This seventh meeting of the JTF was convened to assist WHO in review of Member State comments, feedback from field quality assurance and address issues related to structure for chapters 14, 23 and 24, some detailed clinical categories, transition management for implementation of ICD-11, and planning the next steps towards the release of ICD-11 in 2018.

Contents

1 Feedback from Member States .................................................................................................................. 2
2 Input from field quality assurance (FQA) .......................................................................................................... 3
3 Update on mapping work ............................................................................................................................... 4
4 Mortality testing progress ............................................................................................................................... 5
5 Chapter 23, ‘External causes’, final draft ........................................................................................................ 6
6 Chapter 24, ‘Factors influencing health status or contact with health services’ ............................................ 8
7 Chapter 14, ‘Diseases of the skin’ ................................................................................................................ 8
8 SNOMED CT discussion ................................................................................................................................ 9
9 Discussion papers .......................................................................................................................................... 9
  9.1 Lyme disease ............................................................................................................................................ 9
  1.1 Postcoordination of manifestations ........................................................................................................ 10
  1.2 Insect bites ............................................................................................................................................. 11
  1.3 Sequelae ............................................................................................................................................... 11
  1.4 Sepsis ................................................................................................................................................... 12
10 Overview of quality and patient safety coding ............................................................................................ 12
11 Functioning pattern approach and allocation in ICD-11 ............................................................................. 13
12 Code structure - update ................................................................................................................................ 13
13 Transition for countries with and without national modifications ............................................................. 14
14 WHO Family of International Classifications (FIC) paper ......................................................................... 15
15 Next Steps .................................................................................................................................................. 15
  1.2 Steps to Mexico conference and agenda preparation ............................................................................. 15
  1.3 Outlook post 2017 ................................................................................................................................ 16
16 Annex 1 - Agenda ...................................................................................................................................... 19
17 Annex 2 - List of participants ...................................................................................................................... 21
1 Feedback from Member States

Overview
- To date over 20 responses have been received from Member States (MS), including Eurostat. Two states have asked for an extension
- Compilation of MS comments (anonymized) circulated to all members of JTF
- Comments were supportive of the present development of ICD-11 and recommendations or suggestions for improvement of ICD-11 addressed known points.
- Notable issues raised in the comments included:
  - The use of postcoordination and need for more guidance
  - The updating of mortality rules
  - Resources and timelines for implementation
  - Readiness for implementation
  - The joint use with SNOMED CT
  - Relevance of postcoordination for mortality
- Additional comments addressed specific topics of individual chapters.

Discussion
- WHO may need recommendations from the TF to address some statements, and state issues can be fixed but help will be needed. Clarification on the next steps after the end of this year are necessary. Countries are continuing to assist on a classification that they are not yet using. The plans do foresee that some specific work can be done after the release for implementation. So, the structure will be stable but user guidance will be further improved. ICD-10 is regularly updated while waiting until ICD-11 is released. However, WHO has to roll out ICD-11 in order to start implementation in countries.
- Based on the Member State comments, recommendations from the JTF include:
  - Creation of a table that includes Member State comments (anonymized) and WHO response, or progress of action taken
  - That there be a transparent updating mechanism and governance
  - Codes are stable
  - A definition of ‘readiness’ from the JTF perspective is provided
  - Education/training is essential
- WHO advised that the next steps would include:
  - Determination of the priorities for the release version
  - Information sharing,
  - A review meeting to be held in December,
  - Finalisation of the content.
- WHO highlighted that an ICD-11 training session for the whole WHO-FIC Network will be undertaken at the WHO-FIC Annual meeting in Mexico City in October 2017 but it will still be important to have dedicated training sessions with Member States. Regional workshops for training and information sharing on ICD-11 will occur in the course of this year.
- The release version 2018 is to be used for implementation. The expectation is that initially, more updates will be needed because some issues will be identified only as the classification begins to be used.

Criteria for readiness of the 2018 release version are:
- Availability of:
  - Tabular list
  - Index
  - Basic rules including postcoordination
  - Reference Guide
• Mapping tables to and from ICD-10
• Implementation package to include:
  o Advocacy
  o Training materials
  o Quick guide
  o Maps from and to ICD-10
• Stability of codes
• Described updating mechanism /governance

• In national implementation, all decision making levels need to understand the value added by ICD-11.
  ▪ Short paper needed to explain a country would want of ICD-11
• Member States need to know what they are using and what will happen with errors they find or changes they suggest
• For a release, ICD-11 needs to be stable, but with room for improvement. The message related to initial more frequent updating needs to be clear.

Action items
• JTF to continue to work on criteria for readiness of a release version of ICD-11, based on the set specified above, what changes after release are permitted and which ones are done only if absolutely necessary.
• JTF and WHO to formulate a paper on the need to move to ICD-11

2 Input from field quality assurance (FQA)

Overview
• Field testing has 2 components
  1) line coding which represent 47 priority areas and
  2) generic case coding to confirm the selected main condition.
• 23 countries are on their way to complete the line coding
• Draft outcomes, so far show a range of points that need to be addressed, in particular in user guidance:
  ▪ Coder errors
  ▪ Coder habits influencing code selection
• Other issues relate to the testing system or the classification itself, as system errors, ambiguity of line coding questions, classification terminological issues, handling of coding tool and browser, coding rules.
• There is need for more guidance for adverse events coding
• JTF should provide support on:
  ▪ The best way to communicate the results form field testing
  ▪ Explaining postcoordination
  ▪ Link field testing outcomes to the advantages of ICD-11
  ▪ Approaches to incorporate the results of FQA into the proposal mechanism
  ▪ Review of progress of FQA and related timelines
  ▪ Need for language specific FQA

• Other FQA and scientific reviews and testing include German medical societies, Dermatology, Quality and Safety (Q&S), Mortality, and Pain.
• Feedback from the German societies –
Not all the terms can be found; but all terms have to be translated onto English, first.
In total 11 large and small scale tests are ongoing. Results will be provided as soon as possible.
One test is designed to code almost all index terms from the German index to ICD-11: 70000 index terms from the German clinical modification are being mapped to the best fit in ICD-11 by 40 raters (2000 each).

- Q&S – undertaken a number of field trials –
  - Snowballing method was used where people were asked to share their feedback
  - 2 case studies tested how well health related harm could be linked to documentation.
  - Another case study is using discharge summaries.
  - Larger field trial doing full record coding using ICD-11 with trained coders is waiting to start.
- Dermatology field trials.
  - Dermatologists coded only dermatology terms.
- International Association for the Study of Pain (IASP)
  - An international group will test the utility of the categories related to pain in different countries

### Discussion
- The training material needs to be updated and available for use in the various trials.
- The meeting noted that from a primary care perspective, the level of detail and complexity of the Chapter 14, ‘Diseases of the skin’, are very high. Coders would get lost in the detail. Problems arise from mixed axes of classification and selection of a single category is not always easy.
- Differences exist in search results and related FQA outcomes between browser and coding tool. It appears some incorrect coding results in the field trials may have arisen because the coding tool was not used.
  - It was clarified that the coding tool is the reference for coding (alike the index for ICD-10). It provides a level of functionality that guides the users, but with a methodology that is different from the one used in the print index. In view of its design and the deep integration with ICD-11 foundation, it should be possible to implement the coding tool in all countries, for all languages - adding language specific search algorithms, as required.

### Action Items
- Chapter 14, ‘Diseases of the skin’, to be reviewed by non-dermatological expert and by a classification expert.
- Field trials to include skin cases.
- Statement on Coding Tool being the Reference Coding Tool needs to be communicated

### Update on mapping work

#### Overview
- Mapping has been done for all chapters, manually and electronically
- Currently reviewing the entities that have moved to different chapters, and entities that have no direct map.
  - One issue results from old dagger/asterisk combinations, that are now precoordinated but show inconsistency in allocation of the primary parent – some are to the aetiology and others to the manifestation.
The mapping also still identifies residuals of ‘hijacking’ of entities by TAGs for their own chapters.

Mapping of residual categories of ICD-10 needs further work

Discussion

- The meeting noted that some of the movements of categories were breaking the taxonomy rules. A rationale for the move needs to be obtained from the involved TAG, or the move undone.
- Genetic disorders should be moved back to the congenital chapter.
- Discussed the issues raised in the Discussion paper - Postcoordination of manifestations.
- Mapping in some instances needs to include cluster coding to allow easy coding of some detail that was precoordinated in ICD-10 and its clinical modifications.

Action Items

- WHO to move all congenital disorders into the Developmental disorders chapter.
- WHO to make sure that cluster coding is included in the mapping where necessary.

4 Mortality testing progress

Overview

- Only small problems were found, because testing has addressed only a small range of diagnoses at this stage.
- Issues were highlighted of the precoordinated terms with ‘due to’ or ‘associated with’ and the incorrect placing of some of these in the classification.

Discussion

- It was discussed if postcoordination can be used for mortality coding. It is already being used in Iris, in the form of flags that specify specific details on some categories.
- Postcoordination is already recommended for injuries and external causes
- Summary and JTF recommendations:
  - Postcoordination is possible and is already being used in mortality – it is necessary to define what the minimum level of postcoordination is.
  - ICD-11 MMS uses and should continue to use postcoordination for both mortality and morbidity.
  - Ask the mortality co-chairs to consider how we engage with others
  - The Reference Guide should depict what that looks like – granular examples could be reviewed
  - MRG need to be better informed and see examples
  - Develop a paper with examples and do some testing with some of the mortality people before the October meeting and ask for their comments and additional examples, as well as verify implications for electronic systems. The paper needs to go to the MRG members before the WHOFIC meeting in October.
  - WHO has resources to pay someone to do this work, with technical support by relevant mortality experts. Dedicated contractors need to be identified.
  - The authors of IRIS need to look at the software as to where it would need to be changed. Would also need to look at the mortality rules and determine how much they will need to be changed to fully address cluster coding. It is hoped that it is possible to use cluster code at all levels in Mortality coding.
Action Items

- Subgroup of the JTF to develop a paper with worked examples to enable a clearer sense of what is being proposed and supported by the JTF. If possible, the paper is to be written in a format that would enable it to be incorporated in part into the Reference Guide. The paper should be reviewed at the Iris meeting if time permits. The paper is to be circulated to the MRG members before the WHO-FIC meeting in October.
- Paper to be reviewed by - Volunteers from the JTF.
- Members of MRG and other mortality experts to do some testing and ask for input to address as many aspects as possible
- Support WHO in identifying experts that could be contracted for additional editing of the mortality rules in relation to the points mentioned above.

5 Chapter 23, 'External causes', final draft

Overview

- The chapter has been revised following advice by the JTF and statistical users at WHO.
- Precoordinated entities have been reduced from >3000 to <400
- The land transport section has been edited to place the on-road/off-road distinction at the first level after intent, in line with advice offered at the previous JTF meeting.
- Vulnerable road user types are distinguished in stem codes. Other road user types and the remaining characteristics that are distinguished in ICD-10 transport codes can be coded by clustering stem codes with extension codes.
- The Armed Conflict section has been revised based on a recommendation by WHO statistical team, with minor variations.
- The chapter makes now larger use of existing extension codes and the clustering mechanism
- Top level blocks where precoordination of intent was inappropriate or not applicable, have been revised.
- For the section on substances, there is the new name “Exposure to and harmful effects of substances” with 16 broad types of substances precoordinated that can be expanded for extra detail using extension codes, as desired.

Discussion

- Discussion did not include Q&S section as this was to be addressed later in the agenda.
- The new model has moved from single code use for mortality, to adopting a clustering version of incorporating the changes that the TAG had created.
- Mapping will be possible if clustered codes are used.
- Only the applicable extension codes should be used and preferably be listed in order of importance.
- Updates to Reference Guide will be needed to accommodate this new version of the external causes
- These changes were welcomed. It was noted that while the Armed Conflict section is shorter than before, it is long in the context of the much shorter new version of the chapter. It was recommended that it be shortened further. If feasible, the removed aspects could be converted into an extension section sub-classification.

In a breakout session, the present draft was reviewed in detail by a subgroup and the following points were reported back to the plenary:

- It needs to be described how much postcoordination will be required for reporting to WHO
should postcoordination match what is in ICD-10? Some Member States may not require any, while others will want to add postcoordination.

- Should postcoordination be mandatory or optional?
- Need to decide if the proposed stem code categories are enough, too many, or too few.

- It was advised that the section for railway events (missing in the draft) will be put back.
- Changed the order of the construct – Motor vehicle accidents has changed axes to on-road and off-road, with type of vehicle being an extension code.
- The object list currently in the extension codes is to be supplemented to ensure that it includes all objects that are pre-coordinated in ICD-10 external cause categories.
- Substances are mostly the same as in ICD-10 and have high level groupings. The INN will be the definitive source for medicaments to be used in cluster coding.
- Intentional self-harm has more precoordinated concepts.
- Special circumstances have been given their own categories
  - By tradition Legal intervention is not treated the same as assault
  - Exposure to extreme forces of nature does not have ‘intent’ assigned
  - Category for maltreatment will eliminate the need for maltreatment Syndrome in the injury chapter
  - Changes to Armed conflict following discussions with WHO statistical team

- ‘Space’ as a place of occurrence was missing and will be added.
- For substances, some ‘street names’ may need to be added. May need to add ‘Other’ and ‘Unspecified’. There needs to be a note that the use of ‘multiple drugs’ in Mortality should be limited when the drugs are not specified. Otherwise, there are mortality rules that apply.
- The new list is going to be sufficient for WHO to cover the causes of death for international purposes. It was noted that there will need to be some modifications to the death certificate to accommodate some of the changes for the postcoordination details.
- Rules regarding drugs will need to reflect the most dangerous drugs.
- Armed Conflict is more detailed now than Traffic Accidents and needs to be reduced. Use of postcoordination for adding detail.
- It was suggested that there needs to be a residual category for the extension codes describing the ‘intent to die’. This is particularly relevant to morbidity, as many intentional self-harm cases are not suicidal and ICD-10 provides no way to distinguish them from suicidal self-harm. The new proposal will need to be confirmed by the larger international community.
- The meeting asked if there was a default for when intent not known or mentioned or rules for defaulting. Decision to add a new ‘unknown intent’ category and use postcoordination for why it is not known. Postcoordination options to include:
  - Undetermined intent confirmed
  - Undetermined intent with ongoing investigation
  - Unknown intent

**Action Items**

- WHO to implement new structure and categories so they can be checked in the browser, and possibly be addressed in mortality field trials.
- WHO to update Reference Guide with information on the use of the external cause chapter.
- WHO statistical team to review Armed Conflict.
- J. Harrison will create a new optional list of postcoordination.
6 Chapter 24, ‘Factors influencing health status or contact with health services’

Overview
- Multiple revisions of chapter 24 have been undertaken in the last 2 years by different groups with different views.
- A full review needs to be done at this meeting with the focus on the intent of the categories within this chapter.
- Chapter 24 was last reviewed by J. Hargreaves and members of the MbRG and recommended changes are being provided for consideration by the JTF.
- Issues included
  - Inconsistent or incorrect terminology within the chapter
  - Adherence to the intent of codes within this chapter being for reasons for encounter or influencing a health condition but they themselves are not a disease, disorder or injury.
  - Organisation of the chapter and placement of entities were mixed or inconsistent.
- Primary care experts suggested changes to placement of certain categories and terminology used.

Discussion
- The meeting undertook a review of the chapter in a breakout session, addressing the points raised line by line.
- Specific discussion concerning the Q&S categories for ‘Provider performance’ concluded that these categories were more appropriately located within the external cause chapter or as extension codes.

Review
- The chapter was reviewed in breakout sessions for consistency, terminology and primary care needs.

Action Items
- Review to be undertaken by JTF members in breakout session during the meeting.
- WHO to make changes to Chapter 24 based on the line by line review of the JTF.

7 Chapter 14, ‘Diseases of the skin’

Overview
- A number of sources raised the point that there was too much detail within the chapter.
- Difficulties with locating required entities for Primary Care use.

Discussion
- The meeting was advised by the Chair of the former Dermatology TAG, that the categories were drawn from the foundation and that there are many that are relevant to the skin. To be sure that they could be found they were multiple parented. Feedback from the Dermatology trials was that it was easy to use and logical.
- JTF discussions highlighted the need for this chapter to be reviewed by a classification expert. A small group of the TF including Primary Care expertise will undertake this review.
- ‘Phythiosis’ and ‘protothecosis’ are to be moved to the infectious chapter (Ch 1.).
- It was suggested that categories referring to ‘Dermatitis’ could be all grouped together and postcoordination be used to describe the allergens.
**Action Items**

- WHO to provide a linearization output of the Chapter 14, ‘Diseases of the skin’, to be used for the review.
- Review of the Chapter 14, ‘Diseases of the skin’, by JTF members

**8 SNOMED CT discussion**

- Member state feedback included mention of the need for linkage with SNOMED CT. The linkage with SNOMED CT is slowly progressing. Measures to accelerate the progress and allow for extensive bilateral collaboration essentially consist of allocating sufficient resources for this work.
- SNOMED CT International is working on a mapping between SNOMED and the ICD-11 MMS.
- The common ontology would have allowed for a fully functional joint use of ICD and SNOMED CT. But neither SNOMED International, nor WHO have resources to continue the work on the common ontology. In the past, there has been support for this work by SNOMED International, but this is not the case now. Funding could be sought externally.
- Maps between SNOMED CT and the ICD: Not working on the common ontology has clear limitations. Mapping is not the best way to use the two systems together as the maps between SNOMED CT and ICD-10 have previously shown. For endorsement of such tentative maps, a process needs mutual review and a systematic methodology needs to be in place.
- With the previous experience of working with WHO and SNOMED CT, good integration between terminologies and ICD would be desirable. JTF is acknowledging the issues would support the creation of a subgroup dedicated to the joint use of SNOMED CT and ICD.
- James Harrison proposed a paper be written along these lines with C. Chute involved in the writing of it.

**Action items**

- WHO communicate the status of the linkage between ICD-11 and SNOMED CT
- A subgroup should be formed that would address methodology for joint use
- Small group to formulate a paper on mapping and relationship between SNOMED CT and ICD

**9 Discussion papers**

**9.1 Lyme disease**

**Overview**

A number of proposals have been added to the ICD-11 proposal platform requesting new entities for a number of conditions related to Lyme Borreliosis. The proposers are both researchers in the field of Lyme disease and there have been some ‘advocacy letters’ sent on this topic. WHO is requesting advice from the JTF as to whether these new entities should be implemented or not into the MMS or the foundation.

**Discussion**

- WHO advised members that several proposals had been received concerning Lyme disease and requesting precoordinated entities to be included in ICD-11.
- Consensus by members to only add combination terms when confirmed to be clinically correct.
1.1. Postcoordination of manifestations

Overview
The elimination of the dagger/asterisk system did not eliminate the need to capture the aetiology of certain conditions that are essentially manifestations of an underlying disease. While these conditions (e.g. myocarditis, arthritis, encephalitis) are often the focus of care in a morbidity setting, the need to capture their relevant aetiologies for mortality and morbidity primary data tabulation remains. Postcoordination in ICD-11 provides and promotes the ability to capture both the aetiology and manifestation and allows either to be coded first depending on the data needs of the use case. Some inconsistencies in the handling of former dagger asterisk combinations were introduced in earlier stages of authoring that need resolution.

Discussion
- The meeting discussed in detail the issue of the former dagger/asterisk combinations and the inconsistency in selection of the primary parent with some being the aetiology and others the manifestation. The question is whether or not these conditions can all be constructed equally in ICD-11, or is their rationale for differences in some cases.
- JTF advised to go with primary parenting decision on an individual basis (option 2 in the discussion paper). There is rationale for some of this type of condition to be classified differently. They may require precoordination because the manifestations have a different clinical presentation.
- Further discussions evolved around clustering and ordering of the codes within a cluster syntax. More descriptions and examples are necessary in addition to the description in the Reference Guide.
- The meeting discussed about the ordering in relation to the underlying cause of a condition in morbidity and underlying cause of death in mortality. The need and impact of a specific order for combination codes (e.g. diabetic retinopathy) has to become clearer. The sequence of codes does play a minor role in analysis, because ‘aetiology codes’ and pure ‘manifestation codes’ can be identified. The first mentioned in morbidity may refer to the specific reason for treatment. The problem is that a second code is always at risk of being lost and if this would be the etiological one, the comparability with mortality (focus on aetiology) would be limited.

Action Items
- WHO to favour former dagger asterisk combinations to be classified differently and some to be primarily parented to the aetiology, others to the manifestation. They may require precoordination because the manifestations have a different clinical presentation.” (option 2 of the discussion paper). If it is precoordinated in ICD-10 (specifically mentioned as a term), leave it precoordinated in ICD-11 – if not postcoordinate.
- Mortality group to look at the clustering - sequencing issue.
- A small subgroup of the JTF to look at the clustering-sequencing issue from the DRG perspective.
- Sequence and order of the codes as well as definitions of the terms ‘sequence’ and ‘order’ as they relate to the use of ICD-11 need to be determined.
1.2. Insect bites
A proposal was suggesting to have the types of biting insects combined with ‘skin reaction’ placed in the Chapter 14, ‘Diseases of the skin’.

Discussion
- R. Chalmers advised that a proposal had been added to clarify the cutaneous reaction to insect bites and stings categories.
- The meeting agreed that it is not necessary to have precoordination of the cutaneous reaction and the insect type. Postcoordination is to be applied.

Action Items
- WHO to add postcoordination options to the appropriate categories in the chapter ‘Diseases of the Skin’.

1.3. Sequelae

Overview
ICD-10 included many categories for sequelae of conditions but they lacked detail as to what the sequelae was. Additional codes were always required to completely describe the nature of the sequelae being treated as the sequelae codes referenced the aetiology in their code titles. Therefore, for ICD-11, the concept of sequelae was incorporated as an extension code (Consequence of Sequelae) to be applied to the code representing the current condition being treated. This method provides more complete information as to the nature of the condition and the types of services required to treat it. All categories titled ‘Sequela of’ have been removed from ICD-11 except for categories for late effects of cerebrovascular disease.

Discussion
- General agreement with limitations and not used for everything, that coding rules in the Reference Guide will stipulate that the extension code ‘Consequence/sequelae’ must be applied to both the actual sequela and the condition that is the aetiology of the sequela. These codes will be clustered to show that they are related. The code for the sequela, or manifestation, could be sequenced first, followed by the stem code identifying the aetiological condition.
- The meeting preferred the term late effect to that of sequela and suggested the title of ‘Consequence of sequela’ to ‘Condition as cause of late effect’.
- Definition and rules need to be added. The rule being that the postcoordination is added to the underlying disease not the sequela condition.
- Sequencing will be ‘underlying condition code’ & ‘extension code for sequela’ / ‘code for actual condition’.
- Currently there are specific sequelae categories for cerebrovascular accidents (CVA) and members suggested that these needs to be postcoordinated.

Action Items
- WHO to implement changes to sequela codes and extension codes
1.4. Sepsis

Overview
In ICD-10, the way sepsis was coded resulted in doubling the number of cases of sepsis. This is likely a result of reporting rather than an actual increase in the number of cases. The new clinical classification for sepsis comes with a change in meaning compared to the terminology used in ICD-10. The new meaning of ‘sepsis’ (recommendation Sepsis 3) changes the meaning of ICD-10 codes and thus their use.

Discussion
- The meeting suggested that this proposed change needs to go through the proposal mechanism as one consensus proposal from many rather than many proposals from individuals.
- Suggestion that a small discussion group with mortality and morbidity experts be formed to prepare a consensus proposal.
- It was noted that any changes to the coding of sepsis may impact on ICD-10 as well.
- The meeting noted that the people reporting on this new classification were using ICD-10-CM but referring to them as ICD-10 codes.

Action Items
- O. Steinum to work with C. Chute to organise a meeting with relevant parties, including dedicated IPC WHO team, to produce the proposal by October to enable inclusion into the May 2018 release.
- WHO to advice authors of the report of the incorrect reference to ICD-10 codes

10 Overview of quality and patient safety coding

Overview
- Background provide by W. Ghali on the work of the Quality and Safety TAG and the codes that have been included in ICD-11

Discussion
- The meeting acknowledged that the presentation has clarified the use of this new area.
- A number of questions came from the mortality group with regard the use of these codes as extension codes would not be applied.
- The meeting noted:
  - Need for definitions to better understand cases to be included in certain categories
  - Some of the information may not be documented at the time of the patient’s admission but after, or may not even be in the patient’s record.
  - Terminology of events/incidents/harm needs to be reviewed to be sure that it leads to the detail needed for assigning the codes.
  - Some of Q&S categories address matters that are sensitive and, in some contexts, might imply legal liability. Institutions might see a need to obtain legal advice before using these codes.

Action Items
- Change language of ‘events without harm’ to ‘circumstances’.
- Provider performance codes to be moved from Chapter 24 and into the extension codes.
- Discussion to be held regarding the use of these codes in the mortality use case at the next Q&S meeting
11 Functioning pattern approach and allocation in ICD-11

Overview
- Following decisions at the JTF Meeting July 2016 on the inclusion of some functioning properties into ICD-11, the proposed new structure was presented.
- A set of generic functioning codes has been added to the supplementary section for functioning.
- There has been development of 20 core sets for inclusion into the ICD that could be considered a linearization of ICF. These would be optional codes to be used via postcoordination.
- Functioning properties have been removed from Chapter 24.
- The functioning is to be used as one set and all listed functioning items need to be coded.
- The set will be expanded to 48 entities, following discussion with WHO/BDD. This will allow scoring with WHODAS and MDS.

Discussion
- The meeting noted that the inclusion of these functioning codes into ICD-11 is adding another dimension to ICD-11 that should remain in ICF.
- Mortality would not use this extension.
- Specific information on the use of functioning needs to be added to the Reference Guide
- Updating of these codes need to aligned with updating of corresponding ICF codes

Action Items
- JTF members to review the list of supplementary functioning codes.
- Complete the work to include all 48 planned entities

12 Code structure - update

Overview
- Update provided on the code structure for ICD-11 including:
  - New chapter order with addition of supplementary section for Functioning and movement of Extension codes, and suppression of the former gap between chapter 25 and chapter 27.
  - Need for availability of code space for future updates during the maintenance phase
  - Shortening of extension codes, to make them handier for manual coding
  - Identifiers for Groupings, as requested earlier
  - Codes for linearizations other than the MMS, and their matching with MMS codes.

Discussion
- There was discussion about the use of the Level indicator in the groupings, whether the levels are counted top-down or bottom-up.
- There was further discussion related to the meaning of ‘sequence’ and ‘clustering’. A suggested definition was that ‘Sequence’ is only related to the order of a diagnostic statements or a death certificate. ‘Cluster’ refers to an event or condition.
- The term ‘order’ should be reserved for describing the ‘sequence of codes with in a cluster’.
**Action Items**

- The block code structure should follow the syntax: ‘Block-L1-1A0’, meaning the level of the block is described with its level (first is the one directly under the chapter level), followed by the first code in that block.
- Review and amend - if necessary, the existing descriptions of ways of reporting individual diagnoses with one or more codes compared to diagnostic sequences or comorbidity
- Code space should be allocated, as presented
- Options for shortening the extension codes should be explored - in particular converting the decimal code into code base 34

**13 Transition for countries with and without national modifications**

**Discussion**

- All translations should be done and stored in the one tooling environment, because:
  - Allows for better updating and collecting of information.
  - Support for translation and updating in one place.
  - Promote electronic environment vs paper/manual.
  - Will require less training, less complication.
  - Allows easier verification of consistency of translation within one language and in between languages.
- The software will be able to be used by everybody; a system of permissions regulates who can translate.
- It was noted that Iris is not open source but is free to everyone.
- The coding tool searches on coding phrases located within the foundation. The same set of terms can be accessed for any linearization which helps with translations.
- The number of synonyms varies in different languages but the number of entities does not.
- Issues may occur with certain languages due to the differences of the language itself from other languages and also its use within its own countries. Some countries use different language translations for the different volumes.
- It will be beneficial to collect further questions and requirements from users and vendors.

**Organizational implications for WHO**

- Member States have raised in their comments concerns about current and future resources for ICD at WHO, and the need for risk management
- Resources at the WHO for ICD-11 development are limited now, and lacking clarity on resources in the future could put finalisation and maintenance of ICD-11 at risk. One proposition was that JTF, through its chairs, could write to WHO emphasizing the need to allocate sufficient resources. Alternatively, JTF members could act individually, through national representatives, to reinforce the same message.
- There need to be clear arrangements for the maintenance of the classification and the tools and transparent processes on how countries would be able to collaborate with WHO, before countries would relinquish their control on their national modifications. Collaborative groups could be formed to maintain ICD, share their expertise and make available workforce to assist with the maintenance of the classification. Possibility of providing rotating staff to work at WHO was mentioned. However, continuity of experienced personnel at the WHO secretariat with respective backup solutions is still necessary.
- Some countries would need to look at the practicality of shared maintenance due to statutory regulations with their respective governments.
WHO advised that JTF does represent the Member States but certainly can voice aspects relevant to the MS present in JTF.

The meeting suggested that mechanisms for risk management of the ICD-11 should include:
- Member States to assist with provision of expertise in the future.
- Member States representatives to recommend support and sustainable resources be allocated to the ICD-11 and its maintenance.

The meeting suggested that the WHOFIC network is also a resource, but it needs to focus on the strategic priorities of WHO. A statement from the JTF encouraging contributions from the Network would be helpful as there is a need to ensure the commitment of the Collaborating Centres is backed with resources.

A core team is needed at WHO that can sustain the minimum updates, maintenance and tools for ICD-11. There should be no decrease in central capacity at WHO. Network resources should be kept separate to this. Alignment of future requirements of the classification with core functions of the network is needed without one substituting the other. The Network should support the core activities of WHO more than at the moment. It was suggested that JTF members are to take back these points to their governments.

**Action items**
- JTF to work on a paper about sustainability and risk management.
- Continue work on transition and implementation paper.
- JTF to produce a statement about the importance of active contributions and focus to ICD-11 from the Network to ensure the commitment of the Collaborating Centres is backed with resources.
- WHO & SEG & JTF to organize a separate session at the WHOFIC Network meeting in Mexico October 2017 to discuss implementation issues - space to be identified in the agenda.

**14 WHO Family of International Classifications (FIC) paper**
- Discussions have been held in FDC, MbRG and JTF on how to redesign the FIC and the relationship between the classifications and their integration.
- The meeting recommended that the final information on the FIC should be reflected in the Reference Guide.
- JTF requested clarifications regarding the schematic figure in the paper, noting that it indicates all classifications are derived from the foundation which is not the case for ICF or ICHI. The figure is not a true reflection of where we are now and it is recommended that there be a schema for where we are now and one for where we want to be in the future.
- In their comments, Many Member States asked about the use of SNOMED CT and its relationship to the ICD. It will be important to include something here as well.

**Action items**
- JTF members to review schema in the Family paper and send suggestions and comment to the authors.

**15 Next Steps**

**1.2. Steps to Mexico conference and agenda preparation**
- Review and discussion of the WHO-FIC agenda for Mexico.
- MRG will not be holding a meeting beforehand and plans to work during their allocated sessions including the table discussions.
• Need to have a teleconference with MRG chairs following the paper on postcoordination to validate the rules on linkage and how well they work.
• Suggestion to highlight on the agenda any sessions that will be focussing on ICD-11.
• Concerns raised that an hour ICD-11 meeting may not be enough time to address all late Member State comments related to medical scientific reviews
• MRG to allocate action items for the supplementary 2 sessions for ICD-11 at the HWOFIC meeting - to be prepared jointly with JTF subgroup on mortality

1.3. Outlook post 2017

• Planning for a meeting in December to allow Member States and their experts to assist in a review of the classification based on their comments. Suggested that JTF be involved as observers rather than participants and be available if any explanations are needed. Maybe have another JTF-meeting afterwards (back-to-back) in order to assist WHO in addressing concerns raised in December meeting.
• WHO provided an overview of the current working list to discuss the priorities in view of the release. This included:
  ▪ Primary care edits
  ▪ Review added codes from national modifications
  ▪ Updates from field testing
  ▪ Terminology work
  ▪ Mapping review
  ▪ Updates to the Reference Guide and training manual, including postcoordination
  ▪ Edits to Chapter 24, ‘Factors influencing health status or contact with health services’
  ▪ Updates to Chapter 23, ‘External causes’
  ▪ Edits to Chapter 14, Diseases of the skin’, following review
  ▪ Postcoordinate the codes for mode and mechanism for patient safety
  ▪ Inclusion of most recent URC updates
  ▪ Proposals for ICD-11
• JTF recommended that the Chapter 23, ‘External causes’ and Chapter 24, ‘Factors influencing health status or contact with health services’ needed to be completed first followed by the mapping work. Member State comments need to be addressed before proposals.
• Agreed that creating a core implementation package is of high importance in the context of the training session. The transition paper would be a good advocacy paper to include.
• JTF suggested that a repository of training material should be setup and made available to other groups for both adding and sharing of materials.
• Further discussions occurred to preparations for the release version.
  ▪ Useful to have a description of interfaces available and how to use the different components to provide a better understanding of how the data files will integrate with other systems.
  ▪ Envisage more complex field trials but need to strike a balance between bringing this to a close and achieving implementation and evaluation by end of September. There should be no field trials late in the process, because they could be destabilizing. However, the same materials can be used for hands-on experience and training.
  ▪ Complete the cluster coding paper for mortality and field test mortality cases after this. Testing for proof of concept and assurance that the results are transparent and published appropriately.
• WHO noted that with some input coming later than expected, and with recent discussions, some topics may come up that the newly formed CSAC may find it difficult to make decisions
about. WHO asked the JTF members if they would be willing to continue until next year. Final date to be confirmed but expect it to be October 2018.

- Meeting schedule:
  - No meeting next week, WHO will discuss the draft minutes with the co-chairs.
  - August and September teleconference calls to be held – best use of those has not been decided.

**Action Items**

- MRG to allocate action items for the supplementary 2 sessions for ICD-11 at the HWOFIC meeting - to be prepared jointly with JTF subgroup on mortality
- WHO first complete edits to Chapter 23, ‘External causes’ and Chapter 24, ‘Factors influencing health status or contact with health services’ first followed by the mapping work.
- Complete the ICD-11 implementation package
- EIC to have a repository of training materials
- JTF to complete the cluster coding paper for mortality and morbidity
- Review mortality rules for options for cluster coding
- WHO to invite JTF continuation until October 2018
16 Annex 1 - Agenda

Agenda:

Tuesday July 11
- Opening and welcome
- Review of Agenda
- Feedback from Member States
  - Overview
  - Implications for the structure
  - Agreement on necessary structural amendments
- Date of formal update proposals
- Input from field testing
  - Overview
  - Implications for the structure
  - Agreement on necessary structural amendments
- Update on Mapping work and resulting issues
- Mortality testing progress
- Summary of structural and procedural recommendations

Wednesday July 12
- Chapter 23, ‘External causes’, final draft
  - Review of transport accidents
  - Review of detail in the non-accidental sections of chapter 23
  - Agreement on the structure
  - Testing
- History and background of Chapter 24, ‘Factors influencing health status or contact with health services’
- Chapter 24 final draft
  - Review and agreement on structure
- Feedback from breakout sessions and decisions

Thursday July 13
- Discussion papers
  - Lyme Diseases
  - Postcoordination of manifestations
  - Sequelae
  - Insect bites of skin
- Sepsis – new terminology
- Overview of quality and patient safety coding
- Functioning pattern approach and allocation in ICD-11
- Code structure - update

Friday July 14
- Transition for countries with and without national modifications
  - Tooling development
    - Priorities
    - Integration of classifications with MMS
  - Legal implications
  - Organizational implications for the country
  - Organizational implications for WHO
  - Timelines
  - Guidelines
Next Steps
  o Steps to Mexico conference and agenda preparation
  o Outlook post 2017 (updates, workflows, national modifications)

Closure
## Annex 2 - List of participants

<table>
<thead>
<tr>
<th>LIST OF PARTICIPANTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Harrison</td>
</tr>
<tr>
<td>Stefanie Weber</td>
</tr>
<tr>
<td>Christopher G. Chute</td>
</tr>
<tr>
<td>Robert Anderson</td>
</tr>
<tr>
<td>Lars Berg</td>
</tr>
<tr>
<td>Kees van Boven</td>
</tr>
<tr>
<td>Vincenzo Della Mea</td>
</tr>
<tr>
<td>Vera Dimitropoulos</td>
</tr>
<tr>
<td>James Eynstone-Hinkins</td>
</tr>
<tr>
<td>William Ghali</td>
</tr>
<tr>
<td>Francesco Grippo</td>
</tr>
<tr>
<td>Jenny Hargreaves</td>
</tr>
<tr>
<td>Richard Madden (apologies)</td>
</tr>
<tr>
<td>Kaori Nakayama</td>
</tr>
<tr>
<td>Emiko Oikawa (apologies)</td>
</tr>
<tr>
<td>Donna Pickett (apologies)</td>
</tr>
<tr>
<td>Olafr Steinum</td>
</tr>
<tr>
<td>Naoko Tajima</td>
</tr>
<tr>
<td>Martti Virtanen</td>
</tr>
</tbody>
</table>