Joint Session of the WHO-FIC Asia Pacific Network (APN), Education and Implementation Committee (EIC), and Functioning and Disability Reference Group (FDRG)
June 3, 2016
Bangkok, Thailand

Seminar on International Classifications

1- Welcome and introductions

Huib Ten Napel and Yukiko Yokobori, the Co-Chairs of EIC, and Catherine Sykes and Andrea Martinuzzi, the Co-Chairs of FDRG, welcomed the participants. Catherine Sykes chaired the meeting.

2- Review of agenda

The proposed agenda was accepted without modification.

3- ICHI introduction – Presentation by Richard Madden

The International Classification of Procedures in Medicine (ICPM) was published by the World Health Organization (WHO) as a classification for interventions and procedures in 1978. Although it was a good classification, it could not be properly maintained and its use came to a halt in 1989. Countries developed their own national classifications of interventions and procedures, notably the ICD-9-CM in the United States, but no classification existed that could be used for meaningful international comparison of data. Against this backdrop, it was recognized at the WHO-FIC Network meeting in Tunis in 2006 that work should start on developing an international classification of interventions and procedures, and that work was started in the following year for development of a classification called the International Classification of Health Interventions (ICHI), which would be broad in scope, including medical and surgical interventions as well as primary care, rehabilitation, assistance in functioning, prevention and public health, and traditional medicine.

The usecases of ICHI range from international comparison of data, national uses whereby countries could introduce or migrate to the use of ICHI or add elements of ICHI to an existing national classification of interventions, uses to describe strategies for UN Sustainable Development Goals (SDGs) and Universal Health Coverage, patient safety and quality, public health, and case-mix systems.

Based on the ICHI organizing principle of "What is done to what target, and how," ICHI has a three-axial structure revolving around the Target, Action, and Means, as a way to compact information while allowing for a broad capture of information. Similar to ICD-11, it has a content model, extension codes, such as for therapeutic and assistive devices, drugs and medicines, and anatomical details, and coding rules.

ICHI includes medical and surgical interventions, functioning interventions, nursing

interventions, mental health interventions, and public health interventions, among others. The medical and surgical interventions are based on ICD-9-CM, for the reason that it is in the public domain and can be freely used. The alpha draft of ICHI is available at the University of Sydney website. The Italian Collaborating Centre for the WHO-FIC is developing an interactive ICHI browsing tool.

The aim is to have ICHI approved at the World Health Assembly in 2019. The Alpha draft 2016 will be reviewed to produce the Beta draft by mid-2017, which will be further reviewed and tested to complete the final version in early 2018.

Richard invited members of the APN to join in the review and testing of ICHI and its accompanying materials and to exchange ideas about how ICHI could be used in APN countries.

4- ICF introduction – Presentation by Andrea Martinuzzi

As ageing changes the landscape of health services, with more and more people receiving treatment for chronic conditions and the focus of services shifts from "cure" to "care," the importance of the International Classification of Functioning, Disability and Health (ICF) is increasing as a tool that meets the challenges of the 21st century.

The ICF conceptual model captures data on persons with disability as well as environmental factors and personal factors. For example, in the case of a grandmother with arthritis who has a problem buttoning up the coat of her granddaughter, the body structure that is affected is in the joint, the body function affected is mobility, the activity limitations are in buttoning up the coat, in other words, caring for others, and participation limitations is in interacting with her granddaughter. ICF can capture all of these elements that encompass a person's experience.

Another important concept of ICF is that it sees functioning and disability on a continuum, for instance, that extends from full vision to complete blindness. There is no preset level where disability begins, and disability and functioning, which is influenced by a person's environmental and personal factors, could change over time, for instance, when a person gains functionality after rehabilitation.

The aim of ICF is to provide a systematic coding scheme for health information, to give a scientific base for understanding health outcomes and determiners, and enable international comparison of data and systems. ICF has a wide range of usecases, including statistical and epidemiological surveys, data collection, monitoring and assessment, rehabilitation evaluation, case-mix systems, education, and community care. It can also be used with ICD to capture data on both conditions and functioning of a patient.

ICF is a tool but it does not necessarily provide the solution. It is up to the user to decide how the ICF conceptual model can be applied to a problem at hand and design a solution with ICF to capture the reality.

5- <u>Result of ICD-ICF use in Thailand – Presentation by Chompunut
Pongakkasira</u>

There are around 30,000 new cases of disability a year in Thailand. The total number of persons with disability in Thailand is from 2 million to 5 million. Those who have been screened and registered as having disability in the following nine categories of disability can receive social benefits: vision, hearing, communication, mobility, body image, mental problems, autism, intellectual problem, and learning disability. Body image, such as a burn of a person's face that may inhibit employment and social participation, and autism were added in an effort to lessen the social stigma of having those conditions. The disability certificate is valid for five years and is not renewed once disability is cured.

A project for the joint use of ICD and ICF, carried out by Sirindhorn National Medical Rehabilitation Centre and the Thai Ministry of Public Health, was started five years ago in recognition of the fact that while ICD can capture data on the causes of disability, it could not capture data on functional performance for improvement of the capacity of persons with disability. National data on disability and functioning could also be used for policy advocacy and to provide evidence for budgeting disability benefits.

A committee of disability-related experts was established. Training on data collection was provided, a field trial was conducted at nine hospitals, including a pediatric hospital, on 16,000 cases using a selected ICF code set, and the results were provided to the expert committee.

One of the major issues in promoting the use of ICF is the need to persuade physicians and other health care professionals to use ICF when issuing disability certificates. There is a training manual on the use of ICD and ICF, and there are workshops for physicians and other health care professionals. However, the capacity and budget is limited to provide sufficient education and training on ICF coding.

The project is still ongoing. A small number of hospitals have begun to send ICF data to the ministry.

6- <u>Interactive discussion (Q&A)</u>

On the use of ICF in Thailand, Ros Madden suggested the use of the environmental factors for discharge planning during the early stages of a hospital stay, which evidence showed reduced the length of stay and saved money. Chompunut said that although environmental factors were not included in the ICF core set used in Thailand, she hoped to include them in the future and appreciated the advice. She said that the core set was selected mainly by ICD experts from major institutions and lacked sufficient input from ICF experts, particularly in relation to major life areas after discharge. With respect to pediatrics, some efforts were made to use the ICF-CY and other tools in children's rehabilitation facilities.

Michael Millington asked if there was a strategic direction for each of the boxes of a matrix – with macro/policy, meso/system, and micro/personal levels as the rows and

situation analysis, assessment, planning, action, and outcome as the columns – presented by Andrea. Andrea replied that the 15 boxes were what the goal should look like and that the aim was to expand what is now scattered use of ICF to a broader use of ICF with chronological continuity. Catherine suggested using the matrix as a tool for implementation and advocacy. Andrea agreed that it could be used to show evidence of continuity. Ros indicated that there could be alignment with community-based rehabilitation (CBR), which uses monitoring tool for functioning and disability using ICF and a PDCA (Plan-Do-Check-Act) cycle, in ways that would give more power in information management and in negotiating with funding organizations regarding their information needs.

Takenobu Inoue, who is a member of ISO working group, noted that he would like to see some changes in the ISO rules governing ISO 9999 on assistive products so that they could be made more accessible for use in ICHI. He observed that it was meaningful for ICHI's assistive devices classification to include service provision. Catherine reported that the Global Cooperation on Assistive Technology (GATE) initiative, a WHO project on innovation and technology, identified 50 priority assistive devices for governments to enable their populations to function better. It was remarked that it would be worth mapping the 50 priority assistive devices to ISO 9999 and ICHI.

7- Closure

Catherine thanked the Thai Collaborating Centre for hosting the joint meeting of the APN, EIC and FDRG and Japan Hospital Organization for organizing the meeting. Catherine thanked all for participating and declared the meeting closed.