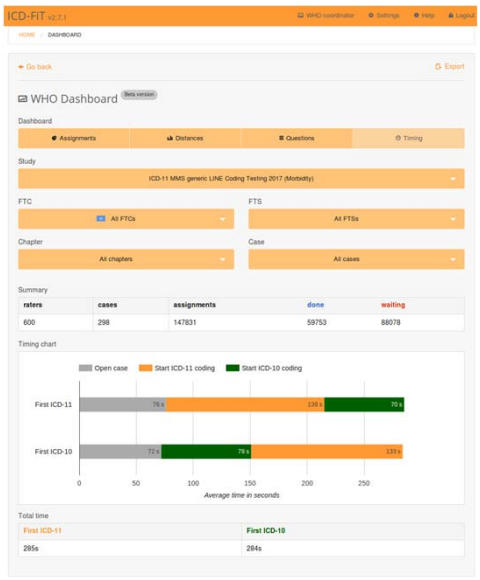


Figure 5 – dashboard: time for coding

Usage data

At present, ICD-FiT activity can be described as follows:

- FTC: 29 (31 countries involved)
- FTS: 49
- Users: 1673 (86 nationalities)
- Studies: 61
- Case summaries and terms for line coding: 1933
- Coded instances: 112383

ICD-10 updates looking at ICD-11: nosological entities limitations.

16-21 October 2017
Mexico City, Mexico

C415

Zavaroni C., Tonel P., Frattura L.
Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC

Abstract This poster presents our ICD-10 update proposals dealing with ICD-10 limitations about some nosological entities. We proposed supplementary subclassifications taking into consideration the international classifications and ICD-11. The level of granularity considered the limited possibilities to extend ICD-10 codes to completely follow ICD-11.

Introduction

Some ICD-10 code titles are limited about the nosological entity which they classify. They are outdated towards the state of the art. At international level we cannot wait ten years, the time likely to be needed to fully implement ICD-11 for an operational use.

Methods & Materials

In order to correctly distribute the nosological entities among the different homogenous groups of resources, the update proposals follows: a) ICD-11 Beta Draft classification [1]; b) formal international classifications of some nosological entities; c) standardized (but not formal) classification systems of some nosological entities, universally accepted in the international scientific community; d) state of the art on each issue.
Supplementary subclassifications are proposed taking into consideration international classifications and ICD-11. Moreover, the limited possibilities to extend ICD-10 codes [2] to completely follow ICD-11 are sometimes considered.
These supplementary subclassifications follow the optional use currently present in ICD-10 that concerns 4-character subcategories and therefore it leads to the construction of 5-character codes. If applicable, in any proposed update, disorders are specifically classified with progressive optional numbers, with the aim to facilitate the choice between similar alternatives.

Results

The update proposals regard very important disorders classifiable in two groups: a) diseases with higher impact on the biopsychosocial condition of the person, family and society (e.g.: motor neuron diseases; acute myocardial infarction); b) diseases with lower impact, but more frequent (e.g.: thalassaemias, other hemoglobinopathies, double heterozygous sickling disorders and other sickle-cell disorders, that affect hundreds of millions of people, in particular, people living in South Europe, Middle East, South-West Asia and North Africa; sleep apnoeas).
Figure 1 presents the supplementary subclassification of motor neuron diseases (in blue font).

Motor neuron diseases are diseases of high relevance with a catastrophic impact on the biopsychosocial condition of the person, family and society. The differential diagnosis allows to differentiate nosological pictures [3,4,5,6,7] that are extremely useful to define the needed resources, both when using health services or health and social services (hospital, nursing home, hospice, home care, etc.) and when planning and programming health and social protection systems at regional and national level. Moreover, at international epidemiological level it is important to identify - in prevalence and incidence terms - the most severe types, also to promote studies on etiology, prevention and treatment, and to improve and refine current studies.

Figure 1: Supplementary subclassification of motor neuron diseases.

G12.2 Motor neuron disease
[...]
The following supplementary subclassification to indicate the type of motor neuron diseases is provided for optional use with subcategory G12.2.

- 0 Amyotrophic lateral sclerosis
- 1 Progressive bulbar palsy
- 2 Monomelic amyotrophy
- 3 Progressive pseudobulbar palsy
- 4 Progressive muscular atrophy
- 5 Primary lateral sclerosis
- 6 Amyotrophic lateral sclerosis-Plus
- 8 Other specified
- 9 Unspecified

Figure 2 illustrates the supplementary subclassification of sleep apnoeas (in blue font).
According to the International Classification of Sleep Disorders (Third Edition) [8], Sleep Related Breathing Disorders should be grouped into "Obstructive Sleep Apnea Disorders", "Sleep Sleep Apnea Syndromes", "Sleep Related Hypoventilation Disorders" and "Sleep Related Hypoxemia Disorder" but this choice would lead to other subclassifications in further subcategories that cannot be proposed for ICD-10. Therefore, the update proposal does not group the proposed conditions into these groups, but classifies them with progressive numbers, reconciling the international classification itself, ICD-11, and the necessity of mutual exclusivity intrinsic to the distribution of different disorders in different homogeneous groups of resources that correspond to a single organ system or cause and that are generally associated with a particular medical specialty. The proposed numerical order meets the criteria of contiguity among sleep disorders that belong to different groups of the international classification with the aim of facilitating the ICD-10 code choice between similar alternatives.

Figure 2: Supplementary subclassification of sleep apnoeas.

G47.3 Sleep apnoea
[...]
The following supplementary subclassification to indicate the type of sleep apnoeas is provided for optional use in G47.3.

- 0 Central with Cheynes-Stokes respiration
- 1 Central without Cheynes-Stokes respiration
- 2 Central due to high-altitude periodic breathing
- 3 Central due to substances including medications
- 4 Primary central of adults
- 5 Obstructive
- 6 Congenital central alveolar hypoventilation
- 7 Non-obstructive alveolar hypoventilation
- 8 Other specified
- 9 Unspecified

For other proposals please refer to the ICD update platform [9].

Conclusions

The proposed subclassifications are in line with the state of the art. Their use and related statistical data processing are the basis for planning and programming health and social protection systems aimed at satisfying the needs of people.

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How to code mental disorders in 0-3 years old children using ICD-10.

16-21 October 2017
Mexico City, Mexico

C416

Frattura L. (1), Bruno L. (2)

(1) Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT
WHO-FIC CC, Udine, (2) Bologna Local Health Authority, Emilia Romagna Region

Abstract In order to facilitate the ICD-10 use by the clinicians and coders who use the *DC:0–3R Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* for describing mental conditions in infancy, a regional working group was created. A crosswalk table from *DC:0–3R* to ICD-10 was prepared taking into account some similar tables made by experts from Minnesota. The final crosswalk table is slightly different and clarifies which modifications could be made in the Italian ICD-10 version. Practical tests have been scheduled.

Introduction

ICD-10 has limits for coding health conditions under Chapter V in 0-3 years old infant and toddlers. The *DC:0–3 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (*DC:0-3R) was meant to complement, but not replace, the DSM-IV-TR and the ICD-10 (1). It was intended to enhance the understanding of young children by making it possible to assess, diagnose, and treat mental health problems by allowing the identification of disorders not addressed in other classifications. This paper presents specific activities carried out by the Italian WHO-FIC CC (LF) to implement the full use of ICD-10 in the Emilia Romagna region (Italy) where in 2015 a long lasting training programme was started by involving professionals from children neuropsychiatry services who use DC:0-3R (1) and WHO Multiaxial Classification of Child and Adolescent Psychiatric Disorders . The aim was to set up a consensual crosswalk table from the Axis 1 (Clinical disorders) of the DC:0-3R to ICD-10.

Methods & Materials

In 2017, a regional working group was created with neuropsychiatrists and psychologists from public health services of Emilia Romagna Region (2).
A draft of a crosswalk table from DC:0-3R clinical disorders to ICD-10 was compared to the most updated Minnesota crosswalk table (3) and other available crosswalk tables (4). Some changes were discussed and the table was tested.

Results

A draft of a crosswalk table from DC:0-3R Axis 1 to ICD-10 was set up (Figure 1). Some modifications were proposed for some .8 ICD-10 codes in order to explicit how to include some DC:0-3R diagnostic concepts.

Conclusions

The crosswalk table will be used to implement regional information systems, to update the draft of the Italian ICD-10 Clinical modification, and to be shared in the Italian professional community. The crosswalk table should be updated considering the new DC:0-5 version (4).

Figure 1: Draft of the Italian DC:0-3R crosswalk to ICD-10.

DC: 0-3R Axis I Clinical disorders	DC: 0-3R code description	ICD-10 consensual code	ICD-10 code description
100	Posttraumatic Stress Disorder		
		F43.0	Acute stress reaction
		F43.1	Post-traumatic stress disorder
150	Deprivation/Maltreatment Disorder		
		F94.1	Reactive attachment disorder of childhood Incl: Deprivation/maltreatment disorder, pattern 1 (0-3)
		F94.2	Disinhibited attachment disorder of childhood Incl: Deprivation/maltreatment disorder, pattern 2 (0-3)
		F94.8	Other childhood disorders of social functioning Incl: Deprivation/maltreatment disorder, mixed pattern (0-3)
210	Prolonged Bereavement/Grief Reaction		
		F43.8	Other reactions to severe stress
220	Anxiety Disorders of Infancy and Early Childhood		
221	Separation Anxiety Disorder	F93.0	Separation anxiety disorder of childhood
222	Specific Phobia	F93.1	Phobic anxiety disorder of childhood
223	Social Anxiety Disorder (Social Phobia)	F93.2	Social anxiety disorder of childhood
224	Generalized Anxiety Disorder	F93.8	Other childhood emotional disorders
225	Anxiety Disorder NOS	F93.8	Other childhood emotional disorders Incl: Anxiety Disorder NOS of infancy and early childhood
230	Depression of Infancy and Early Chilhood		
231	Type I: Major Depression	F32.8	Other depressive episodes Incl: Major Depression of infancy and early childhood
		F33.8	Other recurrent depressive disorders Incl: Major depression of infancy and early childhood, recurrent episodes
232	Type II: Depressive Disorder NOS	F32.9	Depressive episode, unspecified
240	Mixed Disorder of Emotional Expressiveness	F92.0	Depressive conduct disorder
		F92.8	Other mixed disorders of conduct and emotions
		F92.9	Mixed disorder of conduct and emotions, unspecified
		F93.8	Other childhood emotional disorders Incl: Mixed Disorder of Emotional Expressiveness of infancy and early childhood
		F93.9	Childhood emotional disorder, unspecified
300	Adjustment Disorder	F43.2	Adjustment disorders
400	Regulation Disorders of Sensory Processing		
		F88	Other Disorders of Psychological Development
410	Hypersensitive (see codes for subtypes)		
411	Type A: Fearful/Caution	F98.8	Other specified behavioural and emotional disorders with onset usually occurring in childhood and adolescence Incl: Hypersensitive Type A of infancy and early childhood Hypersensitive Tipo B of infancy and early childhood Hyposensitive/Underresponsive of infancy and early childhood Sensory Stimulation-Seeking/Impulsive of infancy and early childhood
412	Type B: Negative Defiant		
420	Hyposensitive/Underresponsive		
430	Sensory Stimulation-Seeking/Impulsive		
500	Sleep Behavior Disorder		
510	Sleep-Onset Disorder (Protodyssomnia)	F51.8	Other nonorganic sleep disorders Incl: Sleep-Onset Disorder (Protodyssomnia) of infancy and early childhood Night-Waking Disorder (Protodyssomnia) of infancy and early childhood
520	Night-Waking Disorder (Protodyssomnia)		
600	Feeding Behavior Disorder		
601	Feeding Disorders of State Regulation	F98.2	Feeding disorder of infancy and childhood Incl: Feeding Disorders of State Regulation Feeding Disorder of Caregiver-Infant Reciprocity Infantile Anorexia Sensory Food Aversions Feeding Disorder Associated with Concurrent Medical Condition Feeding Disorders Associated with Insults to the Gastrointestinal Tract
602	Feeding Disorder of Caregiver-Infant Reciprocity		
603	Infantile Anorexia		
604	Sensory Food Aversions		
605	Feeding Disorder Associated with Concurrent Medical Condition		
606	Feeding Disorders Associated with Insults to the Gastrointestinal Tract		
700	Disorders of Relating and Communicating		
		F84.0	Childhood autism
		F84.1	Atypical autism
		F84.2	Rett syndrome
		F84.3	Other childhood disintegrative disorder
		F84.4	Overactive disorder associated with mental retardation and stereotyped movements
		F84.5	Asperger syndrome
		F84.8	Other pervasive developmental disorders
		F84.9	Pervasive developmental disorder, unspecified
710	Multisystem Developmental Disorder (MSDD)		
		F89	Unspecified disorder of psychological development
800	Other Disorders (DSM-IV-TR or ICD-10)		Other mental health-related classification in ICD 10.

References

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(2)Frattura L., Bruno L. ICD-10 use in children psychiatry between old approaches and ICD-11. WHOFIC Annual Network meeting booklet 2016
(3)Minnesota DC:0-3 crosswalk to ICD codes. 2014-2015
(4)https://www.zerotothree.org/resources/1540-crosswalk-from-dc-0-5-to-dsm-5-and-icd-10

Aknowledgments

Working group

Emilia Romagna coordinator: Bruno Licia (AUSL BOLOGNA), ICD-10 consultant: Frattura Lucilla (IT WHOFIC CC)

Neuropsychiatrists: Catenio Tamara (AUSL PIACENZA), Dazzani Gloria (AUSL REGGIO EMILIA), Folegani Patrizia (AUSL FERRARA) Piantoni Alessandro (AUSL REGGIO EMILIA), Squarcia Antonella (AUSL PARMA), Tullini Andrea (AUSL DELLA ROMAGNA - RIMINI), Zucchini Elisabetta (AUSL IMOLA)

Psychologists: Busconi Chiaretta (AUSL PIACENZA), Fagioli Micaela (AUSL DELLA ROMAGNA - RIMINI), Impagliazzo Sandra (AUSL BOLOGNA), Piana Samanta (AUSL BOLOGNA), Rossi Angelica (AUSL DELLA ROMAGNA - RAVENNA), Scimeca Giuseppe (AUSL FERRARA), Ventimiglia Anna AUSL PARMA

ICD-10 coders' difficulties: "clinical manifestations and differential diagnosis" update proposals looking at ICD-11.

16-21 October 2017
Mexico City, Mexico

C419

Zavaroni C., Tonel P., Frattura L.
Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, IT WHO-FIC CC

Abstract In order to support the coders, Italian WHO-FIC CC submitted on the ICD-10 platform some proposals dealing with limitations and restrictions about the clinical manifestations in different organs and systems, and differential diagnosis among nosological entities. The proposals followed ICD-11 and considered the limited possibilities to extend ICD-10 codes.

Introduction

ICD-10 has limitations with regard to some nosological entities which it classifies. It is outdated because it is not able to make a differential diagnosis among certain similar nosological entities and it does not unravel the heterogeneity of the nosological entities that are classified under the same category. ICD-10 includes in the same sub-category nosological entities that are very different at the epidemiological, care, and resource absorption levels. Unfortunately, ICD-11 will be fully operational only in a decade. At international level we cannot wait ten years, because of the consequences at epidemiological, clinical, and health and social protection system levels, including resource absorption.

Methods & Materials

The update proposals follows:

a) ICD-11 Beta Draft classification [1];
b) formal international classifications of some nosological entities;
c) standardized (but not formal) classification systems of some nosological entities, universally accepted in the international scientific community;
d) state of the art on each issue.

Moreover, they consider the limited possibilities to extend ICD-10 codes [2] to completely follow ICD-11.

Results

The update proposals regarding clinical manifestations (e.g.: specified crisis of sickle-cell disease and compound heterozygous sickling disorders; sphingolipidosis; bone pathological fractures) and differential diagnosis (e.g.: disorders of consciousness; bone-marrow transplant rejection vs graft-versus-host reaction or disease) look at ICD-11 differentiations, subclassifications and definitions of some disorders. These update proposals are in line with the state of the art and consider the ongoing international debate and the continuous gradual refinements of the desease definitions. De facto, the conditions present in proposed updated classification structure require a different clinical and health and social protection approach and involve a different absorption of resources, in care and rehabilitation terms.

Figure 1 presents the Volume 3 update proposal about the clinical manifestations in different organs and systems of specified crisis of sickle-cell disease and compound heterozygous sickling disorders. It shows in blue font the introduction of new terms into the Alphabetical index.

Figure 1: Volume 3 update proposal about the clinical manifestations in different organs and systems: e.g. specified crisis of sickle-cell disease and compound heterozygous sickling disorders.

Sequestration – *see also* Sequestrum
- disk - *see* Displacement, intervertebral disk
- lung, congenital **Q33.2**
- splenic in
- - other sickle-cell disorders D57.80† **D77***
- - sickle-cell anemia **D57.0**† **D77***
- - sickle-cell thalassemia D57.20† **D77***

Syndrome – *see also* Disease
...
- acute abdominal **R10.0**
- acute chest syndrome in
- - other sickle-cell disorders D57.80† **J99.8***
- - sickle-cell anemia **D57.0**† **J99.8***
- - sickle-cell thalassemia D57.20† **J99.8***

Figure 2 illustrates the Volume 1 update proposal about differential diagnosis among disorders of consciousness. In particular, it compares the proposed changes (in blue font) with the pre-existing situation.

For other proposals please refer to the ICD update platform [3].

Conclusions

The achievement to update ICD-10 according to the state of the art would encourage and support appropriate epidemiological studies that can facilitate the identification of new treatments, the prevention of complications and comorbidities, and the planning and programming of health and social protection systems to meet the needs of a great number of people.

At international level we cannot wait ten years, the time likely to be needed for an operational use of ICD-11.

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1. The ICD-11 Beta Draft
http://apps.who.int/classifications/icd11/browse/f/en#/
http://apps.who.int/classifications/icd11/browse/l-m/en
2. WHO. ICD-10 "International statistical classification of diseases and related health problems - 10th revision". Fifth edition. Geneva, Switzerland, 2016
3. The ICD update platform
https://extranet.who.int/icdrevision/nr/login.aspx?ReturnUrl=%2Ficdrevision%2FDefault.aspx

Figure 2: Volume 1 update proposal about differential diagnosis between nosological entities: e.g. disorders of consciousness.

R40 **Somnolence, stupor and coma**
Excl.: coma:
- diabetic (**E10–E14** with common fourth character .0)
- hepatic (**K72.-**)
- hypoglycaemic (nondiabetic) (**E15**)
- neonatal (**P91.5**)
- uraemic (**N19**)

R40.0 **Somnolence**
Drowsiness

R40.1 **Stupor**
Semicoma
Excl.: stupor:
- catatonic (**F20.2**)
- depressive (**F31–F33**)
- dissociative (**F44.2**)
- manic (**F30.2**)

R40.2 **Coma, unspecified**
Unconsciousness NOS

R40.3 **Persistent vegetative state**

R40.4 **Permanent vegetative state**

R40.5 **Minimally conscious state**

R40.9 **Disorders of consciousness, unspecified**

[...]

G83.5 **Locked-in syndrome**

[...]

G93.8 **Other specified disorders of brain**
Postradiation encephalopathy
Use additional external cause code (Chapter XX), if desired, to identify cause.
The following supplementary subclassification to identify the type of other specified disorders of brain is provided for optional use with subcategory **G93.8**.
0 **Brain death**
8 **Other**

16-21 October 2017
Mexico City, Mexico

C501

The ICF update process: suggestions for improving outcomes.

Frattura L., Tonel P.
Central Health Directorate, Classification Area – Friuli Venezia Giulia Region
Italian WHOFIC CC – URC ICF Co-Chair and Secretariat

Abstract After the phase in which URC has processed ICF-CY proposals, and before entering a new phase, some needs should be analysed in order to make the ICF update process more efficient.

Introduction

After the phase in which URC has processed ICF-CY proposals (only 4 2010-2016 accepted proposals were new proposals), and before entering a new phase, we would like to briefly analyse 4 needs:

1. need to optimize the ICF update process lifecycle;
2. need to involve more people in proposing updates;
3. need to dedicate specific time during the year to make collaborative proposals;
4. need to prepare "comprehensive" ICF update proposals taking into account some priorities.

Main aim: to make the ICF update process more efficient.

Methods

We analysed how the process was implemented over the last years, considering the steps defined in the methodological document and the use of the update platform.

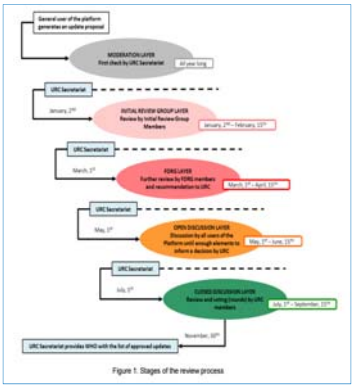
Results

People at work on the ICF Update Platform (1).
The current lists of Closed Groups in the ICF update platform are only two and are not updated. The URC list is not present (Figure 1).

Figure 1: List of Closed Groups

FDRG group
In the ICF Platform user guide it is explained that «after review by the IRG, the proposal is passed on to the second closed group, the FDRG. FDRG members further review and discuss the proposals and decide if there are enough review elements to move the proposals to the next layer. When possible, they express a recommendation (approval, rejection, approval with modification).
The group is coordinated by the FDRG co-chairs and its Secretariat, with the assistance of the IRG moderator(s)».

Figure 2: The ICF update process lifecycle



Initial review group (IRG)
In the ICF Platform user guide it is explained that IRG works in «the second layer of the platform, where the review work begins. Review is here carried out by a closed group of FDRG reviewers. The concept of closed group has been created to allow a selected group of experts to first review a proposal before opening it up to the general public». The list in ICF update platform is not updated and the criteria for creating the IRG group are not communicated in the ICF update process user guide.

URC members involvement
In the ICF Platform user guide it is explained that in the Closed Discussion layer «commenting on proposals is done only by URC members. A voting process with two or three rounds is used as a consensus building mechanism. This is the last step in the proposal review process on the platform».
In the current proposal lifecycle, the URC voting members are involved with a specific role in the Closed Discussion layer, starting their active involvement in July, but they are invisible to the users of the ICF update platform.

Proponents
Two WHO-FIC groups with more than 100 members, with some overlaps, could submit update proposals:
✓ FDRG: nearly 50 members;
✓ URC-ICF: nearly 50 members.

WHO-FIC network members who submitted proposals up to now are nearly 20%.

Proposals in the new phase (2017-)
In 2017, a new course has started. Update proposals dealing with the EF component have been submitted, as well as 'comprehensive' proposals, in which issues that affect more than one part of ICF are addressed.

Conclusions

Suggestions:
About the life cycle
1. Revise the timetable
2. Change some points on the Platform that refer to the ICD update process.
3. To make the process fully transparent, we need FDRG updated lists with respective role, comprising the co-chairs and Secretariat.
4. The current list of IRG members on the Platform has to be verified and updated. To make the process fully transparent, the criteria for selection of IRG members and IRG moderator(s) have to be made explicit in the ICF update process user guide. The moderator(s) could be shown in the IRG list.
5. The URC voting members need be present in the current closed groups lists, and the URC list should also include ICF URC Co-chair and Secretariat.
6. It would be suggestive to imagine:
   - ✓ collaborative (very small/small) groups made up of FDRG and URC members;
   - ✓ proposal "sessions" during the year, as the MRG does for updating ICD;
   - ✓ involving FDRG in proposing updates;
   - ✓ reduce the "inactive time" in the process.

About the content
Prepare "comprehensive" ICF update proposals taking into account some priorities that in the short term could be related to:
- ✓ the EF component;
- ✓ the BF component, taking into account the block of proposals submitted this year;
- ✓ the rejected proposals coming from ICF-CY.

Different ways and timing to analyse these proposals should be required.

References

(1) https://extranet.who.int/icfrevision/nr/loginICF.aspx
(2) URC report, 2017

ICF IMPLEMENTATION IN KYRGYZSTAN

16-21 October 2017
Mexico City, Mexico

Matilde Leonardi [1,2], Alexander Shoshmin [3,4], Kubanychbek Monolbaev [5], Chinara Ismatova [6]

[1] Fondazione IRCCS Neurological Institute Carlo Besta, Italy, [2] Italian WHO-FIC CC Research Branch, Italy, [3] Federal Scientific Center of Rehabilitation of the Disabled named after G.A. Albrecht, Russia, [4] Russian WHO-FIC CC, Russia, [5] WHO Country Office in Kyrgyzstan, Kyrgyzstan, [6] World Bank, Kyrgyzstan

C504

Abstract From 15 to 17 June 2016 WHO Regional Office for Europe organized a three day mission on ICF introduction and on disability issues to Kyrgyzstan. According to mission team recommendations trainings aimed at introducing ICF and its implementation in health and social care practices were conducted in March 2017.

Mission on Introduction of ICF in 2016

According to the request by the Ministry of Health and Ministry of Labor and Social Development of Kyrgyzstan WHO Regional Office for Europe organized a three day mission on the International Classification of Functioning, Disability and Health (ICF) and on disability issues from 15 to 17 June 2016 in order to support the reform of the disability assessment system. The Government planned to use the provisions of ICF in work with persons with disabilities and on disability issues.

The mission consisted of meetings at the Ministry of Labor and Social Development, the Ministry of Health, the National Statistics Committee, the Center of Medical and Social Expertise, visits to WHO Country Office, Project Office of the World Bank in Kyrgyzstan (project "Health and Social Protection"), rehabilitation organizations, and NGOs (Association of Persons with Disabilities, Association of Parents of Disabled Children and others).

During the workshops experts of the mission team, Dr Matilde Leonardi and Dr Alexander Shoshmin gave consultations on using the ICF in connection with the ratification of the Convention on the Rights of Persons with Disabilities, in disability statistics and in assessment of health of the nation, and in practices of health care, social protection, education, employment, and development of individual programs of rehabilitation (IPRs).

Drs Matilde Leonardi and Alexander Shoshmin

Mission Team Recommendations

The mission team recommended that the following activities are considered by the Ministry of Health and Ministry of Labor and Social Development and other appropriate Ministries and authorities in Kyrgyzstan.

• To map the national legislation to the ICF concept as the framework.

•To develop a system for cross-sectoral cooperation in rehabilitation.

•To conduct a survey of population health status using the ICF assessment tools to get an objective picture of disability in Kyrgyzstan.

•To implement an integrated national information system that contains ICD-10 and ICF for describing health conditions of citizens.

•To organize joint trainings for professionals who develop and implement IPRs (medical-social expertise, education, social protection, labor service, and the others) including all professionals working with children with disability and representatives of NGOs.

•To elaborate a procedure for development and implementation of IPRs based on ICF and a disabled person's opinion.

•To support a transition for disability evaluation that considers the ICF biopsychosocial model, so as to have a full picture of functioning of a person.

•To use the ICF-based criteria for disability assessment after learning the ICF for development, implementation and control IPRs.

•A specialist in rehabilitation, a psychologist and a social worker need to join a medical-social expertise commission for comprehensive multidisciplinary assessment of needs of in social support.

•To organize continuous ICF training for professionals in medical-social expertise.

Participants of the final meeting in Kyrgyzstan, June 2016

Trainings in 2017

In March 2017, in accordance with the recommendations by WHO mission team (2016) and the request by the Government of Kyrgyzstan Dr Alexander Shoshmin conducted trainings for two groups of professionals. Trainings were aimed at introducing ICF and its implementation in health and social care practices.

The first group consisted of 65 professionals from medical and social expertise commissions and regional health coordinators.

Heads of departments and leading specialists from the Ministry of Labour and Social Development, the Ministry of Health, Health Department of the city Bishkek, the Ministry of Education and Science, Fund of Compulsory Medical Insurance, State Agency for Local Self-Government and Interethnic Relations, UNICEF, and heads of a number of NGOs were trained in the second group.

After the training participants from of the latter one demonstrated higher results of knowledge, and agreed on further ways for cooperation.

Participants of the second training group in Kyrgyzstan, March 2017

Acknowledgements

The mission to Kyrgyzstan was organized by the Ministry of Health of Kyrgyzstan, Ministry of Labor and Social development of Kyrgyzstan, Project Office of the World Bank Project 'Health and Social Development', the WHO Regional Office for Europe, and the WHO Country Office in Kyrgyzstan.

Trainings were arranged by the WHO Country Office in Kyrgyzstan and Project Office of the World Bank Project 'Health and Social Development'.

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C506

The ICF water issue: analysis and proposals looking at SDGs and ICHI.

Frattura L.
Central Health Directorate, Classification Area – Friuli Venezia Giulia Region
Italian WHOFIC CC

Abstract Two 2017 ICF update proposals open a "water issue" inside the ICF that is very similar to a Pandora's box, which, once opened, asks for a lot of different decisions in many ICF EF parts. A lot of suggestions were found for improving the current classification of water in ICF and for making comments on the two 2017 proposals, in order to submit other new proposals and review some other ICF concepts linked to the "water issue". Here only the first set of options are presented.

Introduction

Since ICF publication in 2001 no updates have been made relative to Chapter 2 of the EF component. The ICF-CY, published in 2007, shows no changes in this Chapter compared to ICF (2001). For the first time, in 2016, a proposal was submitted regarding Chapter 2 of the EF component. The proposal was initially the addition of a new code for "water quality". The history of the proposal is summarized by the Author in the ICF update platform. In 2017, the revised proposal is currently under evaluation. At the same time, in 2017, we have another proposal for adding "drinking water" in Chapter 1 of the EF Component (1). Both the proposals open a "water issue" inside the ICF. The "ICF water issue" is very similar to a Pandora's box, which, once opened, asks for a lot of different decisions in many ICF EF parts.

Methods

Some policy sources published by WHO and UN around the «water issue» were considered, without any systematic ambition. Web pages of international bodies active on substainable environment were also considered (2-8). In order to harmoniously improve ICF, attention was paid to the classification coherence with regard to parent-child relationships and among different chapters (9). Relationships with ICHI were also considered with regard to the section of public health interventions. ICF was considered regarding the EF definition and the coding rules for facilitators and barriers. In particular, some sentences from page 171 of ICF were selected to guide the introduction of a new EF or the revision of the current ones.

Results

Different kinds of water exist and they could have a place in ICF. A first set of options are presented: **water is classified in the ICF EF Chapter 2, but where?**

Step 1: Review e210.
The proposed new code for water is e270. This is a very bottom position for a basic life element as water is.
The first place in which the current ICF speaks about water is in e2101. Considering the thesaurus of terms found in the above analysed documents, we need to distinguish freshwater. Where in ICF?
e210 Physical Geography is also affected by a problem regarding the title: Physical Geography is a science that studies the "physical features of the Earth".
To better describe water bodies in e210, we could also modify the parent code.

Step 2: A Freemind scheme and the concept of "resources"
A Freemind scheme was created, taking into account the ICF description of Chapter 2 of the EF component: " *This chapter is about animate and inanimate elements of the natural or physical environment…."*
It would be possible: (i) to introduce the construct of "natural elements and resources", as an intermediate step before distinguishing inanimate and animate resources (instead of inanimate and animate elements as it is written in the current – and original - ICF version); (ii) to define a hierarchy of the new concepts (Figure 1).

Step 3: Add the concept of "Earth water" (Earth's hydrosphere)
The UN glossary proposes the following definition: "Water quality refers to the physical, chemical, biological and organoleptic (taste-related) properties of water". It seems evident that the water properties define water. The term "properties" could substitute the term "characteristics" used in the proposal.

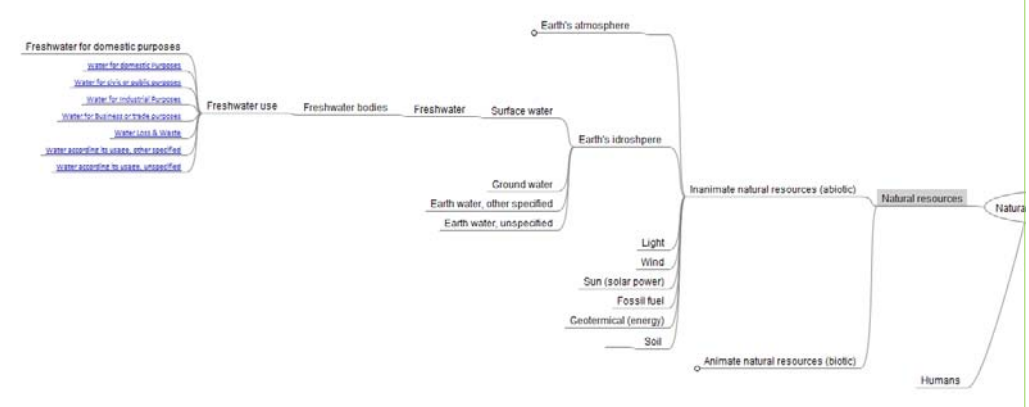
Step 4: Additional options
Some additional materials came from the new EU Water Framework Directive (WFD), just as an example of concepts that are around the "water quality". The WFD aims to solve the problems derived from the use of water, a limited natural resource, by extending the scope of protection to all water uses. It seems important to assess "water quality parameters" in order to distinguish water according to usage. For example, only after "water quality assessment" we can assure drinking water safety. The other aspect to consider is water quantity, and water supply quality assessment.

Step 5 : Specific additions to Chapter 5: Services, systems and policies as new targets for ICHI
e530 *Utilities services, systems and policies* is a very generic code, as usual in this chapter. The analysis about water suggests to add a specific code for freshwater sector, using terms and content provided by Agenda 21 and other reference policy documents on water. We could define parent and children as appropriate.

Conclusions

A lot of suggestions were found for improving the current classification of water in ICF and for making comments on the two proposals, in order to submit other new proposals and review some other ICF concepts linked to the "water issue". The possible updates would concern three different EF chapters: 1, 2, 5 (see a summary in the ICF update platform, Open Discussion layer, proposal ID 306).The study of these proposals required a lot of time and it will require time for discussion. A vis-a-vis meeting is not fit for such a study process. But we need such a study process for preparing, submitting, discussing and voting a valid update proposal.
Minimal changes could be made to the proposal ID 306 (and consequently to the proposal ID 307), taking into account that water quality is not a part (a subclass) of water. The characteristics of water define the water itself. The inclusions could become subclasses. The exclusion has to cite the code with its precise description. The same analysis would affect code e260 *Air quality*, which describes the characteristics of the atmosphere/air inside building, and proposal ID 307.

Figure 1: A Freemind scheme for the classification of water



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WHO - FAMILY OF INTERNATIONAL CLASSIFICATIONS NETWORK ANNUAL MEETING 2017

ICF AS A PLANNING TOOL FOR CHILDHOOD REHABILITATION IN Uttar Pradesh: a way through lights and shadows

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C508

Martinuzzi A*, Toldo M**, Animesh Manjhi**, Pawan Kushwaha**, Shikha Sharma**, Preeti Singh**.
*IRCCS Medea. Italian WHO-FIC collaborating Centre, Conegliano, Italy;
**Kiran Society, Madhopur, PO, Kuruhuan, Varanasi, UP, India.

Abstract

Objective: The biopsychosocial model embodied by the WHO International Classification of Health Interventions (ICF) offers many potential advantages when implemented in a rehabilitation setting, but its complexity and the departure from more usual approaches hinder its diffusion especially in low resource settings. A stepwise strategy was devised to test the feasibility of the introduction of ICF as master planner for the multiprofessional rehabilitation programs in a childhood rehabilitation Center in Varanasi.

Methods: Kiran Society is a centre for rehabilitation and education / vocational training of disabled children and youths. The primary school (nursery to 8th class) has an inclusive setting; it gives education and rehabilitation to children mainly affected by cerebral palsy and/or cognitive delay. The multi-professional team includes special educators, physio- and occupational therapists, a speech therapist, a clinical psychologist and a neurologist The introduction of ICF was planned as a medium term strategy (3 years) identifying three steps: information/training, pilot simplified testing using a well-established methodology (Martinuzzi et al 2013), evaluation and diffuse implementation. Nine professionals were directly involved in the plan. A mid-project check was carried on by reviewing the ICF based programs, completed on 23 children affected by cerebral palsy, and by probing the response of the involved professionals. Results: The implementation plan was well received by all participants and ICF identified as a tool easing communication and transparent connection between needs and interventions. Use of the ICF components was appropriate but environmental influence was sometimes underreported. Use of the qualifiers in A&P still poses the harder challenge. Conclusions: Stepwise introduction of ICF in a multi-professional setting requires careful medium term planning and monitoring but has the potentiality to greatly improve rehabilitation efficiency and team cohesion.

Introduction

After the its approval and even more after the publishing of the -CY version was in 2007, ICF use has been reported in various sectors, exploring the strengths and challenges associated with its comprehensive and powerful framework. However, its complexity and the departure from more usual approaches has hindered its diffusion, especially in low resource settings. Positive experiences have been reported implementing an original methodology in the use ICF as a framework to plan a rehabilitation project and program in order to describe and quantify the needs to be targeted by rehabilitation team in a neuropaediatric hospital setting. Rehabilitation project was used to plan the medium to long term goals and to identify relevant environmental modulators. The rehab program details the implementation plan of the project. The introduction of ICF was felt important in Kiran Society, a childhood rehabilitation center in Varanasi (India), so as to improve the dialogue, mutual understanding and integrated team work among professionals and intervention effectiveness, by assuming a common language and a shared rehabilitation program. A stepwise strategy was devised based on the approach and methodology used in the study conducted by Martinuzzi et al. considering the factors applied in low resource settings. Therefore, the aim of the study was to test the feasibility of the introduction of ICF as a master planner for the multi-professional rehabilitation programs in low resource settings.

Methods & Materials

Kiran Society is a centre for rehabilitation and education / vocational training of disabled children and youths. The primary school (nursery to 8th class) has an inclusive setting; it gives education and rehabilitation to children mainly affected by cerebral palsy and/or cognitive – speech delay. The multi-professional team includes special educators, physical and occupational therapists, a speech therapist, a clinical psychologist and a neurologist. The introduction of ICF was planned as a medium term strategy (3 years) identifying three steps: information/training, pilot simplified testing using a well-established methodology (Martinuzzi 2013), evaluation and diffuse implementation.

A mid-project check was carried on by reviewing the ICF based programs, completed on 26 children affected by cerebral palsy, and by probing the response of the involved professionals.

Nine professionals were directly involved in the plan. Four of them underwent a week-long basic training on ICF organized by WHO's Indian Collaborative Centre for ICF-ICD at Lucknow (India) in Nov 2016. This step was followed in Feb. 2017 by a practical introduction to categorization and coding rules by Dr. Toldo (using teaching material provided by the Italian WHO-FIC CC). In April 2017 the first assessment of 26 CP children was performed using ICF framework. In June 2017 all the projects-programs were revised after the first functional assessment using ICF language and categories. At the end of the first functional assessment and after the framing of the rehabilitation project/program, in July and August 2017, the nine professionals had focused sharing and discussion meetings regarding the difficulties encountered, solutions applied, and persistent issues in the implementation of the ICF concept framework. Then, to quantify the pros and cons of the new methodology, they filled up an individual questionnaire with Likert grading of 1 to 5 (1 for "not at all' and 5 for "completely").

Cerebral Palsy Sub classification		Age (mean, yrs)	Male/Female
Diplegic	13	11.2 (range 6-16)	19/7
Quadriplegic	7		
Hemiplegic	2		
Dystonic	4		

Chart 1: The demographic and diagnostic details of the patients

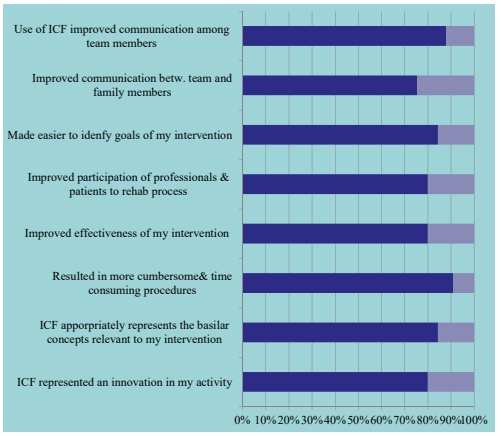

Fig 1: Results of the questionnaires filled up by team professionals

Results

The implementation plan was well received by all participants and ICF identified as a tool easing communication and transparent connection between needs and interventions. Use of the ICF components was appropriate but environmental influence was sometimes underreported. Use of the qualifiers in A&P still poses the harder challenge.

Communication between team and families/ children was improved, but we expect further improvement by virtue of the empowered relation among them.

At present, the only negative aspect reported by all professionals has been increased time consumption in coding and filling up files. However, knowing that this drawback has been common to all centers at the beginning of ICF implementation and has been solved by the following increased acquaintance with the procedures, we are confident that the same will occur with our team.

Conclusions

Stepwise introduction of ICF in a multi-professional setting requires careful medium term planning and monitoring but has the potentiality to greatly improve rehabilitation efficiency and team cohesion. No specific difficulties are found in low- resource setting compared to what has been reported in secondary and tertiary care centers of high resource Countries.

In the coming clinical follow-ups we shall use a similar questionnaire to evaluate the changed level of satisfaction felt by parents after introduction of ICF.

References

Martinuzzi A et al. Implementation of an ICF-base project/program in a pediatric neuro-rehabilitation hospital: follow-up evaluation by stakeholders; Disability and Rehabilitation, 2013 35(13):1059-1064

Disability determination using WHODAS 2.0 and ICF: first results

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C525

Frattura L., Morassutto C.
Central Health Directorate, Classification Area – Friuli Venezia Giulia Region
Italian WHO-FIC CC

Abstract WHO has developed ICF and WHODAS 2.0 in order to describe and measure functioning and disability. No agreement exists on how group persons according to the WHODAS 2.0 score and the WHODAS does not correspond to an ICF core set. The aim was to verify the consistency of the scores calculated by using WHODAS 2.0,36 items and a derived WHODAS-based ICF core set in a sample population useful in disability determination.

Introduction

WHODAS 2.0 domains refer to the Activity and Participation (AP) component of ICF, but do not make explicit that the questions are about the performance.

No agreement exists on how group persons according to the WHODAS 2.0 score.

The WHODAS does not correspond to an ICF core set; it is not an ICF database and it does not produce a functioning profile.

The aim was to verify the consistency of the scores calculated by using WHODAS 2.0, 36 items and a derived WHODAS-based ICF core set in a sample population.

Methods & Materials

1. 36 questions of WHODAS 2.0 were mapped to ICF second-level categories; an ICF core set with 27 AP categories was created, corresponding to 27 WHODAS questions (Table 1).
2. A web application was created to code the 27 ICF-mapped WHODAS 2.0 questions/answers into ICF (AP category.performance qualifier).
3. The WHODAS syntax for automatic computation of overall score using SPSS was used.
4. A syntax for automatic computation of overall ICF score using SPSS was created.
5. Five severity ranges were created following the ICF (no disability, 0 to 4; mild disability, 5 to 24; moderate disability, 25 to 49; severe, 50 to 95; and extreme disability, 96 to 100).
6. 109 persons were recruited: 62.4% were males, 15.6% were less than 18 years old, 65.1% had a mental disorder (ICD 9-CM codes 290-319).
7. Spearman's rank correlation rho was calculated.
8. The agreement between the WHODAS score and the WHODAS-based ICF core set score was quantified by using Altman and Bland analysis.[2,3]

Table 1: WHODAS 2.0, 36 items over six domains with the corresponding ICF codes

WHODAS 2.0 DOMAIN	WHODAS 2.0 QUESTION	ICF CODE ACCORDING TO WHO (1)	ICF CODE ACCORDING TO THE ITALIAN WHOFIC CC
1: Cognition	**In the last 30 days, how much difficulty did you have in:**		
1.1	Concentrating on doing something for 10 minutes	d160 focusing attention; b140 attention functions; d110-d129 purposeful sensory experiences	d161 directing attention
1.2	Remembering to do important things	b144 memory functions	d230 carrying out daily routine
1.3	Analysing and finding solutions to problems in day to day life	d175 solving problems; d130-d159 basic learning	d175 solving problems
1.4	Learning a new task, for example, learning how to get to a new place	d1551 acquiring complex skills	d155 acquiring skills
1.5	Generally understanding what people say	d310 communicating with – receiving – spoken messages	d310 communicating with - receiving - spoken messages
1.6	Starting and maintaining a conversation	d3500 starting a conversation; d3501 sustaining a conversation	d350 conversation
2: Mobility	**In the last 30 days, how much difficulty did you have in:**		
2.1	Standing for long periods such as 30 minutes	d4154 maintaining a standing position	d415 maintaining a body position
2.2	Standing up from sitting down	d4104 standing	d410 changing basic body position
2.3	Moving around inside your home	d4600 moving around within the home	d460 moving around in different locations
2.4	Getting out your home	d4602 moving around outside the home and other buildings	-
2.5	Walking a long distance such as a kilometer (or equivalent)	d4501 walking long distances	d450 walking
3: Self-care	**In the last 30 days, how much difficulty did you have in:**		
3.1	Washing your whole body	d5101 washing whole body	d510 washing oneself
3.2	Getting dressed	d540 dressing	d540 dressing
3.3	eating	d550 eating	d550 eating; d560 drinking
3.4	Staying by yourself for a few days	d510-d650 combination of multiple self – care and domestic life tasks	d571 looking after one's safety
4: Getting along	**In the last 30 days, how much difficulty did you have in:**		
4.1	Dealing with people you do not know	d730 relating with strangers	d730 relating with strangers
4.2	Maintaining a friendship	d7500 informal relationship with friends	d750 informal social relationships
4.3	Getting along with people who are close to you	d760 family relationships; d770 intimate relationships; d750 informal social relationships	d760 family relationships
4.4	Making new friends	d7500 informal relationships with friends; d7200 forming relationships	d750 informal social relationships
4.5	Sexual activities	d7702 sexual relationships	d770 intimate relationships
5: Life activities	**In the last 30 days, how much difficulty did you have in:**		
5.1	Taking care of your household responsibilities	d6 domestic life	d650 caring for household objects; d660 assisting others
5.2	Doing must important household tasks well	d640 doing housework; d210 undertaking a single task; d220 undertaking multiple tasks	d640 doing housework
5.3	Getting all the household work done that you needed to do	d640 doing housework; d210 undertaking a single task; d220 undertaking multiple tasks	-
5.4	Getting household work done as quickly as needed	d640 doing housework; d210 undertaking a single task; d220 undertaking multiple tasks	-
5.5	Your day-to-day work/school	d850 remunerative employment; d830 higher education; d825 vocational training; d820 school education	d815 preschool education ;D820 school education; d825 vocational training; d830 higher education; d850 remunerative employment
5.6	Doing your must important work/school tasks well	d850 remunerative employment; d830 higher education; d825 vocational training; d820 school education; d210 undertaking a single task; d220 undertaking multiple tasks	-
5.7	Getting done all the work that you needed to do	d850 remunerative employment; d830 higher education; d825 vocational training; d820 school education; d210 undertaking a single task; d220 undertaking multiple tasks	-
5.8	Getting your work done as quickly as needed	d850 remunerative employment; d830 higher education; d825 vocational training; d820 school education; d210 undertaking a single task; d220 undertaking multiple tasks	-
6: Participation	**How much of a problem do you have**		
6.1	Joining in community activities	d910 community life	d910 community life
6.2	Because of barriers or hindrances in the world	d9 community, social and civic life	-
6.3	Living with dignity	d940 human rights	d940 human rights
6.4	From time spent on health condition	Not applicable (impact question)	d570 looking after one's health
6.5	Feeling emotionally affected	b152 emotional functions	-
6.6	Because health is a drain on your financial resources	d8700 personal economic resources	d870 economic self-sufficiency
6.7	With your family facing difficulties due to your health	Not applicable (impact question)	-
6.8	Doing things for relaxation or pleasure by yourself	d920 recreation and leisure	d920 recreation and leisure

Figure 1: Spearman's rank correlation

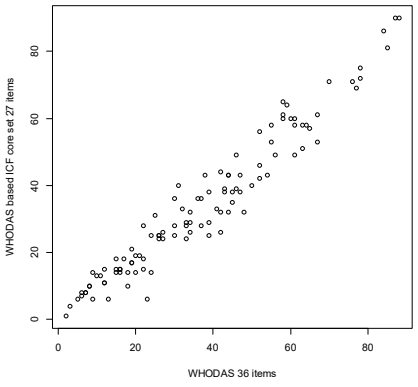
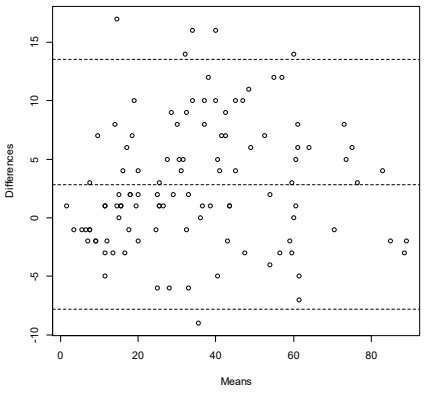


Figure 2: Bland Altman plot



Results

The correlation between the two scores was very strong (rho=0.96188, p-value<2.2e-16) (Figure 1). The level of the agreement between the two scores was very high (Figure 2).

Conclusions

The WHODAS 2.0, 36 items score and the WHODAS-based ICF core set, 27 items score provide the same information.

27 WHODAS questions mapped to ICF AP categories seem sufficient to generate a valid score useful to distinguish five severity classes.

This new WHODAS-ICF method may be useful in the disability determination process.

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Environmental factors in disability assessment: how to combine WHODAS and ICF.

Frattura L., Morassutto C.
Central Health Directorate, Classification Area, Friuli Venezia Giulia Region, Italian WHO-FIC CC

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C526

Abstract EFs were analysed in an Italian sample interviewed with the WHODAS 2.0, 36 items mapped to 27 ICF Activities and Participation categories. The aim of this contribution is to present some preliminary results.

Introduction

WHO has developed ICF and WHODAS 2.0 in order to describe and measure functioning and disability.
WHODAS 2.0 domains refer to the Activities and Participation (AP) component of ICF, but do not make explicit the type and number of Environmental Factors (EFs) that the respondent should take into consideration to point out the difficulties experienced in the last 30 days.
EFs were analysed in an Italian sample interviewed with the WHODAS 2.0, 36 items mapped to 27 ICF AP categories. The aim of this contribution is to present some preliminary results.

Methods & Materials

1. 36 questions of WHODAS 2.0 were mapped to ICF second-level categories; an ICF core set with 27 AP categories was created, corresponding to 27 WHODAS questions (1).
2. A web application was created to code the 27 ICF-mapped WHODAS 2.0 questions/answers into ICF (AP category.performance qualifier).
3. Disability scores were calculated using the syntax provided by the WHODAS 2.0 Manual and a new syntax developed by one of the Author (CM); five disability classes were defined following the ICF severity ranges (2,3) (no disability, 0 to 4; mild disability, 5 to 24; moderate disability, 25 to 49; severe disability, 50 to 95; extreme disability, 96 to 100).
4. EFs were investigated by adding four specific questions to each ICF-mapped WHODAS question. The four additional questions asked about the facilitator/barrier role of (i) support and relationships, (ii) products and technology used by the person, (iii) social and welfare services and (iv) health services used by the person in the previous 30 days (Table 1).
5. The distribution of the EFs as facilitators and barriers for each ICF-mapped WHODAS question was calculated.
6. The distribution of the EFs for each disability class was calculated.

Results

109 persons were interviewed using WHODAS 2.0, 36 items: 62.4% were males, 15.6% were less than 18 years old and 65.1% had a mental disorder (ICD 9-CM Chapter V codes 290-319) (Table 2).

Four groups were described according to the disability scores (no one showed extreme disability).

The EFs were present in all groups.

Support and relationships was the most frequent EFs, followed by the products and technology (Figure 1).

Ninety percent of the EFs considered were facilitators (Figure 2).

Table 1: EFs groups

ENVIRONMENTAL FACTORS
Health services, systems and policies
e580 - Health services, systems and policies
Services, systems and policies
e525 - Housing services, systems and policies
e555 - Associations and organizational services, systems and policies
e570 - Social security services, systems and policies
e575 - General social support services, systems and policies
e585 - Education and training services, systems and policies
e590 - Labour and employment services, systems and policies
Support and relationships
e310 - Immediate family
e315 - Extended family
e320 - Friends
e325 - Acquaintances, peers colleagues, neighbours and community members
e330 - People in positions of authority
e335 - People in subordinate positions
e340 - Personal care provoders and personal assistants
e350 - Domesticated animals
e355 - Health professionals
e360 - Other professionals
Products and technology
e110 - Products or substances for personal consumption
e115 - Products and technology for personal use in daily living
e120 - Products and technology for personal indoor and outdoor mobility and transportation
e125 - Products and technology for communication
e130 - Products and technology for education
e140 - Products and technology for culture, recreation and sport
e150 - Design, construction and building products and technology of buildings for public use
e155 - Design, construction and building products and technology of buildings for private use
e165 - Assets

Table 2: Some characteristics of the sample by disability class

Demographic characteristics (n=109)		Severity categories				
		No disability	Mild	Moderate	Severe	Total
Gender	Male	1 (1%)	20 (29%)	31 (46%)	16 (24%)	68
	Female	1 (2%)	17 (41%)	14 (34%)	9 (22%)	41
Age	<18	-	3 (18%)	6 (35%)	8 (47%)	17
	≥18	2 (2%)	34 (37%)	39 (42%)	17 (18%)	92
Disease	Mental	2 (3%)	34 (48%)	28 (39%)	7 (10%)	71
	Other	-	3 (8%)	17 (45%)	18 (47%)	38

Figure 1: Distribution of the EFs groups for each disability class

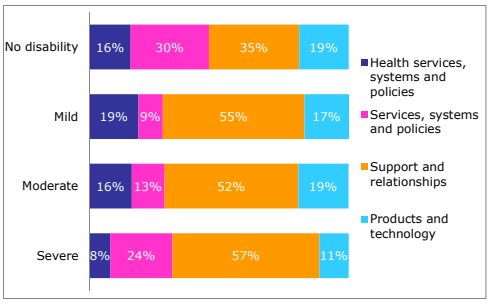
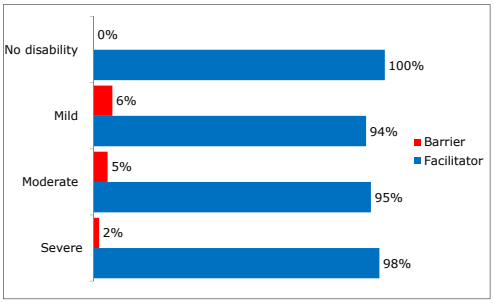


Figure 2: Distribution of facilitators and barriers for each disability class



Conclusions

Investigation of the role of EFs allows to look at the persons with disabilities in a different light.

The role of several EFs in the 27 ICF-mapped WHODAS activities showed that severe disability exists in the presence of facilitators.

This allows to redefine persons with disability as persons with insufficient facilitators with respect to their needs.

On the other hand, in our sample, persons without disability used a lot of EFs facilitators.

In this case the absence of disability should be linked to the availability of "sufficient" facilitators with respect to their needs.

References

(1) Frattura L., Morassutto C. Disability determination using WHODAS 2.0 and ICF: first results. WHOFIC Network Annual Meeting 2017
(2) Murray Weeks et al., Can J Psychiatry. 2016: 61 (1 Suppl.): 56S-63S
(3) Wen-Chou Chi et al., Int. J. Environ. Res. Public Health 2014, 11(12):12148-61

Comparison between two different ways to calculate disability scores using WHODAS 2.0 and ICF: impact on the disability prevalence.

16-21 October 2017
Mexico City, Mexico

C529

Frattura L., Morassutto C.
Central Health Directorate, Classification Area – Friuli Venezia Giulia Region
Italian WHOFIC CC

Abstract To compare two different ways to calculate disability scores and to group assessed persons for decision-making purposes using WHODAS 2.0 and ICF.

Introduction

The aim is to compare two different ways to calculate disability scores and to group assessed persons for decision-making purposes using WHODAS 2.0 and ICF.

Methods & Materials

1. 36 questions of WHODAS 2.0 were mapped to ICF second-level categories; an ICF core set with 27 Activities and Participation (AP) categories was created, related to 27 WHODAS questions.
2. A web application was created (VilmaFABER system) to code the 27 ICF-mapped WHODAS 2.0 questions/answers into ICF (AP category.performance qualifier).
3. Disability scores were calculated using the syntax provided by the WHODAS 2.0 Manual and a new syntax developed by one of the Author (CM); five disability classes were defined following the ICF severity ranges (no disability, 0-4; mild disability, 5-24; moderate disability, 25-49; severe disability, 50-95; extreme disability, 96-100) (1).
4. For each question, EFs were explored by adding four specific questions to each ICF-mapped WHODAS question. The four additional questions asked about the facilitator/barrier role of (i) support and relationships, (ii) products and technology used by the person, (iii) social and welfare services and (iv) health services used by the person in the previous 30 days.
5. Disability scores were automatically calculated using algorithms which took into account the presence of EFs and the performance qualifier value.
6. A new disability indicator, Cumulative Disability Ratio (CDR), was developed (Figure 1) (2).
7. Eight classes of disability were created according to the CDR value.
8. To each CDR class corresponded a specific VilmaFABER EcoLabel.
9. A field test was carried out in a sample of 109 outpatients.
10. The agreement between the WHODAS-based ICF core set score and CDR was quantified by using the Altman and Bland analysis.
11. The distribution of the sample according to the two different ways to calculate disability scores was analysed.

Results

The two scores had a high degree of agreement (Figg 1, 2). 41% per cent of the sample showed moderate disability according the WHODAS-based ICF core set score; 36% of the sample showed very few problems in interaction with the EFs (from no problems to mild problems in interaction with the EFs) according to CDR (Table 1). The CDR score allowed a greater differentiation of the disability levels. The outpatients that fell into the moderate disability class with the WHODAS-based ICF core set score were distributed over 6 different disability classes when using the CDR value score.

Figure 1: Functioning Ratio and Disability Ratio for ICF Activities and Participation component: an example

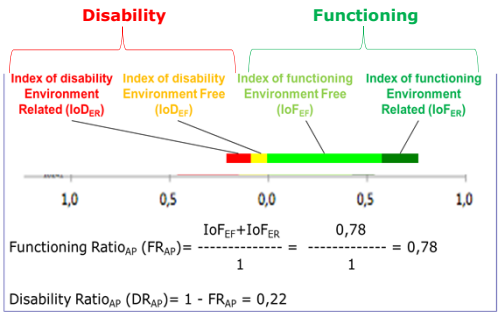


Figure 2: Spearman's rank correlation

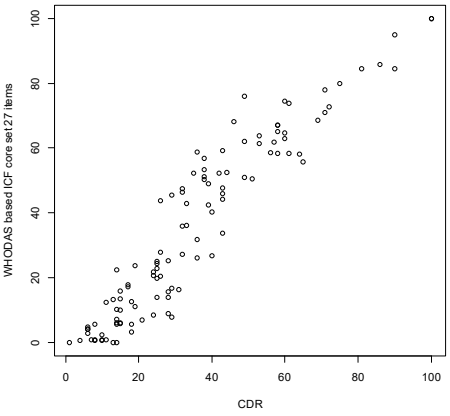


Figure 3: Bland Altman plot

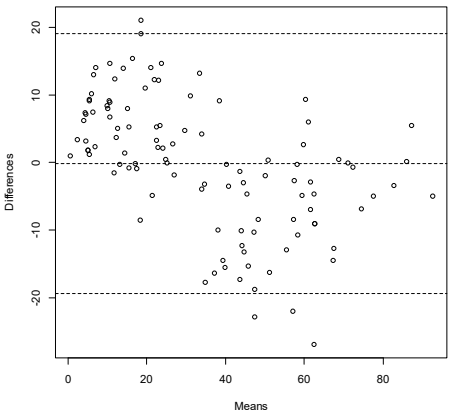


Table 1: Distribution of the sample by CDR and disability classes

CDR	Ecolabel VilmaFABER	WHODAS based ICF core set, 27 items					
		No disability (0 – 4)	Mild (5 – 24)	Moderate (25 – 49)	Severe (50 - 95)	Complete (96 – 100)	Total
0		1	2	0	0	0	3
1 - 14		1	28	4	0	0	33
15 - 29		0	7	13	0	0	20
30 - 45		0	0	9	0	0	9
46 - 60		0	0	16	6	0	22
61 - 75		0	0	2	13	0	15
76 - 90		0	0	1	5	0	6
91 - 100		0	0	0	1	2	3
Total		2	37	45	25	2	111

Conclusions

Different ways to investigate disability and to calculate disability impact on the disability prevalence and on the eligibility criteria. WHODAS-based ICF scores seem less specific than CDR.

References

(1) Frattura L., Morassutto C. Disability determination using WHODAS and ICF: first results. WHOFIC Network annual meeting 2017
(2) Frattura L., Simoncello A., Castelpietra G., Bassi G. The infographic Family of Functioning Indicators (FaFI). WHOFIC Network Annual meeting booklet 2015

The ICHI Platform

16-21 October 2017
Mexico City, Mexico

C602

Authors: M.Donada[1], M.Cumerlato[2], N.Rankin[2], V.Della Mea[1], R.Madden[2]
1 University of Udine and Italian WHO-FIC Collaborating Centre, Udine, Italy
2 University of Sydney, Australia

Abstract After one year of redesign and development, the ICHI platform now allows for maintenance and update of the International Classification of Health Interventions. The present poster illustrates the new features of this web-based system, with a snapshot of how it is has been used to produce the ICHI 2017 Beta release.

Introduction

The International Classification of Health Interventions (ICHI) has been initially available on the experimental ICHI browser, developed at the University of Udine, Italy. In the last year, a joint effort of the Australian, Chinese and Italian Collaborating centres contributed to an upgrade of the web-based browser to full platform functionalities, allowing its use not only for browsing, but also for updating and maintaining the classification.
The present poster visually introduces the new functionalities, with a summary of their usage at September 2017.

New features

Among the new features of the ICHI platform, it is worth mentioning the following functions now available:

- **Entity editing**: interventions can be created, modified and retired from within the platform;
- **Axes editing**: axis entities can be edited in a similar fashion as the interventions;
- **Comment management**: while comments were already present in the browser, now they can be better exploited to drive the classification update;
- **Privilege management**: different features are available to anonymous users, registered users and editors;
- **Versioning**: multiple releases are hosted in the system and can be independently browsed.
- **History management**: connected to the versioning system, it is possible to see how an entity has evolved over time (creation, modifications, etc);
- **URI identifiers**: the system has been designed to exploit the URI scheme currently used for identifying entities in ICD-11. This will further open to an URI based API for programmatically accessing ICHI;
- **Secure access**: the ICHI platform is now accessible through the HTTPS secure protocol.

The ICHI platform is available at the address:
https://mitel.dimi.uniud.it/ichi/

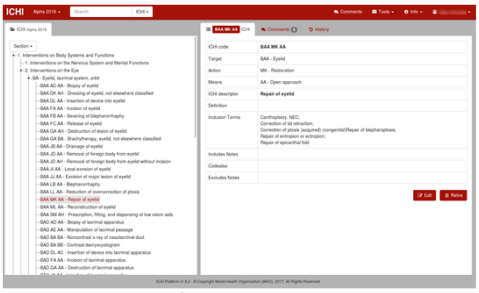


Figure 1 – main browser

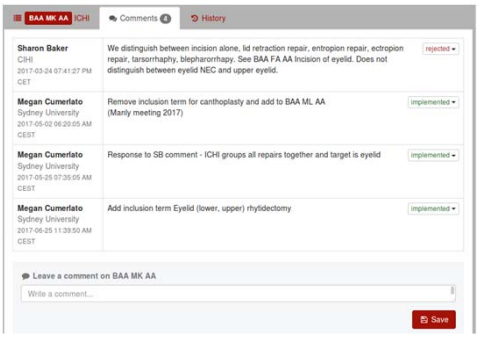


Figure 2 – code comments

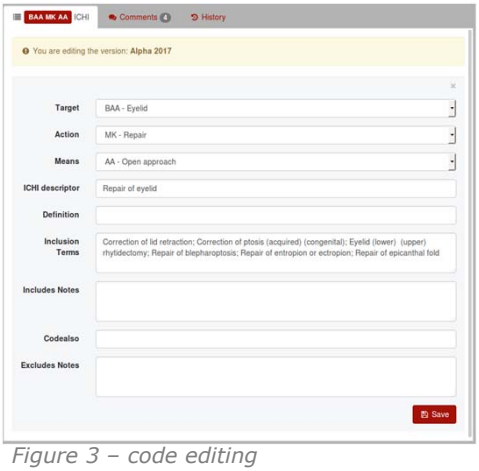


Figure 3 – code editing

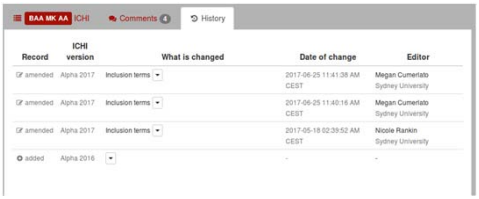


Figure 4 – code history

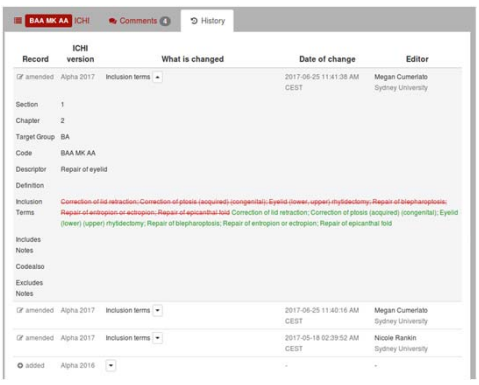


Figure 5 – history detail

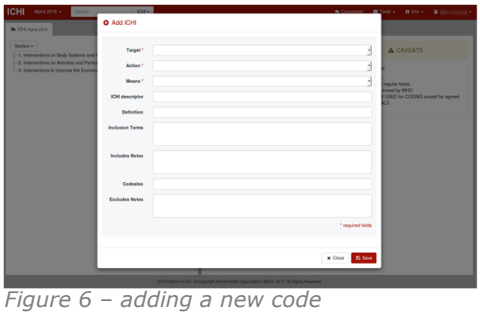


Figure 6 – adding a new code

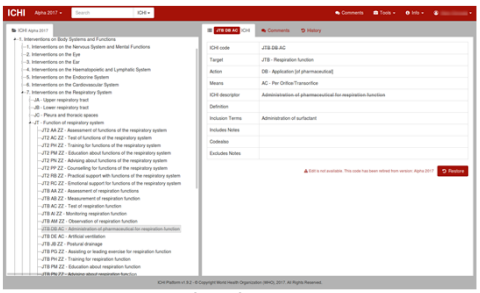


Figure 7 – retired code

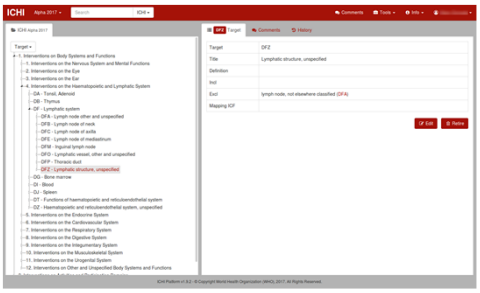


Figure 8 – axis entity

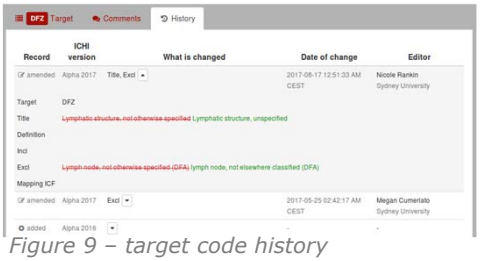


Figure 9 – target code history

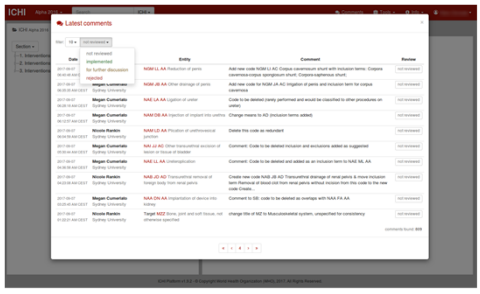


Figure 10 – latest comments by status

Usage data

At the time of writing and starting from the FDC meeting (6/2017), 76 users have registered to the ICHI platform, and contributed to updating ICHI by means of 2822 comments. As a consequence, a total of 1742 changes have been recorded in the history.

WHO - FAMILY OF INTERNATIONAL CLASSIFICATIONS NETWORK ANNUAL MEETING 2017

The WHO-FIC as a tool to monitor and promote Universal Health Coverage (UHC).

16-21 October 2017
Mexico City, Mexico

Martinuzzi A*, Hanmer L^, Macpherson B°, Jakob R~

C701

*Italian Collaborating Centre-E. Medea Research Branch, FDC Co-chair
^South Africa Medical Research Council and WHO-FIC Collaborating Centre South Africa, FDC Co-Chair
°Australian Institute for Health and Welfare and Australian Collaborating Centre, FDC Secretariat
~World Health Organization, Data Standards and Informatics, FDC Liaison Officer.

Abstract UHC is just one of the 13 targets of SDG3 (healthy lives and well-being for all at all ages) but it seems to be the real engine that could propel the achievement of the other set targets. Moving towards UHC should thus be a priority for member states but the path, given the wide heterogeneity of health service organization and delivery across the WHO regions, is not simple nor uniform. Careful and timely monitoring is thus of paramount importance to map the starting situation and check progress of both processes (outputs) and outcomes. To this end the WHO-FIC jointly used may represent the best available standard.

The FDC has been exploring since 2015 how to best use the WHO-FIC to monitor UHC. The development of ICHI, the last member of the WHO-FIC core classifications, in this perspective represents the ideal complement enabling the precise reporting of delivered and available services, as well as the accounting of public health initiatives. The one to one mapping exercise started in 2016 with the generic targets of SDG3 can now be expanded to cover the 100 Core health indicators, offering a selected array of categories from the three core (reference) classifications: ICD, ICF and ICHI.

Introduction

The shift in 2015 from the Millennium Development Goals 2000-2015 to the Sustainable Development Goals 2015-2030 has been paralleled by a focused attention not on specific diseases but on the whole system, as a means to achieve better health for all at all ages (SDG3). Such shift of attention explains why Universal Health Coverage (UHC), being one of the 13 targets of SDG3, has the potential to be the actual driver for the whole SDG3 agenda.

Quality, full access, full coverage, financial risk protection, equitability, resilience and accountability are all elements that characterize UHC and will assure its sustainability. These determinants, however, need to be measured and monitored.

Monitoring the path towards the achievement of each target has been emphasized by the WHA as a cardinal activity to assure that progress is made in the right direction. The monitoring activities are responsibility of each Country, but the comparability is essential to allow proper global analysis especially in the health sector, where interdependence and intersectorial links are pervasive.

Many of the available sources provide low quality data towards the 42 health related indicators (HRI) and the 100 Core Health Related Indicators (CHRI) chosen to monitor SDG3 (World Health Statistics 2017). The suite of classifications making the WHO-FIC have the scientific basis and the statistical power to work as monitoring tools for UHC, improving data quality and assuring global comparability.

Methods & Materials

Hypothesizing the joint use of the three reference classifications to track each of the 100 CHRI's as they are grouped into 4 clusters, we tentatively assigned the appropriate tool/s for monitoring each CHRI.

Results

Table 1: List of CHRIs with the indication of the WHO-FIC reference classification most appropriate for monitoring

		100 CORE HEALTH INDICATORS	WHO-FIC ICD	ICF	ICHI	OTHERs
Health status indicators	Mortality by age and sex	Life expectancy at birth	X			
		Adult mortality rate between 15 and 60 years of age	X			
		Under-five mortality rate	X			
		Infant mortality rate	X			
		Neonatal mortality rate	X			
		Stillbirth rate	X			
	Mortality by cause	Maternal mortality ratio	X			
		TB mortality rate	X			
		AIDS-related mortality rate	X			
		Malaria mortality rate	X			
		Mortality between 30 and 70 years of age from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases	X			
		Suicide rate	X			
		Mortality rate from road traffic injuries	X			
	Fertility	Adolescent fertility rate		X		
		Total fertility rate		X		
	Morbidity	New cases of vaccine-preventable diseases	X			
		New cases of IHR-notifiable diseases and other notifiable diseases	X			
		HIV incidence rate	X			
		HIV prevalence rate	X			
		Hepatitis B surface antigen prevalence	X		X	
		Sexually transmitted infections (STIs) incidence rate	X			
		TB incidence rate	X			
		TB notification rate			X	
		TB prevalence rate	X			
		Malaria parasite prevalence among children aged 6–59 months	X			
		Malaria incidence rate	X			
		Cancer incidence, by type of cancer	X			
Risk factors indicators	Nutrition	Exclusive breastfeeding rate 0–5 months of age		X	X	
		Early initiation of breastfeeding			X	
		Incidence of low birth weight among newborns	X	X		
		Children under 5 years who are stunted	X	X		
		Children under 5 years who are wasted	X	X		
		Anaemia prevalence in children	X	X		
		Anaemia prevalence in women of reproductive age	X	X		
	Infections	Condom use at last sex with high-risk partner		X	X	
	Environmental risk factors	Population using safely managed drinking-water services		X	X	
		Population using safely managed sanitation services		X	X	
		Population using modern fuels for cooking/heating/lighting		X	X	
		Air pollution level in cities		X	X	
	Noncommunicable diseases	Total alcohol per capita (age 15+ years) consumption	X	X		
		Tobacco use among persons aged 18+ years		X		
		Children aged under 5 years who are overweight	X	X		
		Overweight and obesity in adults (Also: adolescents)	X	X		
		Raised blood pressure among adults	X	X		
		Raised blood glucose/diabetes among adults	X	X		
		Salt intake		X		
		Insufficient physical activity in adults (Also: adolescents)		X		
	Injuries	Intimate partner violence prevalence		X		
Service coverage indicators	Reproductive, maternal, newborn, child and adolescent	Demand for family planning satisfied with modern methods			X	
		Contraceptive prevalence rate	X	X	X	
		Antenatal care coverage	X		X	
		Births attended by skilled health personnel	X		X	
		Postpartum care coverage	X		X	
		Care-seeking for symptoms of pneumonia	X	X	X	
		Children with diarrhoea receiving oral rehydration solution (ORS)	X		X	
		Vitamin A supplementation coverage			X	
	Immunization	Immunization coverage rate by vaccine for each vaccine in the national schedule			X	
	HIV	People living with HIV who have been diagnosed	X			
		Prevention of mother-to-child transmission	X		X	
		HIV care coverage	X		X	
		Antiretroviral therapy (ART) coverage	X		X	
		HIV viral load suppression	X			
	HIV/TB	TB preventive therapy for HIV-positive people newly enrolled in HIV care	X		X	
		HIV test results for registered new and relapse TB patients	X		X	
		HIV-positive new and relapse TB patients on ART during TB treatment	X		X	
	Tuberculosis	TB patients with results for drug susceptibility testing	X			
		TB case detection rate	X		X	
		Second-line treatment coverage among multidrug-resistant tuberculosis (MDR-TB) cases	X		X	
	Malaria	Intermittent preventive therapy for malaria during pregnancy (IPTp)	X		X	
		Use of insecticide treated nets (ITNs)			X	
		Treatment of confirmed malaria cases	X		X	
		Indoor residual spraying (IRS) coverage			X	
	Neglected tropical diseases	Coverage of preventive chemotherapy for selected neglected tropical diseases	X		X	
	Screening and preventive care	Cervical cancer screening			X	
	Mental Health	Coverage of services for severe mental health disorders	X	X	X	
Health systems indicators	Quality and safety of care	Perioperative mortality rate	X		X	
		Obstetric and gynaecological admissions owing to abortion	X			
		Institutional maternal mortality ratio	X			
		Maternal death reviews	X			
		ART retention rate	X		X	
		TB treatment success rate	X		X	
		Service-specific availability and readiness			X	
	Access	Service utilization		X	X	
		Health service access		X	X	
		Hospital bed density		X		
		Availability of essential medicines and commodities		X		
	Health workforce	Health worker density and distribution		X		
		Output training institutions		X		
	Health information	Birth registration coverage	X			
		Death registration coverage	X			
		Completeness of reporting by facilities				x
	Health financing	Total current expenditure on health (% of gross domestic product)				x
		Current expenditure on health by general government and compulsory schemes (% of current expenditure on health)				x
		Out-of-pocket payment for health (% of current expenditure on health)		X		
		Externally sourced funding (% of current expenditure on health)				x
		Total capital expenditure on health (% current + capital expenditure on health)				x
		Headcount ratio of catastrophic health expenditure		X		x
		Headcount ratio of impoverishing health expenditure		X		x
	Health security	International Health Regulations (IHR) core capacity index				x

Conclusions

All bar 8 CHRIs could be mapped to one or more of the WHO-FIC reference classifications. The indicators for which no proper place could be found among the WHO-FIC RCs were all related to health financing.

ICD can be used to capture 63 items, mostly (24) from the Health Status indicators group.

ICF was identified as an appropriate tool for 33 indicators, mostly (20) from the Risk Factors indicators group.

ICHI would work well to provide information on 38 items, mostly (23) from the Service Coverage indicators group.

Next Steps

From this preliminary exercise a more specific list of relevant codes from the 3 reference classifications could be developed to ease the monitoring and provide immediate longitudinal and cross-sectional comparability.

References

- Monitoring health for the SDGs. 2017 World Health Statistics
- Global Reference List of 100 Core Health Indicators. 2015 WHO

Assessing the actual and potential future joint use of the WHO-FIC

A Martinuzzi[1], L Hanmer[2] and B Macpherson[3]

[1]E.Medea Scientific Institute, Italian Collaborating Centre and FDC Co-Chair
[2]South African Medical Research Council, South African Collaborating Centre and FDC Co-Chair
[3]Australian Institute of Health and Welfare, Australian Collaborating Centre and FDC Secretariat

16-21 October 2017
Mexico City, Mexico

C702

Abstract The Family Development Committee (FDC) have been considering how the WHO-FIC can be used together, in terms of efficient use and best practice. A survey has been developed to ask WHO-FIC users to provide examples of current joint use of the WHO-FIC. The results of the survey will help to inform the FDC with classification development opportunities as well as the development of guidelines describing the best practice of joint use.

Introduction

A key work area of the WHO-FIC Family Development Committee (FDC) is to develop the WHO-FIC as an integrated and comprehensive suite of classifications, including in its application.

The WHO-FIC is increasingly being used in an integrative way. The FDC have been discussing best practices to support this use.

Information on the potential joint use of the WHO-FIC has been added to the revised 'Family' paper.

The FDC have considered the potential use-cases where classifications may be used together, including who the users are and at what point the integration occurs.

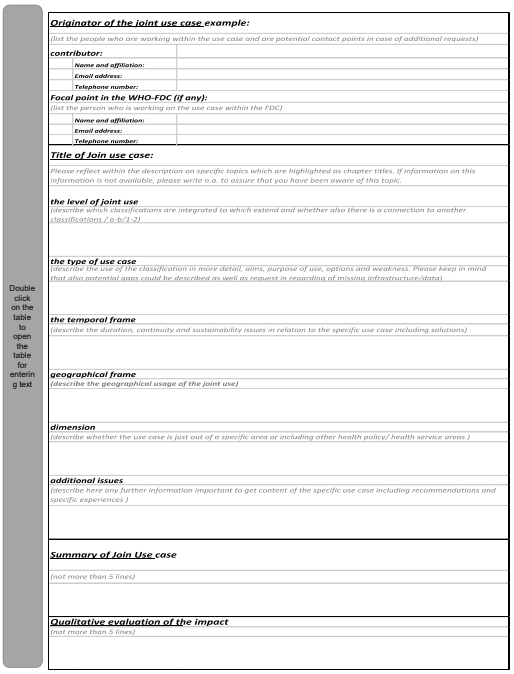
This item was again discussed at the 2017 FDC mid-year meeting where it was suggested by members that a survey be developed to canvas actual examples of joint use of the classifications.

A small working group was formed, tasked with the development of this survey. The group consisted of Andrea Martinuzzi, Janice Miller, Ann-Helene Almborg, Catherine Sykes, Hans-Peter Dauben, Marie Vikdal, Soon-Cheol Hong and Nicola Fortune.

This poster presents the survey template that was developed and invites the Network to participate in the survey.

The results will help to inform the FDC with classification development opportunities, as well as the development of guidelines describing the best practice of joint use.

Materials



Double click on the table to open the table for enterin g text

Originator of the joint use case example:

(list the people who are working within the use case and are potential contact points in case of additional requests)

contributor:

Name and affiliation:
Email address:
Telephone number:

Focal point in the WHO-FDC (if any):

(list the person who is working on the use case within the FDC)

Name and affiliation:
Email address:
Telephone number:

Title of Join use case:

Please reflect within the description on specific topics which are highlighted as chapter titles. If information on this information is not available, please write n.a. to assure that you have been aware of this topic.

the level of joint use
(describe which classifications are integrated to which extend and whether also there is a connection to another classifications / a-b/1-2)

the type of use case
(describe the use of the classification in more detail, aims, purpose of use, options and weakness. Please keep in mind that also potential gaps could be described as well as request in regarding of missing infrastructure/data)

the temporal frame
(describe the duration, continuity and sustainability issues in relation to the specific use case including solutions)

geographical frame
(describe the geographical usage of the joint use)

dimension
(describe whether the use case is just out of a specific area or including other health policy/ health service areas)

additional issues
(describe here any further information important to get content of the specific use case including recommendations and specific experiences)

Summary of Join Use case

(not more than 5 lines)

Qualitative evaluation of the impact
(not more than 5 lines)

Figure 1: Screenshot of the survey form.

Next Steps

Timeline:

- Communicate to FDRG the task and show an example
- Distribute the format to the FDC/FDRG/EIC - ASAP
- Data gathering (mid July – mid October)
- Progress check (beginning of November)

Once all responses have been received, analysis of the data will be progressed at the 2018 FDC mid-year meeting.

Results

Definitions and dimensions explored by Joint Use survey form

Joint Use of WHO-FIC Classifications

Using WHO-FIC Reference Classifications (ICF, ICHI, ICD) together: Use Cases

Definition of joint use:

a. Actual data collection using WHO-FIC reference classifications together (2 of 3, or all 3 classifications)

b. Actual data collection that could be mapped to 2 or more classifications

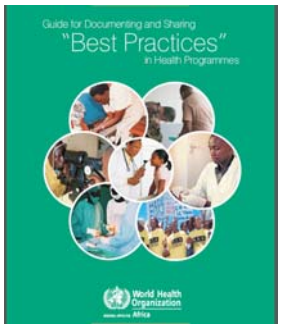
Reality check:

1. Use cases based on current practice in local, national or international setting
2. Use cases based on the potential for data collection using core classifications

Format:

Follow the principles outlined in the "best practice paper" (WHO, see the front page aside) with adaptations reflecting:

- The level of Joint use (a-b/1-2)
- the type of use case and
- the temporal frame (duration and continuity)
- geographical frame
- dimension (number of cases)
- if possible details on how the classifications are used



Conclusions

The strengths and pitfalls in WHO-FIC joint use can be best highlighted by tracking real world experiences. Best practices can that become guiding indications for other intended users.

In the same time the identification of datasets that are already structured in such a way as to allow easy data mapping onto one or more of the reference classifications can provide an indication of the potential extension of WHO-FIC joint use.

Both outputs emerging from the survey presented here will in turn feed back to WHO and WHO-FIC Network informing next steps in WHO-FIC update and revision and indications for use.

WHO-FIC Family paper: Progress on revision for the ICD-11 era

16-21 October 2017
Mexico City, Mexico

C703

L Hanmer[1], A Martinuzzi[2], B Macpherson[3], C Linton[4], K Denny[4]

[1]South African Medical Research Council, South African Collaborating Centre
[2]E.Medea Scientific Institute, Italian Collaborating Centre
[3]Australian Institute of Health and Welfare, Australian Collaborating Centre
[4]Canadian Institute for Health Information, North American Collaborating Centre - Canada

Abstract The WHO-FIC is a reflection of WHO activities and related outputs in health classification. The current version of a general paper describing the WHO-FIC – the Family paper - was published in 2007. The WHO-FIC Family Development Committee (FDC) is developing a revised Family paper to reflect changes in the classification environment, as reflected most directly in the approach to the development of ICD-11 and the electronic tools to support this development.

The Family paper revision process has required some seminal developments, including revision and updating of the diagram of the Family and updating of the concepts of 'derived' and 'related' classifications. The revised Family paper is being developed by a writing group of the FDC, with inputs from other members and observers of the FDC, members of the wider WHO-FIC Network, and the WHO ICD-11 Joint Task Force (JTF). Final approval of the Family paper will be required from the WHO-FIC Network and WHO.

Introduction

The 2007 World Health Organization Family of International Classifications: definitions, scope and purpose paper (the Family paper) describes the Family, principles of classification and the processes of adding, updating and maintaining classifications in the Family.

It was agreed at the 2010 WHO-FIC Network meeting that the FDC should revisit the paper and redraft to reflect current approaches to classification development and, in particular, the work on the ICD-11 revision.

Suggested changes to the document have been presented to the Network at previous annual meetings.

At the Tokyo Network meeting in 2016, the FDC continued discussions on the Family paper. It was decided that a small writing group should be formed to progress outstanding issues and to present a final draft at the Network meeting in Mexico City in 2017.

Discussions over the past 12 months have addressed the purpose of the paper, its intended audience and its focus – the current or future WHO-FIC.

Changes to Structure

The following content and structure to the paper has been proposed:

Introduction

1. The WHO-FIC

2. Scope and conceptual framework

3. Structure

4. Processes and considerations for adding and deleting classifications to and from the Family

5. Governance

References

Outstanding issues

- Finalisation of Figure 2: Schematic representation of the WHO-FIC.
- Finalisation of all components of the text, in consultation with WHO and WHO-FIC Network.
- Formal approval of the final version of the Family paper.

Next steps

After incorporating any comments from the 2017 Network meeting into the draft, the paper will be finalised and publication sought, in time for the release of ICD-11 in 2018.

Content changes

1. The WHO-FIC

This chapter describes the purposes and characteristics of WHO-FIC. It also introduces the differences between statistical classifications and clinical terminologies.

A new section has been added to introduce the WHO-FIC as a set of tools for the monitoring of Sustainable Development Goal 3 (*Healthy lives and well-being for all at all ages*) and Universal Health Coverage (a target under SDG3).

2. Scope and conceptual framework

This chapter describes the scope of the Family and relates WHO-FIC reference classifications to the bio-psycho-social model as its common underpinning conceptual framework (Figure 1).

- The **ICD** classifies **health conditions** (diseases or disorders as causes of morbidity or mortality). Although not its major role, it also classifies some **environmental factors** (for example as external causes of injury and poisoning) and some **personal factors** (for example as reasons for contact with health services).
- The **ICF** includes classifications of **body functions and structures**, **activity and participation** and **environmental factors.**
- The **ICHI** classifies health interventions. It incorporates classifications of **body structures and functions**, **activities and participation, environmental factors** and **personal factors** into its Target axis.

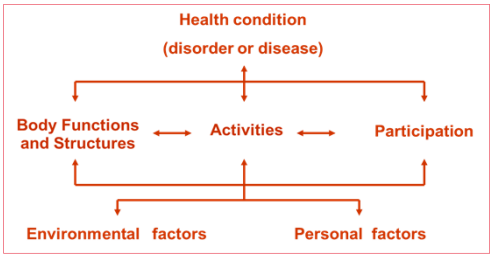


Figure 1: Interactions between the components of the WHO bio-psycho-social model of health

3. Structure

The schematic representation of the WHO-FIC in the 2007 paper has been updated to include relationships to the Foundation component and terminologies (Figure 2 – Draft for discussion).
The semantic anchor in Figure 2 signifies the same meanings across terms.

The Reference classifications are discussed in detail in this chapter, including a section for ICD-11. Derived and Related classifications are also discussed, and sections have been added regarding alignment of classifications (future challenge) and their use together.

4. Processes and considerations for adding and deleting classifications to and from the Family

This chapter is similar to the previous section in the 2007 Family paper, and includes the *Principles for including classifications in the Family of International Classifications* (a previous Attachment) as a section in its own right.

5. Governance

This short chapter introduces the FDC as a stakeholder in the development of the WHO-FIC as an integrated, consistent and comprehensive set of classifications.

It retains the information for contacting the World Health Organization and the WHO-FIC Network regarding changes to the reference classifications or introduction of a new related classification.

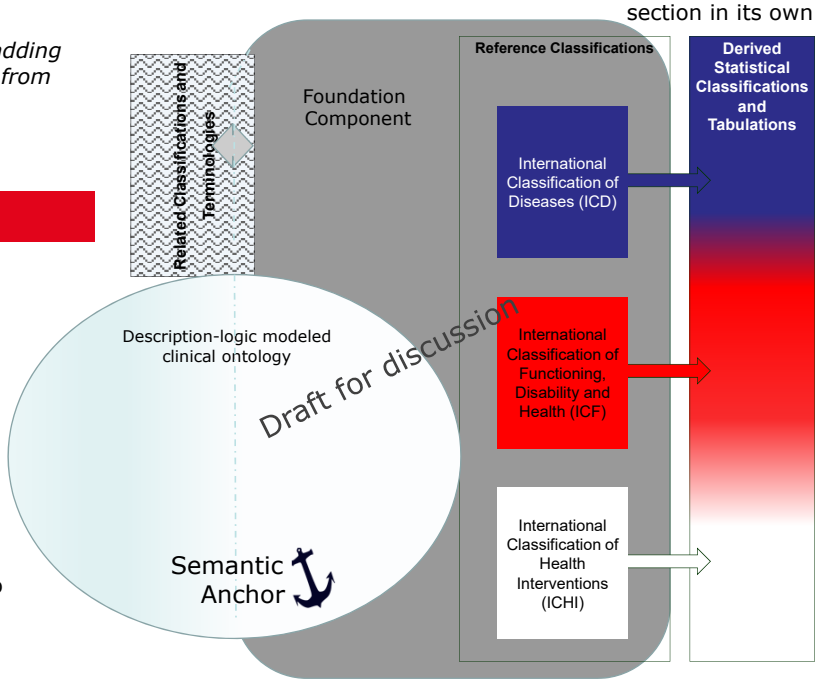


Figure 2: Draft schematic representation of the WHO-FIC

Acknowledgements

Thank you to all of the contributors to the revision of the Family paper, especially the writing group and the many others from the FDC, JTF and Council members.