



WHO Family of International Classifications (FIC)

NEWSLETTER

ICanFunction (mICF) mHealth solution

A Mobile Solution for the International Classification of Functioning, Disability and Health

Editorial Board

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An International mICF Partnership was formed in 2014 to collaborate on the development of the ICanFunction (mICF) mHealth solution. The mICF is a mobile-friendly health service solution providing an integrated care decision-support system that will facilitate individualized, predictive care by utilizing big data models. Out of this collaborative, a facilitation team of nine persons (see names on page 2) emerged to coordinate the implementation through various working groups including: content specification; lean design of minimum viable product (MVP) and technical implementation; disciplined in-market experimentation; dissemination and agile commercialization (see figure 1).

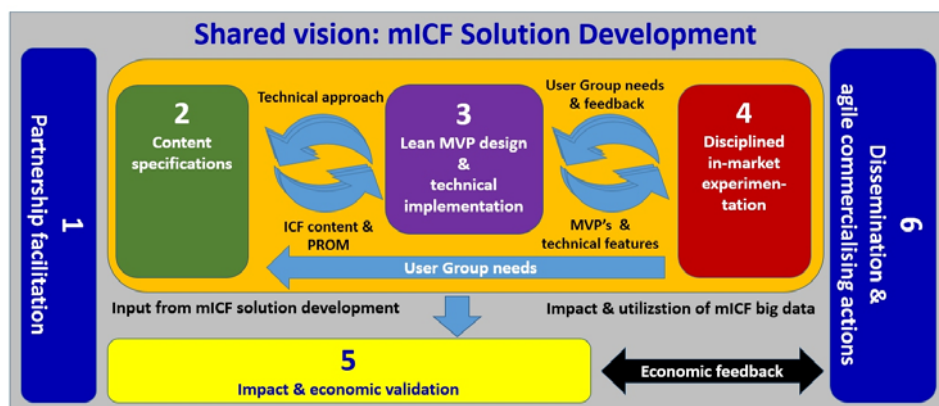


Figure 1: Six interrelated work packages to develop mICF solution

Contents

mICF mHealth Solution	1
Editorial	2
International organizations	
International Org. for Standardization	3
World Confederation for Physical Therapy	3
World Health Organization	4
FIC around the World	
Japanese health intervention classifications	6
Early interventions in Cerebral Palsy	8
ICF References	9

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The Facilitation team

To engage mICF with the broader community a dedicated website was launched: <http://icfmobile.org>, as well as a Twitter (@icfmobile) and Facebook (<https://www.facebook.com/ICanFunction>) account. Subsequently, for effective partnering and fostering trust relationships, a Memorandum of Agreement (MoA) has been finalised to serve as a guide for our collaboration.

At the previous WHO-FIC annual meeting in Manchester, six posters were presented and a poster prize awarded for the presentation of the mICF Development Plan. For developing a Proof of Concept (POC) of mICF, grant proposals were prepared and Finland succeeded to get a one-year project funded by the Social Insurance Institution (Kela). Abstracts to present mICF were submitted and accepted for several conferences including the Rehabilitation International Conference (Edinburgh), the 2nd PHO Conference (Copenhagen), ICT4Health conference (Cape Town), Towards Unity for Health conference (Johannesburg) and last, but not least, the Stanford Medicine X conference in the USA coming September. An article presenting mICF has been written to Special Issue on Knowledge for Disability Inclusive Development and is currently under peer-review.

(continues on page 2)

Editorial

Nights get shorter, days are longer. Northern hemisphere summer is present. For a lot of people also the time to go on a holiday. And what better reading material to take with you than the WHO-FIC Newsletter?! In this issue we publish contributions from the mICF collaborative, we have updates from both the WCPT as well as the ISO. In the rubric 'FIC around the world' we have an article about comparing intervention classifications from Japan and a conference report on ICF-CY applied in cerebral palsy from the Netherlands.

In fact, all reference classifications are represented in this issue: we have got news on ICD, ICF and on ICHI (2x!). And as always, the last pages are filled with ICF literature references from our ICF literature database. This issue we publish over 150 ICF related references.

This leaves me with wishing you all a nice and relaxing summer (depending on your location) and hoping to see you at the WHO-FIC 2016 annual meeting and ICD-11 revision conference in Tokyo in October! In the meantime, please share your thoughts and experiences on using WHO classifications with us, and send us your contributions! Please also feel free to send us your feedback on Newsletter articles should you feel compelled to do so.

Enjoy reading and let us know your WHO-FIC news!

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ICanFunction (mICF) mHealth solution

(continues from page 1)

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The content specifications

The content specifications group has taken in use the Term Editor developed by the National Institute for Health and Welfare (THL) (Finland) with funding support by the Social Insurance Institution. . The Term Editor is open source software suited for developing and maintaining terminologies, ontologies and information structures. The content of the multi-language term editor for mICF includes ICF terms (labels, categories, codes), natural language terms

(i.e. related terms and synonyms) and instruments to measure functioning.

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The mICF development includes big data analysis by connecting front end data capturing (the interface) with the back end (ICF Term Editor) (see figure 2). Currently the MVP prototype front end (interface) of mICF is bilingual in Finnish and English (see mock up derived from Finnish: <https://projects.invisionapp.com/m/share/B77HCQ5XZ#/162952446>). However, the front end can be of various interfaces and languages depending on the user group as presented in figure 2. For example: interfaces can be problem-oriented or goal-oriented. Currently, the back end (the Term editor) includes English, Finnish, Danish, Portuguese, Dutch, and German ICF terms. If funding becomes available, the plan is to add the Japanese, French, Chinese, Russian, Spanish and Swedish languages. The scalable design will allow the inclusion of all other languages as well. To link the natural terms to the ICF terms, a protocol has been developed and is in the process of ethical approval in several countries.



Figure 2: mICF vision of connection between various front ends, big data warehouse and Term editor

Lean minimum viable product (MVP) design

In Finland a feasibility study of a patient-driven ICF-based assessment tool is in progress. The user experience and acceptance will be tested with children and adults of short stature. The aim is to evaluate how this solution assists in shared decision-making. Data are collected in individual and focus group interviews from the service users and providers. Data from service users will also be compared to data provided by the mICF (see www.thl.fi/en/micf). A follow-up project, to integrate the user interface to the Finnish national health archives, is planned. Pilot projects are being planned in the Netherlands, Germany, Denmark, Portugal, South Africa, Canada and Brazil.

Big data analytics

For collecting anonymised *m*ICF data to enable big data analytics, various cooperation possibilities with service user organisations and service providers are being explored. In cooperation with Stone Three Venture Technologies (South Africa), big data modelling will be explored with the Dutch BigMove Institute Amsterdam and with the Japan Association of Geriatric Health Services Facilities (Zenroken).

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International Organizations

International Organization for Standardization

Status of the fifth revision of the ISO 9999: the ISO 9999:2016

The fourth revision of the ISO 9999: Assistive products for persons with disability – Classification and Terminology (ISO 9999:2011) was published in July 2011. The responsible subcommittee (ISO TC 173/SC 2) decided to start a new revision of ISO 9999, and a new work item proposal (NWIP) for the revision of ISO9999:2011 was accepted in November 2011. In parallel, SC 2 established a new working group, WG 12, in order to handle the fifth revision of ISO 9999.

ISO9999:2016 available in August or September

Now, almost four and half years later, the Final Draft International Standard (FDIS) is finished and voting has started on June 1, 2016. The voting will end on July 27. The ISO office will circulate a report on FDIS ballot ultimately on August 11 and then ISO9999:2016 will be published in August or early September provided that the FDIS voting is approved.

Next revision

The secretariat of ISO TC 173/SC 2 will be able to establish a committee internal balloting (CIB) ballot for NWIP for next revision just after the circulation of the report, that is on August 11 or earlier when the report is circulated earlier. A ballot for the NWIP is two months provided that a

resolution is made among SC 2 members. Just in time for the next meeting of SC 2 and WG12 on October 13/14 2016 in Tokyo; in which meeting the results of the ballot are available and SC2 is able to discuss/confirm the NWIP. This will be the start of the sixth revision, which will probably result in a new version of ISO 9999 in 2021.

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World Confederation for Physical Therapy

Where the world of physiotherapy meets

The World Confederation for Physical Therapy is the international voice for physical therapy/physiotherapy. The confederation represents more than 350,000 physical therapists through it 112 member organizations. Every two years the WCPT holds the largest international gathering of physical therapists to showcase the best research, to network and celebrate the profession and its significant role in improving health and wellbeing.

2017 Congress in Cape Town

The next WCPT Congress is to be held on 2nd - 4th July 2017 in Cape Town, South Africa. Pre- and post-congress courses will be held on the days before and after. It is the people who attend a WCPT Congress from all around the world who give the event its unique sense of global professional unity. At no other event are there such opportunities for the physical therapy community to network with colleagues from around the world and interact with international leaders in their field. It is where the world of physical therapy meets.



Focused symposia central to congress program

Already, members of the International Scientific Committee are putting together the congress program. They have been selected for the breadth of their experience to ensure that the congress is relevant to all physical therapists, whatever their professional interest and whether they work as a clinician, manager, researcher, student or educator.

Focused symposia are central to the congress program; these and the pre- and post-congress courses have been selected. First glimpses of the congress program will be published in July.

WCPT hopes that all physical therapists will embrace this opportunity to attend the largest international physical therapy gathering. It is through extending our knowledge and connecting with colleagues from different cultures and backgrounds that we strengthen our profession advancing practice for the benefit of populations and the individual patients we serve.

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World Health Organization

ICD-11 Revision conference

From 8-12 October 2016 the annual meeting of the WHO Family of International Classifications Network (WHO-FIC) will take place in Tokyo, Japan. The theme for this year is: "Health Information in the New Era". In conjunction with this meeting, the ICD-11 Revision Conference will be held from 12- 14 October, also in Tokyo.

Goal of ICD-11 Revision Conference

The ICD-11 Revision Conference will bring together representatives of Ministries of Health, representatives of national statistical agencies, academics, and others to:

- review current progress;
- address questions about practical aspects of the classification; and
- identify remaining issues or concerns from these high-level stakeholders.

Active participation of member states needed

It will be the highlight of the ICD Revision Process to date, and will represent a major opportunity for stakeholders to provide input into ICD in terms of national requirements and requests for implementation support before finalization and publication of the ICD-11-MMS. As evidenced by the discussion and contributions of the Executive Board, Member State participation in the ICD-11 Revision Conference will be of critical importance to the success of ICD-11. The Conference will reflect on the advances made, outline implementation approaches, and identify the way forward in 2017 and 2018.

Joint Task Force progress

In anticipation of the Revision Conference the joint task force took several key decisions, and significant technical work was completed, including:

- Given feedback on the terminology used, a decision was taken to rename the Joint Linearization for Mortality and Morbidity statistics as the International Classification of Diseases, 11th Revision, for Mortality and Morbidity Statistics (ICD-11-MMS).
- ICD-11 will undergo structural changes in governance

reflective of the transition from development to update and maintenance.

- With the governance changes, additional focus will be placed on the informatics aspects of ICD-11, including mobile and web services WHO may provide to Member States in support of implementation.
- A release of the ICD-11-MMS will take place at the ICD Revision Conference from 12-14 October 2016 in Tokyo, Japan. Important to note, though, that the Tokyo Release will not be the "final" version of ICD-11, nor will it be ready for implementation in countries. This release will represent a high-level overview of the structure of the ICD-11-MMS to support discussion about national requirements and support for implementation.
- Definitions for each category are seen as a useful advancement in ICD-11 to help guide users to the correct code, but will need further technical editing before they can be released. As such, the Tokyo Release of the ICD-11-MMS will not include the draft text definitions.
- The JTF is currently focused on a new, rapid, and optimistic mechanism for high-level review of each individual chapter in advance of the Tokyo Release of the ICD-11-MMS.

More news on the ICD-revision and the revision conference can be found in WHO's ICD-11 newsletter:

http://www.who.int/entity/classifications/2016_06_20_ICD11JuneNewsletter.pdf

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Classification of interventions in mental health care: the ICHI way

The demand for an international standard classification of mental health interventions is growing, as this is necessary to support data collection and electronic health records for care monitoring, health logistics, management, planning, financing and research purposes. There is currently limited systematization and categorization of mental health care, at

either national or international level. The International Classification of Health Interventions (ICHI) can provide an international standard for collecting and reporting data on mental health interventions, and may be further helpful in improving existing national classifications of health interventions.

Mental health interventions covered in ICHI

First steps towards a classification of mental health interventions within ICHI were taken in 2011, during a workshop in Sydney, Australia. Since 2011, work has continued to progressively expand the coverage of mental health interventions in ICHI. However, significant progress in the development of a comprehensive classification of mental health interventions within ICHI has been made this year. In February 2016, a meeting focused on mental health, involving 10 experts from Italy, Sweden and Australia, was held in Trieste, Italy. A review of axis categories and intervention codes relevant to mental health was conducted. Options for improving the coverage and description of mental health interventions in ICHI by adding, deleting or modifying codes were considered. There were further discussions, involving participants from three WHO regions, during the FDC-ICHI mid-year meeting, held in May 2016 in Conegliano, Italy.

ICHI targets relevant for mental health

In ICHI, codes of particular relevance for describing mental health interventions are those that target 'Mental functions' (based on ICF categories in Chapter b1), and those that target 'Health-related behaviours', as well as interventions that target 'Activities and Participation' and 'Environment' (based on ICF Chapters in Activities and Participation and Environmental factors domains). Key changes agreed for ICHI 2016 to improve coverage of mental health interventions are summarized below.

Review of interventions targeting 'Mental functions'

A review of the interventions to 'Mental functions' targets was undertaken. It was agreed, as a general principle, that interventions used in mental health should utilize the targets 'Mental functions' (ICF chapter-level), 'Global mental functions' and 'Specific mental functions' (ICF block-level), and not the more detailed targets at ICF 3-digit level. If greater detail is required, more specific targets can be recorded using an extension code added to the classification for this purpose. This change will result in a more parsimonious system of codes for mental health interventions. The existing intervention codes with more specific 'mental functions' targets will mostly remain in the classification where they are needed to describe interventions typically delivered by nurses or allied health professionals (e.g., 'Assessment of consciousness function').

Interventions targeting 'Health-related behaviours'

The 'Health-related behaviour' targets were reviewed from a mental health perspective. Several new targets that were

needed for describing interventions within mental health care were added: Self-harm, Family and partner violence, Community violence, Gambling, and Digital technology use. Other targets relevant to mental health care, such as Alcohol use, Tobacco use, Illicit drug use and Eating behaviours, were previously part of 'Health-related behaviour' section. Targets' definition is still under revision and small changes may be added prior to their publication in ICHI Alpha 2016.

Examples of health-related behavior targets

Examples of targets' definition in 'Health-related behaviour' section, relevant to mental health, include:

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

Work is progressing to develop sets of intervention codes for each of these new targets for inclusion in ICHI Alpha 2016.

These health-related behavior targets could be used in intervention codes like:

- Assessment of Family and partner violence behaviours
- Test of self-harm behaviours
- Education about behaviour concerning patterns of alcohol consumption
- Counselling about gambling behaviours
- Capacity building interventions targeting illicit drug use behaviours

Actions: seclusion, restrain and "stabilizing"

ICHI Alpha 2015 included the action categories 'Seclusion' and 'Restrain', and the interventions 'Seclusion in order to avoid self-harm' and 'Applying restraint to a person'. The 2013 UN resolution A/HRC/22/53 states very strongly that seclusion and restraint should not be practiced, as they "may constitute torture and ill-treatment", and WHO recommends outlawing the improper use of these actions. Therefore, it was agreed to delete the actions 'Seclusion' and 'Restrain' and the corresponding intervention codes from the classification. A new action, called 'Stabilizing', was agreed

upon. This action can be used for a range of interventions, from the stabilization of blood pressure to mental care interventions, including pharmacological stabilization by compulsory treatment order.

Peer support interventions

Peer support (FA) has been added to the Means axis, to be used together with the action ‘Provision’ to describe interventions in which a health provider establishes a peer support network or links a patient with a peer support person. The means category ‘Peer support’ is defined as ‘Emotional, social and practical assistance given by a person/group who possesses experiential knowledge of a specific behaviour or stressor’. A set of new ‘peer support’ codes for mental health and public health interventions will be included in ICHI Alpha 2016.

Example of provision of peer support includes:

- Providing emotional, social and practical assistance to behaviour concerning patterns of alcohol consumption - given by a person/group who possesses experiential knowledge of a specific behaviour or stressor.

Conclusions

These changes to axis categories, and corresponding revision of the tabular list of intervention codes in ICHI Alpha 2016, will enable more comprehensive representation of mental health interventions, so that ICHI is better able to meet clinical and statistical information needs. The availability of a standard classification of mental health interventions as part of a broader international classification of health interventions will be valuable in ensuring that mental health care is visible in health information systems.

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FIC around the World

Japan

Comparing ICHI to the Japanese health intervention classifications

In 2007, International Classification of Health Intervention (ICHI) development was launched. The aim of ICHI development is to provide a basis for international

	List of medical service fee (National classification)	Japanese Health Insurance Federation for Surgery (JHIFS)' classification (Private classification)
Developer	Ministry of Health, Labour and welfare	Japanese Health Insurance Federation for Surgery (JHIFS)
Aim	To make a list for medical service fee	To analyze proper and reasonable medical service fee scientifically To establish rational system of medical service fee
Revision cycle	2 year (since 1950s)	2 year (since 1982)
Basic structure	4-digit code (1 alphabet + 3 figures)	7-digit code (Combination of alphabets and figures) Consist of 4 parts <ul style="list-style-type: none"> • Target (3-digits) • Action (2-digits) • Approach (1-digit) • Assisting device (1-digit)

Table 1: Two major classifications of health interventions in Japan

comparisons of health interventions as focus on the efficiency, structure and quality of health systems. ICHI is still under development and preliminary version “ICHI Alpha 2015” is available. ICHI includes interventions across all functional sectors of the health system, covering acute care, primary care, rehabilitation, assistance with functioning, prevention, public health, and ancillary services such as patient transport [1].

Japanese health intervention classifications

There are two major classifications of health intervention in Japan. One is the so-called “National classification” (Medical service fee-schedule) and the other is the Japanese Health Insurance Federation for Surgery (JHIFS) classification. Japan achieved universal health coverage in 1961[2]. Uniform fee-schedule was implemented across the countries since 1959, all health interventions performed in hospitals and clinics are included in this fee-schedule. This fee-schedule has been revised every two years, in order to keep up with development of medicine, reform of the health care system and improvements in quality of care. On the other hand, JHIFS has created JHIFS classifications since 1982. JHIFS is kind of consortium composed of 100 societies regarding surgery. The aim of JHIFS classification is to analyze Medical service fee-schedule scientifically on the basis of hospital surveys (Table 1). These hospital survey components include surgical skills, the number of medical staffs such as surgeons, nurses and so on, the amount of time, and medical materials, and add up to the total (estimated) cost of each health intervention.

Characteristics of JHIFS

JHIFS classifications are composed of 4 Values such as “Surgical Operation Value”, “Medical Procedure Value”, “Medical Examination Value” and “Anesthesia Value”. The coding scheme of Surgical Operation Value comprises 7-character structure and for the four axes; “Target (3-character)”, “Action (2-character)”, “Approach (1-character)” and “Assisting device (1-character)”.

The main purpose of this study is to make comparison and code-mapping between ICHI and JHIFS classification as to report health intervention statistics according to ICHI. Furthermore, we explore the possibilities to contribute the development of ICHI.

Methods

Surgical Operation Value ver.8.3 (released in 2015) in JHIFS classification was compared with ICHI Alpha 2015 in terms of basic structure in surgical area such as “Target”, “Action” and “Means” in ICHI and “Target”, “Action”, “Approach” and “Assisting device” in JAHIFS classification by 2 experts who are engaged in development of JAHIFS classification. Furthermore, code mapping in “Cholecystectomy”, Hepatic and biliary structures” and “Taking out without replacing” was performed by using both classifications.

Results

Table 2 shows the overview of both ICHI and JHIFS. Section 1 in ICHI (Interventions on Body Systems and Functions) seems to correspond to Surgical Operation Value codes in JHIFS classification. The number of codes in ICHI and JHIFS are 3838 and 2033 respectively.

ICHI code	JHIFS classification code (only Surgical Operation)
<ul style="list-style-type: none"> The number of codes : about 5300 Section 1: 3838 Section 2: 849 Section 3: 598 	<ul style="list-style-type: none"> The number of codes : 2033 - 3386 surgical operations are included in classification - Collecting several surgical methods into 1 code.
Section 1: Nerve systems : 356 Eye : 188 Ear : 100 Blood system : 145 Endocrine : 102 Cardiology : 370 Respiratory : 264 Digestive : 660 Skin : 177 Musculoskeletal : 487 Urogenital : 606 Other : 383	Nerve systems : 134 Eye : 84 Ear : 44 Head : 183 Cardiology : 223 Respiratory : 80 Digestive : 344 Skin : 40 Neck, Thyroid : 16 Breast : 14 Musculoskeletal : 596 Urogenital : 230 Obstetrics and Fetus : 15

Table 2: Comparison of numbers of surgical intervention codes in ICHI and JHIFS

Comparing basic structures

Table 3 indicates the result of a comparison between ICHI and JHIFS in term of basic structure. Though there are some differences between Means in ICHI and Approach and Assisting device in JHIFS, it can be seen that the basic structure in both classifications are very similar. In Target, there is more specific structure of code in JHIFS than in ICHI, but conversely, in Action, there is more detailed structure in ICHI than in JHIFS.

Tables 4a through c explains the results of code mapping in “Cholecystectomy”, “Hepatic and biliary structures” and “Taking out without replacing”.

	ICHI code	Surgical Operation Value's code in JHIFS classification
Target	<ul style="list-style-type: none"> 3-character code Number of codes : 635 “Target” is mainly categorized in Section 1,2,3 Section 1 include codes for organs : 424	<ul style="list-style-type: none"> 3-character code Number of codes : 1046
Action	<ul style="list-style-type: none"> 2-character code Number of codes : 135 Diagnostic:16 Therapeutic:79 Managing:16 Preventing:24	<ul style="list-style-type: none"> 2-character code Number of codes : 66 Including actions related to therapy, not including diagnostic, managing and preventing
Means (ICHI) / Approach and assisting device (JHIFS)	<ul style="list-style-type: none"> Number of Means codes : 59 Approach : 12 Technique : 22 Facilitator : 3 Method : 14 Sample : 7 Unspecified : 1 	<ul style="list-style-type: none"> Number of Approach codes : 6 Number of Assisting device codes : 12

Table 3: comparison of ICHI and JHIFS basic structures

Conclusion

This is the first study to make comparison between ICHI and JHIFS classifications. This study showed the possibilities to report health intervention statistics according to ICHI by creating code mapping between ICHI and JHIFS. In addition, an unique finding is that there are some inconsistencies between ICHI and JHIFS in terms of specificity of code. This implies that the concept and structure of both ICHI and JHIFS classification would be informative materials to develop each classification.

ICHI		JHIFS classification	
Code	title	code	title
KCF JK AA	Cholecystectomy	Q81A204	Cholecystectomy (laparotomy)
		Q81A207	Cholecystectomy on malignant tumor (Localized within gallbladder)
		Q81A200	Cholecystectomy on malignant tumor (with resection of part of liver)
		Q81A200	Cholecystectomy on malignant tumor (with hepatectomy)
		Q81A207	Cholecystectomy on malignant tumor (with pancreatoduodectomy)
		Q81A200	Cholecystectomy on malignant tumor (with hepatectomy and pancreatoduodectomy)

Table 4a: Cholecystectomy

ICHI: Target		JHIFS classification code: Target	
Code	Title	Code	Title
KCF KCM	Gall bladder Bile duct	Q80	Gall bladder and bile duct
		Q81	Gall bladder
		Q82	Cystic duct
		Q83	Common hepatic duct
		Q84	Intrahepatic bile duct
		Q85	Extrahepatic bile duct
		Q86	Hilar bile duct
		Q87	Common bile duct
		Q88	Bile duct of duodenal papilla

Table 4b: Hepatic and biliary structures

	ICHI		JHIFS	
	Code	title	Code	title
Taking out without replacing	AD	Biopsy	A9	Biopsy
	JL	Excision, local	A1	Excision/Resection
	JJ	Excision, partial		
	JK	Excision, total		
	JL	Excision, extended		
	JN	Amputation	A3	Amputation

Table 4c: Taking out without replacing

Acknowledgement

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Conference report on “Early intervention in the light of the ICF-CY”

From April 7th to 9th 2016 a conference was held at the University of Groningen with the title:
Early Intervention – The power of parenting and practice, early intervention in the light of the ICF-CY.

Early intervention in Cerebral Palsy

Two in every 1000 newborn infants is later diagnosed with cerebral palsy (CP). CP is caused by a lesion of the brain during early development. Current early diagnostics allow for the detection of a large proportion of these infants at early age. This offers the opportunity for intervention at an age that is characterized by high plasticity of the young nervous system.

Most knowledge on these early interventions is based on studies in high-risk infants without a lesion of the brain, i.e., without CP. In these infants early intervention programs promote cognitive development until preschool age; motor development profits less. Up until recently little was known about the effect of early interventions in infants later diagnosed with CP. Recently completed trials started to close this gap in our knowledge.

Medical perspective versus biopsychosocial model

The ‘medical’ perspective has been prevailing for a long time, but as several ‘medical’ disciplines are becoming

more and more aware of the fact that while a medical diagnosis can –sometimes- explain an underlying cause for a health problem, it does not explain the not-so-standard reactions to a specific treatment on the level of functioning of a patient. We can also state that no two persons would have the same functioning-profile, even if they have the same disease/health problem. In fact we need to think differently about what constitutes health to be able to understand the complexity of health and health-problems, such as CP.

This is where the ICF, and more specific the ICF-CY, appear on the scene. The ICF and ICF-CY both share the same aim: to provide an unified standard language and framework for the description of health states. Especially the framework offers a new way of thinking about health in what we call the biopsychosocial model. “The ICF(-CY) and ICD together provide us with exceptionally broad and yet accurate terms to understand the health of a population, and more specific how the individual and his or her environment interact to hinder or promote a life lived to its full potential“ (Bruntland, WHO Director General, May 2002).

Conference program

The themes of the conference were structured on the basis of the framework of the ICF-CY. Presenters from several health disciplines, from all parts of the world, participated in the conference.

First, the scene was set by a presentation on Early Intervention in the light of ICF-CY. Next, from a body function and structure perspective novel insights in neural plasticity were presented. This includes a discussion on the possibilities of stem cell therapy. Following sessions were structured according to:

- Interaction between body structure and function and the environment
- Early intervention: practice and its effect on body function, activities and participation
- Early intervention: parenting and its effect on the child’s activities and participation and family function
- Early intervention: modification of the environment and its effect on the child’s activities and participation and family function. For an overview of presenters and topics, refer to: <http://www.developmentalneurology.com/2016/programme.html>

At the end of the three day congress, the organizer Mijna Hadders-Algra, returned to the framework of the ICF-CY, and reflected on all the presentations and challenges to work towards this new way of thinking about health and disability.

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