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WHO Family of International Classifications (FIC)

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Is there scientific evidence for the benefits of international classifications?

A question out of the audience

Most readers of this newsletter will be acquainted with delivering an address on ICD or ICF before an audience. We are prepared for frequently asked questions such as: Is there a definition for classification?

The answer can be derived from the WHO-FIC family paper, <http://www.who.int/classifications/en/FamilyDocument2007.pdf>:

‘The ISO standard 17115 defines a classification as ‘an exhaustive set of mutually exclusive categories to aggregate data at a pre-prescribed level of specialization for a specific purpose’. Classification involves the categorization of relevant concepts for the purposes of systematic recording or analysis. The categorization is based on one or more logical rules.’

And we can extend our answer by referring to the same paper, including the formal benefits of international classifications by their aims.

‘ICD and ICF are the core classifications in the Family of International Classifications that have been endorsed by the WHO to describe various aspects of the health and the health system in a consistent manner. The purpose of the Family is to assist the development of reliable statistical systems at local, national and international levels, with the aim of improving health status and health care.’

However, what answering the tenacious questioner, who wants to know our opinion on the scientific evidence of the benefits of classifications such as ICD-10 and ICF.

I do not know a written overview of all aspects that has to be covered in answering this apparently innocent question. Nevertheless, we can have a try in front of an inquisitive audience.

Scientific evidence presupposes a scientific procedure. I remember three phases: exploration, description and explanation. Exploration needs an open mind; the categories of an established international classification might be inadequate to denote an obviously new phenomenon. In that case there is a need for a new category. As long as the international classification is in use, one has to code that phenomenon in the category ‘other’. If there is an update mechanism a new (sub)-category might be implemented, e.g. Avian flu in ICD-10; otherwise one has to await a new revision. Furthermore the new concept might conflict with the existing subdivision in the classification. A regrouping and a different selection of concepts might represent the new insights better than one single category. The conclusion might be that in the phase of exploration the scientific evidence for the benefits of an international classification is restricted; new concepts or categories or subdivisions might help more.

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The same situation goes for explanation. If an established theory cannot be falsified, e.g. a significant number of specific syndromes proves to be autoimmune diseases, a regrouping of widespread subcategories under one new category appears to be justified (my examples are of course fully speculative, I do not want to interfere into the current revision process). Again, the scientific evidence for the benefits of an international classification is restricted. It is for reason of an improvement in exploration and explanation that we revise international classifications and does not stick for ever to the common language of the existing ones.

In my view, the question on the scientific evidence for the benefits relates mainly to the descriptive features of international classifications. Is an international classification useful in the mutual communication between professionals either within the same discipline or between diverging disciplines? Does it help in the communication with clients/patients? Does the interchangeability of data give a more complete picture of somebody's health status? Does the use of an international classification contribute to more satisfaction with health care and quality of life? Finally, the comparison of data from the most prominent applications of ICD, the underlying cause of death and main discharge condition, does it have a surplus value?

To start with the last question, the answer is an affirmative one. We can refer to a famous epidemiologist in the Netherlands, dr. Dick Hoogendoorn, who analyzed for a few decades epidemiological disease data, recorded in mortality and morbidity statistical systems, in the second half of the twentieth century. Especially preventive medicine has benefitted from his pioneering work. The more recent thesis of Lars Age Johansson, summarized in our last newsletter (Vol. 6 No 1, 2008), demonstrates that this kind of benefits of the multiple use of international classifications are difficult to underpin. One has to analyze a lot of coded data and the

conditions of applications, prior to come to the conclusion that in an ageing population an increasing number of deaths are due to an accumulation of etiologically unrelated conditions; justifying by this conclusion that both systems deliver partly independent, epidemiological valuable information.

Even restricting the evidence question to a single application of one classification, the disadvantages often exceed the benefits. The (scientific) criticism on ICD has resulted in an extensive family of derived and related classifications, and supposed relatives such as SNOMED CT. All these concept systems have of course a specific purpose, justifying their existence, but in the end it tells that the scientific evidence for the benefits of the core, the ICD, is at least problematic. Due to the coding culture different derived and related classifications are developed instead of different applications of one classification. I mean with coding culture the practice to apply a classification directly by using its codes according to a set of application rules.

Probably a different situation holds for ICF. In ICF there are also guidelines for coding (appendix 3), but a number of applications are based upon existing measurement instruments or develop these instruments by using parts of ICF. Up to now only one derived classification, ICF-CY, and one related classification, ISO-9999, exists. The scientific evidence for the benefits of the ICF might be less problematic than the benefits of the ICD. In ICF we really have to do with different professionals, a language that clients can understand, the possibility of a full profile of the functioning, disability and health at different levels, running from the individual to the population at large. Questions on communication, comparability of data, a more complete picture of health status, satisfaction with health care and quality of life might get a richer answer by applying ICF next to ICD or one of its derived/related classifications. Recently, there was some – indirect –

evidence for the benefits of the ICF. It was defended in a Dutch dissertation that where the RAP approach was integrated in inpatient care, clients were more satisfied with that care and their quality of life, than in care units where this was not the case. The RAP, Rehabilitation Activity Profile, is an assessment instrument related to ICF, with specific parts for the different disciplines in the rehabilitation team, see John Verhoef, Integrated Care for Patients with Rheumatoid Arthritis Proefschrift, Leiden 2007, 152 p.

We would like to have available more examples on the scientific evidence for the benefits of ICF and ICD. In our view this would help to enhance the status of the family and to convince persons and institutions to use international classifications.

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Editorial

We wish all readers a good and fruitful 2009. Looking at the activities accomplished last year, 2008 was fruitful. Our collaborating centre has been invited by the ministry to start the implementation of the ICD-10 (Dutch version) in all Dutch hospitals. We see this activity as a good start enabling us to contribute to the ICD updating and revision process. A corrected reprint of the Dutch version of the ICF was published and the Dutch translation of the ICF-CY is available now.

This newsletter starts with a question coming from the audience, and we hope to receive your reactions or the way you should reply to this kind of questions. Furthermore we offer information concerning the ICD revision, ICNP (the newest related member of the WHO-FIC) and some contributions presented during the recent annual WHO-FIC Network meeting in Delhi, India; see report and papers at www.who.int/classifications/network/meeting2008/en/index.html.

In August 2008 the annual ICF NACC meeting was organized back-to-back to

the RI conference in Quebec. All ICF related presentations are at www.cihiconferences.ca/icfconference.

Life must go on, but some dear persons had to leave us too early. We regret the death of Marijke (Muller-)Scholman, Philip Wood and Henk Lamberts. They contributed substantially to the development and use of health related classifications:

- Philip Wood, 1928 - 2008, father of the ICIDH;

- Marijke (Muller-)Scholman, 1939 – 2007, she introduced the ICIDH in Canada;

- Henk Lamberts, 1940 – 2008, founder of the ICPC.



Philip Wood, Paris 1988

International Organizations

WHOFIC Network Meeting 25 - 31 October 2008



The 2008 Annual meeting of the WHO Network of Collaborating Centres for the Family of International Classifications in Delhi, India, was hosted in the Heritage Village Manesar hotel by the WHO Regional Office for South-East Asia in collaboration with designate Collaborating Centre for WHO-FIC in India at the Central Bureau of Health Intelligence (CBHI), Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India.

All documents are published on the website of the 2008 Annual Meeting of the WHO-FIC Network, see <http://www.who.int/classifications/network/meeting2008/en/index.html>.

See that website for the meeting report summary to overview the results. We highlight in this Newsletter a selection of posters that can be downloaded, especially revealing the implementation of the ICF in three priority areas of application:

Social policy

The Italian WHO-FIC Centre and its partners presented the preliminary results in a two year research project, financed by the Ministry of Labour, Health and Social Policy, on the development of a common conceptual framework for disability assessment and certification at national and regional level. The poster (D007p) is entitled: *Towards a disability certification reform in Italy*.

Surveys and censuses

The Italian Ministry supported also an observational multi-centre national study to assess the needs of Persons with Disability getting invalidity pension, through the cooperation of researchers (neurologists, psychiatrists, psychologists, etc.), persons with disability and their family members. This project is the widest door-to-door Italian study on disability and enabled researchers to identify common problems of Italian persons with disability, independent of health condition, age and other variables; its results are published in the *'White Book of Invalidity in Italy'*. The poster (D031p) is entitled: *Population Survey on Invalidity Pension in Italy: defining needs of Persons with Disabilities with ICF*.

Health information systems and measuring health outcomes

Six posters at least reported on this broad field of application. *An Update of the ICF Core Sets Development* (D046p) was given and two of its projects were described specifically: *Development and evaluation of an ICF-based patient education program for stroke patients* (D045p) and *The use of the ICF Core Sets for medical*

reports of the German national pension insurance of patients suffering low back pain and chronic widespread pain (D044p).

Again an Italian field trial catches the eye: *Structuring rehabilitation project and program through the ICF-CY conceptual framework in a neuro-pediatric rehabilitation hospital* (D013p). It was concluded that the ICF-CY may be used to inform the project and program; the positive consequences need, however, be weighted against the perceived increase in complexity and the increase of workload.

Japan reported on *Changes of Activities over a Year in Older Out-patients of seven General Hospitals* (D028p).

At last a poster on the ICF in French contains information on a *Descriptive Study of Functional and Contextual Criteria for Sick Leave Prescriptions in General Practice in France and Belgium, using the ICF* (D042p)

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ICNP & WHO-FIC

In the Delhi meeting of the WHO-FIC Network in October 2008 the ICNP has been accepted by the council as a related family member. Part of the acceptance is that the precise relation between the ICNP terminology and terms within the family members of WHO-FIC is elaborated in terms of conceptual conformity. The ICNP e.g. contains terms from ICF, ICD-10, ICPC, ISO9999, ICECI. It is important to harmonize terms within the family, but first and particularly a new member needs to bring its terminology in line with the existing family members.

A report drawn up by the Dutch Centre, and supported in the August meeting 2008 of the Family Development Committee at DIMDI/Germany served as the basis for the start of the harmonization of the ICNP within the family. As part of an ongoing effort to harmonize ICNP, a plan will be drawn up by the International Council of Nurses (ICN)

that covers all parts of the ICNP related to the family. The first step in this plan is the mapping of ICNP and the International Classification of Functioning, Disabilities and Health (ICF). This work is now underway. This is a large project, involving collaborators from Switzerland, the Netherlands and the US. The purpose of this mapping is not only to harmonize the classifications within the family, but also to trace terms that might be of relevance for either the ICNP or one of the family members.

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ICD Revision

The International Classification of Diseases (ICD) is a key instrument of the World Health Organization and a core member of the WHO Family of International Classifications. The ICD is used by public health bodies, clinicians and researchers, ensuring the provision of language and system-independent definitions that are applied for: National and International health statistics (mortality and morbidity); epidemiology, surveillance and monitoring; individual patient records and electronic health records; reimbursement and health system financing; reference for treatment guidelines, scientific literature and research; and quality assessment at the level of individual cases up to assessment of health system outcomes and monitoring.

The ICD forms the basis for numerous additional & derived modifications. WHO owns all rights and processes that relate to ICD (and the other core classifications) and has the responsibility to ensure conceptual consistency in all changes that are introduced accordingly. The ICD has been revised every 10 years, with the exception of the 20-year interval between the revisions of ICD-9 to the most recent ICD-10. The ICD-10 was completed in 1990 and the WHA requested that it should be revised as necessary.

In the Network meeting, October 2008 in New Delhi, India, a draft revision plan and organization structure has been presented, based on goals of revision from ICD-10 to ICD-11. These goals address items such as: update ICD to accommodate new scientific, clinical and public health knowledge; internet-based technologies for information gathering, integration and sharing; integration of and cross-referencing with health related terminology systems such as SNOMED –CT; harmonization with ICD-related and derived classifications; build in needs driven adaptations based on real Use Cases; and a strong focus on facilitating the implementation in developing countries.

A first Beta-draft is planned for 2011, after which Field trials will take place. The official publishing in the six WHO languages is expected for 2014.

The revision process of ICD is too complex to be explained in this Newsletter in detail. More details will follow in subsequent issues.

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International Organization for Standardization

Harmonization of ISO 9999 & ICF

In March 2007 the fourth edition of the ISO 9999, a related member of the WHO family of international classifications (WHO-FIC), was published. In ISO 9999, *Assistive products for persons with disability - Classification and terminology*, assistive products are classified according to their function. ISO 9999 was prepared by Technical Committee ISO/TC173, *Assistive products for persons with disability*, Subcommittee SC2, *Classification and terminology*. Translations in many languages are started soon after publication of the international standard controlled by national standardisation institutions. The current version has been translated in many languages. The Dutch translation of the fourth version will be published at the end of 2008 or the start of 2009.

During the mid-year FDRG meeting in Quebec in August 2008 two options for harmonization of the first level subdivision of ISO 9999 and chapter 1, *Products and technology*, of the list of environmental factors of ICF were discussed. The options were formulated by WG11, the working

Proposed subdivision	ICF	ISO9999
products used to test / measure / monitor functioning and contextual factors	(e115)	(04)
products used to treat / prevent problems in functioning and to train functions and activities	(e115)	(04)/05
products used in self care	(e115)	09/(06)
products used in domestic life	(e115)	15
products used in mobility	e120	(06)/12 / (18)
products used in communication / information	e125	22
products used in education / learning	e130	xx
products used in employment	e135	(24)/(27)
products used in recreation / leisure / social, cultural and spiritual life	e140/e145	30/xx
design and construction of buildings	e150/e155	18
consumption goods, incl. food and drugs	e110	xx
products used in land development	e160	xx
Assets	e165	xx

group for the ongoing Revision established by Subcommittee 2. Based on the discussion in Quebec a proposal was formulated for the FDC-meeting in New Dehli by Yvonne Heerkens (the Netherlands, chair of ISO/TC173/SC2), Theo Bougie (the Netherlands, member of ISO/TC173/SC2) and Petra Winkelmann (Germany, member of ISO/TC173/SC2). The three authors are also experts of Task Group 7 'Environmental Factors'. As it was not possible for the authors to attend the meeting in New Dehli, Marijke de Kleijn-de Vrankrijker, head of the Dutch Collaborating Centre of WHO-FIC, presented the proposal. In the proposal an explanation is given how chapter 1 of the list of environmental factors of the ICF and the ISO9999 classes could be harmonized and be complementary to each other. The option presented in this proposal is the one which has been endorsed by the FDRG in Quebec. A process for coordinating the efforts of DDRG and WG11 of ISO is now under consideration.

The results of the New Dehli meeting and the way to go forward were discussed by WG11 and SC2 in November 2008 in Helsinki. Based on this discussion the publication of Committee Draft of the fifth edition of ISO 9999 is postponed to give the possibility to elaborate on the consequences of the harmonization for ISO 9999. One of the decisions already made is to include a new class in ISO 9999, class 31 *Assistive products used in employment*. The fifth edition of the ISO 9999 will be published at the end of 2011. The revision process of the ISO 9999 parallels, in time, the present update and revision process of the ICF.

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FIC around the World

China

Development and application of ICF in China

The ICF was officially endorsed by 191 WHO Member States in the Fifty-fourth World Health Assembly on 22 May 2001 (resolution WHA 54.21) and was endorsed for use in Member States as the international standard to describe and measure health and disability.

China, as a WHO official member, has participated in the development of ICF in all respects since 1998 when Dr. Qiu Zhuoying and Dr. Wu Xiangguang, invited by WHO, attended the Tokyo meeting and officially participated in the development of ICF. A research team led by Prof. Qiu Zhuoying, from China Rehabilitation Research Centre, had done many works on the development of ICF Chinese Version (one of six official versions of ICF). The research results have been contributed to the development of ICF and ICF-CY and applied in many aspects: such as disability statistics (the 2nd National Sampling Survey of Disabled Persons), clinical and rehabilitation medicine practice, disability services, professional training and so on.

The development, application and training of ICF in China mainly focused on the following aspects:

- Application of ICF in the 2nd National Sampling Survey of Disabled Persons. In 2006, China adopted ICF as the *official framework for measuring disability in the general population* (in national sampling survey) which contained the criteria, procedures, sampling, statistics and research; it developed a scheme and tools for the survey, including the definition, grading system, core survey items, screening and assessment tool following WHO-DAS-II, questionnaire design and encoding system of the survey data, a database from the survey has

developed by experts to provide standardized information for professionals. The terminology of disability such as in BF, BS, A & P and environment is well known by applied ICF in the survey.

- Application of ICF in public Policy. China has accepted the ICF notions and adopted in legislation related the disability, mainly including in the service for the disability, implemented UN convention on Right for People with Disability, amended the Law for the protection for the people with disability, revised the national classification of disability with ICF framework, integrated the concepts into education, employment and other related areas.
- Application of ICF in clinical setting. The principle of ICF has been adopted by the professionals at the clinical setting progressively. For example, they consider ICF as a major framework of *health outcome assessment*, develop a comprehensive rehabilitation plan, standardize the instruments, develop the clinical tools, establish the disability-related health database, and manage the clinical terminology referring to ICF.
- National training seminar, publications, and lectures on ICF. In January 2003, a special issue of ICF had been published by *Chinese Journal of Theory and Practice of Rehabilitation*. In 2005, a special chapter on ICF, written by Dr. Qiu Zhuoying, had been published in *China Rehabilitation Medicine* edited by Dr. Zhuo Dahong. The ICF had been one part of rehabilitation education at college level. In April 2007, a national training program on ICF had been conducted in China and more than 30 peoples from health care, medical rehabilitation and social services for people with disability had attended the training course. With the promotions by the official advocacy and promotion such as seminar, workshop and symposium, ICF is accepted by more and more Chinese professionals in health care, disability and rehabilitation field.

France

News of the ICF French-speaking network

Since 2004, the WHO-FIC Collaborating Centre Inserm-CTNERHI for the ICF in French, situated in Paris, has developed, as one part of its activity, a French-speaking network aiming at (i) disseminating the ICF, (ii) training potential users and trainers, (iii) promoting its implementation and use for assessment tools, studies and information systems. Collaborations have been established with Belgium, Switzerland, Québec, Algeria, Tunisia and France, involving professionals, Disabled People's Organizations' representatives and social scientists in various health and disability domains.

The functioning of the French-speaking network consists in several thematic groups that meet three to four times a year and communicate through Internet the rest of the time. Each group is coordinated by a specialist of the chosen theme. Three teleconferences and one face to face meeting a year are organised for the groups' coordinators to report and assess the works in progress and to discuss new themes and further studies to be promoted and developed. The French ICF Collaborating Centre is involved in every thematic group. In 2008 the most active groups have been those dealing with ICF training, with using the ICF in medical expertise, for sick leaves and oro-facial pain descriptions and assessments.

- Training is a major concern that is why a group has been set up, made of 7 French, Belgian and Swiss special education, social work, health and health-related vocational national schools and one NGO (*Handicap International*). Introductory, advanced and training for trainers sessions and corresponding educational material have been developed. The needs for ICF training are continuously increasing since the legislations related to disability in European countries have particularly evolved, following the UN and European Commission recommendations.

One working group is focused on the use of the ICF in medical expertise in legal cases. It is coordinated by Dr Freddy Falez (Bruxelles Free University, member of the EUMASS) in collaboration with the Department of Medical Ethics (Medical School, Paris 5 University), Belgian, Canadian and French insurance and social security medical experts, French occupational therapists, lawyers and DPO's representatives in the field of brain injury. Their work focuses on proposals for the introduction of the ICF approach and dimensions of participation and environmental factors in the legal assessment procedures of injuries for compensation.

Another group, led by Dr. L. Letrilliart (Lyon Medical School), has initiated a Belgian-French study on sick leaves assessment. Based on 400 sick leaves prescribed by general practitioners, the study intends to identify the factors taken into account by GPs, with the use of an adapted ICF checklist. The data are currently being collected, results and publication are expected in 2009.

Coordinated by Dr P. De Jaeger (Paris 5 University, Dental Sciences School), one group of dentists works at mapping oral health quality of life instruments to the ICF, using the linking rules published by Cieza et al¹. Publication in a scientific journal is intended in 2009. Two members of this group attended an ICF Core sets workshop organised by the German ICF Research Branch (Munich, February 2008) in relation with one of their other aim, i.e. to develop an ICF Core set for oro-facial pain.

To support these works, a French bibliographic watch on publications and events related to the ICF and its use is being done.

Beyond the French-speaking region, the Collaborating Centre for the ICF in French is very keen to connect with a larger forthcoming European network.

¹ Cieza A. et al. (2002). Linking health-status measurements to the ICF, *Journal of Rehabilitation Medicine*, 34:205-210. Cieza A. et al. (2005). ICF linking rules: an update based on lessons learned, *Journal of Rehabilitation Medicine*, 37:212-218.

In conclusion, the French Collaborating Centre is pleased to announce that the French version of the ICF-Children and Youth version is forthcoming December 2008. -The *Classification Internationale du Fonctionnement, du handicap et de la santé, version pour enfants et adolescents (CIF-EA)*- is the result of a collaborative effort of Belgian, Canadian, French, and Swiss children and youth specialists and the WHO Collaborating Centre for ICF in French.

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Latin America

WHO Collaborating Centre for the FIC in Mexico (CEMECE)

The year 2008 is very special for us, because CEMECE has been designated as a Collaborating Centre for the WHO-FIC on January 28, 2008. The aim of this article is to present the main features of the CEMECE and its activities in Mexico and Latin America.

The CEMECE (formerly denominated Mexican Center for the Classification of Diseases) was created by the Secretariat of Health in 1985 in the General Direction of Epidemiology (DGE); in 1997 it was transferred to the General Direction of Statistics and Informatics, presently the General Direction of Health Information (DGIS), that has to integrate the national statistics of health relative to resources, services and reasons for medical attention. Like the National Institute of Statistics, Geography and Informatics (INEGI), the office in charge of the information on vital statistics, DGIS processes information on mortality data coming from death certificates, especially to support the monitoring epidemiologist. Since the codification of diseases, medical causes of death and procedures is necessary for the generation and integration of health

statistics, DGIS coordinates the work of CEMECE, but their members not only include personnel of DGIS, but belong also to the most important institutions of the public and private National System of Health and INEGI. CEMECE has work groups, specialized in the handling of classifications, mainly the International Classification of Diseases (ICD), the Classification of Oncology (ICD-O), the Classification of Procedures in Medicine (of the ICD-9-CM) and the Classification of Functioning, Disability and Health (ICF). From its creation, the CEMECE has developed the following functions:

- Training - formation and update of national and foreign coders and instructors.
- Coordination – in collaboration with the institutions of the National System of Health, INEGI, Pan American Health Organization (PAHO), World Health Organization (WHO), Ministries of Health and Offices of Statistics of other countries, CEMECE updates and distributes translations of international classifications, settles down agreements for their use and solves codification problems
- Consultancy - to users of the international classifications and the statistics of morbidity, mortality, procedures in medicine and functioning.
- Research - focused to problems that affect the quality of information such as the registry, coding, coverage, etc. Every year the Center gives advanced training courses to an average of 250 to 300 national coders and, for 7 years it has been imparted a course for the training of 30 to 35 instructors in codification of medical information (national and foreign). CEMECE also collaborates with INEGI to improve the quality of the official statistics of mortality in charge of that institution. The greater contributions are in the improvement of the coverage of deaths of children of less than 5 years of age, and in the deliberate search and classification of the maternal deaths in the country at large, the measurement of the effects of the registry and the codification in

the statistics of morbidity and mortality and in the effects of the changes between the revisions of ICD and in the consultant's office in the automated codification of mortality.

With the object to decentralize the training in codification of medical information, CEMECE has promoted the creation of regional centers of training in the country. The centers of the state of Jalisco, the state of Mexico and the Federal District, have helped CEMECE to satisfy the demand of training of the coders.

After the launch of the ICF, the Center has contributed in the diffusion of the knowledge and use of this classification. In Mexico a Promotional Network of ICF with representatives of the institutions of health created a strategy for its diffusion and implementation. A training model was developed, enriched with international experiences and the advance of knowledge and use of ICF in the world.

CEMECE promotes that trainers in other countries create similar national centers for international classifications. We recommend that these national centers will be integrated with members of every national health institution (public and private) and the national statistics office/institute.

Keys points for the CEMECE:

- to consolidate the roll of the CEMECE as WHO- Collaborating Center for FIC;
- to obtain an initial diagnosis of needs for training in the region, especially in countries with more problems in coverage, quality and use of health classifications;
- to attain closer links between national efforts and international initiatives
- to maintain an active network of collaboration between countries.

Finally CEMECE confirms its commitment to offer training and coaching related to the utilization of international health classifications in Latin America.

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Latin American and Caribbean Network for the promotion of ICF

After the launch of ICF in May 2001, several countries of Latin America started to work in order to accomplish the resolution 54.21. Initial efforts were focused on the development of training materials, on the development of a “training of trainers” strategy and on the searching and analyses of international experiences related to the ICF implementation.

Supported by the National Institute of Mental Health, Pan American Health Organization and the national Ministry of Health, in February 2003 Mexico was the venue for the annual meeting of the ICF Iberoamerican Network. In this meeting, advances on the implementation of ICF were presented and discussed. Additionally, a Program of Work, focused on training, diffusion, research and application, was established.

One year alter, in November 2004, another meeting was performed in Washington to check the advances on the planned activities, to share national experiences and to strengthen the communication between the stakeholders and to keep the network alive.

- Several centres and national networks have been created to be responsible for the dissemination, training and exchange between different countries.
- Material for training and application of ICF were developed.
- ICF has been included in the program of training for Physical rehabilitation specialist and in other programs of medical specialization of some Latin American universities

ICF has been applied in

1. Population surveys:
Nicaragua 2003, Chile 2004, México 2002, Panamá 2006.
2. Disability people certification:
Argentina, Nicaragua and Panamá.
3. Disability people register:
Colombia and México.
4. Clinical settings:
Venezuela and Cuba.
5. Labour health:
Colombia, Uruguay and México.

In April 2008, Mexico was the venue for the meeting of the Latin American and Caribbean Network for the promotion of ICF. The main activities in this meeting were the presentation of national reports about ICF implementation, the analyses and discussion of a paper about disability in the region, a presentation of a model for training and a review of the emergent demands in the field of ICF implementation.

The terms of reference for the organization, functioning and work of the network are currently being reviewed.

Participating countries in the Network are Argentina, Brazil (WHO Collaborating Centre for the FIC in Portuguese), Colombia, Cuba, Chile, Mexico and Venezuela. The Network is supported by the Pan American Health Organization.

To attain a higher involvement of the countries with the network, a 2009 meeting in Brazil, has been planned. The objectives of this meeting are to learn of the successful experiences in the region, to review the collaborative strategies between countries and to identify the needs for training and coaching.

The development of international courses for ICF trainers is being discussed. There is a chance of start with this course in 2009 in Mexico.

Future Activities:

- To continue with the ICF Dissemination and Training Programmes in the countries of the region that have already begun with the implementation of ICF.
- To start the development of diffusion and training programmes in the countries of the region that have not still begun with the implementation of ICF.
- To obtain the license for printing ICF books and for reproducing cds. To increase the resources for distributing books and cds in the region.
- To continue with the development of instruments for different applications of ICF.
- To strength the "Training of Trainers" strategy.

Conclusions:

- It is necessary to learn from successful experiences from other countries.
- It is important to attain closer links between national efforts and international initiatives.
- It is necessary to maintain an active network of collaboration between countries.

The CEMECE confirms its commitment to offer training and coaching related to the utilization of international health classifications in the region and to encourage the activities of the network to obtain more and better evidences to apply the ICF.

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The Netherlands

The Capacity Profile (CAP)

A method to assess additional care needs in children with neurodevelopmental disabilities.¹

Children with developmental disabilities often show a variety of associated impairments that lead to a lifelong need for additional care. Careful assessment of these impairments is required not only for diagnostic purposes but also to inform the parents and others, like service providers, about the expected additional care needs in the future. This additional care differs from the care which is considered usual for the child's age, as it is indicated by the impairments. We hypothesized that this expected additional care should be stable in time in stable disorders, like cerebral palsy (CP), spina bifida or other neurodevelopmental and congenital disorders, provided optimal treatment and environmental factors. We systematically reviewed the literature to identify instruments that classify comprehensively the type and amount of expected additional care needs in the future for the individual child with a non-progressive, permanent medical condition. However, no such instruments were found.² This motivated us to develop the Capacity Profile (CAP).³ The CAP

has been developed based on clinical experience in the field of paediatric rehabilitation. The CAP enables us to assess the expected additional care (see Appendix) and fits into the framework of the International Classification of Functioning, Disability, and Health (ICF),⁴ which classifies human functioning in relation to a health condition in terms of 1) body functions and body structures, 2) activities and participation, and 3) contextual (e.g., environmental and personal) factors. The CAP is a standardized method to assess the need for additional care indicated by a child's impairments in five domains of body functions: physical health (b 280-299, b410-b499, b510-599, b610-639),, neuromusculoskeletal and movement-related (b710-799), sensory (b210-279), mental (b 110-199), and voice and speech functions (b310-b399). Impairments in body functions in ongoing chronic conditions lead to limitation of the capacities of the individual which result in need for additional care. Additional care is categorized in the ICF under the heading of environmental factors. Rehabilitation treatment aims to optimize the performance of activities and participation. In case of ongoing stable conditions the kind of the optimal environmental factors is assumed to be predictable. So, we defined the level of need for care in each domain from 0 (no need for additional care) to 5 (needs help with every activity). Professional assessment of the level of need for additional care in each of the five domains, irrespective of the need for care in the other domains, results in the Capacity Profile for the individual child. By scoring the dependence on additional care for each domain separately, insight is obtained regarding the contribution of additional care to the various domains of body functions. We investigated interrater agreement³, construct validity⁵ and stability over time³. All were good to excellent. It was concluded that the CAP is a reliable instrument for assessing the additional needs of a child with a non-progressive,

permanent neurodevelopmental related disability

Despite the fact that further research needs to be done, there is already much interest among rehabilitation professionals and service providers to implement the CAP. Recently a project to investigate the potential of the CAP to simplify and accelerate the application procedure for indicating services has received a grant. This project to establish the added value of the CAP and accordingly to promote the implementation of the CAP for service delivery will start this year.

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ICD-10 Implementation Project in the Netherlands

A project is underway for the implementation of ICD-10 in Dutch hospital Electronic Health Care Records by January 2011. The aim of the complete project is to support the development of a registration system that serves many purposes. The registration system will be based on a once-only-many uses of health data principle. The ICD-10 is one of the

basic elements for this system, for reasons such as:

- The national DBC system will be based on ICD-10.
- The national hospital care information (LZi) will be based on ICD-10.
- ICD-10 is a standard terminology, which will improve univocal language and transparency in health care.
- ICD-10 will be mandatory for reporting health care data on a European level.
- ICD-10 is in use in all surrounding countries and will therefore improve international cooperation and interoperability.

In a kick-off conference in July 2008 a nationwide support was demonstrated by all parties concerned.

At this moment the work on a project plan has almost been completed for the period 2009-2010. On behalf of the Ministry of Health, the Dutch Collaborating Centre is commissioning and leading the ICD-10 project.

Prismant, Health Care and Advice Institute, a Dutch research and advisory agency, has been commissioned by the Centre to coordinate the project.

The project plan will focus on two main subjects; 1. The availability and maintenance of all supporting material for the implementation of ICD-10, such as books, electronic files, browsers and ICD-9-CM to ICD-10 conversion, and 2. The availability of ICD-10 trained administrative clerks, coders, training material, coding support (e.g. helpdesk, extra hands and advice). An ICD-10 Platform will be in place to coordinate maintenance and knowledge dissemination within a national network and active participation within the WHO-FIC Network.

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