World Health Organization Family of International Classifications (WHO-FIC)

Report
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<td>ACCS</td>
<td>Automatic Cause Coding Software</td>
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<td>ACME</td>
<td>Automated Classification of Medical Entities</td>
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<tr>
<td>AHIMA</td>
<td>American Health Information Management Association</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>CCAM</td>
<td>Classification Commune des Actes Médicaux</td>
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<td>CCI</td>
<td>Canadian Classification of Health Interventions</td>
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<td>CIM</td>
<td>Classification Internationale des Maladies</td>
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<td>DIMDI</td>
<td>German Institute of Medical Documentation and Information</td>
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<td>EU-HDP</td>
<td>European Union Hospital Data Project</td>
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<td>FDC</td>
<td>Family Development Committee</td>
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<td>ICD-10</td>
<td>International Statistical Classification of Diseases and Related Health Problems 10th Revision</td>
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<td>ICD-10 AM</td>
<td>International Statistical Classification of Diseases and Related Health Problems 10th Revision Australian Modification</td>
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<td>ICD-10-CA</td>
<td>International Statistical Classification of Diseases and Related Health Problems 10th Revision for morbidity classification in Canada</td>
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<td>ICD-10-XM</td>
<td>International Statistical Classification of Diseases and Related Health Problems 10th Revision International Clinical Modification</td>
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<td>ICE</td>
<td>International Collaborative Effort</td>
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<td>ICECI</td>
<td>International Classification of External Causes of Injuries</td>
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<td>ICF</td>
<td>International Classification of Functioning, Disability and Health</td>
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<td>ICHI</td>
<td>International Classification of Health Interventions</td>
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<td>ICIDH</td>
<td>International Classification of Impairments, Disabilities and Handicaps</td>
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<td>ICPC</td>
<td>International Classification of Primary Care</td>
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<td>IFHRO</td>
<td>International Federation of Health Records Organizations</td>
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<td>MMDS</td>
<td>Mortality Medical Data System</td>
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<td>MRG</td>
<td>Mortality Reference Group</td>
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<td>NACC</td>
<td>North American Collaborating Center</td>
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<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>PAHO</td>
<td>Pan American Health Organization</td>
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<td>SNOMED</td>
<td>The Systematized Nomenclature of Medicine</td>
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<tr>
<td>Abbreviation</td>
<td>Full Name</td>
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<td>SNOMED-CT</td>
<td>SNOMED Clinical Terms</td>
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<td>T &amp; C</td>
<td>Subgroup on Training and Credentialing (now Education Committee)</td>
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<td>WHO HQ</td>
<td>World Health Organization Headquarters</td>
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<td>WHO RO</td>
<td>World Health Organization Regional Offices</td>
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<td>WHO-FIC</td>
<td>World Health Organisation Family of International Classifications</td>
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<td>WICC</td>
<td>WONCA International Classification Committee</td>
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<td>WONCA</td>
<td>World Organisation of Family Doctors</td>
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Opening Session
Monday, 20 October, 2003
Chair: M. Schopen
Rapporteur: L. Cook

Dr Michael Schopen, Head of the German Collaborating Centre, welcomed participants to the meeting.

Election of Officers
Dr Schopen tabled the list of chairs and rapporteurs. Some changes to the rapporteurs were proposed. The list was then endorsed.

Consideration and adoption of the agenda
The agenda was adopted.

Report back from the Geneva meeting
Following the appointment of JW Lee as Director General in July 2003 there were changes to the organisational structure at WHO. Members of the Planning Committee had met with Dr Timothy Evans, Assistant Director “General Evidence and Information for Policy” and Dr Abdelhay Mechbal, Director (Health Financing and Stewardship) in Geneva on 17 October, 2003. Dr Bedirhan Üstün, Marjorie Greenberg, Dr Richard Madden, Dr Peter Goldblatt, Dr Marijke de Kleijn –de Vrankrijker and Dr Michael Schopen presented aspects of the discussion. Key points made at the Geneva meeting were:

- WHO-FIC are for public good, the building blocks for international health information systems and important applications for mortality, morbidity and functioning and disability
- ICD and ICF are bringing significant funds into WHO and the funds should be used for WHO classifications
- Books are important but there are opportunities to implement through electronic health records into the health information infrastructure
- The WHO-FIC is a powerful network which needs more support of the infrastructure by WHO HQ and RO to make the work productive
- The WHO-FIC could help to address the information paradox where areas with the greatest health problems have the least penetration of vital registration systems and WHO-FIC
- Implementation needs many elements including training tools and training for trainers but the most important element was the roster of experts. The implementation of the ICF needs also to take account of the many professions using it and translations had to be in everyday language
- Dr Evans felt that it was too early to determine the structure of the advisory committee and this should follow from what WHO-FIC wanted to achieve.
Discussion points

- There was a need for quick wins
- 110 member states had implemented ICD-10 but 90 had not. The lack of availability of books was a barrier. Dr Evans had said that ‘print on demand’ might be an option. Electronic files for printing and for an ICD-10 browser were made available to WHO by DIMDI
- It had been impressed on WHO managers that the WHO-FIC had a robust strong work programme
- There was an opportunity to re-evaluate the WHO knowledge assets and this could be linked in with the Millennium Development Goals. Dr Evans had said that this could be done more urgently.

Report from the Sunday meeting of the Heads of Centres

Dr Michael Schopen reported on the meeting.

Advisory Committee

The Business Plan of WHO-FIC prepared in response to the meeting in Geneva would be outlined during this meeting by a group consisting of Committee Chairs and Dr Martti Virtanen, Catherine Sykes and Dr Bedirhan Üstün. Actions and priorities would be identified during committee sessions and the process would continue with business planning. The Committee structure should only change if it does not meet the needs of the business plan. A formal Advisory Committee might not be helpful.

Designation and redesignation of Collaborating Centres

Designation of new centres is helpful to countries with no vital registration systems. Existing centres were asked for their work plans to proceed quickly with the redesignation process.

Terms of Reference for WHO-FIC Committees

These had been discussed in Leiden. The new terms of reference drafted by WHO for the Implementation Committee should serve as the basis for all other committees.

Paper on WHO-FIC Collaboration

Dr Madden will update his paper with the new ideas from the Geneva and the Sunday afternoon meetings.

ICD-11

Discussion on ICD-11 was quite controversial. ICD-10 was expected to last for 20 years. There was some debate about how long ICD-10 has been in use as it was first available for implementation in 1994. Some considered that to begin work on ICD-11 might send out a wrong signal, as some countries may think that it was better to wait for ICD-11 before implementing ICD-10. At present Centre Heads and WHO have no special date in mind for work on ICD-11 to begin. Dr Madden is proposing a workshop in 2004 to work out the policy.

Update and revision of WHO-FIC Elements

Dr Bedirhan Üstün outlined the differences between an update and a revision and described the drivers for change. These include client and IT needs, changes in
clinical currency and compatibility within the WHO–FIC. A revision needs to be evidence based. A plan for revision needs to include real needs, resources, timescales and partners.

**Discussion points**
- There are problems with the update process including the dissemination. There is a need to start some projects to look at the update problems
- Only a small number of updates have been made to ICD-10. However there are some areas where there is a need to confront clinical changes
- There is a need to put more effort into the implementation process of ICD-10
- Although completed in 1989, ICD-10 was only implemented in 1994
- A new revision of the ACCS system is very costly
- There is a strong need to systematically evaluate the update process and what it can accomplish when fully implemented and review what cannot be accomplished by updating
- There is no established mechanism for updating the ICF.

**Summary**
Dr Schopen summarized the discussion by saying that the updating and the revision process should continue in parallel. There must be an evaluation of the update processes and a plan for the revision.

**Annual reports of committees and work groups**

**Family Development Committee** (WHO/HFS/CAS/C/03.19)
Dr Richard Madden presented the committee report.

**WHO Mortality Reference Group Report 2001-2003** (WHO/HFS/CAS/C/03.21)
Dr Donna Hoyert presented the report.

**Discussion points**
Mary Chamie asked about the review of the Shortlist for mortality and morbidity as part of MRG work. Lars Age Johansson said he would add it to the list of topics to be considered.

**Subgroup on Training and Credentialing: A status report**
(WHO/HFS/CAS/C/03.56)
Marjorie Greenberg presented the report

**Discussion points**
Dr Martti Virtanen said that quality assurance of coding was also an issue.

**Annual report for the Update Reference Committee** (WHO/HFS/CAS/C/03.20)
Julie Rust presented the report.
Annual report for the Electronic Tools Committee (WHO/HFS/CAS/C/03.23)
Dr Michael Schopen presented the report.

Discussion points
Prof. Rosemary Roberts said that she was impressed by the DMDI expertise but that equivalent support for electronic development must be demonstrated at WHO. Gerard Pavillon said that the problem with the French translation of the updates was their authorization by WHO. Andre L'Hours has the capacity to do this but the problem was complex, as it was not only a translation issue.

Annual report for the Implementation Committee (WHO/HFS/CAS/C/03.22.1)
Dr Marijke de Kleijn –de Vrankrijker and Dr Peter Goldblatt, presented the report.

Discussion points
Dr Roberto Becker reported that there had been difficulties in identifying a roster of experts. 150 had been contacted but only 21 had replied. He will contact them again after the meeting. He will now also identify experts for the whole of WHO-FIC. There is a need to identify who was using the ICD and the barriers to implementation.

Summary
Dr Schopen said that for the business planning process, during the committee sessions it was important to identify what MUST be done in the coming years and for which there must be resources. Additional activities needed to be prioritized and the resources needed identified.

Dr Martti Virtanen, proposed that the WHO-FIC meeting due to be held in Reykjavik in 2004 should start on 24 October to avoid clashing with the “Patient Classification Systems Europe” meeting in Budapest.
Dr Laurenti reminded the meeting about the concept of Family of International Classifications and how work in many areas had expanded through the collaboration of the Family Development Committee (FDC) of WHO-FIC and a range of other international organisations in the field of health classifications. Richard Madden, head of the Australian Centre and Chair of the FDC, thanked Martti Virtanen, Gunnar Schioler and Willem Hirs as well as Niels Bentzen and his WICC colleagues for their hard work in the field of classifications for primary care.

Ruy Laurenti referred the meeting to the second report on the WHO-WONCA collaboration, and introduced Martti Virtanen, who presented a summary of the discussions of FDC on 20 October, 2003, and at their earlier meeting with WICC in Malta. Dr Virtanen proposed that we continue collaboration with WICC in the development of future revisions of ICPC. He proposed that each ICPC code should map to only one ICD-10 code, but ICD-10 to more than 1 ICPC code.

Decisions of the WHO-FIC network meeting, following recommendation by the FDC:

- ICPC-2 is regarded as a WHO-FIC related classification for general practice and primary care and reason for encounter coding wherever relevant
- FDC (and WHO-FIC network) expects that WONCA (and WICC) will develop ICPC to correspond better to ICF in responding areas (-28 codes)
- FDC expects that WONCA (and WICC) will co-operate in the development of future WHO-FIC systems to better cover the information needs of primary care / general practice, including:
  - ICD Primary Care version (symptoms, signs, etc.)
  - ICF PC Version for functioning and disability
  - ICHI PC Version for interventions and procedures
- This suggestion is subject to the acceptance of satisfactory protocol.

Discussion

Dr Laurenti began the discussion by presenting the history of use of ICPC in Brazil, including a test of ICPC against ICD-9, using reasons for encounter codes in addition to codes from other chapters. It was possible to code all encounters using ICD-9. However, ICPC gave more detail for cases coded to ill-defined chapter in ICD-9.

Dr Niels Bentzen from WONCA pointed out that the settings in which ICPC and ICD-9 were used were very different. ICPC is used by primary care physicians who code during their consultations. The codes they use must provide them with the information they need for patient management, not just for statistics or health service administration.
Marjorie Greenberg commented that this was a very positive collaboration between WICC and WHO-FIC. Dr Üstün thanked the WHO-FIC centres involved in producing this positive resolution. WHO's mission to produce Primary care compatible versions of the FIC remains. We need to remember the variety of primary care models across the world. Primary care is the bedrock of health care, and important to capture information on encounters at this level.

Prof. Rosemary Roberts asked what the relationship between ICPC and ICD-10 was and how this might impinge on the work of the URC. In particular, should modifications of ICD-10 take account of its relationship to ICPC, or to ICD-10 for primary care? Martti Virtanen said this was an open question, which would require close collaboration between the working groups involved. Richard Madden commented that Martti Virtanen had left open the number of joint working groups. He felt it was important that there be a single working group between WHO-FIC and WICC to deal with ICD and ICF issues. Niels Bentzen agreed and emphasized the small number of people to do the work of WICC. Martti Virtanen agreed we should start with a single group under FDC, but there might be need for sub-groups. Moriyo Kimura said classification for primary care (first encounter) was important for health statistics. She wondered whether coding by physicians might be skewed by payment or academic interests. Martti Virtanen said there was a danger that any coding scheme or classification could be mis-used. Systems for payment vary, and how they relate to classifications also varies.

Rosemary Roberts asked whether any consideration had been given to classification of interventions in primary care. There are codes for these in ICPC. Martti Virtanen said relationships with ICHI was also part of their work plan. Niels Bentzen said this should enable us to go forward to map out the way to collect information on this and on process of care. Co-operation will be important to maximize what can be achieved by the small numbers of people involved in each country.

Ruy Laurenti concluded that there was consensus that it was important to have ICPC as a member of the WHO-FIC. The workgroups can now proceed with their work.

**ICF Training Session**

*Tuesday 21 October, 2003*

*Chair: Marjorie Goldberg*

*Rapporteur: Rune J. Simeonsson*

“**WHO-ICF- Relevance and Applicability to Physiotherapy**”

Catherine Sykes presented a shortened version of a training workshop that she and colleagues Janice Miller (Canada) and Jane Miller (UK) had made earlier this year at the International Congress of the World Confederation of Physical Therapy (WCPT).

Questions and discussion followed the presentation around several issues:

- Whether the workshop could be extended to other clinical groups.
- Whether there had been follow-up to establish learning outcomes. An evaluation carried out by WCPT revealed favourable response.
The level of the training. The workshop provided introductory training, following an overview of the ICF. The participants were professionals with an interest in the topic and had prior knowledge that related to ICF. It was suggested that for individuals with little prior knowledge of the ICF, finding how their work fits in with the ICF is a good introduction to ICF, “the foot in the door technique”. A relevant feature of the workshop in this regard is the use of block headings initially to engage participants.

Features of the workshop. Several features of the workshop were commented on favourably, including use of interactive approach with ‘hands on’ experience for participants, the use of video clips and given the size of the audience, the use of comments from prior material.

Circulation of the workshop materials. The issue of quality control and the importance of recording who was using the materials and the sorts of modifications that were being made to either content or mode of presentation was discussed.

It was agreed that Collaborating Centres could use the materials, but that further distribution would be unwise without a supporting package for presenters other than the authors.

Implementation issues: The content and approach of the workshop were seen as a very positive contribution to extending the message of ICF. Consideration should be given to preparing the materials for inclusion on the WHO website as part of a family of training materials. In this regard if adequate control is made of quality of content, the material could be offered for distance education.

The Education Committee could consider the workshop in relation to the education and training needs of ICF users.

In WHO there is a department for health education that has been contacted in regard to health information about the ICD and ICF classifications. The department’s approach is based on adult education principles. The education committee could do a review of the training materials that have been developed and assign levels from basic to more advanced.

There is strong demand for training and training materials and it would be valuable to share materials and experiences within network.

Further steps to consider in regard to training:

Inventory of educational needs
Identification of learning objectives
Inventory of existing training materials that are being used- there are others out there, for example, work in France and Code ICF in the US

An important role of the education group is to identify what are the main topics that need to be provided in training. To what extent are materials available to address those topics and training objectives- identify best practices.
Subgroup for Hospital Discharge Data
Tuesday 21 October, 2003
Chair: Björn Smedby
Rapporteur: Martti Virtanen

The presentation followed the report from the subgroup (paper WHO/HFS/CAS/C/03.47). Thus, the results of the EU Hospital Data Project (EU-HDP) were shortly described. The main problem was the differences in the data collection in different countries. The designed short list seemed to work well, but the short list of procedures was not satisfactory. The list on procedures is based on ICD-9-CM Classification of Surgical Procedures (CSP), which seemed to be the least common denominator for procedure grouping.

The major problem of any comparative study is that the basic definitions for collection of data differ. What is a hospital? What is a discharge? How to define the length of stay? What is an inpatient? How to deal with geriatric long term care? For example newborns had to be excluded from EU-HDP because healthy newborns are recorded in some countries as patients but not in others. In EU-HDP metadata about these definitions was collected and included in the report. This makes it possible for the user of the data to explain some of the differences. These definitions may affect the results more than the diagnosis and procedure groupings. Without common definitions the usability of the results will be questionable.

The EU-HDP data covers both private and public hospitals. However, the coverage of private hospitals is possibly not complete. Similarly the psychiatric patients are in principle covered, but the reporting systems may result in differences between the countries. These and other similar questions are described in the EU-HDP metadata.

The aim of the data collection affects both which data is collected and how it is analyzed. The EU-HDP concentrated on hospital activity analysis. There was a discussion on what is hospital activity analysis. The interest could be focused to health analysis where activity refers to the spectrum and number of patient problems treated, or it could be directed mainly to the number of procedures or interventions performed. One possible line in the analysis is the amount of ‘avoidable hospitalisation’. Australia promised to provide an algorithm for this analysis.

The subgroup work started late because the EU-HDP report was available late. Three countries (Australia, Canada and USA) have indicated ability to deliver national pilot data for the project. Björn Smedby proposed that the work of the working group should continue. At the time only Roberto Becker has been able to actively react to the material. Björn Smedby recommends that the model of EU-HDP is applied to other countries and combined with the European data. The data will be made available for analysis to anybody in the subgroup. Any reports and ideas from such analyses are welcome. The differences should be analysed based on metadata.
since at this point it is not possible to achieve a common definition on all discussed variables and collect data based on these new definitions.

**Plenary Session ICF**

*Wednesday 22 October, 2003*

*Chair: Marijke de Kleijn*

*Rapporteur: K. Bränd Persson*

The chair introduced the session by saying that the following six presentations had been selected as examples of ICF used in a range of applications, and to introduce some of the concepts used.

**Application of ICF – Return to Function/Return to Work**

*Diane Caulfeild*

This presentation was a report on the work of the Ontario Round Table Project on Safe and Timely Return to Function/Return to Work (RTF/RTW). The objective is to improve the systems that help people with illness, injury or disability to develop and secure their social, personal and economic self-sufficiency and to explore opportunities in which ICF may be applied to facilitate this, such as in providing a common language of communication.

The present system was described as chaotic, with information gaps and overlap, lack of co-operation, training and human resources. This contributes to social isolation, discrimination in the workplace, economic hardship and poverty for people with disabilities. A process had been developed for feedback, to bring about changes necessary for return to work/function. By using ICF, common forms were developed that would facilitate immediate actions and timely decisions, clarification of roles and provide less costly solutions. A need for a common language that can be used by the persons themselves, physicians and employers was identified. A team assessment form was developed using ICF items and codes.

**ICF and social disability insurance**

*W.E.L. de Boer MD*

In this presentation it was argued that according to social disability insurance people with disabilities can be compensated for a loss of earning provided they meet certain criteria on their health status, i.e. if they are “sick enough”. The concept of disability is important to people’s social rights. While definitions and criteria in the different schemes appear to vary largely between countries, criteria are very similar. Medical criteria, functioning and rehabilitation efforts are common operationalisations. It was suggested that ICF provides a useful model to develop a common language for aspects of disability evaluation, especially for impairments, disabilities and participation, but not for the determination of normal functioning or on rehabilitation. The gradation of severity of problems is badly operationalized in ICF. The aspects of personal factors and environmental factors are ruled out of decision-making in social insurance. It was concluded that explicitly using ICF items would be a way to make criteria and decision-making more transparent. However, the problems are not easily overcome simply by using ICF.
Australian disability data items
Nicola Fortune, Ros Madden and Samantha Bricknell (Australia)
The Australian Collaborating Centre reported on the development of a set of standard, agreed disability data items, based on the ICF, for inclusion in national data dictionaries. This is seen as an important step towards bringing ICF into daily use, promoting and improving disability data consistency in Australia. Some of the disability data items have already been used as a basis for developing data items in national data collections: a data item on support needs, included in the national disability services data collection, and two data items in a new medical indemnity claims data collection—‘Primary body structure or function of the patient alleged to have been affected as a result of the incident’, and ‘Extent of harm’. Background information was given about the Australian national data dictionaries and their role in promoting data consistency. The disability data items were introduced and their application in national data collections described. The material can be found on the AIHW website.

ICF in educational systems
Judith Hollenweger
This presentation concerned possible applications of ICF in educational settings to aid the collection of meaningful statistics. An example from Switzerland was given. ‘Disability’ is used very loosely in educational settings. ‘Special needs’ refers to children who need extra resources. These are in fact children at risk who may later develop problems. This is a complex issue. Current statistics on education collected by OECD are largely based on additional resources offered – not needs. The conceptualisation varies; with an example such as the student/teacher ratio. The variation between OECD countries is considerable, which seems to indicate that different thresholds are applied for these criteria. This goes beyond national data collection that often is lacking. Another aspect is equity: there is inequity in access to resources. Schooling situation and labelling is socially different, and depends on the provider. In the conceptualisation of difficulties different terms for the same phenomena as well as the same terms for different phenomena were observed. This makes it hard to plan intervention efforts. Another important goal is to share views and to empower parents and teachers. This is essential to approach effectiveness of intervention.

The process of sharing views is important to create a common system of reference. This process consists of developing a shared understanding, to have team discussion, to formulate goals, and to translate measures into own language of expertise. Areas of competence should be discussed in relation to the curriculum.

ICF training tool for trainers
Catherine Barral, Marc Maudinet (ICF French Collaborating Centre)
Faced with an increasing number of demands for information on ICF and its use, the French ICF Collaborating Centre has developed an ICF trainers' training tool intended to multiply the capacity of response to demand in the French territory. The training tool is composed of a Power Point presentation of ICF consisting of 100 sheets, divided into 5 modules: (1) Historical overview of WHO's classifications; (2) Typology of disability approaches; (3) ICF: aims, structure, definitions, coding exercises, examples of use; (4) ICF social and political determinants and main
(5) French Health and Social Action main legislative benchmarks. One-day training sessions are proposed to any professional, service, institution or authority related to the field of disability and who can act locally as a resource person. Along with the ICF book and a CD-Rom of the ICF training slideshow, other documentation tools are provided to the trainees (analytic bibliography of ICIDH-ICF, thematic bibliographies on request). Other additional tools are under construction: ICF user guide, Internet forum for the trainees on the website of CTNERHI (National Disability Studies and Documentation Centre hosting the French ICF Collaborating Centre). An English version of the PowerPoint ICF training is available to all Collaborating Centres, who are invited to send their comments and contribute to its improvement.

ICF implementation activities of the ACC: priorities, challenges and opportunities
Ros Madden (Australia)
The Australian Collaborating Centre (ACC) for the WHO-FIC has developed a work program for the implementation of the ICF in Australia. The outline of the work program, in terms of priorities, challenges and opportunities was presented. Completion of the early components, 2001–03: Publication of the Australian ICF User Guide, Finalisation of ICF-related data items for Australian national data dictionaries and for implementation in data collections. Current and planned activities: Leadership (strategies and policies) on ICF implementation in Australia, education, information, promotion and advice, measurement and application, record keeping and evaluation. The ICF international work program should reflect the content of national work programs, as well as a broader vision fostered by international experience and perspectives. The balance of these two visions must be achieved if national and international work programs are fruitfully to co-exist and strengthen each other.

Health Professions' Manual for ICF: Results of Clinician Field Trials
Geoffrey Reed
This was a presentation of the development of a health professions' manual for ICF and clinician field trials that were initiated to progress on development of the use of ICF in health systems. The objective was to address some perceived obstacles in ICF implementation in the US, such as a low level of awareness among health professionals, availability of other systems for assessing disability and functionality. There were also questions regarding incorporation of functional information in reimbursement mechanisms and ICF was seen as too complex. This suggested that ICF is unlikely to be widely used or influential in the US without a guide for standardized application by its users and major educational efforts.

However, ICF would provide a clinically meaningful description of functional status, “best” and “typical” functioning in clinical and everyday environments. It would make the results of specialized professional assessments broadly understandable, and provide a more rational and meaningful basis for conceptualizing treatment needs, allocating resources, and assessing outcomes than diagnosis alone. It is seen as a strength that it is not a measurement tool, since a wide range of instruments already exist, but it is compatible with psychometric measures, clinical interviews, and direct observation and self-report, specific assessment procedures that vary with
profession, and clinical judgement in assessment. Health professionals embrace the conceptual model, but they are more measurement oriented in their work.

The goals of a procedural manual and guide for a standardized application of the ICF are: standard approach to the classification that is clinically grounded, consistent interpretation of concepts and operational definitions of terms, reliable, valid, and clinically useful classification using the ICF system. The manual should be available as text and interactive versions (Internet-based or CD-ROM). Development of the manual was a multidisciplinary and multiorganizational endeavour.

The scope of coding included recommendations such as to code only relevant items, to use the checklist, to develop a code set that reflects individual or clinic’s area of practice, and to use disease-specific code sets. Examples of coding with qualifiers were supplied. Information about prototype field trials was supplied. The issue of handing over existing training material to others was raised. This discipline specific training is performed by skilled professionals and contains much coding practice.

Discussion
A question was raised with regard to the proposed recommendation regarding a for activity and p for participation, specifically to use d instead of a and p. It was said that the generic scale cannot be applied with this approach. In reply to this Dr Reed said that the recommendation is to code performance. It was argued that four options are allowed and that no specific recommendations should be made at this stage. What is the reason for choosing the first option, instead of allowing several choices? In response to this it was stated that clinicians are mostly interested in assessing a specific behaviour.

Another issue that was raised was the coding of current environment. It was said that this environment may vary across settings, something that was not taken into account. Assessment of walking in a rural area is not the same as in an urban environment. In reply, it was said that this would be capacity assessment; with performance it would be the current environment. The manual is developed specifically with the US in mind, but it may be applicable to other areas. It is regarded as important to start with this manual and to expect some change over time.

Some concern was raised about the potential implications for comparisons if different rules are to be introduced and applied in different parts of the world and for specific user groups. It would perhaps be possible to look at modifications of this manual for cultural differences. One comment stated that this manual is probably the first beta-testing of some quite difficult concepts, including performance. The session was concluded by saying that those interested can contact the authors for more information.
Breakout Sessions

Electronic Tools Committee
Monday 20 October, 2003
Chair: M. Schopen
Rapporteur: S. Walker

Terms of Reference
The Chair provided redrafted Terms of Reference for the Electronic Tools Committee, based on its extended role supporting WHO and the WHO-FIC network for the Family of International Classifications.

The UK Centre asked about the work of the Committee on electronic developments and its relationship to the MMDS software for coding causes of death. The Chair noted that this software is outside the ambit of the committee; however knowledge of the existence of such software and the ability to direct interested parties and potential users to relevant people is necessary. It was further noted that the Terms of Reference regarding liaison with other groups, such as the ICE on Automated Coding, covers this point. The UN Statistics Division representative suggested the committee consider further association with the UN Expert Group on International Economic and Social Classifications. It was also noted that an electronic registry for classifications in economics and trade already exists and may provide a useful model for WHO-FIC classifications. The structure allows users to make comments about the interpretation or use of specific codes in the classifications, which are then considered by technical groups and when updating the classifications. Further harmonisation of classifications activity could be helped through use of the ISO Object Identification system.

It was suggested that a server to hold XML versions of all WHO-FIC classifications could be developed, as a means for delivering the classifications to users, maintaining the classifications and making updates to the classifications through a standard updating mechanism. This would be a long term and very large project but could be included under the Term of Reference for maintenance systems.

A further question regarding the development of tools for other WHO language versions of the classifications was raised. The German Centre proposes to develop its XML version in English for maximum international utility. It may be possible to strip back to the basic classification structures so that Collaborating Centres with responsibility for language versions could then enter relevant text and code descriptions. It was noted that this would work well for the Tabular List of ICD-10 but that exact translations of the Index are difficult as there is not a 1:1 relationship between languages.

The Australian Centre noted that the work of the committee is not focussed on educational tools except to the extent that these may require electronic copies of the classification, but rather concentrates on classification-related tools (such as mappings, ASCII lists etc). Joint work with the Training and Credentialing Subgroup may be necessary for educational developments.
The Chair asked the committee about the necessity for a co-chair with expertise in ICF issues. ICF issues may be quite different to ICD issues and should be clearly articulated. ICD needs are well known, ICF less – so a needs assessment would be helpful to determine what tools are required for ICF. This should be a priority. The North American Centre believes that ICF users have similar needs to ICD users in terms of consistency, standards for use of the classifications, reliability. Parallel structures and tools should be a long term aim and it was recognized that generic frameworks for some tools may be possible. It is vital to ensure that ICF users who understand needs are involved in future electronic tool developments.

Paul Placek from the North American Centre agreed to take care of a survey and needs assessment for ICF. It was pointed out that a questionnaire for ICD-related electronic tools was already available and might serve as a starting point. Whether co-chairs and sub-committees will be necessary should be decided after an analysis of the needs assessment.

The revised Terms of Reference for the WHO-FIC Electronic Tools Committee are printed in the Annex to this report.

Work program
The Committee then considered its work program and re-arranged some activities to reflect priorities. Each activity was given a high or low priority rating for action over the next twelve months. It was recognized that some activities require longer term strategies, such as the standardized maintenance tools.

Electronic version of ICD-10
The Chair reported on work at DIMDI towards making available an electronic version of ICD-10. He noted that, following discussions with WHO, a PDF version of the classification print version without hyperlinks and an HTML version of the Tabular List will be made freely available to the public on the World Wide Web. Rules and regulations relating to its use will be provided, with specific information about issues relating to copyright and the illegality of use for commercial purposes or re-publication. A watermark may be included on the PDF as added protection. A browser version in PDF with hyperlinks will only be made available to WHO-FIC Centres because of WHO’s plans to make this a commercial product. The Australian Centre enquired about the possibility of some form of licensing even if the products are free of charge, to enable WHO to be aware of who is using the classification and to ensure that users are aware when new versions become available. The Chair, whilst agreeing that this would be useful, indicated that the experience of the German Centre is that often very little valid information is provided. However, it is a useful idea to consider and to discuss with WHO, particularly when bearing in mind the need for version control.
Prioritized action list

High priority

- Finalize Electronic Version in English (within months)
- Publish book and CD Rom for 2003 (within months)
- Establish Dissemination and Sales Plan (WHO/CAS) (within months)
- Prepare Electronic Version in French (within months, but depending on availability of authorized updates)
- Get ICF into the work program (as soon as possible)
- Survey and needs assessment for ICF (as soon as possible)
- Identify gaps and current needs for ICF (as soon as possible)
- Get ICD-10-XM Working Group operational
- New Maintenance Environment for ICD-10 (within 2 years)
  1. printed version
  2. electronic version
  3. crosswalks
- Multilingual CD Rom with versioning
- Maintain personal links

Lower priorities

Proceed with other WHO official languages
Get forum for members operational
Criteria for evaluation
Electronic Code-specific Registry of Family of Health Classifications (Feedback Registry)
ISO Object Identification System

Tuesday 21 October, 2003, Morning session
Chair: M. Schopen
Rapporteur: S. Walker

The paper WHO/HFS/CAS/C/03.27 regarding the recent ICE on Automated Mortality Statistics plenary meeting was presented by the North American Centre. Major outcomes from the meeting were:

- All countries should move towards adoption of the automated system for mortality coding, in an effort to improve the quality and consistency of international data
- Of particular concern is the provision of support for countries in central and eastern Europe and the developing world
- Rapid diffusion of the software requires language-independent system development.

The ICE planning group has developed a work plan to address these issues, including a workshop regarding the automated system for central European countries which is to be conducted in Prague in June 2004 and a further plenary meeting planned for about 2007.
The German Centre presented paper WHO/HFS/CAS/C/03.108 relating to the
development of an XML version of the ICD-10 made available by WHO in late 2002.
A version of this is currently available on a restricted-access webpage on the DIMDI
website. An evaluation of the initial development revealed issues with the quality of
the files, in relation to incomplete data, a lack of updates, unclear data sources,
problems with the XML structure and the slowness of the HTML version. For these
reasons, the German Centre proceeded with an SGML development based on its
own maintenance processes for the German language version of ICD-10, as
described in paper WHO/HFS/CAS/C/03.97. A demonstration of the current versions
of Volumes 1, 2 and 3 was provided, with files including ASCII lists, HTML versions
with and without hyperlinks, metadata files and PDF (print) versions. Volume 2 is
currently only available in PDF. It was noted that the PDF files can be searched using
Adobe’s search functionality, but that the search is rather slow.

A related development is the creation of a browser version of ICD-10 by Dr Zaiß at
the University of Freiburg for WHO in collaboration with the German Institute of
Medical Documentation and Information (DIMDI). All volumes of ICD-10 are
completely linked and a fast search is possible using the Adobe full text search
facilities. This was demonstrated by the German Centre to critical acclaim from
participants.

It was also noted that there are not currently links from the electronic products to
official WHO updates to ICD-10 but that a link to the Update Reference Committee
website will be added to the DIMDI webpages.

A question was raised regarding the use of the electronic versions of volumes 1 and
3 related to the use of British and American English as occurs in the hard copy
publication – this is still a problem with the electronic version and is to be forwarded
to WHO as an issue that requires addressing. It was noted that the US automated
mortality system and the Australian ICD-10-AM use ‘standardized’ English across
volumes.

The German Centre reported that the SGML-based maintenance is not totally
satisfactory for the future due to decreasing support of SGML by software houses.
The Centre outlined plans for an ‘XMLification’ of the products. Other work to be
done includes development of an ASCII version of volume 2, development of
database versions of volumes 1 and 3, completion of the French version with the
inclusion of the official ICD-10 updates and the initiation of a regular cycle to make
updated files readily available for software development and implementation. The
German Centre also outlined a proposal to use a Folio-based system as was used
for WHO’s previous multilingual CD-ROM development, as this appears to have
more functionality than that available using Adobe Acrobat.

All electronic files except for the browser are currently available on a restricted area
of the DIMDI website at www.dimdi.de. User code and password were given to the
participants. Following discussions with WHO, the HTML and PDF versions without
hyperlinks are to be moved to a public access section of the website and will be
freely available for interested parties for download over the internet. The browser
version is considered a commercial product and therefore will not be made freely
available. The hyperlinked versions will be available to Collaborating Centres. A
registration process to be completed prior to download of any files is likely to be put into place in an attempt to track use of the electronic version of the classification.

Further information about the Electronic Tools Committee’s webpage was presented. Information available on the webpage includes the original Terms of Reference for the committee, the results of the survey regarding available electronic tools, annual reports from the Committee for 2000, 2001 and 2002 and selected papers from past WHO-FIC Network meetings. The Chair requested feedback on the site and the available documentation to schopen@dimdi.de.

Tuesday 21 October, 2003, Afternoon session
Chair: M. Schopen
Rapporteur: S. Walker

The Netherlands Centre presented the papers WHO/HFS/CAS/C/03.35, related to the use of CEN Technical Standard Format for maintenance of the Dutch versions of ICD-10 and ICF. The use of ClaML, CEN/TS 14463, was described. This encompasses a structured mark-up language designed specifically for classifications, allowing explicit representation of classification elements using an electronic classification management tool, ClaML. The future for hard copy printed versions of the ICD was discussed, with the view that there will be less demand for this in the future but that it was still necessary to have the capability to produce a printed classification. The issues of classification ‘representation’ compared with ‘presentation’ were examined, with the latter presenting a considerable challenge for classifications like ICD-10 which relies heavily on structure and printing conventions. Browser versions of both ICD and ICF in the Dutch language were demonstrated. In response to a question, the benefits of ClaML as an international standard were described. The use of this is seen as beneficial and possibly an improvement over WHO’s browser which does not conform to any known standards. It was suggested that the browser could be developed in English but that official approval from WHO would be required due to copyright issues.

The use of HL7 as a messaging standard was also raised and it was noted that ClaML is to be considered by ISO as a way of addressing issues caused by the need to update classifications.

An additional point about the inclusion of ATC codes to link to ICD poisoning codes was raised. A mapping between ICD and ATC would be necessary if this were to be included in the browser.

In summary, the Chair noted that there is still a need for the production of the classification in books, in particular for developing countries, but that there is also the need for one tool to create both electronic and paper-based versions.

A further paper from the Dutch Centre was provided (WHO/HFS/CAS/C/03.36). This paper related to the use of a Dutch tool for publication of ICD updates and the development of derived and related classifications. This addresses the issue of the need for both hard copy and electronic versions whilst allowing the development of an updating mechanism using ClaML, deriving related classifications from the source files and mapping related classifications. The Dutch Centre reported what ‘Ist’ (exists now) and contrasted this with their aspirations (‘Soll’). One of the ‘Soll’ issues is the
use of ClaML, an electronic classification management tool. ClaML can store classifications in electronic format whilst preserving their internal structure and can explicitly represent the various classification elements, such as codes, rubrics and hierarchies. In addition, various classification manipulation functions are available, as is the ability to present different ‘views’ of a classification, to develop a user-defined indexing scheme, reference classification elements using tags or hyperlinks, compare changes between classifications or different versions of the same classification, and to maintain a historical record of changes made. Using ClaML should make the maintenance of derived classifications easier and more standard, allowing central or parallel editing with the source classification.

ClaW, an electronic classification workbench, was explained. ClaW allows the exploration of formal relationships between codes and terms, including mapping to a reference model. However, the need to identify the purposes for mapping is required.

The North American Centre presented paper WHO/HFS/CAS/C/03.65, outlining lessons learned in the development of a bilingual electronic database for ICD-10-CA and CCI at the Canadian Institute for Health Information (CIHI). There have been various iterations of the classification database development, beginning with Word files on CD-ROM, then moving through a SQL server environment to the current Oracle database. This database enables the production of both hard copy and electronic versions of the classifications, however it was noted that use of the electronic product is mandated by law once the initial implementation in a province is completed. Coders appear to have embraced the use of an electronic product, even if they have previously been unfamiliar with computer technology. A key element is the provision of comprehensive training regarding the available products.

In addition to the CD-ROM, print versions and PDF products, the CIHI offers various support products, including a web-based coding query database, a change order database for tracking classification updates, errata and addenda. A Classification Advisory Committee is in place to advise on clinical content and electronic products user groups are popular. CIHI staff provides comprehensive training to users, through face to face workshops, web-based e-learning and using self-training packages. Additional advanced workshops on specialty topics are also provided.

Various issues encountered and problems experienced in the bilingual development were raised, both in terms of semantic differences between the English and French languages and also because of technical concerns with the classification databases. Positive aspects of the development were also highlighted, including the availability of dedicated information technology staff, increased staffing levels of personnel fluent in French, use of weekly meetings, detailed work plans and Gantt charts to keep developments on track in the short development time available.

Discussion ensued regarding the electronic classification ‘shadow’ file, which enables coders to enter notes, errata etc. Although this cannot be carried over from edition to edition, it was noted as a useful feature and appreciated by coders. A network version of the shadow file is available and costs for the classification are based on the number of users.

A further question related to the use of the official WHO CIM-10 as the basis for the Canadian version of the classification in French. Because there are various French
‘dialects’ in Canada, it was noted that Canada makes use of this version for consistency, with ICD-10-CA enhancements.

The group briefly discussed update cycles, with the Canadians indicating that they generally have a two-yearly update cycle but this has been extended to three years until the ICD-10 CA/CCI based grouping methodologies have been ‘bedded down’. It is planned to resume the two year cycle after 2006, unless there is representation from users to remain at a three yearly cycles. The German Centre reported that users in Germany require an annual update to the classification.

The Australian Centre queried whether the Canadians have, or have considered, the development of an educational edition of ICD-10-CA and CCI. It was noted that some diagrams and clinical information have been included in the CCI and, to a limited extent, in ICD-10-CA, but that this is a very expensive undertaking, particularly considering the costs of copyright for use of certain diagrams.

The final presentation for the session was provided by WHO Headquarters and provided a demonstration of an ICF browser and coding tool development. There was no paper to accompany this presentation. The browser currently consists of a multilingual search engine, incorporating the six official WHO languages (Arabic, Chinese, English, French, Russian and Spanish) and is available on CD-ROM or from the WHO website. A further fourteen languages will be included also, once translations are made available to WHO, anticipated to be in late 2003 or early 2004. These languages are:

- Dutch
- Estonian
- Finnish
- German
- Hungarian
- Italian
- Japanese
- Korean
- Latvian
- Portuguese
- Romanian
- Slovakian
- Slovenian

A number of additional features are also to be included in a future revision, with these developments dependent on the availability of time and resources at WHO:

- The ability to display two languages simultaneously
- The display of case numbers and demographic data, including an ICD code – this will be used in the mapping of ICD into ICF Framework
- The use of drop down boxes for definitions and selection of qualifiers (frequency, duration, intensity), the ability to include user-defined or customized scales. It was noted that the qualifier data is an attempt at standardisation and the detail is already included in the ICF checklists – the purpose is to refine the anchor points on an ordinal qualifier scale
- The inclusion of various existing assessment instruments and measurement tools, such as surveys, questionnaires, schedules using ICF. It was noted that cross-mapping to these instruments is vital and should be done by the American Psychological Association. WHO noted that this work has already been completed and is ready for field testing. The Australian Centre stated that it is planning work on a similar project and would find it helpful to look at what has been done and consider it in its own context
• The inclusion of a glossary to explain the various domains and provide examples.

WHO further outlined the four interlinked databases built on the official qualifiers that sit as layers ‘underneath’ the browser database structure. All or part of these databases can be used or user-defined instruments could be included.

WHO is looking for Collaborating Centres to assist in the development and to test the browser product. Alpha testing is anticipated to commence in January 2004. The North American Centre indicated that it might be beneficial to have a contractor do a thorough evaluation, rather than relying on people who may or may not have sufficient time to spend on this.
Family Development Committee

All Sessions
Chair: R. Madden
Rapporteur: C. Sykes

Classifications for Primary Care

Decisions:
The FDC thanked members of the WHO/WICC working group for their commitment and work over the years and noted that the Working Group as it has stood is now dissolved (Chair and Secretary).
Centre Heads agreed with the proposal to accept ICPC for primary care coding in general practice as a related member of the WHO-FIC.
It was agreed that one working group would be sufficient to progress the work outlined in the proposal. Sub-groups may be established to perform particular tasks. The working group would be a sub-committee of the FDC.

Proposal to the Centre Heads meeting

FDC recommends that:
- ICPC-2 is regarded as a WHO-FIC related classification for general practice and primary care and reason for encounter coding where ever relevant.
- FDC (and WHO-FIC network) expects that WONCA (and WICC) will develop ICPC to correspond better to ICF in responding areas (-28 codes)
- FDC expects that WONCA (and WICC) will co-operate in the development of WHO-FIC systems to better cover the information needs of primary care / general practice.
  - ICD Primary Care Version (symptoms and signs etc)
  - ICF-PC (functioning and disability)
  - ICHI-PC (processes and procedures)

FDC suggests that joint working group(s) is/are formed to implement these decisions.

Submission of the International Classification of External Causes of Injury (ICECI)
The committee noted that this matter had been under discussion since 1999 and welcomed the significant progress made in indexing, electronic presentation and commitment to making the classification freely available.
It was agreed that the comments from the Nordic Centre should be referred to the ICECI Management and Coordination committee.
**Decision:**
The FDC agreed to recommend that the ICECI be accepted as a related classification in the WHO-FIC.

**ISO 9999 Classification of Technical Aids for disabled persons (Paper 33)**
The FDC thanked Marijke de Kleijn for bringing the formal proposal to the meeting. The value of the classification as a complement to the ICF was noted.

**Decisions:**
FDC agreed to recommend that ISO 9999 be accepted as a related member of the WHO-FIC. The meeting agreed with the expectation that the classification should be readily available.

**Anatomical Therapeutic Chemical (ATC) Classification System with Defined Daily Dose (DDD) (Paper 112)**
The FDC thanked the Nordic Centre for bringing the formal proposal to the meeting and noted the value of bringing together the work of two separate arms of WHO. There was discussion on the need for a classification of illicit substances as well as marketed drugs.

**Decision:**
The meeting agreed to recommend that the ATC/DDD system be accepted as a related member of the WHO-FIC.

**Protocol for the WHO-FIC (Paper 111)**
The meeting welcomed an updated version of the protocol and noted comments made by the proposers of ATC/DDD and ISO 9999 on the protocol.

**Decision:**
The meeting agreed that version 3 of the WHO-FIC protocol should include refinements to clarify the principles for established classifications. The FDC will review the document at its mid-year meeting.

**Action:**
Refinement of the protocol in line with comments from those that have prepared submissions for the WHO-FIC (Catherine Sykes, Marijke de Kleijn, Kristina Bränd Persson)

**Representation of the WHO-FIC on the World Wide Web (Paper 109)**

**Decision:**
The meeting agreed with the proposals for improvement of WHO-FIC representation on the WHO website in the paper and referred it to the relevant areas of WHO facilitate the implementation of the recommendations.

**Action:**
Refer the proposal to the relevant area of WHO.
Report of the Hospital Data Working Group (Paper 47)
The meeting noted the progress reported by Professor Smedby including the outcome of the special meeting the previous evening. The capacity of the work on sentinel conditions and procedures to promote more comparable hospital statistics across countries was welcomed.

**Decision:**
The meeting thanked Björn Smedby for his work with the Hospital Data Working Group and agreed to review progress on this project at the 2004 meeting.

International Classification of Health Interventions Beta Version (Paper 51)
The Australian Centre advised of progress on the development of ICHI including testing to date. There was discussion around the potential for ICHI to assist with mapping of sentinel procedures across countries. The Hospital Data Working Group will include this potential in its work.

**Decision:**
The meeting noted the urgency for adopting the ICHI for countries that do not have a procedure classification and agreed to continue discussions on publishing the classification early in 2004.

**Actions:**
To review the latest version of ICHI by the end of the year (André L’Hours). Continue discussions with the WHO office of publications concerning publication of ICHI for further field testing through the regional offices. (Rosemary Roberts)

Discussion on the possible revision of ICD (Paper 49)
Professor Roberts spoke to the paper and updated the meeting on the discussions at the Update Reference Committee the previous day. The Chair then sought comments from each Centre and organisation present. Issues raised included:

- The value of the updating processes and the need to evaluate them
- The need for stability in time series
- The importance of clinical currency
- The rapidly evolving electronic health information industry
- The incomplete implementation of ICD-10
- The implications of new members of the WHO-FIC for ICD
- The need for strong collaboration with expert groups in any revision
- The need for strong leadership from WHO for a consistent approach

It was agreed that interventions should not be considered in a revision of ICD.
Decision:
To draft a proposal for the plenary session recommending the way forward and reflecting the views of this meeting.

Progress on interventions classifications
The following presentations were warmly received.
- The Canadian Classification of Health Interventions (CCI) Structure and Application (67)
- CCAM, the new French procedure classification (91)
  The similarities and differences between the French and Canadian classifications were discussed.
- Results of the ICD-10-PCS feasibility testing in Germany (90)
  The feasibility testing in Germany had resulted in preference for CCAM over ICD-10-PCS as the basis for a new German classification of interventions.
- XML presentation of hierarchical classifications (94)

Report of the Terminologies Working Group (UK)
Two Australian papers described recent analysis of SNOMED-CT particularly in relation to ICD-10-AM.
A Netherlands paper raised several difficulties that would need to be addressed if SNOMED-CT were to be considered for use nationally.
A US paper tabled at the meeting described the arrangements agreed for public use of SNOMED-CT within the US.
In discussion the cross national use of mappings between SNOMED-CT and ICD versions was identified as a concern. The legal and commercial positions will need to be clarified.

Decision:
The Terminologies working group should seek to build stronger relationships between the WHO-FIC Network and SNOMED International so that the use of terminologies such as SNOMED-CT within national health systems properly supports the classifications.

Action:
Terminologies working group report on progress to FDC at the April meeting.

Terms of Reference FDC
The Terms of Reference were discussed at the FDC meeting in Leiden and were presented for endorsement. They are printed in the Annex to this document.
Implementation Committee

Monday 20 October, 2003
Chair: P. Goldblatt
Rapporteur: Nenad Kostanjsek, WHO

The chairs of the committee welcomed members and introduced the draft agenda, which included the following items: discussion and adaptation of Terms of Reference for the committee, discussion of ICD & ICF workplan and its integration into the business plan and a two-tier approach for WHO-FIC implementation, discussion on the implementation of new WHO-FIC members.

The draft Terms of Reference for the WHO-FIC Implementation committee were discussed and adapted.

The amended Terms of reference are printed in the Annex to this document.

Tuesday 21 October, 2003
Chair: Marijke W de Kleijn
Rapporteur: N. Fortune

The group discussed each of the items on the draft list of priorities for international ICF implementation work, which was developed at an informal meeting in St Louis back-to-back with the NACC meeting (Paper 22.1). The table below sets out the decisions of the group regarding how each item should be progressed within the work plan of the Committee. There was not time to develop a detailed plan against each item; this will be done later.
<table>
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<tr>
<th>What</th>
<th>Suggestions and decisions</th>
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<tr>
<td>Develop a method for collecting information on usage and implementation of ICF including a roster of experts relating to...</td>
<td><strong>Decisions:</strong>&lt;br&gt;The list of categories should be modified as follows:&lt;br&gt; - Delete training (now addressed by the Training and Credentialing committee)&lt;br&gt; - Include all dimensions of ICF (not just A&amp;P)&lt;br&gt; - Replace 'clinical and administrative records' by 'areas of application'&lt;br&gt; - Add 'types of users'&lt;br&gt; - Add 'comments/suggestions for improvements to ICF' (i.e. that could feed into updating of ICF in future)&lt;br&gt; - Add 'comments on coding experience and need for guidance'&lt;br&gt; - This last dot point would include gathering information on 'enhanced' versions of ICF developed by individual countries.&lt;br&gt;The revised list could be used in other committees as a structure in which 'needs assessments' could be done (i.e. Implementation Committee information gathering would then fit into the template used for needs assessment by other committees.)&lt;br&gt;A small group will work on how to achieve the gathering of information. Members will be Marijke de Kleijn, Ros Madden/Nicola Fortune, Paul Placek and Nenad Kostanjsek. It is hoped that Nenad Kostanjsek and/or Huib ten Napel*, on behalf of WHO, will be able to help develop a technical means of sharing information between the centres and WHO. (The group will meet Thursday at breakfast.)</td>
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<td>Implementation strategy&lt;br&gt;Translation and dissemination&lt;br&gt;Coding&lt;br&gt;A/P&lt;br&gt;Qualifiers&lt;br&gt;Training&lt;br&gt;Surveys&lt;br&gt;Clinical and admin records&lt;br&gt;Mapping&lt;br&gt;Use of ICD and ICF</td>
<td><strong>Develop a plan for maintenance and updating that is consistent across WHO-FIC members</strong>&lt;br&gt;Nenad reported that the principles/mechanisms set out by WHO for update of WHO-FIC members apply equally to ICF, and it is the responsibility of the URC to develop detailed plans for maintenance and updating.&lt;br&gt;<strong>Decisions:</strong>&lt;br&gt;The Implementation Committee should do some 'preparatory' work on this issue, by collecting comments from users, etc., relevant to future ICF revision.&lt;br&gt;ICF input into ICD updating is also important (because of overlap issues to be addressed in developing ICD-11); it will be important to ensure ICF expert input to ICD updating via appropriate representation on the URC.</td>
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<td>Define WHO-FIC in a box and a work plan for developing specific elements including best practices concerning... Implementation strategy Translation and dissemination Coding A/P Qualifiers Training Surveys Clinical and admin records Mapping Use of ICD and ICF</td>
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<td><strong>Decisions:</strong></td>
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<td>This is a second-order priority, and could follow from an evaluation of information gathered under item 1. The list of categories should be updated to match the new list in item 1, except that 'training' should remain in this list.</td>
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<th>Examine the work plans of other WHO-FIC committees and how ICF work fits in</th>
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<td><strong>Decisions:</strong></td>
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<td>The terms of reference and workplans of all committees (except MRG) should either talk about WHO-FIC generally, or mention both ICF and ICD. There should be exchange of information relating to ICF between committee chairs. There should be cross-membership of ICF experts between the Implementation Committee and each of the other committees (except the Mortality Reference Group). It was noted that ICF membership is lacking on URC at present. Cross-members would then have special responsibility to ensure information flow between committees. A full list of committee membership should be available so people know which ICF experts are on which other committees.</td>
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<tr>
<th>Identify strategic forces and opportunities at the national and international level that will drive implementation of ICF</th>
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<td><strong>Decisions:</strong></td>
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<td>Diane Caufield presented a paper on conducting a SWOT (Paper 70) analysis to help identify strategic forces and opportunities at the national and international level that will drive implementation of ICF. All agreed it was a good presentation and that SWOT analysis would be a useful starting point to develop a strategic plan for ICF implementation. <strong>Decisions:</strong> The group will meet at lunchtime tomorrow to begin working on a SWOT analysis.</td>
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| Achieve international consensus on coding guidelines and standards including further definition of generic qualifier [begin with list identified in Brisbane] | **Decisions:**

This item should be progressed in the same way as the other categories under item 1; that is, information on experience with ICF coding, at country level, in a range of different contexts, should be collected and shared. This information could later be analysed to identify what aspects of ICF coding work well, and where the problems lie. |
| --- | --- |
| Develop an overall training strategy for ICF addressing different types of users, including clinical coders and clinicians, etc. and at different levels, and train the trainers program for international use, including tools | This item now comes under the umbrella of the Training and Credentialing Committee (proposed to be renamed the 'Education Committee')

**Decisions:**

This item should be progressed by the Training and Credentialing (Education) Committee. Cross membership between the two groups will enable information flow on ICF education issues. |
| Explore relationships between clinical vocabularies and ICF and the possibility of developing standard maps | **Decisions:**

Addressing relations between classifications and vocabularies should be a general WHO-FIC issue, and should be addressed by the Terminology Working Group of the FDC; it should not be part of the workplan for the Implementation Committee. |
| Follow work on Subjective Dimension | **Decisions:**

Dr Satoshi Ueda will present on this tomorrow. The item will be considered further after the presentation. |
| Follow work concerning Derived and Related classifications (e.g. ISO 9999, Children’s Version, and ICECI). | **Decisions:**

Rune Simeonsson will present on the ICF for children tomorrow. The item will be considered further after the presentation. The group should also follow work concerning ICF elements in the ICPC – the WHO/WICC group will be looking at this. The group may develop guidelines on how to prepare derived classifications. * |
Report of the Ninth Annual North American Collaborating Center Conference on ICF” (WHO/HFS/CAS/C/03.61)
Diane Caulfeild presented the paper.
- The discussion pointed out that the meeting is open to all, whether North American or not, and is a good opportunity to network. A comprehensive summary of the 40 papers presented will be on the NACC Clearinghouse on ICF at [http://www.cdc.gov/nchs/about/otheract/icd9/icfhome.htm](http://www.cdc.gov/nchs/about/otheract/icd9/icfhome.htm). This website also will soon have information about the Tenth NACC meeting on ICF to be held June 1-4, 2004 in Halifax, Nova Scotia.

Development of the ICF for children and youth – status report
(UNESCO/WHO/CAS/03.63)
Rune Simeonsson presented paper
This document uses the current ICF structure but adds age-appropriate information. It will be presented to WHO in late 2004 after testing in late 2003 through March 2004, with WHO to facilitate the testing.
- Dr. Simeonsson was asked by the chair of the Implementation Committee to propose a plan for implementation of the children and youth version, and he agreed.

Subjective Dimension of Functioning and Disability: Report of the Study Group (In-depth Literature Survey) (WHO/HFS/CAS/C/03.42)
Satoshi Ueda presented paper
It was impressive that 24,626 bibliographic references refer to the subjective dimension, satisfaction, and quality of life.
- Discussion revealed that the group has not yet determined whether to propose a new classification to “add on” to the ICF, to propose a new qualifier, or to wait for ICF-2.
The Dutch Electronic tool for following the ICF in applications (statistics, surveys, records)
Huib Ten Napel presented
The goal was to track terminological analysis of activity and participation (A & P) using an empirical approach.
• Discussion revealed that the effort was just beginning. It was pointed out that a 2001 paper by Deborah Stewart of Canada used Beta-2 results to address A & P delineation, and a 2003 paper by William Reynolds of the U.S. involved structured interviews with North American ICF experts regarding the need for and criteria for A & P delineation. The Australian representative stated that Australia has guided Australians towards several of the four A & P options. The chair of the Implementation committee stated that there was utility in the Napel work for her committee; however, Napel agreed that no international prerogative on A & P should be dictated by his work.

Finally, Geoffrey Reed presented “Health Professions’ Manual for the ICF” Parts of the Manual have been completed and tested in recent consensus conferences across disciplines. There was no time for discussion and a one hour version of this talk was to be presented this evening.

Wednesday 22 October, 2003, Afternoon Session
Chair: P. Goldblatt
Rapporteur: S. Cole

The Use of the ICF and ISO 9999 for expressing the intended use of assistive technology (WHO/HFS/CAS/C/03.41)
ISO 9999 version 4 in 2006 will be fully compatible with ICF and the current version has been accepted for inclusion in WHO-FIC.

The question of the consumer’s experience was raised. In Europe, the manufacturer must specify the intended use of the technical aid, but there is now a project to incorporate the user’s experience of the product, so that this aspect will not be merely a commercial view.
It was suggested that the ICF code in combination with an ISO 9999 code would describe the added value of the assistive technology.

Dissemination of ICF: six tools (WHO/HFS/CAS/C/03.62) was presented.

National programme on medical causes of death in Tunisia (WHO/HFS/CAS/C/03.71) was presented. It was thought that the process and issues raised in this paper would be applicable to many countries trying to introduce medical certification and coding of death certificates. The difficulties experienced in introducing death certificates to hospitals especially, shows that administrative responses are required, in addition to medical support.
The impact of ICD-10-CA and CCI on interim grouping methodologies in Canada (WHO/HFS/CAS/C/03.64) was presented. The difficulties encountered highlighted the need to plan bridge coding when classifications or groupers are changed.

The workplan for the Implementation Committee was discussed. The plan drawn up in Brisbane for ICD was reviewed, taking account of the issues for ICF that were considered in a previous session (2.5b). The most important issue for both classifications is the development of a method of collecting information on current levels of usage and implementation in member states. As discussed in session 1.3.a, it was agreed that a database of basic information should be compiled with the cooperation of Regional Offices and Collaborating Centres. It will also take forward work on a roster of experts.

The Health Metrics Network at WHO is to collect wide ranging information on health systems in all countries, and the Implementation Committee should try to influence the network to get information that is required on implementation status.

The second priority in ICD implementation is the concept of “WHO-FIC in a box”. ICF is not yet ready to take this step. The chairman proposed that the core group progress this. For ICF a pressing requirement is to identify strategic forces and opportunities at the national and international level that would drive implementation. A separate group will take this forward.
Lars Age Johansson, Chair of the Mortality Reference Group (MRG), opened the meeting with an introduction of the history and purpose of the MRG. He informed the approximately 20 persons in attendance that the MRG had met the previous week and addressed many substantive issues in contrast to this session which focuses on procedural issues.

Terms of reference: The current terms of reference were reviewed and modified (see end for the modified Terms of Reference).

Response to URC paper on ICD-11: The MRG discourages considering a whole new ICD revision effort. Emphasis should be on establishing an updating process that works. When that is realized, then the ICD will evolve and there will be much less call for a revolutionary or distinct break between revisions.

Concerns with the idea of an ICD-11 include some of the following: a) even if start out intending to make a minor change are likely to end up with much bigger task than intend; b) premature to move ahead before ICD-10 and the subsequent updating process is fully implemented; c) financial, personal, and temporal costs are prohibitive in developed and developing countries; d) updating process may be abandoned while spending time and personnel on developing revision and then will have to be re-established shortly after the new revision is adopted.

Implementation dates in MMDS software: While various problems exist with distributing approved updates, one efficient way is as part of ACME. There are two classes of decisions: those involving a change in the ICD have to go through the URC while those that do not involve changing the ICD volumes do not have to go through the URC. As a courtesy, the MRG informs the URC that the MRG has discussed these issues.

There are timing issues with ACME that people should keep in mind. The schedule for change requires that decisions be complete by May to give enough time to update relevant tables before they are submitted for publication on August 1. An initial version of the system is mailed out to the States and countries at the end of October, but then work continues on other parts of the system. A second version of the system is mailed out at the end of December. The December version is the version that should be used.

There are qualifications on timing of implementation. Some of the decisions can be implemented with far less difficulty than others. Those that are easy to incorporate into the system can be done quickly while others cannot be incorporated at the first opportunity. For instance, the MRG might decide upon a minor change for the ICD in April, submit it to the URC that month, the URC could accept the decision in October, and then it could be incorporated into the software released a year later. There is not an easy way to anticipate which of the changes can be quickly incorporated in the software before the system's staff begin working on the change.
**ACME as an international standard:** The MRG recommends that ACME should be recognized as the international standard with the decision tables incorporated as a volume 4 of the ICD-10 because this operationalizes the rules. However, ACME needs further development before getting recognized as the standard: the MRG needs to identify what work is needed to make this happen.

Comparisons between manual coding/automated coding often find 5-10% variation. This points out issues that may need to be resolved in ACME. Others are problems with manual coding requiring no change to ACME.

**Miscellaneous:** Andre L’Hours reported that prospects for an updated WHO web page are much more promising. A redesigned page may appear by the end of the year.

The MRG discussed Mary Chamie’s request to review the WHO short tabulation list. The decision was to report back to the plenary session that the Centre Heads need to consider establishing a separate group to do this review. It would be nice to have some overlap in the membership with the MRG; however, a number of people who do not attend the Centre Heads meeting should participate in this kind of group.

**Terms of Reference**

The following issues concerning the Terms of Reference for the MRG were raised and discussed.

Work of the Mortality Reference Group (MRG) covers issues of ICD-10 updates for mortality coding, classification, and reporting purposes:

1. Determine and prioritize problems and issues for review, emanating from the Mortality Forum and other sources.
2. Make decisions regarding the application and interpretation of ICD-10 for mortality.
3. Deliberate on updates to the classification itself (e.g., correction of errors and additions) and on clarifications of application and interpretation (of the classification and its associated rules) to establish international practice.
4. The MRG finalizes annual recommendations by the end of April.
5. Make recommendations to the Update Reference Committee, through a democratic process, with attempts to achieve consensus.
6. Once the MRG has discussed and agreed upon a recommendation, MRG members will support the recommendation of the MRG.
7. Provide documentation of discussions and decisions.
8. The MRG will work electronically, meet in person twice a year, and use telephone conferences as needed.

**Additional guidelines:**

1. ICD-10 must be the international standard for mortality.
2. The MRG selects the chairperson and informs the Secretariat.
3. Decisions from the MRG should be available from the WHO ICD-10 home page (directly or through a link) using the most suitable accessible technology. The decision may be available from several sites (mirror or replicate sites), but, if so, they should all be updated concurrently.

The revised Terms of Reference are printed in the Annex to this document.
Work Plan 2002-2003

1. Continue to hold periodic meetings: one face-to-face meeting at WHO Centre Heads annual meeting and one roughly 6 months later, and telephone conferences as needed (2002 and 2003)
3. Make recommendations to the Update Reference Committee (by April 2003)
4. Prepare annual report for Centre Heads meeting (August 1, 2003)

Wednesday, 22 October, 2003
Chair: L. A. Johansson
Rapporteur: Donna Hoyert

Lars Age Johansson opened the second session of the Mortality Reference Group (MRG). The audience consisted of approximately 20 persons. Several papers were presented before the group resumed discussions of standing issues.

Database for MRG discussions: Robert Jakob gave a presentation on a database for the MRG discussions so they will be easier to trace. Currently, information is located in several different places rather than in a central location. The database would have a number of features: free text search; include codes; and easy to update. This database would not be designed to be web-accessible; instead, it would be available for downloading and use on a local machine. It might be helpful to refer to the Australian chronicle for ICD-AM for an example. Start with MRG issues and then add in Mortality Forum issues in developing the MRG database. A small group consisting of Donna Glenn, Sue Walker, Robert Jakob, Donna Hoyert, and Lars Age Johansson will discuss this issue further, and refer to others if they need additional advice.

The MRG discussed dissemination issues. The Mortality Forum Web site has proven to be very useful; however, more people need to know about it. For instance, we need a link to the Mortality Forum from WHO’s Web site. There are parallels for the MRG database. The discussion focused upon establishing links to the bulletin board at the Australian Bureau of Statistics (ABS) and future developments on the ABS site. We have been reluctant to put ongoing discussions on the ABS bulletin board, but we don’t have concerns with posting completed discussions for wide distribution.

Paper on rules of selection and the true underlying cause: Ruy Laurenti presented a paper on rules of selection for underlying cause and the true underlying cause. The purpose of the paper (#88) is to examine how well the rules compensate for physicians completing cause-of-death certifications poorly. The study was completed using a sample of 2,677 women of reproductive ages. A new death certificate is completed using a number of sources and comparing the underlying cause on the created certificate with the original certificate. The study found close agreement (over 90%) between these two certifications. The degree of agreement was higher in a parallel study completed about 12 years ago which might reflect that the other study included elderly decedents. Although this
study found encouraging results on the value of the international selection rules, this
doesn’t absolve vital statistics’ offices of the responsibility of instructing physicians on
how to complete the death certificate.

Comments from the floor: There was a question about the criteria for the sample. Dr
Laurenti described that the sample was taken from capitals in the states in Brazil for
set time periods.
Mr Johansson stated that it was very reassuring that work of the MRG is of value.
Dr Rooney asked for Dr Laurenti’s assessment of what to do about problems with
death certification. Dr Laurenti reported that Brazil relies on the development and
wide distribution of instructional material. He thinks that it is useful to provide these
materials to nurses since they end up teaching physicians how to certify. Dr Laurenti
indicated that he believes things are getting better based on the percent of cases for
which the General Principle applies. He stated that certification is improving since
the General Principle applies for a larger percent of cases.

ICD-10 MMDS Chronicle: Sue Walker gave a presentation (#50) on the
development of an ICD-10 MMDS Chronicle on behalf of Margaret Campbell. The
idea is to develop a tool to electronically keep track of changes in ICD-10 rules and in
the MMDS. This will meet a demand and reduce the time coders spend answering
these questions.
Currently, this is a work in progress and consists of a series of WORD files
hyperlinked to each other. The files are as follows:

Historical file: Includes ICD entries from all volumes. They had been starting with
ICD-10-AM files but will now use the DIMDI ICD files. This is the central
navigation file and will include any code that has ever existed with highlights on
the codes with a link to a status file.

Status file: Has information about particular codes, the date of any changes,
references to the URC web site, enough information so the user doesn’t have to
have the ICD in front of him/her, and a link to the change file.

Change file: Has background information abstracted from URC documents, who,
why, when, and release info from MMDS developers, year that Australia started
using a particular version of the software, and a link to MMDS file.

MMDS file: Information on any changes in the ACME decision tables or other
materials created by referring to release information from MMDS developers
(Australia is using this as quality control to check on implementation of URC
decisions).

Australia plans to develop formal procedures and a time table. They also need to
decide where to put the chronicle: it could be posted on the ABS bulletin board or the
NCCH Web site or it could be made into a more international product (in which case
some changes would be needed with version dates). Australia has some questions
on how to reflect code changes, rule changes, and is interested in getting comments
(send comments to Sue Walker or generic ncch.brisbane@qut.edu.au).

Comments from the floor: This was well received by the audience. A question was
raised regarding how long it would be before people can access this chronicle. Sue
Walker’s answer was probably this time next year.
Mortality Forum Annual Report: Lars Age Johansson referred the audience to the Mortality Forum annual report (#45) for details. He did show some slides on a few statistical aspects: one demonstrated that the Mortality Forum received and circulated more questions last year than in previous years; another showed that the percent agreement in the mortality forum on issues with major potential impact is in the range of 40-50% which is why a MRG needed to be set up; and a last slide showing that problems forwarded to the MRG have increased over time, largely reflecting MRG processing and ability to accept new issues.

Comments from the floor: Dr. Becker reported that he hopes to have parallel information on the Spanish language and English language forum (for the Caribbean region) at next year’s meeting.

Problem set 2, question 1, Infectious diseases problem: Lars Age Johansson provided the audience with a general introduction on this issue which has been on the MRG’s agenda for a number of years. The main issue at this meeting is a list that Dr Becker and others at PAHO developed. Dr Becker described the process and rationale used in developing the list. Mr. Johansson commented that the innovation in this list concerned HIV. Dr Rooney commented on principles used, but that she had spent a lot of time with the previous list and consulting specialists and was not immediately able to determine if she could apply the advice she had received. She needs additional time to figure out if more advice is needed. Mr Johansson commented that some additional changes would be needed if this list is accepted. Dr Becker asserted that some confusion is introduced by referring to infections instead of infectious diseases. He may have some other proposals related to this idea.

Decision: Wait until members have adequate time to review and consult with own specialists.

Excessive length of MRG suggestions: The MRG is sensitive about the potential expansion of Volume 2 as MRG recommendations are incorporated. The issue here was to solicit comments and suggestions for alternatives to putting things in Volume 2. The group discussed 3 alternatives: the ICD-10 MMDS Chronicle, MRG Database, and a new Volume 4. The audience thought all 3 could be valuable; however, the favourite was for a Volume 4. The principles must be shown in Volume 2, but the other changes can be made available in electronic ICD-10 and in a print-on-demand product. There needs to be links to entry text. The action items needed to progress the Volume 4 idea is to build in review of the causal tables as part of the MRG process. There was a discussion of the difficulties of reviewing tables. The most effective process seems to figure out what manual-automatic coding comparisons have been done and work off of that. Already have an iterative process with the countries using software in which problems are sent to Ms Glenn. This needs to be a priority. Regardless of the distribution type, people need to know about the lists and how to access them. The Australian Centre recommended that MMDS causal tables be incorporated into ICD-10 as a potential 4th Volume, with intention of improving international comparability between manual coders and those using MMDS.
Subgroup on Training and Credentialing (Education Committee)

Monday 20 October, 2003
Chair: Marjorie, Greenberg
Rapporteur: Chris Sweeting/Sue Walker

The Chair welcomed new and existing members of the Training and Credentialing Subgroup and reviewed the agenda for the three sessions to be held during the week. Of particular note is the ICF strategy discussion to be held on Tuesday morning.

WHO/HFS/CAS/C/03.56

The Terms of Reference were discussed in light of the expanded role for the subgroup to include both ICD and ICF. Generic terms of reference were included where possible.

Purpose
The purpose was reviewed in the light of discussions at the Implementation Committee regarding terms of reference. First priority for work of the subgroup is on the core reference terminologies (ICD & ICF), but future work on other members of the Family is possible.

The Australian Centre discussed the need for the addition of education as a priority, encompassing more than just training and credentialing, to underpin the functions of the subgroup. The subgroup’s work needs to address the needs of data users and also incorporate advocacy and awareness raising.

It also was confirmed that the subgroup needs to work with existing educational mechanisms in different countries and internationally, where these are available. For example, the work is related to existing training strategies present in various educational institutions. The work with IFHRO or any other non-governmental organisation is to support the coding profession within countries that may or may not have this support.

Background
Discussion was held regarding the different applications of ICD and ICF – the concept of ICF ‘coders’ is not recognized by some participants. It also was noted that coding guidelines for ICF are not sufficiently mature to support standardized training and credentialing. The background will be modified to recognize the subgroup’s initial beginnings in ICD development but to also include the subsequent integration of ICF where applicable.

Functions
References to training and credentialing in the functions were modified to include education. WHO noted the challenge to strike a balance between ICD and ICF in terms of the work of this subgroup. It is necessary to start with generic issues, then move to specific ICD and ICF issues, including needs assessment, learning objectives, learning content and educational methodology and mechanisms. The
Chair informed the group that needs assessment questionnaires, definitions of skills and functions and core curricula have already been clearly defined for ICD mortality and morbidity coders and nosologists. An inventory of training materials and capacity also has been completed, with plans for updating. A parallel development for ICF needs to occur.

The importance of sensitising health managers and other users to the importance of coded health data was discussed in terms of support for coders and furthering the coding profession and the health information systems which depend on the coded data.

In light of discussions, the Chair agreed to review the terms of reference to incorporate the views of the members.

Tuesday 21 October, 2003
Chair: Marjorie Greenberg
Rapporteurs: Sue Walker/Chris Sweeting

Summary of discussion from the Training and Credentialing meeting held on Oct. 20, 2003:
The Subgroup on Training and Credentialing was founded in 1999 within the ICD Implementation Committee. The initial impetus was to address issues regarding mortality coders identified by the International Collaborative Effort on Automating Mortality Statistics; however, it was agreed to add morbidity coders to the International Training and Credentialing proposal. In 2001, WHO-FIC was launched, and the International Classification of Functioning, Disability and Health was given greater importance in the scope of the group.

This group should incorporate not only ICD and ICF but also other members of the WHO-FIC. The Terms of Reference should be reviewed to be responsive to the whole family.

Given the discussion yesterday, as well as the decision by the Implementation Committee not to have official subcommittees, it was suggested that the Training and Credentialing Group could evolve to become the Education Committee. ‘Training’ does not seem to be broad enough, and ‘Credentialing’ seems to have less relevance for ICF. ‘Education’ is more inclusive of what should be considered for the different classifications.

Also, education and training are important beyond the implementation phase of a classification to foster continuous quality improvement and to support users.

The proposed revised Terms of Reference for the Subgroup on Training and Credentialing (Paper #56) had been re-drafted following Monday’s meeting. Generic functions for the terms of reference were proposed as follows:

- Assessment of the needs of users of the classifications, including those who provide source information, apply codes or use the resulting data.
- Identification of the learning objectives for educational approaches.
- Inventory of existing educational materials and capacity.
- Recommendations for learning content including development of core curricula.
- Recommendations for best practices for promotion and delivery of educational material.
This will be followed by specific tasks for ICD and ICF (and other classifications as appropriate.) ICD and ICF educational efforts will be inter-related and inform each other. As noted by one participant, the goal is to encourage integrated use of ICD and ICF, as well as individual use.

The components of the ICD strategy should include physicians as well as clinicians in strategy no. 2 (ref. Identify the additional groups requiring education and training about ICD, e.g., statisticians, epidemiologists, policymakers, relevant systems managers, clinicians and health sciences students)

Education should include educating individuals in the use of the data. A challenge is to integrate the efforts of the Implementation, Training and Credentialing (Education) and Electronics Tools Committees for the benefit of WHO-FIC.

It was noted that there are a number of relevant papers on training and education that will be presented throughout the meeting. A separate session for such papers might be considered for the 2004 annual meeting.

Today, the goal is to develop an ICF education strategy that would follow the generic functions and parallel the ICD strategy where appropriate.

A participant reported that in the Electronics Tools Committee yesterday, there was discussion about assessing the needs of the ICF users. Such a needs assessment could embrace both education needs and electronic tools needs. It is desirable to leverage and coordinate the activities of both committees.

A Working Group was established with the mandate to develop a work plan to flesh out the ICF tasks in the Terms of Reference and recommend how they should be addressed. This will be accomplished prior to the WHO-FIC meeting 2004.

- This working group will hold its first meeting at 07.30 hr, Oct. 22, 2003 (breakfast meeting in the hotel restaurant).
- Members: Marjorie Greenberg, Marijke de Kleijn, Ros Madden, Nicola Fortune, Catherine Sykes, Diane Caulfield, Paul Placek, Catherine Barral, Cassia Maria Buchalla, Jaime Botelho, Kristina Bränd Persson, Seija Talo, Pattriya Jarutat, and Sirimart Tongsiri

The Working Group on the ICF Terms of Reference met as planned on October 22, 2003. In addition to those listed, other participants were Michael Schuntermann and Patricia Welch Saleeby.

Ros Madden, Nicola Fortune and Catherine Sykes agreed to draft a framework for collecting information on education/training needs and existing materials based on generic functions 1 2& 3. The Framework would parallel the information collection requirements of the Implementation Committee where appropriate.

Paul Placek, Diane Caulfield and Trish Welch Saleeby agreed to draft a questionnaire for gathering information on ICF training materials. Drafts will be sent to the Chair, who will distribute them for comments by the full Education Committee.

The revised Terms of Reference for the WHO-FIC Education Committee are printed in the Annex to this document.
Wednesday 22 October, 2003
Chair: Marjorie Greenberg
Rapporteur: Chris Sweeting /Sue Walker

The Chair reviewed the history of the Training and Credentialing subgroup. The integration of other members of the Family, including ICF, has now occurred and it was noted that there are similar and related issues to be considered – but also some fundamental differences to be worked through. The plan is to work collaboratively and to ‘blend’ ideas and cultures. To this end, a small group has been working during this meeting on components of the Terms of Reference, education strategy and functions to ensure that ICF requirements are included.

In discussing the work of the group to date, the Chair noted that membership is open to anyone with an interest in its work, including other members of the Collaborating Centres who may not be present at the WHO-FIC Network meeting.

Chris Sweeting was invited to give a brief report of a meeting held on October 2, 2003, in Rochdale, UK, with the IFHRO Executive Committee. Chris provided information to the committee about the Training and Credentialing subgroup’s plans and solicited feedback, reactions and suggestions. The committee was enthusiastic about progress and reaffirmed its commitment to working with the WHO-FIC group. The Chair noted that it has been very helpful to have Kathy Brouch as a member of the T&C subgroup, representing IFHRO. Other issues discussed during the meeting in Rochdale related to:
Issues of cost – a business plan is to be developed for presentation to IFHRO in 2004
The possibility of joint IFHRO/WHO certification of training materials
Format for training materials – electronic and/or hard copy and language versions
Administration of the examination, if there is to be one
The needs of so-called ‘information poor’ countries and their requirements for support.

At this point, Willem Hogeboom, the President of IFHRO, joined the meeting and outlined what IFHRO is and the organisation’s interest in international standards for health records. IFHRO is an NGO in official relations with WHO. Willem reiterated IFHRO’s interest in, and support for this work. However, he noted that IFHRO is not an organisation with a large infrastructure base, and this needs consideration in any work program. Its principal interest is currently in certifying courses or materials, not individual coders.

The Chair highlighted for members the various attachments available in the annual report of the Subgroup – feedback from all participants would be appreciated and should be sent to the Chair (msg1@cdc.gov) by the end of November 2003 at the latest. There was discussion about the proposed survey to be conducted by the Implementation committee and the potential for overlap with the T&C needs assessment questionnaire for mortality and morbidity coders. The Implementation committee is considering a short questionnaire to capture basic information on implementation of the classifications and may seek funding to assist with more extensive survey development and distribution. It was further noted that WHO is
participating in the Health Metrics Network, which might also collect similar information. The groups responsible for these activities were specifically requested to provide feedback in an effort to ensure that WHO regions do not face overload and similar surveys. It was noted that, although certain questions appear to be similar, the T&C survey contains specific items relating to education and educational needs, which are required for development of the business plan and presentation to IFHRO in October 2004. It may be possible to unify the first section of the survey with the needs of the Implementation committee and use the needs assessment questionnaire as a template for further development. The Australian Centre is planning to develop a database to store results of the needs assessment and this could be made available to other interested parties.

The Chair then outlined the international credentialing proposal which had been refined in Washington in April 2003. It was further noted that the abstract regarding the work of the T&C subgroup had been accepted for presentation at the 2004 IFHRO Congress during the International Clinical Coding Symposium. The Chair welcomed the opportunity to highlight WHO-FIC, the T&C group’s work and potentially ICF in this session. It is understood that there are still gaps in the program for this session, and interested speakers should contact AHIMA.

The Australian Centre presented the paper WHO/HFS/CAS/C/03.69 regarding the development of a brochure and strategy to inform a wide audience about the T&C subgroup and the training and credentialing program. The underlying purpose of the whole development is to support coders internationally, improve coded data quality and consistency and to enhance the status of coders. Of particular importance is the need to support coders in countries without well-established HIM organisations or infrastructure. The Chair requested that participants consider the content of the proposed information brochure and feedback comments to Sue Walker by mid-November (s.walker@qut.edu.au). WHO has agreed to set up a hyperlink from the WHO-FIC webpage to the T&C webpage hosted by the NACC. Willem also agreed that links to and from the IFHRO webpage would be useful. He also offered the IFHRO mailing database as a possibility for distribution of information or brochures.

The Office of the ICD for Japan presented paper WHO/HFS/CAS/C/03.79 regarding the development of a training program for Japanese coders. The introduction of DRGs in Japan produced great demand for coder and HIM education, and a revised program was developed. Common problems facing Japan include the lack of appropriately-qualified teaching staff to support the drastic increase in applicants wishing to complete the two-year training program and the differentiation between coders and Health Information Managers.

The Chair stated that there is a need for a further face to face meeting to review the results of the needs assessment questionnaires and updated training inventory, continue work on the core curriculum, and develop a business plan for the international training and credentialing program. It was proposed to hold this in late May in Prague, prior to a suggested MRG meeting and a workshop on automated coding for Eastern European countries. This latter workshop is to be funded by the Soros Foundation, and it was noted that the education group should seek similar funding to assist with its ongoing work program. The Chair extended an invitation to IFHRO to send a representative to the meeting. It was further noted that there is to
be a NACC meeting regarding ICF in Halifax, Nova Scotia in 2004 and potentially work on an educational strategy for ICF could be considered at this meeting.

**Action Plan for 2003-2004:**

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<td>November 30, 2003</td>
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<td>Committee members send comments to Chair on Needs Assessment</td>
<td>November 15, 2003</td>
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<td>Questionnaires (Attachments 6 and 7 of Annual Report)</td>
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<td>Committee members send comments to Chair on Definitions document</td>
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<td>(Attachment 4), International Training and Credentialing proposal</td>
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<td>(Attachment 5), and Educational Needs documents (Attachments 8 and 9)</td>
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<tr>
<td>Committee members send comments on brochure to Sue Walker</td>
<td>November 15, 2003</td>
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<tr>
<td>Finalize ICD documents</td>
<td>December 15, 2003</td>
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<tr>
<td>Translate ICD needs assessment questionnaires and circulate to regional offices for completion by member countries</td>
<td>January 15, 2004</td>
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<tr>
<td>Analysis of needs assessment questionnaires</td>
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<tr>
<td>Update matrices on ICD training materials and capacity in the context of the Educational Needs documents and identify gaps</td>
<td>2004</td>
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<tr>
<td>Finalize brochure</td>
<td>January 2004</td>
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<tr>
<td>Organize mid-year meeting</td>
<td>May 24-26, 2004</td>
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<tr>
<td>Develop business plan for International Training and Credentialing Program for presentation to IFHRO Executive Board</td>
<td>May – October 2004</td>
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<tr>
<td>Develop educational strategy for ICF</td>
<td>2004</td>
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<td>Conduct inventory on ICF training materials and capacity</td>
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Update Reference Committee

Monday 20 October, 2003
Chair: Rosemary. Roberts
Rapporteur Julie Rust & Lori Moskal

Professor Roberts (The Chair) opened the first session of the Update Reference Committee (URC) and welcomed all present. She noted the limited time available for the large amount of work facing the committee and proposed that the discussion of Terms of Reference for the URC and the workplan be referred to later sessions, when deliberation of update/revision issues of ICD-10 have been considered by other Committee sessions. Copies of the Terms of Reference, committee structure and workplan were distributed to all present.

This session then proceeded to review the URC work items, as previously distributed to members of the URC.

Section 1 included 45 recommendations supported by the URC for inclusion in ICD-10 (2005) [minor updates] and ICD-10 (2006) [major updates]. These recommendations for change had been previously agreed via e-mail and were proposed for ratification. Lars Age Johansson, representing the Mortality Reference Group (MRG), requested:
- The withdrawal of URC 0176 Combination/linked codes so that more work on this proposal can be done by the MRG
- The inclusion of the excludes note recommended by the Australian Centre for URC 0196 Compartment syndrome – non-traumatic. Andre L’Hours noted that the exclusion note at M62.2 Ischaemic infarction of muscle should read ‘Excludes: Compartment syndrome (traumatic) (T79.6)

With the above amendments, the remaining 44 recommendations were accepted for inclusion in ICD-10.

Section 4 included 4 work items that had been withdrawn. Their withdrawal from the work program was accepted.

Section 3 included 7 work items that have been held over/not for discussion. These work items were tabled for members’ information and it was noted that the lack of progress on a number of these recommendations was due to the limited/late feedback from relevant international bodies. The Chair noted that discussion on how best to progress these proposals will be included in Terms of Reference and workplan discussions in later sessions of the URC.

Section 2 included 44 work items that required further discussion.

URC 0110: Morbidly adherent placenta
There was mixed support for this proposal. The Australian Centre still supports the need for an antenatal classification of this condition. The Nordic Centre, with subsequent advice provided by consultant obstetricians, wished to withdraw their compromise proposal of 2001. They feel that this condition only causes a problem at
delivery, therefore an antenatal code is not necessary and that abnormal findings on ultrasound screening may be captured with R93.8 *Abnormal findings on diagnostic imaging of other specified body structures.*

**Decision**
The Australian Centre agreed to withdraw this item temporarily in order to obtain further information from Australian obstetricians and frequency data (when available) on this code in ICD-10-AM.

URC 0137 Formaldehyde/Formalin – Table of drugs and chemicals
Canada had made a further clarification to the recommendation from the Australian Centre, with the inclusion of an extra line in the Table of Drugs and Chemicals (in line with ICD-9 layout). Michael Schopen’s recommendation to code all forms of formaldehyde/formalin (liquid, gas, vapour etc) to T59.2 and therefore retain specificity was considered sensible by all present and confirmed by Andre L’Hours.

**Decision**
With the above changes, the proposal was accepted as circulated.

URC 0138 Duchenne’s paralysis

**Decision**
The recommended index changes were accepted as circulated, noting that comparable indexing must be made at ‘Duchenne’s, paralysis’.

URC 0147 Vapour asphyxia or suffocation NEC

**Decision**
Clarification of the Nordic response to this proposal was sought prior to this meeting. An excludes note had been overlooked. This work item was therefore accepted as circulated.

URC 0150 Cruveilhier-Baumgarten cirrhosis
All members agreed to this proposal with the exception of Moriyo Kimura who felt that this condition was not a type of cirrhosis, but a portal vein hypertension. The Chair noted that the original proposal was simply for standardisation of index terms, and suggested that the Office of ICD Japan submit a separate proposal for consideration of the classification Cruveilhier-Baumgarten disease.

**Decision**
The proposal was accepted as circulated.

URC 0180 Hereditary Creutzfeldt-Jakob disease
There was general agreement that this proposal was worthwhile however no actual codes or index entries had been suggested. Jackie Ashworth (UK Centre) offered to withdraw this proposal in order to gain further detailed clinical information and provide subcategories for the various types of Creutzfeldt-Jakob disease (iatrogenic, hereditary and variant).
**Decision**
The UK Centre withdrew this proposal temporarily in order to gain further clinical and classification information.

**URC 0181 Contact with needle**
All members agreed in principle for a separate code or subcategory for contact with needle, in order to specify needlestick/sharps injuries.

**Decision**
The UK Centre agreed to resubmit this proposal with suggestions for code placement and associated index entries.

**URC 0198 Subsequent myocardial infarction**
There was mixed support for this proposal. Currently there are two ways countries are interpreting I22 *Subsequent myocardial infarction*:
- All recurrent myocardial infarctions, irrespective of the time elapsed since the first infarction (this is the definition in the MRG proposal), or
- A myocardial infarction (MI) occurring within 4 weeks of a previous MI.
Andre L’Hours stated that the original intent of WHO was to capture all second and subsequent myocardial infarctions with this code. Björn Smedby noted that obtaining this information clinically was not always very reliable. It was suggested that perhaps there could be a different interpretation of the definition for morbidity as against mortality.

**Decision**
MRG offered to liaise with WHO and obtain further information from both the MONICA project and the WHO cardiovascular diseases group who originally formulated the definitions. This work item to be held over for 2004.

*Tuesday 21 October, 2003, Morning Session*

*Chair: R. Roberts*

*Rapporteur Julie Rust & Lori Moskal*

The second session consisted of a review and a brief discussion of the two papers submitted for this session. The papers included the following:

**Towards revising the ICD/FIC Mental Health Component, WHO-WPA Collaboration**
(paper not yet forwarded to WHO HoC meeting)
Dr Carlos Berganza and Professor Juan Mezzich provided an overview of the work of the World Psychiatric Association in the area of clinical classification. Eighty experts worldwide meeting regularly to discuss psychiatric classification issues and they are very keen to be involved in the revision of the mental health chapter (Chapter V) of ICD-10.

**Discussion points**
This paper was well received, with the Chair noting the evolutionary process of maintaining the psychiatric classification. Mary Chamie queried whether any consideration had been given to an associated review of ICF in order to improve the
classification of mental health in this classification. Professor Mezzich responded that he agreed with identifying functioning and skills and looked forward to working with ICF in the future in order to capture this information.

Dr Üstün provided a background on the development of WHO specialty adaptations of the mental health chapter (Chapter V). There was general discussion on the concept that individual chapter revision should be part of the overall revision process of ICD-10 and the Chair welcomed new proposals from the World Psychiatric Association (WPA) in the ICD-10 update process.

Application of ICD-10 in clinical setting

( WHO/HFS/CAS/C/03.80)

Dr Moriyo Kimura reviewed some of the shortcomings noted in ICD-10 since its implementation in Japan, in particular in the area of gastroenterology and provided some recommendations for change.

Discussion points

Dr Üstün responded that for some clinical areas, for example helicobacter pylori, it took 10 years for the clinicians alone to reach consensus. He noted that WHO does not have all the expertise to distil new information and/or judge the relevance of certain specific conditions for inclusion in ICD-10. He also suggested that the Japanese Office for ICD may want to consider a Japanese version of ICD-10.

The Chair noted that it was important to remind clinicians the rubric names in ICD-10 are fairly artificial labels for bundles of conditions for which there are many more terms in the alphabetic index. A number of participants noted that Dr Kimura’s paper highlighted the fact that not all clinical concepts can be represented in ICD-10 and that there may be a need to combine codes from different classification systems to provide the complete clinical picture. Martti Virtanen suggested that a formal proposal of these specific gastroenterology issues be forwarded to the URC as a recommendation for change.

The Chair proceeded with the continuing review of the URC work items.

URC 0204 Severe Acute Respiratory Syndrome (SARS)

There was a great deal of discussion on this proposal. The issues raised included:

• In which chapter should a unique code for SARS be located
• How soon can a permanent code for SARS be assigned
• Should a temporary unique U code be assigned for now or should SARS be coded within the current classification structure, for example, J12.8 Other viral pneumonia, together with the code for coronavirus, B97.2 Coronavirus as the cause of diseases classified to other chapters.
• Is there a need for a split in the temporary code for suspected and probable cases
• Not all of those infected with the coronavirus go on to develop SARS, and conversely, not all cases of SARS have the coronavirus detected.
• The capability of the MRG and URC in responding to similar classification ‘emergencies’

Andre L’Hours reminded members of the paragraph in the Instruction Manual Of ICD-10 (Volume 2), which prescribed the correct use of the U codes, i.e. U00-U49 are
reserved for international use as temporary solutions to classification issues and codes U50-99 may be used as permanent codes by individual nations for research and other special needs. Subsequently, Marjorie Greenberg, Head of the North American Collaborating Centre, addressed the committee in reference to the remark made by Andre L’Hours regarding the correct use of U codes. She explained that some codes from U01- U03 have been assigned in ICD-10- for capturing terrorism events in the United States. It is not feasible to undo these changes currently.

**Decision**
The proposal submitted by the MRG was accepted with U04.9 *Severe Acute Respiratory Syndrome (SARS), unspecified*, being the temporary code. André L’Hours agreed to post this information on the WHO website, on both the SARS and WHO classification pages. Due to the unique nature of this proposal, the suggested implementation date will be October 2003.

**Tuesday 21 October, 2003, Afternoon Session**
*Chair: R. Roberts  
Rapporteur Julie Rust & Lori Moskal*

The following paper was then presented:

**The role of the Update Reference Committee and the development of ICD-11 (WHO/HFS/CAS/C/03.49)**
Prof. Rosemary Roberts presented this paper which provided an overview of the working of the URC and the difficulties faced by this Committee in both making updates to ICD-10 in areas which are in need of major clinical revision and disseminating these updates to world-wide users of ICD-10. Recommendations for the path forward to ICD-11 were provided for information and discussion.

**Discussion**
This paper generated a great deal of discussion, the main points of which are outlined below:
- The current update process was introduced to cope with a larger interval between major revisions of the classification
- There is need of an updating process that works well. If a new revision is started now, it will be out of date by the time it is implemented
- It would be premature to assign a timetable for the introduction of ICD-11 at this meeting
- There is a need for a full evaluation of the update process
- There needs to be an electronic database version of ICD-10 before there is any thought of moving to ICD-11. This is the first priority of the Electronic Tools Committee.
- This issue again highlights the ‘information paradox’, in this case, stability versus clinical currency. Maybe there is a need to look to the future where different classifications are used for different purposes
- The input of terminologies is important. There is a need to look at how information is going to be extracted from electronic health records using terminologies and how that relates to classification systems
The WHO must have a stronger leadership role in the development of any future revisions of ICD

Dr Üstün commented that such an important decision cannot be left to personal opinions alone. It is inevitable that there will be a future revision of ICD-10; the questions are when and how. He stated that there were important lessons to be learnt from the development of ICF and there needs to be a scientific, evidence-based approach to the development of ICD-11.

The Chair then summarized the recommendations from URC in relation to this presentation and discussion:

- The inevitability of ICD-11 is accepted, given the mandate of the World Health Assembly, scientific advances and IT progress
- Evaluation of the current updating process is required
- A policy meeting is required to plan the mechanisms and timeline for ICD-11
- An electronic database version of ICD-10, and possibly an ICD-10-XM, is necessary in order to streamline and maintain the updating process of ICD-10
- There is an urgent need for international multidisciplinary clinical consultations and projects on topics requiring clinical update, e.g. mental health
- The introduction and maintenance of a accompanying procedure classification is a separate issue
- Work on terminologies must begin in ICD-10, not wait for ICD-11

Due to the very limited time available to review the remaining work items in Section 2, the Chair proposed that the URC accept the following minor proposals with majority agreement, without further review.

URC 0133 Lung mass NOS
URC 0153 Transport accidents – add exclusion note
URC 0155 Medical devices and complications
URC 0160 Mental and behavioural disorders due to alcohol
URC 0174 Osteoporosis with fracture
URC 0179 Neuro-endocrine neoplasm
URC 0189 Acute renal failure
URC 0200 Hepatitis C
URC 0202 HIV/cause of death

This proposal was accepted. The following recommendations for change were then presented.

URC 0002 Procedural complications
The large amount of changes for the alphabetic index still appeared to be the major problem for most members. The Australian Centre explained the background for these changes; clinical advice provided common postprocedural complications which were then indexed in order to provide standardisation of code assignment. The Australian Centre still felt that there was ambiguity between early and late complications and that the definition provided in ICD-10 did not solve the problem. Roberto Becker also noted the problem that both the T80-T88 category and the
postprocedural categories in the anatomic chapters are both 'not elsewhere classified' and this poses problems for correct code assignment.

Decision
The Australia Centre agreed to resubmit this proposal with a reduction of index changes and only include those relating to terminology of postprocedural/postsurgical.

URC 0030 Sacroiliac joint
URC 0031 Ankylosing spondylitis

Decision
Due to problems with the inconsistency of the classification of ‘sacroiliac joint’ in ICD-10, both of these proposals are to be withdrawn until a major revision of this area of the classification (musculoskeletal) either in ICD-10 or a future revision.

URC 0037 Snapping hip

Decision
The proposal was accepted with minor amendment to index, subterm of knee to be added

URC 0078 Calcification of tendon

Decision
The proposal was withdrawn for reasons outlined in URC 0030/0031.

URC 0083 Moeller’s glossitis
Due to the low frequency for this condition, the Australian Centre accepted the majority decision of assigning K14.0

Decision
The proposal was accepted, with all related index entries to K14.0

URC 0094 Right ventricle fibrous dysplasia
The UK Centre noted the most recent information in relation to this proposal, from the International Working Group for Mapping and Coding of Nomenclatures for Paediatric and Congenital Heart Disease (known as 'Nomenclature Working Group'), who suggested that synonyms for this condition are mapped to I42.8 Other cardiomyopathies

Decision
The proposal for a new code for this condition was not accepted. All agreed that this condition should be classified to I42.8 Other cardiomyopathies. An appropriate index entry will be included in ICD-10.

URC 0097 Face to pubes presentation
The Australian Centre had previously noted the inconsistencies in this section of the classification, as part of their work on ICD-10-AM. Face to pubes presentation is not
a face presentation; the more common term is persistent occipitoposterior. The correct code for this presentation, without obstruction, is O32.8 *Maternal care for other presentation of fetus*.

**Decision**
The original proposal was not supported. All members supported the recommendation from Australian Centre; therefore appropriate amendments will be made.

**URC 0103 Eisenmenger’s syndrome**
The URC secretariat had requested information on this condition from Dr Marie Beland, Secretary of the Nomenclature Working Group. Excellent feedback was provided from Dr Beland, however this information was not able to be included in the latest round of recommendations for update in time for this meeting.

**Decision**
This proposal was held over for 2004. The URC secretariat will collate these comments and forward again as part of the revised proposal.

**URC 0149 Intermittent claudication**
This proposal did not receive wide support. Most members felt that intermittent claudication is a symptom which may have a range of underlying causes, even though atherosclerosis of the arteries of the extremities may be the most common one.

**Decision**
The Australian Centre agreed to withdraw this proposal.

**URC 0162 Lower chronic respiratory diseases**
While there was support for the further work that the Australian Centre had provided in relation to this proposal, it was felt that such major changes were outside the scope of the URC at present.

**Decision**
The original proposal was accepted as circulated.

**URC 0166 Bacterial hepatitis**

**Decision**
The MRG agreed to take the circulated comments from the URC back to the MRG and to resubmit this proposal in 2004.

**URC 0172 Hypoxic ischaemic encephalopathy**

**Decision**
This proposal was accepted as circulated on proviso of the Office of ICD in Japan checking with their own specialist obstetricians/neonatologists.
URC 0182 Passive smoking
Members felt that this recommendation for change requires further work with some parameters for when ‘passive smoking’ should be coded.

Decision
The UK Centre agreed to take back this proposal in order to provide further information and draft definitions and resubmit in 2004.

URC 0184 Kyphosis due to rickets
The current recommendation for change is not acceptable as it introduces a new precedent/convention of providing two codes in the alphabetic index where one of the codes is not part of a dagger/asterisk combination.

Decision
The UK Centre agreed to resubmit this proposal in 2004, taking into account comments and feedback from other URC members.

URC 0186 Transsexualism/gender identity disorder
There was mixed support for this proposal. While most members agreed that the mental health chapter was probably not the most appropriate place for this condition, there was no strong alternative code provided.

Decision
The UK Centre agreed to resubmit this proposal in 2004 with suggestions for an alternative classification structure for gender identity disorder.

URC 0195 Acute coronary syndrome
Members were divided on this issue. The Australian, UK, and in part, the North American Centres supported the use of I20.0 Unstable angina for acute coronary syndrome, where no further clarification was available or there was no evidence of actual myocardial infarct. The Nordic and German Centres and MRG felt that due to the lack of further clarification, I24.9 Acute ischaemic heart disease, unspecified was the better code.

Decision
The proposal was accepted, but with a code change from I24.8 Other forms of acute ischaemic heart disease to I24.9 Acute ischaemic heart disease, unspecified, with the addition of ‘NEC’ in the alphabetic index.

URC 0197 Place of occurrence/activity codes
Decision
This proposal was accepted, with a minor wording change on p1013 – delete ‘except Y06.- and Y07.-’.

URC 0201 External cause of fractures
There was mixed support for this proposal, with some members and Andre L’Hours expressing concern about the mix of concepts (external cause and diagnosis) being introduced in a new code.
Decision
The proposal was accepted

URC 0203 Alcoholic pancreatitis
Most members agreed with this proposal, and with the further subcategories suggested by the German Centre, with the exclusion of postprocedural pancreatitis. Andre L’Hours suggested that these subcategories may be better organized and the German Centre agreed to provide a further draft, including alphabetic index entries.

Decision
The German Centre will resubmit this proposal in 2004.

URC 0208 International Nomenclature for Congenital Heart Disease Project
Members agreed that the work of this group is of great interest to the URC and agreed that the way forward may be to enrich the ICD-10 index with cardiac terms and synonyms which have been mapped to ICD-10 codes.

Decision
The Chair will respond to Dr Marie Beland.

URC 0155 Medical devices and complications
Although this item had been previously agreed as accepted with other minor proposals with majority agreement, the North American Centre sought further clarification as to the actual use of codes Y70-Y82 Medical devices associated with adverse incidents in diagnostic and therapeutic use.

Decision
The MRG agreed to provide further clarification on this proposal and will resubmit in 2004.

URC 0125 Dichloroethyl ether

Decision
Following review of comments from other members, the Australian Centre agreed to withdraw this proposal.

URC 0130 Familial nonhaemolytic congenital jaundice
While this proposal was simply to standardize index entries for familial nonhaemolytic congenital jaundice, the North American Centre noted that there were further issues in relation to the classification of Crigler-Najjar and Gilbert’s Syndromes.

Decision
The original proposal is withdrawn and The North American Centre will submit a proposal, including their background information on these syndromes.
URC 0171 Malignant pleural effusion
The MRG noted that this proposal had been previously accepted

Decision
The proposal was accepted, with minor change – inclusion of ‘NEC’ in the alphabetic index at ‘Effusion, pleura, malignant’.

URC0185 Perforation of tympanic membrane with otitis media
There was divided support for this proposal with some Centres wishing to capture the two components separately. Other opinions supported the clinical preference for not coding the ruptured tympanum separately.

Decision
The proposal was accepted as circulated

URC 0199 Valvular disorders

Decision
This proposal was accepted with a minor wording change and MRG will supply further enhancements to the alphabetic index.

The Chair then proceeded to discussion of Terms of Reference and work plan for 2004.

Terms of Reference
The purpose, meetings, scope and workload of the URC were discussed. Some of the issues raised included:
The need for extra face-to-face meeting time for members of the URC to deal with the increase in workload
The question of whether the URC takes on the updating process for other members of WHO-FIC and derived classifications, such as ICD-O.
The updating of different language versions of ICD-10, where the particular issue is in relation to the language rather than the classification structure.

As a result of these discussions, the following recommendations were formulated:

Updates to other members of WHO-FIC and derived classifications should be dealt with on a parallel basis by their specialty groups with a process for cross-fertilisation with the URC
Issues with particular language versions of ICD-10 should be in the first instance referred to the Collaborating Centre that is responsible for that language version, and then if applicable, referred to the URC for review.
The URC wishes to trial a one full-day technical meeting, attended by members of the URC, just prior to the 2004 WHO-FIC Network Annual Meeting in order to progress work items efficiently
WHO to disseminate the updates to ICD-10 via the WHO website and electronic versions of ICD-10
WHO to convene meetings of clinical advisory groups
The URC to be renamed as the Update and Revision Committee
The revised Terms of Reference for the URC are printed in the Annex to this report.

A summary of the work items dealt with over the four breakout sessions is as follows:

| 44 proposals, previously agreed via email, were ratified for inclusion in ICD-10 |
| Of the 44 remaining work items to be discussed at this meeting: |
| • 25 proposals were accepted for inclusion in ICD-10 |
| • 14 proposals were held over for further discussion/re-working in 2004 |
| • 5 proposals were withdrawn/rejected |
Mortality Reference Group
Lars Age Johansson presented the report of the Mortality Reference Group which included sessions on 16 and 17 October and 2 sessions during the WHO-FIC meeting.
There was no further discussion.

Update Reference Committee
Prof Rosemary Roberts presented the report of work over the last 12 months and at the WHO-FIC meeting.

Discussion
- Dr Martti Virtanen said the Australian centre does very good work in relation to the update process but the decision process is unclear. It consists of mortality and morbidity experts deciding what should be done in clinical coding. He suggested that there should be a clinical coding group to look at ICF and eventually ICECI. Marjorie Greenberg said that Dr Virtanen had made a good point but that it was important to identify why it was difficult to connect to these groups and overcome the barriers. Dr Cleo Rooney said there was a need to get mechanism to consult clinicians. For cancer the International Agency for the Research of Cancer can be consulted but other groups for example neurologists or for diabetes are hard to identify. This needs to be formalized for a revision process.
- Marjorie Greenberg said that with regard to ICD-11, it was important to evaluate the update process and to understand the scope before planning a timetable.
- Dr Richard Madden expressed concern that the URC had recommended a closed meeting. Prof. Rosemary Roberts responded by saying that the suggestion was response to the mechanics of decision making where it was important that URC members were informed of the previous discussion so that they could reach conclusions in the limited time in face to face meeting. Marjorie Greenberg, sharing similar concerns, suggested that there should be ground rules so the discussion was limited to members but all could attend as observers. Richard Madden suggested that the meeting was called a ‘technical meeting’.
- Dr Bedirhan Üstün said that the question of clinical involvement had not been raised so clearly before now but it was possible within the new environment in WHO to have multi stakeholder consultation and the structure of these consultations should be discussed.
- The ICD should be examined in the light of the ICF so that concepts such as ‘handicap’ are treated consistently within WHO-FIC. Prof. Rosemary Roberts said there should be more discussion about updating of ICF as URC does not currently have expertise. Ros Madden said there should be some thinking ahead to get a framework to discuss the updating process as had been discussed in the implementation committee. Dr Martti Virtanen suggested nominating a clinical
reference group to cover both ICD and ICF and it was also suggested that it should cover the ICECI working group

- Gerard Pavillon said that, mortality data being the more widely used health indicator, it was essential to preserve this ICD-10 function

Dr Willem Hirs summarized the discussion so far. On the one hand the URC has to deal with revision questions within ICD-10 and its role within WHO-FIC as a reference classification. On the other hand it has to deal with the acquisition of the appropriate clinical input to morbidity to decide upon update proposals. More work is therefore needed on the way we want to organize these different tasks in the coming years when we have to discuss the results of the update and revision processes. It was agreed that the planning/advisory group should work on the issue and make recommendations.

**FDC report**

Dr Madden reported on the six sessions of the Family Development Committee.

**Discussion**

**ICD-11**

- Dr Susan Cole supported Gerard Pavillon’s suggestion that it was important to consider that at its core the ICD is a statistical classification of mortality from which other clinical modifications will come. Dr Cleo Rooney said that it was important to work on international classifications for diagnoses for health care and morbidity for use in electronic health records and health services, but also for measures of morbidity. Marjorie Greenberg said that we had to be cautious separating ICD mortality from morbidity as it had the potential to reduce the credibility of the ICD as application in health services. It was agreed that there were a whole range of issues to be considered around ICD-11.

**Procedures**

Dr Bedirhan Üstün conveyed thanks for ICHI work for countries which do not have an intervention procedure classification. There now needed to be field trials consultation with WHO Regional Offices to ensure compatibility with WHO-FIC. Dr Willem Hirs stressed that the work on procedure classifications should incorporate also approaches such as that presented by the German Centre.

**Terminologies**

- Dr Peter Goldblatt raised the difficulties of mapping classifications where there was restricted access to the classification by third parties. Dr Bedirhan Üstün said that WHO-FIC may get left behind if we don’t take action to get cover in Intellectual Property rights and in electronic systems. There is now a great opportunity to sort out legal and practical issues. Dr Martti Virtanen said that these issues should not only centre around the English language. Prof Rosemary Roberts asked Dr Peter Goldblatt how the Terminologies Working Group can be represented on the SNOMED International Convergent Terminology Group for Mapping. He responded by saying he is to email centre heads to invite them to
nominate group members The terminologist at WHO has already started working at WHO and will be an ex officio member of this group.

- Dr Peter Goldblatt commented that terminologies and classification are distinct logically. There was discussion about definitions and usage of the word ‘terminologies’ and whether the usage has changed. The notion that ‘terminology’ is an umbrella term has now been lost. But there does need to be clarity of what we mean by these words.

*Plenary 23 October, 2003*

*Chair: Dr Martti Virtanen*

*Rapporteur: L. Cook*

**Electronic Tools Committee**

Dr Michael Schopen presented the report

**Discussion**

- Prof Rosemary Roberts asked about the distribution of the ICD-10 browser. Dr Schopen said that WHO has to decide on distribution. It was currently on restricted area which was available to all WHO offices.
- Cleo Rooney asked about the availability of the Electronic version of ICD-10. Dr Bedirhan Üstün said it would be available shortly and he would notify centre heads although orders could be placed now.

**Training and Credentialing**

Marjorie Greenberg presented the report of the Training and Credentialing Subgroup of the Implementation Committee. The Group is recommending that it be reconstituted as the Education Committee.

**Discussion**

Ms Ros Madden asked if the Training and Credentialing Committee meeting in Prague only covered the ICD. Marjorie Greenberg replied that it was not a full meeting but coincided with the ICE on Automation training programme for Eastern Europe and would address the ICD education strategy.

Dr Moriyo Kimura commented that it is important that doctors are trained in the ICD in order to understand the differences in the use of the ICD in mortality and morbidity. This will be important for the updating procedure. Ms Marjorie Greenberg said that the inventory of training materials will include physician training.

**Implementation Committee**

The report was presented by Dr Marijke de Kleijn and Dr Peter Goldblatt.

**Discussion**

- Mary Chamie commented that we should also consider outflows and streams of statistics as part of implementation. Dr de Kleijn said that a minimum data set must be part of WHO-FIC in a box.
- Dr Richard Madden was concerned about the loss of specificity in the work plan - we had to give some attention to dates.
• Prof. Rosemary Roberts said it was important to stock-take clinical modifications. Ms Marjorie Greenberg said that it would be part of the planned needs assessment - the results of which would be recorded on a database.

• Dr Roberto Becker reminded the meeting that many countries do not have any data at all. It was important to find a way to strengthen vital registration systems. Dr Bedirhan Üstün said that it was important to start addressing the information paradox and focus on equity across countries.
WHO-FIC in Europe
Plenary 24 October, 2003
Chair: Dr Michael Schopen
Rapporteur: L Cook

The Implementation of the ICF in Germany (WHO/HFS/CAS/C/03.92)
Dr Schuntermann presented his paper.

Discussion
- The ICF presents users with options for the use of activity and participation. Only 2 qualifiers limit options for use. It is not clear what capacity and performance mean in the context of participation.
- German Adaptation of ICF might be a threat to international comparability.
  Capacity to work is a complex term in Germany; need to find how to solve these problems. This might be a candidate for the ICF updating process.

Application and dissemination of international classifications in health information systems of Estonia (WHO/HFS/CAS/C/03.77)
Presented by Peret Simmo.

Discussion
Estonia already has contacts with international groups using the ICF.

The Dutch Family of International Classifications:ICPC-2, ICD-10 and ICF (WHO/HFS/CAS/C/03.31)
Presented by Dr Kees van Boven.

Discussion
- The 14,000 terms were developed from ICD-10 and ICPC and from General Practice usage. They are uniquely identified.
- Measure of severity scale only used for research.
- It was important to see a demonstration use of the generic tool.

ICF - a frame to develop aspects in Knowledge management in social and health care, a Finnish Perspectives (WHO/HFS/CAS/C/03.107)
Presented by Dr Seija Talo.
ICF Developments in Hungary WHO/HFS/CAS/C/03.106
Presented by Prof Lajos Kullmann.

Discussion
• Hungarian group helped put ICF core set into practice. It is important to come up with core set for statistics
• Different strategies for the translation of ICF learning from the experience of the ICD were discussed including starting with often used terms and the use of translator software with usage confirmed by specialists.

Using the International Classification of Functioning, Disability and Health (ICF) in nursing practice (WHO/HFS/CAS/C/03.98)
Presented by H A Stallinga.

Discussion
• It is important for nurses to be able to record risk. A possible solution to this problem would be to use qualifiers. It is important that the definition of qualifiers should be arranged internationally. One of the first priorities identified for the implementation database is to collect information on actual use and to develop information sharing
• Validation of the ICF can be achieved through experience of using it as well as medical validation. There is a subtle distinction between these two methods.
• ICF can be used in multi disciplinary assessments.

The 'ICF in Italy Project' and the activities of the Disability Italian Network (WHO/HFS/CAS/C/03.102)
Presented by Matilde Leonardi.
Results of the England and Wales ICD-10 Comparability study: the effect on main injury and external cause (WHO/HFS/CAS/C/03.84)
Presented by Cleo Rooney.

Discussion
• Similar results from Brazil. There is a need to compare studies around the world.
• There is a need to be able to pick the major injury if several injuries are mentioned rather than code to multiple injury.

Proposals to change the investigation and certification in England and Wales following the Shipman Inquiry and the Fundamental Review of the Coroner Service (WHO/HFS/CAS/C/03.83)
Presented by Cleo Rooney.

Discussion
• Experience of heat wave deaths in France shows the limitations of systems. There is need to collaborate within WHO-FIC and take advantage of new technologies to incorporate death registration data in health care systems.
• Would new systems detect Shipman? With hindsight the pattern of deaths does stand out but in current systems cannot identify an individual doctor via a code. Same system used in Finland as in Australia. Denmark has just abolished a similar system. Policing function of doctors will not help much. Have to balance likelihood that health care workers do not usually kill patients. How do you deal with false alarms in a monitoring system?

Comparability of cause of death between ICD-9 and ICD-10: results from mortality data in United States (WHO/HFS/CAS/C/03.57)
Bob Anderson of the North American Centre presented paper 57, updating the centre heads on this continuing research. Following discussions about producing ICD-11, he added lessons he felt had been learned about the task of implementing a new revision of the ICD and carrying out comparability studies.

Lessons learned- following discussions of ICD-11
• Plan well in advance
• Choose data file to double code prior to processing for the old revision
• What will be needed - e.g. amendments to cause
• Be aware that processing comparability study will compete with routine processing]
Gerard Pavillon proposed that papers related to ICD-9/ICD-10 comparison studies be put on the website of the Australian Bureau of Statistics

There was discussion about whether the participants believed that the statistics of underlying cause of death were better in ICD-10 than they had been in ICD-9. Dr Laurenti's paper, *Are the rules for selection of the cause of death useful for the selection of the 'true' underlying cause?* WHO/HFS/CAS/C/03.88 presented in the MRG on 22 October was discussed. It showed that the selection of underlying cause of death following the ICD-10 rules corresponded well with the cause chosen after in-depth investigation of cases by an expert panel.

Lars Age Johansson from the Nordic Centre remarked that implementation and comparability studies almost inevitably took far more time and resources than initially envisaged. Participants discussed the possibility of using smaller samples of test death records (such as are used to train coders or test versions of the automated coding system) to identify areas of the classification which were likely to change substantially in a new revision. It might than be possible to bridge - code a targeted sample of records to calculate comparability ratios. However, it is clear from this presentation and others that comparability ratios near unity may hide large movements in and out of cause groups. Samples targeted on expected changes may miss important movements that were not foreseen, and so not give a true measure of the net effect. Any sampling would have to take this into account in order to produce comparability ratios that could be generalized to all deaths in the country.

**Maternal deaths: Accuracy of death certificates and an adjustment factor for estimating the mortality ratio in Brazil** (WHO/HFS/CAS/C/03.86)

**The accuracy of the medical statement of cause of death in the death certificate** (WHO/HFS/CAS/C/03.87)

**The quality of Suicide Mortality Data** (WHO/HFS/CAS/C/03.85)

**Aids Mortality: Information Quality Assessment** (WHO/HFS/CAS/C/03.89)

Ruy Laurenti and Cassia Buchalla of the Brazilian Centre presented a series of papers on mortality statistics.

Discussion of maternal mortality and suicide centred on the difficulties of getting complete statistics on suicides in countries around the world for a variety of reasons, including reluctance of families to accept suicide as the cause of death. The increased risk of suicide in the year following childbirth was noted, and it was suggested that even if suicides were not included in the measurement of the maternal mortality ratio (MMR), they might be included in publications about maternal mortality. Dr Laurenti said that half the depression associated with suicide in women in the RAMOS (Reproductive Age Mortality Survey) study was puerperal.

Colin Mathers of WHO asked whether the Brazilian centre had also looked at AIDS mortality in men and whether the results were similar. Dr Buchalla said that parallel studies were being undertaken. She said they were still exploring the contribution of complications of HAART (Highly Active Anti-Retroviral Therapy) and of viral drug resistance to the continuing mortality from AIDS.
Could they quantify adverse drug reactions and resistance - not yet but continuing
the analyses - HARRT known to increase cholesterol, and diabetes and risk of
myocardial infarction.

Ruy Laurenti, head of the Brazilian centre, regretted that he and Dr Buchalla had to
leave on Friday afternoon. He took the opportunity to congratulate the German
Centre for an excellent meeting, and thanked Michael Schopen, Robert Jakob and all
of the staff of DIMDI for the organisation of the meeting and support to the
participants. He ended by welcoming the new German Centre to the family of
collaborating centres.

Plenary 24 October, 2003, Afternoon Session
Chair: Gerard Pavillon
Rapporteur: L Cook/C Rooney

The impact of contagious disease in Japanese pre modern population
stagnation - smallpox as an example (WHO/HFS/CAS/C/03.81)
Dr Moriyo Kimura presented. She showed differences in demographic trends in
Japan and Europe in pre-modern and early modern periods, and discussed possible
reasons for these using data from Buddhist temple registers in a central mountainous
part of Japan.
The meeting participants were fascinated to see mortality and morbidity data from
such an early period. Very few other countries could produce case fatality ratios for
smallpox.

Clinical application of ICF- core sets. (WHO/HFS/CAS/C/03.93) Professor Gerold
Stucki showed how ICF could be used to classify functioning and health problems
from a patient's point of view. ICF core sets define what should be measured, but not
how it should be measured.

Discussion
Geoffrey Reed pointed out that starting from published literature may limit the ability
to look at issues of interest to patients, and restrict study to clinical / medical issues.
Rehabilitation professionals may have a more function oriented view. Marijke de
Kleijn asked about Geoffrey Reed's study, and whether they had felt the need for
some 'core set' development in operationalizing ICF in clinical settings. Clinicians
may need more limited sets of ICF items to select from in their daily practice. WHO
has made it clear that condition specific core sets alone cannot be enough. There
must also be a more global assessment of functioning. In contrast, Martti Virtanen
remarked that it was useful to define and measure functions that are typically limited
in a particular condition.

Use of the ICF by allied health professionals. WHO/HFS/CAS/C/03.40
Yvonne Heerkens showed that ICF was widely incorporated into records kept by
allied health professionals in the Netherlands, and that they had found some
advantages in describing quality of care and in uniformity of language.

Discussion centred on the need for data at a range of levels - micro, meso and
macro level, for example in Individual patients electronic records, in the classification
of aids for daily living. Different levels and types of detail might be wanted by different specialists, for example physiotherapists might need to go into detail of different types of muscle power - isometric, isotonic, as well as the types of activities affected. Should there be a detailed clinical modification of ICF to meet these needs or not? Is it better to use existing validated measurement instruments such as psychometric tests used by psychologists that are independent of ICF. Is it the role of ICF to go into such detail? Is this outside its role? Does ICF have many roles and applications, for which different levels of detail are required?

Martti Virtanen pointed out that it was sometimes necessary to use free text to capture individual patient's details. It may be that this level of information used in clinical practice does not need to be coded at such a detailed level to a standardized instrument. A higher level of grouping, as in ICF may be sufficient for summarising and exchanging information.

**Health expectancies and the International Classification of Functioning, Disability and Health (ICF)**

WHO/HFS/CAS/C/03.76 Rom Perenboom presented work on population health status measures of longevity and quality of life. Measures based on ICIDH were developed in the 1990s, including Disability free life expectancy and Disease free life expectancy. ICF based updated measures were needed, but there were some difficulties, such as differentiating between participation and activity and a lack of data.

Discussion points- changes of methods used in successive surveys make trend analyses difficult, and it is difficult to convert the ICIDH definitions. An equivalent measure in ICF might be 'Years lived without specific activity limitations'

**Strategy and Workplan**

*Plenary 25 October, 2003, 1st Morning Session*

*Chair: Richard Madden*

*Rapporteur: Catherine Sykes*

Participants discussed the draft strategy and workplan for 2003–04. Changes to the draft were made on screen during the session, and some further changes were agreed to be made after the meeting. At the close of the session the document was endorsed by Centre Heads, subject to the remaining agreed changes being made.

The final draft, containing all agreed changes, is attached.

Other points and actions that arose during the discussion are as follows:

It was agreed that membership of the Terminologies Working Group will include the UK, North American, Dutch, and Australian Centres, WHO, and any other Centres that have an interest in this topic. The North American and UK Centres will provide the co-chairs for the Working Group. The UK co-chair will seek nominations to the Working Group by contacting Heads of Centres. The list of relevant terminologies to be compiled will not be limited to English terminologies.

It was noted that many WHO member countries are not associated with a Collaborating Centre. Dr Pattriya Jarutat (Thailand) emphasized the importance of
support for countries not associated with a Collaborating Centre, and the need for greater participation of South East Asian countries in the WHO-FIC Network meetings. She commented that the style of the meeting made it difficult to engage those who are not familiar with the Network and are less comfortable with English as a working language.

A meeting of health information system focal points is planned for mid-2004 in South East Asia; this may help to facilitate greater involvement of the region in WHO-FIC activities, and provide an opportunity to identify institutions that could become Collaborating Centres. Support for this meeting from WHO and Collaborating Centres is sought. The Australian CC indicated willingness to provide support.

The meeting supported the view that there should be progress on creating new collaborating centres during the year.

These issues should be progressed by the Planning Committee during 2003–04.

Closing Session

*Plenary 25 October, 2003, 2nd Morning Session*
Chair: Marjorie Greenberg, Peter Goldblatt
Rapporteur: L Cook

**Adoption of the draft meeting report**
The draft meeting report was accepted subject to inclusion of the current terms of reference for each committee and correction of minor drafting points. Recommendations from the Committees were accepted by the meeting.

**Adoption of the Strategy and Work Plan**
The Strategy and Work Plan was adopted. Dr Richard Madden was nominated as Chair of the Planning Group and Dr Michael Schopen as the Vice Chair. They will both serve for two years. A footnote to this effect will be added to the WHO-FIC network paper.

**Evaluation of the meeting**
Marjorie Greenberg expressed thanks to the German and Dutch Collaborating Centres for a superb meeting. Marjorie explained that the Planning Committee had given some thought to the conduct of future meetings. As the meeting had grown in size, it was being suggested that some business could better be conducted by the Centre Heads and Committee Chairs rather than in large plenary sessions. The general reaction of the participants was that plenary sessions provided the opportunity for everyone to participate and to learn and understand the background to decisions and developments.

Dr Bedirhan Üstün, expressing his thanks for the organisation of the meeting, said that the WHO-FIC network was growing and finding new ways to express itself. The availability of the WHO web site and intranet would mean that members could work more effectively between meetings making face to face meetings more productive.
Place time and Topics for 2004 meeting
It was confirmed that the 2004 meeting hosted by the Nordic Centre will take place between 24-30 October in Reykjavik.

Place for 2005 meeting
Dr Moriyo Kimura said that subject to agreement within her country, the 2005 meeting would be hosted in Japan.

Dr Michael Schopen introduced and thanked the team from the Dutch and German Centres who had organized the meeting: Robert Jakob, Dr Stefanie Weber, Dr Ursula Küppers, Hildegard Willmes-Ibsch, Susanne Breuer, Dr Willem Hirs and Dr Marijke de Kleijn-de Vrankrijker.
Annex (Terms of Reference)

WHO-FIC Mortality Reference Group

The objective of the Mortality Reference Group (MRG) is to improve international comparability of mortality data by establishing standardized application of the ICD-10.

Functions:

1. To identify and solve problems related to the interpretation and application of ICD-10 to coding and classification of mortality.

2. To establish standardized application of mortality coding rules and guidelines by a) making decisions regarding the interpretation of rules and guidelines for mortality, and b) deliberating on updates to the classification and the rules and guidelines. Such updates include both clarifications and correction of errors.

3. To develop recommendations for ICD-10 updates through a democratic process which attempts to achieve consensus.

4. To submit annual recommendations to the Update Reference Committee by the end of April.

5. To provide documentation of discussions and decisions.

The MRG will endeavour to ensure that its membership reflects the widest possible representation from centres and WHO regional offices.

The chairperson is elected by the MRG. The election is submitted to the Centre Heads for confirmation.

The MRG will work through email, meet in person twice a year, and use telephone conferences as needed.

Once a recommendation to the Update Reference Committee (URC) has been has been agreed to by the MRG, members will support the recommendation.

Decisions from the MRG which are endorsed by the URC and the Centre Heads should be available from the WHO ICD-10 home page.
WHO-FIC Implementation Committee

Purpose

Assist and advise WHO and the WHO-FIC Network in improving the level and quality of implementation and use of WHO-FIC members in Member States, with priority for WHO-FIC core members (ICD & ICF).

Functions

1. To conduct through the WHO HQ and ROs international stock-take of WHO-FIC implementation in all WHO Member States on a continuous basis: with annual updates and in a systematic and comprehensive manner.
   
   1.1 to develop and maintain an information database of current and planned use of classifications and in the development and refinement of mechanisms for collecting and analyzing WHO-FIC implementation data. The database should include information on the use of WHO-FIC in both public and private sectors in terms of: areas and purpose of use, version in use, coverage, barriers and facilitators to implementation, degree of data reporting to WHO, quality control, coding method (automated, physician coders, clerk coders etc.), impact of classification change, measuring impact of the change, understanding effect of change on data output and published statistics, bridge coding, comparability studies;
   
   1.2 prepare a periodic summary of the global implementation status in WHO Member States;
   
   1.3 monitor and make proposals in the improvement of the technical and scientific quality of implementation related studies presented to the annual WHO-FIC meetings and other international meetings.

2. Develop plans and projects for a wider application and implementation of WHO-FIC in all Member States

3. Assist WHO in the development and application of implementation guidelines.

4. Assist WHO and Member States in the creation of methodologies for the joint use of WHO-FIC members in health information systems and surveys

5. Provide WHO with guidance on user needs in terms of instruments, tools, training materials etc.

6. To act as an international support network for countries, through the WHO, on issues relating to implementation. And promote information sharing

7. Interact with other WHO-FIC committees in the establishment of integrated workplans to ensure consistency with the general policy on WHO-FIC implementation.

8. Act as advocates both nationally and internationally, through WHO, to obtain high level support and financial commitment to develop and implement improved information systems using WHO-FIC, particularly in developing nations.
Structure and working methods

The committee should have an integrated mandate of WHO-FIC implementation although the nature and phase of different members of WHO-FIC may differ in different countries. The Main Committee should be responsible to develop generic, overall principles that will apply to all members of the WHO-FIC and to handle implementation matters which are specific and unique to the individual classifications.

The structure of the implementation committee should involve 10-12 permanent members that will primarily devote their time in actually developing methods and application of the tasks in the field. The committee may have temporary members, who work on particular tasks.

Membership is open to Regional Offices and all Collaborating Centres with national and regional responsibilities for WHO-FIC implementation. All WHO-FIC centres may nominate participants and beyond the permanent members additional participants may take part in committee meetings as observers.

The committee is co-chaired at present but a single chair should be established in future to emphasize the integration of WHO-FIC implementation.

The committee shall draw up a workplan, which lists in detail aims, activities, deliverables, timelines and responsibilities. The workplan shall be consistent with the WHO-FIC business plan of the WHO-FIC Network.

Working methods should include e-mail, conference calls and meetings, including an annual meeting during the WHO-FIC annual meetings. Official meetings of the committee must be held in conjunction with international WHO-FIC meetings. Ad-hoc working groups can be established as need arises.
WHO-FIC Family Development Committee

The following Terms of Reference were discussed at the FDC meeting in Leiden and are presented for endorsement.

- To keep under review, and update as necessary, the structure and content of the WHO-FIC
- To specify a mechanism for consideration of new family members
- To consider proposals for membership of WHO-FIC, to nominate location within the family, and to assign an appropriate status to the classification
- To consider the implications for WHO-FIC of the development and implementation of clinical terminologies, and recommend appropriate actions to the Network
- To work with other proprietors of classifications to consider appropriate linkages between WHO-FIC and other classifications
- To oversee work on development or application of WHO-FIC as requested by the Network
- To prepare an annual report to the Network on the activities of the Committee.
WHO-FIC Education Committee

Purpose
Assist and advise WHO and the WHO-FIC Network in improving the level and quality of use of the WHO Family of International Classifications (WHO-FIC) in Member States by developing an education, training and credentialing strategy for the WHO-FIC, identifying best training practices and providing a network for sharing expertise and experience on training. The first priority will be for the reference terminologies, ICD and ICF.

Background
The Subgroup on Training and Credentialing of the WHO-FIC Implementation Committee was established at the 1999 meeting of Heads of Collaborating Centres in recognition of:
The critical role of education and training for the successful implementation, use and maintenance of a classification system and for the quality of data produced
The opportunities for sharing and strengthening education and training in members of the Family of International Classifications through international efforts, and
The resulting benefits for comparability of national and international statistics.

The Subgroup was established specifically to:
Advise WHO and the WHO Regional Offices on best training practices
Provide a network for sharing expertise and experiences on training
Work with WHO Regional Offices in identifying needs for skills and training in countries both covered and not covered by Collaborating Centres
Address the unique issues concerning mortality medical coders and nosologists in an automated environment
Explore the possibilities for developing an international training and credentialing program for coders of WHO-FIC classifications
Make recommendations to WHO and the WHO-FIC Collaborating Centres through the WHO-FIC Implementation Committee.

Following the integration of ICF into the Family in 2001, the Subgroup was expanded to consider parallel and related activities for users of the International Classification of Functioning, Disability and Health. During the 2003 annual meeting, the Subgroup reorganized as the WHO-FIC Education Committee to better describe its broad mission and the role of education beyond the implementation phase of a classification.

Functions
The primary function of the Committee is to develop an integrated educational strategy for the International Classification of Diseases and the International Classification of Functioning, Disability and Health. Other members of the Family of International Classifications will be considered as resources permit. The components of this strategy include the following functions:

Assessment of the needs of users of the classifications, including those who provide source information, apply codes, conduct research or use the resulting data.
Identification of the learning objectives for educational approaches
Inventory of existing educational materials and capacity
Recommendations for learning content including development of core curricula
Recommendations for best practices for promotion and delivery of educational material.

The components of the strategy for the ICD include the following tasks:
1. Conduct needs assessments about the capacity, skills and responsibilities of ICD coders in member states
2. Identify the additional groups requiring education and training about ICD (e.g., statisticians, epidemiologists, policymakers, relevant systems managers, physicians, other clinicians and health sciences students)
3. Identify groups requiring education and training in the proper completion of source documents (e.g., death certificate, health record)
4. Define the skills and levels of education and training required for coders and nosologists, as well as other users of the classification
5. Catalogue, characterize (e.g., purpose, subject, language, availability, media and technology) and disseminate information on current educational and training curricula and modules for the ICD, and identify gaps and methods for filling them
6. Review existing training materials and the mechanisms for their dissemination and identify best practices
7. Gather information from Collaborating Centres and Regional Offices on capacity for ICD-10 training in WHO member states
8. Explore national and international organizations (e.g., the International Federation of Health Record Organizations) with which coders and nosologists can affiliate
9. Explore the capacity of these organizations to support an international training and credentialing program
10. Identify approaches for assuring that training and credentialing are dynamic processes, responsive to changes in medical science, technology, coding rules, etc.

The components of the strategy for the ICF are under development.

Structure and Working Methods
The Committee should have an integrated mandate of WHO-FIC education, although the nature and phase of different members of WHO-FIC may differ in different countries. If necessary, different work groups may be formed on specific WHO-FIC classifications so as to address different issues.

The structure of the Committee should involve permanent members from WHO (including the regional offices) and each collaborating centre who will primarily devote their time to developing and, to the extent possible, carrying out strategies for addressing the functions specified above.

Membership is open to Regional Offices and all Collaborating Centres with national and regional responsibilities for WHO-FIC implementation. All WHO-FIC centres may nominate participants and beyond the permanent members additional participants may take part in committee meetings as observers.

The chair should preferably be a single person to emphasize the integration of WHO-FIC implementation.
The Committee should develop an annual work plan, which lists in detail aims, activities, deliverables, timelines and responsibilities for addressing the terms of reference.

Working methods should include e-mail, conference calls and meetings, including an annual meeting during the WHO-FIC annual meetings. Official meetings of the committee must be held in conjunction with international WHO-FIC meetings.
WHO-FIC Update Reference Committee

The Update Reference Committee recommends modifications to ICD-10 to the annual meeting of the WHO-FIC Network. The committee also develops policy on and mechanisms for updating ICD-10.

Meetings

Face to Face: One full day per year, just prior to WHO-FIC meeting
Technical sessions during WHO-FIC meeting
Teleconferences: 3 per year, to be organized through WHO
E-mail: as necessary

Terms of reference
• Determine policy on updating of ICD-10 (frequency, tabular, index, rules)
• Establish criteria for updates to ICD-10
• Review and comment on ICD-10 update proposals from MRG, Collaborating Centres and the secretariat
• Submit recommendations for ICD-10 updates for ratification by Centre Heads meeting
• Evaluate update mechanism (structure, process, outcome)
• Cover updating for ICD and related classifications
• Coordinate with ICF updating process through limited cross membership with ICF updating committee
• Cover updating for issues arising in English language versions. Problems arising from other language versions to be handled at the relevant collaborating centre.

Policies

Update cycle

Tabular list: Three yearly for major changes, annually for minor changes
Index: Annually for changes that do not impact on the structure of the tabular list

Updates to ICD-10

Minor updates accepted at WHO-FIC meeting are posted the following year to the URC website before implementation in January of the year following posting

Major updates accepted at WHO-FIC meeting are posted the following year to the URC website before implementation in January of the year designated as major.

The Official Updates to the published volumes of ICD-10 are produced in two formats:

1. A cumulative list of all changes made to ICD-10 from 1996 onwards. This list includes the Corrigenda to Volume 1 (see Volume 3, pp 747-750)
2. An annual list of changes made to ICD-10 since 1996.

Both lists indicate the source of recommendation and implementation date. Date of approval has been indicated for all changes except the corrigenda.

Relevant changes in other language versions of ICD-10 and in related tools will also have to be made and disseminated by the appropriate authority.

Version control

The year of implementation is added to all versions of ICD-10. For example, the version of ICD-10 implemented in January 1999 will be labelled ICD-10 (1999), to be organized through WHO, E-mail as necessary.
WHO-FIC Electronic Tools Committee

Purpose
Support WHO and the WHO-FIC Network in developing policies on electronic classification-related tools and their dissemination.

Functions
Agree on the scope and definition of ‘electronic tools’
Cover tools which are only for morbidity, mortality or functioning as well as ones with a more general application or for joint use
Work closely with other WHO-FIC Committees, such as the Education Committee, on overlapping areas
Establish liaison with other organizations/groups working in electronic classification such as the ICE on Automating Mortality Statistics, the EUROSTAT automated coding group or the UN Expert Group on International Economic and Social Classifications
Establish criteria for the evaluation and accreditation of electronic classification-related tools
Survey existing tools and identify gaps
Evaluate such tools on behalf of WHO or oversee such evaluation in some circumstances
Needs assessment.

Structure and working methods
The committee should have an integrated mandate of WHO-FIC electronic tools although the nature and phase of different members of WHO-FIC may differ in different countries. The Committee should be responsible to develop generic, overall principles that will apply to all members of the WHO-FIC. If necessary different sub committees may be formed on ICD, ICF and other WHO-FIC classifications so as to address different issues.

The structure of the Electronic Tools Committee should involve 10-12 permanent members that will primarily devote their time in actually developing methods and application of the tasks in the field.

Membership to the ETC is open to any individuals from collaborating organizations who wish to participate actively in the work and aims of the committee. They should submit their names to the Chair with copy to the WHO-FIC secretariat.

The chair should preferably be a single person to emphasize the integration of WHO-FIC implementation.

The committee shall draw up a workplan, which lists in detail aims, activities, deliverables, timelines and responsibilities.

Working methods should include e-mail and more interactive ways of electronic communication, conference calls and meetings, including an annual meeting during
the WHO-FIC Network Annual Meeting. Official meetings of the committee must be held in conjunction with international WHO-FIC meetings.

Electronic Tools Sub-committees
Within the structure and mandate of the WHO-FIC Electronic Tools Committee, sub-committees for individual classifications can be established as the need arises. Sub-Committees assist and advise WHO on electronic tools matters which are specific and unique to the individual classifications.

The sub-committees shall specify the WHO-FIC Electronic Tools Committee functions for the respective classification in detailed workplans. The workplans shall list in detail aims, activities, deliverables, timelines and responsibilities.

Working methods should include e-mail and more interactive ways of electronic communication, conference calls and meetings, including an annual meeting during the WHO-FIC Network Annual Meeting. Official meetings of the sub-committee must be held in conjunction with international WHO-FIC meetings.

Committee members should give a commitment to work on both, committee and sub-committee tasks.

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   R. Laurenti, S. Giannella, C. M. Buchalla, M.H. P. de Mello Jorge, S.L.D Gotlieb,
   B. Zoca de Oliveira & A. Chiavegatto Fo

89 AIDS Mortality: Information Quality Assessment
   C. M. Buchalla; R. Laurenti; S. Gianella; Maria Helena P. de Mello Jorge
   Sabina L.D. Gotlieb

90 A feasibility study for building up a new system using the methodologies of two other
   medical procedure classifications (ICD-10-PCS, CCAM) and saving the existing content of
   the actual German procedure classification OPS-301
   Albrecht Zaiß*, Susanne Hanser*, R. Jakob**

91 CCAM, the new French procedures classification
   Robert Jakob

92 Implementation of the ICF in Germany
   Dr. Michael F. Schuntermann

93 Clinical application of ICF - core sets
   Prof. Dr. Gerold Stucki

94 Maintenance of procedure classifications in a network: MEL, TARMED and OPS 301
   versus CHOP/ICD-9 CM, OPS 301 and CCAM
   PD Dr. Simon Hölzer

95 XML presentation of hierarchical classifications
   PD Dr. Simon Hölzer

96.1 The mental Health chapter Revision process of ICD (slides)
   Dr. Carlos Berganza

96.2 The mental Health chapter Revision process of ICD (slides)
   Prof. Juan Mezzich

97 Towards an Electronic Version of ICD-10 - A Status Report
   Michael Schopen

98 Using the International Classification of Functioning Disability and Health (ICF) in nursing
   practice
   T van Achterberg (Theo), H.A. Stallinga (Gonda)

99 ICF - A Two hour training package for clinicians
   Catherine Sykes (Australia), Janice Miller (Canada), Jane Millar (UK)

100 Australian disability data items
    Nicola Fortune, Ros Madden and Samantha Bricknell (Australia)

101 ICF in educational systems
    Judith Hollenweger
102 The “ICF in Italy project” and the activities of the Disability Italian Network
   *Leonardi Matilde*, *Francescutti Carlo*

103 Assessment of life situations of long term psychiatric patients in the Paris region
   *Jean–Yves Barreyre*

104 ICF training tool for trainers
   *Catherine Barral, Marc Maudinet* (ICF French Collaborating Centre)

105 ICF in Latvia
   *Dr. Janis Misins; Director of Health Statistics Department; Health Statistics and Medical Technology Agency; LATVIA*

106 ICF – developments in Hungary
   *Lajos Kullmann*

107 ICF – a frame to develop aspects in knowledge management in social and health care, a Finnish perspective
   *Seija Talo*

108 Report on the XML version of ICD-10
   *Michael Schopen*

109 Representation of the WHO Family of International Classifications (WHO-FIC) on the World Wide Web
   *Family Development Committee*

110 Terms of Reference for the Family Development Committee
   *Family Development Committee*

111 Protocol for the World Health Organization Family of International Classifications
   *Family Development Committee*

112 ATC/DDD submission to the WHO-FIC
   *Kristina Bränd Persson, Lill Fevang Harr*

113 Fourth round review: Cologne HoC Meeting, October 2003  URC WORKSHEETS
   RECOMMENDATIONS FOR UPDATES TO ICD-10
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