Wonca International Classification Committee
2010 Annual Meeting
Ghent, Belgium
11-15 October, 2010

MEETING SUMMARY.

GOALS FOR THE MEETING.

1. **Decide (re-decide) core issues for ICPC-3**
    a. ***Data model to guide revision***
    b. ***Coding structure***
    c. ***Where do process codes fit in ICPC-3?***
    d. ***X/Y and chapter revision(s)***
    e. ***Basic plan for prevention and risk factors***
2. **Work plan for ICPC-3 revision**
3. **Identify best options for how to do this work ($/resources)**
4. **Identify leads and action plan for dissemination, training, Web presence**

WICC ACTION PLAN 2010-2011.

1. **Find and use best simple collaborative tool (Google groups? gotomeeting?) Leads: WICC Executive. Timing: ASAP**
    We need to find a common Web-based collaborative tool to enable groups to share documents while working on drafts, and to allow WICC members to comment on completed drafts. We also need to identify the best on-line teleconferencing tool. We have used Skype with some difficulty, and are exploring gotomeeting. Once identified, WICC members will agree to use these on-line tools.

2. **Collect existing ICPC-2 Update items, add proposals for changes or additions to rubrics based on shared data. Leads: Kees van Boven, Julie O'Halloran. Timing: end-2010.**
    This will serve as the basis for making necessary changes in ICPC-2 to support current users until ICPC-3 is introduced. This reverses an earlier decision to make no further change in ICPC-2 and meets the needs of the extensive user base for ICPC-2. However, changes should be made only where necessary to minimize disruption to current users.

3. **Create and circulate draft version of an "ICPC-3 Blueprint", describing its structure and coding principles. Lead: Mike Klinkman. Timing: end-2010.**
    This will be a document describing the basic structure of ICPC-3 (now known as the 2A2N structure), the components and chapters to be included in the base classification, other components to be linked to the basic classification, and how those components will be linked. Working Groups and chapter revision teams will use this document to guide their work.

4. **After 1 and 2 complete, complete initial draft of some (all?) chapters of ICPC-3. Leads: Shin Fujita for Chapter D, Helena Britt for Chapter G (formerly X and Y). Other volunteers needed. Timing: through 2011-2012.**

Work on Chapters will be divided into small teams (2-3), where the first draft of the revised chapter will be drafted. A realistic goal might be to have 3 to 5 chapters available for review by the time of the 2011 Annual Meeting.

5. **Update group will use Update data from Action Item 1 to correct/improve ICPC-2. Lead: Kees van Boven. Timing: through 2011.**
   The Update Group will be re-convened with volunteers to review suggestions for change and make recommendations for specific revisions in ICPC-2.

6. **Update ICPC-2e based upon recommendations from KITH and Terje Sagen. Lead: Terje Sagen, Anders Grimsmo. Timing: early 2011.**
   Terje Sagen, on behalf of KITH, presented a set of recommendations for improving and standardizing the electronic ICPC database (see Minutes and materials from meeting). These recommendations were unanimously supported by WICC members. Funding is available for the initial work through the Norwegian Ministry of Health, but funding to support ongoing maintenance of the electronic files must be secured.

7. **Document standards for descriptions of rubrics as "business rule book" for KITH. Lead: WICC Executive. Timing: end-2010.**
   (See also Terje Sagen presentation). A set of principles describing content standards for construction of the ICPC electronic database, version control, revision procedure and release, content standards for individual ICPC rubrics, and quality control is necessary to guide future development and maintenance of ICPC. This can be created by WICC Executive members with assistance of KITH staff.

8. **Create and circulate second draft of the Data Model White Paper for comment. Lead: Francois Mennerat. Timing: end 2010.**
   An initial draft of the White Paper written by Francois Menneral and Mike Klinkman based on work done in ISO and on US data standards was presented to WICC members. This document will be used to guide work on ICPC-3 by identifying data elements necessary to capture primary care content and the relationships between those data elements.

9. **Complete and circulate NERI White Paper. Lead: Sebastian Juncosa. Timing: by 2011 Annual Meeting.**
   Non-episode related information (NERI) is an important concept derived from the primary care data model, but does not fit within the current ICPC structure. A group of WICC members will review the types of non-episode based clinical content and how that content can best be classified and accommodated. It is expected that a NERI terminology can be drafted to be used outside the basic structure of ICPC, and can be offered as part of an extended suite of classification tools accompanying the release of ICPC-3.

10. **Re-convene process working group to look at place of process codes in ICPC-3. Lead: Shin Fujita. Timing: by 2011 Annual Meeting.**
    The place of process codes in ICPC-3 is not clear. Some current users of ICPC do not use process codes at all, others have expanded / extended the native ICPC-2 process

codes. The Process working group has been charged with reviewing options and recommending how best to accommodate process codes in ICPC-3.

11. **Continue to do exploratory work with ICF. Leads: Laurent Letrilliart, Shin Fujita. Timing: ongoing.**
    We will continue to develop specific ICF applications useful for primary care and explore ways in which ICF can provide functional status content linked to ICPC.

12. **Nominate Francois Mennerat to be formal Wonca liaison to ISO TC-215 Working Group. Lead: Wonca Executive. Timing: ASAP.**
    It is essential that development of ICPC-3 and other primary care classification tools be carried out in accordance with emerging international standards for health informatics. WICC has developed formal relationships with WHO and IHTSDO to members, and this will provide a similar formal link to ISO. Francois Mennerat is already an active member of ISO TC 215.

13. **Explore connection to OpenMRS initiative. Lead: Graeme Miller. Timing: ongoing.**
    The OpenMRS Collaborative is an attempt to create and disseminate a simple open-source electronic health record for use in developing countries. It provides an opportunity to disseminate ICPC as the base classification for coding of health problems in these regions.

14. **WICC Terminology group will put main effort into completing IHTSDO GP-SIG work plan. Lead: Nick Booth (GP SIG Chair). Timing: ongoing.**
    The work plan lists a set of deliverables with deadlines, and is funded through contract to the FMRC of the University of Sydney. WICC members constitute the majority of active members of the GP SIG and are responsible for carrying out the work.

15. **Complete first draft of Community Care White Paper. Lead: Juan Gervas. Timing: by 2011 Annual Meeting.**
    This carries forward Item 4.8 from the 2009-2010 Action Plan.

16. **Continue work to create and fund Primary Care Classification Consortium. Lead: WICC Executive with Wonca Executive. Timing: ongoing.**
    This carries forward Item 1 from the 2009-2010 Action Plan. A first draft business plan has been written by Mike Klinkman and reviewed by Wonca Executive. Wonca executive are soliciting interest in funding and reviewing options for legal structure.

17. **Engage 3-4 WICC members in ICD-11 development process. Lead: Mike Klinkman. Timing: ASAP.**
    The WHO classification unit has planned to create a primary care Topic Advisory Group (TAG) to help guide revision of ICD-10. This may happen during the 2010-11 period. WICC members, where possible, should serve on this TAG.

18. **Where possible, arrange to have WICC members in attendance and presenting at Wonca conferences.**

19. **Develop training materials and consistent training program for ICPC– "training the trainer" approach. Lead: Volunteer needed. Timing: ongoing.**

    We need to identify a common set of training materials, such as the Danish e-learning modules described in the 2009 meeting minutes, and a group of WICC members with experience in use of ICPC to serve as trainers.

Wonca International Classification Committee
2010 Annual Meeting
Ghent, Belgium
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MINUTES OF THE MEETING.

GOALS FOR THE GHENT MEETING.

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Monday 11 October: AM session.
Chair: Mike Klinkman

Welcome and Introduction:
The Chair announced the opening of the 34th annual meeting of WICC and welcomed old and new members and observers. Jan de Maeseneer and Marc Verbeke, local hosts, welcomed the group to Ghent.
Attendance: 29 members, 10 observers.
Members present:

Bentzen, Niels (Denmark) – NB (attended part of meeting)
Bernstein, Bob (Canada) – BB
Britt, Helena (Australia) - HB
Booth, Nick (UK) - NB
Boven, Kees van (The Netherlands) – KB
deJonghe, Michel (Belgium) – MDJ
de Maeseneer, Jan (Belgium) – JDM
Dovey, Susan (New Zealand) - SD
Fujita, Shin (Japan) – SF
Gervas, Juan (Spain) -JG
Grimsmo, Anders (Norway) – AG
Gusso, Gustavo (Brazil) - GG
Jamoulle, Marc (Belgium) – MJ
Juncosa, Sebastian (Spain) - SJ
Kamenski, Gustav (Austria) - GK
Klinkman, Mike (USA) – MK
Kuehlein, Thomas (Germany) - TK

Kvist, Mårten (Finland)- MKv
Kuehlein, Thomas (Germany) - TK
Letrilliart, Laurent (France) – LL
Mennerat, Francois (France) – FM
Miller, Graeme (Australia) – GM
Mohan, Krishna (India) – KM
O'Halloran, Julie (Australia) - JO
Rosendal, Marianne (Denmark) - MR
Simkus, Ray (Canada) - RS
Soler, Jean Karl (Malta) - JKS
Verbeke, Marc (Belgium) - MV
Zorz, Gojimir (Slovenia) - GZ

Observers present:

Ines Baricevic (Croatia)
Pauline Boeckxstaens (Belgium)
Nicola Buono (Italy)
Patrick Chege (Kenya)
Akye Essuman (Ghana)
Shabir Moosa (South Africa)
Ferdinando Petrazzuoli (Italy)
Terje Sagen (Norway)
Tuija Savolainen (Finland)
Diego Schrans (Belgium)
Vo Thanh Liem (Vietnam)

Apologies received from:

Erik Falkoe (Denmark)
Tim Gardner (New Zealand)
Ian Marshall (Australia)
Kumara Mendis (Australia)
Alejandro Orsonio (Argentina)
Xin Jiang (China) (observer, unable to attend)

Not present:

Rubina Ali (Pakistan)
Dimitris Kounalaikis (Greece)
Roland Morgell (Sweden)
Deborah Saltman (Australia)
Nuno Sousa (Portugal)
Martti Virtanen (Finland)

Approval of minutes:

Minutes from the 2009 Annual Meeting in Florianopolis, Brazil were previously approved.

Roundtable Introductions, distribution of documents, review of agenda, nominations process: All attendees. Meeting began with a roundtable session, where attendees reported on work in their countries, and their priorities for this meeting. A brief description of the process for nomination and election of members to the 2 standing committees (Executive and Nominations) was presented by JG.

WICC Vision and Mission Statement:
Discussion led by Mike Klinkman.
Review of the Vision and Mission draft document circulated in January 2010, revised May 2010.
Discussion, suggested changes given.
ACTION: A final draft incorporating suggested changes will be created by Mike Klinkman at/after the end of the meeting, and circulated for approval by the full WICC.

Brief History of WICC:
Presented by Helena Britt.
(see attached document listing all WICC meetings and main products produced by WICC).
Work began as early as 1956, when Bent Bentsen from Norway and a few others met informally to discuss the need for a primary health care classification. WICC was established at the 1st Wonca World Conference in Melbourne. For a summary of major milestones since then, see the attachment.

Chair's Report: State of WICC 2010:
Presented by Mike Klinkman (See PowerPoint presentation at WICC Google site)
Main points:

- Tribute to the life and accomplishments of Charles Bridges-Webb, former Chair of WICC, with a collective moment of silence.
- Theme: finding our way in a new world of classification and terminology.
- Currently 41 WICC members from 25 countries
- Still many areas in which ICPC has limited use
- External work: relationships to other classifications (SNOMED, ICD) and organisations (WHO, IHTSDO)
    - Agreement with IHTSDO on SNOMED CT refset and ICPC map
    - Ongoing work with WHO - MOU between Wonca and WHO in progress and continued participation on ICD-11 development
    - Work on creating Primary Care Classification Consortium underway. First steps taken in coordination with Wonca Core Executive.
    - "report card" on action plan items DONE and NOT DONE.
- Actions to develop ICPC-3
    - Several decisions made at 2009 Annual meeting on ICPC-3 content and working process – these were reviewed in detail (all listed in PowerPoint presentation, 2009-2010 WICC Action Plan Item 3, or 2009 Annual Meeting Minutes)
    - Example of new structure - Genital chapter draft circulated prior to meeting
    - Work on areas of "Clinical findings", Process codes, and risk factors underway
    - Work on new areas including the "patient side" and multimorbidity just beginning, no formal working groups in these areas

    - Data structure / information model – White Paper will be discussed at this meeting
    - "Community care" (public health) White Paper not completed
    - Some use cases for ICPC-3 have been provided to help in planning for core content of ICPC-3
- WICC website status uncertain – no lead, unclear whether funding available to support development
- WICC translations going well overall
- Working tools and process (Protégé, other online collaborative tools) not yet determined

- Priorities for 2010-2011
    - ICPC-3: ESSENTIAL with new content areas
    - Sorting out support and scope
    - Linkages and mappings
    - Dissemination and training (+ translation)
    - Maintenance
- Why ICPC-3?
    - Correct errors in ICPC-2
    - Correct allocation of rubrics to their true component (as per 2 pager)
    - New diagnostic content in existing chapters
    - Merge chapters X and Y
    - Accommodate new rubrics for which there is no space (no re-use of rubrics)
    - Incorporate data elements not now included in ICPC
    - ICPC as central part of expanded data model
    - Resolve current data retrieval problems (ex: retrieval of malignant tumors, infections)
- Organization and funding of WICC
    - WICC structure since 2007 reviewed, "expert volunteer" committee with elected Chair, Deputy Chair, Executive and Nominations committee, full and associate members, observers, Working Groups.
    - Goal is to move toward increasing autonomy of working groups with oversight of Executive, and to use full Committee meetings for information, direction, consensus
    - Current budget- in effect, a WICC "line of credit" of up to USD 20,000 requiring approval of Wonca CEO. Funding not approved for participation in ICD-11 Advisory Groups, WHO-FIC meeting, any/all Wonca Conferences.
    - For 2011, funding = USD $2,000, and can apply to Wonca for special projects related to ICPC-3, paid out of common fund of USD$ 40,000
    - In WICC business plan 2007/8,we committed to create ICPC-3, a new "risk factor" classification, harmonize with ICD-11, map to other classification and terminologies where necessary, and to develop user support and maintenance arrangements.
    - To do this, we need to change how we work.
        - Option 1 – develop Consortium
        - Option 2 – remain as a Wonca WP, do incremental volunteer work

- Goals for this meeting
    - Decide (re-decide) core issues for ICPC-3
        - Agree on data model to guide revision
        - Coding structure
        - Where do process codes fit in ICPC-3?
        - X/Y and chapter revision(s)
        - Basic plan for prevention and risk factors
        - Work plan
    - Identify best options for how to do this work ($/resources)
    - Identify leads and action plan for dissemination, training, Web presence

An extended question-answer session was held at end of presentation.
Key comments:

- In revising ICPC, it is critical that we never re-use codes – causes too much confusion, especially when merging data collected with previous versions of ICPC
- How can we best get the additional space needed for rubrics in ICPC-3?
- We need to change the basic structure of ICPC codes.
- We must base our work on the work done before to establish ICPC

Monday 11 October: PM session
Chair: Mike Klinkman

White Paper on a Data Model for Health Records in Primary Care:
Presentation and discussion led by Francois Mennerat (see PowerPoint file).
The White Paper clarified the importance of data models to the domain of primary care, in terms of the organization of health records in formal information modeling based on work of the ISO TC 215 and EC standards working groups. This work is important as it provides the foundation for interoperability of electronic health records. The implications for the core content and organization of ICPC were presented: it is clear that some core primary content is missing from the current ICPC, and that we will need to accommodate non-episode oriented information if we want to capture necessary primary care data. This has important implications for ICPC-3 development.

General discussion about the White Paper.

- There are now national and international standards for the transfer of patient information, so classifications will need to be related to the data models to ensure they remain relevant in the future.
- There was discussion around whether/the extent to which the episode of care acts as the data model for ICPC. We (WICC) have to choose what parts of a primary care data model we will capture with ICPC. Some countries (e.g. US and Canada) will never use an episode of care model.
- Some core primary care data are independent of the context of an episode, for example patient preferences. The concept of multimorbidity incorporates multiple episodes of care.

- Issues of mnemonic codes to support coded data entry by GPs was raised – in some settings GPS may directly enter coded data, but in many settings data entry is through terms rather than codes.
- The data model needs to be flexible so that new medical knowledge can be incorporated – medicine moves ahead of the data models.

Presentation of alternative structures for ICPC-3

Presentation and discussion led by Helena Britt.

The presentation outlined the Danish proposal for the 2-alpha 2-numeric (2A2N or AANN) coding structure for ICPC-3, built upon the work of Michel DeJonghe. This change was agreed upon by WICC members at the 2009 Annual Meeting in Florianopolis. The basic idea behind the 2A2N structure is to provide more space to correct confusing rubric assignments in ICPC-2 and to allow for new rubrics, especially in Component 7. This does not imply a significant expansion of ICPC rubrics but is meant to provide space in chapters where needed, and to avoid the re-use of codes in the future.

General discussion on ICPC-3 structure.

- Jean-Karl Soler presented an alternative to the 2A2N structure, composed as a 1-alpha 2-numeric 1-alpha (1A2N1A or ANNA). The final alpha character in this structure would be optional and could be used to embed additional clinical content: for example, whether the rubric refers to a symptom or disease, or whether the rubric describes an acute or chronic condition. This alternative, he argued, would allow maintenance of the current "basic" structure of ICPC-2 while providing the added space needed.
- The need for data to inform the decision on the need for additional codes was emphasized.
- The prior WICC decision to adopt the 2A2N structure, and the reasons for doing so, was reviewed.
- There was general concern within the group about losing the mnemonic value of the current 1A2N coding structure in ICPC-2.
- Some sentiment that the term 'diagnosis' should not be used in the context of ICPC (the proper term is problem); however this term is listed in the ICPC-2-R publication as well as previous ICPC publications.
- Vigorous discussion on the merits of the two 4-character options, and the need for changing at all, occurred with no clear consensus.

ACTION: It was moved and seconded to hold an immediate vote to select the preferred option, but the motion was not approved.

- There are 2 main groups of ICPC users: one group has memorized codes and enters coded data, the other uses interface terminologies. The "best" or preferred solution is different for the 2 user groups.
- ICPC does not now cover the full domain of general practice, and additional content must be added in order for it to do so.
- Discussion of costs and benefits of making structural change now, versus in a subsequent generation of ICPC.

- The future of electronic data entry will be driven by terminology – classification tools now in development are created with the expectation that they will be accessed through a (customized) interface terminology at the point of care.
- ICPC is a statistical classification tool, its granularity based on the size of the population. At the level of a single provider, the level of granularity is not sufficient for use in an individual electronic health record.
- There is a dynamic tension between the need for available coding space and the need for change.
- The session ended with the charge to WICC members to consider these issues, then return in the morning session to make a decision on which approach will be taken in the development of ICPC-3.

Tuesday 12 October: AM session.
Chair: Mike Klinkman

Alternative structures for ICPC-3 (continued).
Discussion led by Mike Klinkman.

General discussion continued:

- Comments and general sentiment that the 2A2N option is on balance preferred, and offers the best way forward for ICPC-3.
- 2A2N can embed subcategories (example: infections) in the second alpha, adding in its value for coding ease and data retrieval and resolving some of the inconsistencies in numbering across chapters.
- We need to minimize change for those who currently and effectively use ICPC and who have embedded it in their local or national health information technology solutions.
- We must not ignore current users of ICPC-2, who are familiar with its structure and have adapted to it.
- However, for those new to the classification, the proposed 2A2N structure, due to its symmetry, may be more easy to understand and use than the current 3-character structure.
- We are at the transition point between human and machine language. ICHPPC and ICPC-1 were designed for human interface and coding at point of care. With more complex needs, including knowledge management, semantic interoperability, and integrated electronic health records, we are moving to a machine-readable environment. We need to adapt to this new reality while maintaining system for human interface. Therefore we need 2 products, the current ICPC-2 and a new product to meet new requirements.
- WHO, with transition from ICD-10 to ICD-11, is struggling with this same issue.
- Clear support emerged for continued support of maintenance and updating of ICPC-2 AND work on new structure for ICPC-3.

Chair's proposal: (see also PowerPoint presentation).
Based on the need to provide maintenance and user support, there is a clear need to work to improve the existing ICPC-2. There is also a compelling need for development of a new version of the classification that accommodates the needs discussed over the last 2 days. WICC needs to work in both tracks, maintenance/extension and high-risk research and development. The Chair proposes the following:

1. Re-create ICPC-2 update group – to respond to needs of current (and near future) users of ICPC-2
2. Create ICPC-3 working group to move ahead with development of 2A2N model for ICPC-3
3. Continue Risk Factor working group
4. Continue ICF working group
5. Create "patient side" working group

The 3 work groups will develop content that will either be integrated into the base ICPC-3 or be linked to the base ICPC-3.

ACTION: WICC members agreed by acclamation to the Chair's proposal. No formal vote was required.

Standardization of the second alpha term for the 2A2N structure.

Discussion led by Helena Britt.

Need to reach agreement on how we will label the second alpha so that those working on initial drafts of ICPC-3 chapters can be consistent. Unacceptable letters ("O", "I" as confusion with 0, 1) were ruled out, and discussion led to consensus on a first list. The group discussed how to balance the need to identify some sub-categories that may be of interest to health authorities (for example, chronic diseases, or autoimmune disease) with the principles of parsimony and manifestation before etiology.

ACTION: members agreed on the following list of second alpha characters for the initial draft:

S = Symptoms/complaints
G = infections (Germs)
N = Neoplasms – with much discussion about whether to further divide into Malignant/Benign/Uncertain
T = Trauma/injury
A = congenital Anomalies
D = other Diseases

This list will be reviewed after it has been used over this next year to see whether revision is necessary.

Nominations Committee election.

Presentation led by Juan Gervas.

- Current Associate Members JO, TK, MR, GK, SD were transitioned to full membership status in a small ceremony.
- Current Chair MK was recommended for reappointment as Chair for next 3-year cycle subject to formal appointment by Wonca Executive, and gave a brief statement on his goals for this next period.
- Candidates for the open Executive Committee position are Kees van Boven and Helena Britt (incumbent). Helena Britt was elected to the 3-year term.
- Candidate for the open Nominations Committee position is Thomas Kuehlein. He was elected to the 3-year term.

Tuesday 12 October: PM session

Travel to "Living Tomorrow" exhibition, and to Conference.

Wednesday, 13 October: AM session
Chair: Mike Klinkman

Presentation – Ray Simkus: Arcane Aspects of the EHR.

Impressions of observers:
Discussion led by Mike Klinkman.
In a roundtable discussion format, observers were asked to give their impressions about the meeting, their opinions on issues discussed so far, and areas of concern or important from their individual perspective or that of their countries.
Issues raised included:

- Need for WICC/Wonca to develop partnerships with business and technology suppliers
- Difficulty in getting approval or license to use ICPC
- Very difficult problems to overcome to use even minimal health IT support in developing areas
- Perception that ICPC is very much disease-focused and does not reflect patient's perspective
- The difficulty in balancing needs of practicing GPs from diverse regions with the needs of health authorities for standards
- The very steep learning curve for ICPC and the issues discussed at the WICC meeting
- Similarities in the problems faced in several countries (example: balancing simplicity and granularity in primary care classifications for routine use by GPs in practice)
- There are expectations from Africa for appropriate training in ICPC over time
- A proposal to translate ICPC into Vietnamese.
- From the Italian perspective, the reasons for encounter and the episode of care are very much appreciated, even though Italian GPs are required to use ICD-9 at this time

Working Group Reports.

Chapter X-Y merge/draft Chapter G.
Presentation and discussion led by Helena Britt.

Original proposal to merge Chapters X and Y made in 2008 on grounds that dividing content in rubrics by gender was not consistent with internal ICPC logic or other classifications and terminologies. Initial work on draft of "Chapter G" (Genital) in 2009, new draft in 2010 after discussion on the mailing list, now presented for review.

This draft initially followed the proposed Danish 2A2N coding structure presented at the 2010 Florianopolis meeting. It was distributed in August 2010 for group review, and the resulting discussion led to new 2A2N format in this draft.

The group reviewed in detail the draft Chapter G rubrics presented in spreadsheet form. ***Several of the points discussed will apply to all chapters, so this was an important discussion.***
Key points:

- No decisions yet on "processes" and how to deal with them
  - "pap smear" – in Australia pap smear is recorded as a problem
  - "check up" is also considered as a problem
  - "vaccination" – as for HPV
- "male-" and "female-" specific rubrics are dealt with in the G chapter
- Issues requiring further review highlighted by update committee
  - Perineal problems: where should they be classified – in one chapter only? currently all over the classification
  - Overlap between X07 and X08: including X08 into X07?
  - Is urethritis to be classified as into U chapter or into G chapter?
  - How to deal with circumcision?
  - Menstrual problems – inconsistencies in ICD-10 map. Regular and irregular are the most appropriate categories, as in ICD, but review group not happy to change. Metrorrhagia is currently an issue not yet resolved - does it make sense to separate excessive regular and excessive irregular bleeding?
  - Can process titles such as "pap smear" serve as RFE or diagnosis?
  - X09 –premenstrual symptom and X89 – inclusion criteria are not clear
  - Several issues regarding potential overlap of rubrics between Chapters U, W and G. Consensus was that work on these chapters be done by the same team.
  - Malignancy in-situ: how does it fit within 2A2N structure?
  - Circumcision currently classified as genital injuries,but they are actions –so process codes. How do we do these in ICPC-3? For example, female circumcision and male circumcision are different concepts and need different ICPC categories
  - Malignant / benign / uncertain (all GN) should they be differentiated by the 2N part of the code? (choosing numbers 01-29, 30-59, 60-99??)
  - Need for "other" in all components. Should always be coded as _ _ 99
  - Consistent use of NOS, NEC, ***other***, throughout the classification
  - Some members proposed to distinguish benign and malignant neoplasms by a specific letter in ICPC-3, not just the second alpha term N (neoplasm)
  - X99 needs to be reviewed to determine whether new specific diagnostic rubrics are needed.
- General points (NOT specific to Chapter G) brought out in discussion.
  - Need for "other" in all components. Should always be coded as _ _ 99
  - Consistent use of NOS, NEC, ***other***, throughout the classification
  - Some members proposed to distinguish benign and malignant neoplasms by a specific letter in ICPC-3, not just the second alpha term N (neoplasms) - or by coding in a specific numeric range (01-29, 30-59, 60-69 or such) across each chapter.
  - Some low prevalence but high public health impact problems could be included into ICPC-3. ICPC is a statistical classification where rubrics imply a certain prevalence. If you consider prevalence and impact as a 2x2 table, low prevalence hi impact conditions may need to be considered. (we might apply DUSOI index score to determine impact)
  - How to add new codes according to the specific needs of the countries?
  - Need specificity in some chapters with numbering systems, space to expand in the future, consistent across chapters. For example, "fear of" rubrics in 80-89 in each chapter.

Wednesday, 13 October: PM session
Chair: Anders Grimsmo

Report of Risk Factor Working Group.
Presentation and discussion led by Kees van Boven.

The Risk Factor group has worked to better understand the diverse content that fits under this term. "Risk factor" does not seem to be an appropriate term to describe this content. A better term might be "clinical modifier" – something that can affect the course of care but that is not of itself a direct health problem or disease. It is not part of an episode of care but will modify the course of an episode. Examples include genetic risk factors (such as BRCA1 gene), prior "significant events" such as cerebrovascular accident, prior procedure such as hysterectomy, and preventive services performed. The main question to answer is whether these things should be included within the basic ICPC structure or kept as a separate classification and linked to ICPC? Should these be fitted into the episode of care framework in some way?

The Risk Factor WG recommends a new name for this type of data – Non Episode-Related Information (NERI) - and believes that it should fit outside the episode of care and outside the basic ICPC structure. It fits with the Clinical Modifier section of the Data Model proposed earlier in the meeting.

The WG proposes that this NERI "classification" be divided along the lines of the Quebec Classification:

- Biological (bio-genetic) information
- Information about the physical environment
- Information on social organization
- Information on social and individual behaviors
- Information on patient preferences

The group would like to apply for funding to support work on this over the next year.

General discussion on NERI.

- How and where do you draw the line on assigning a problem or phenomenon as a "risk factor" – isn't everything a risk factor for something else? Why try to do this? Answer – this is not "risk factor" discussion, it is a way to collect and categorize non-episode related information. Risk factors could be derived from this list as well as from connections made between problems using current ICPC data. When specialists in several medical and public health fields are asked what "risk factors" are in their field, answers are widely divergent.
- What is the use case for this type of information- linked to a patient but not an episode? Answer- can be used to study epidemiology and learn about connections between environment and conditions, social factors and disease, and complex comorbidity relationships; can also be used to create and modify clinical decision support protocols in electronic health records.

- Risk factors are the result of statistical links between a "fact" and disease or outcome, and are not contained within an episode of care.
- Patient preferences may not exactly fit with the other things contained in this NERI category.
- …but patient preferences can also serve to modify the relevant outcomes to measure or assess for quality of care. We need to code those things that make us (properly) ignore clinical guidelines.
- Risk factor means that those WITH the specific risk factor are more likely to develop "X". Here, we are considering 2 things: (1) known specific risk factors related to health problems that are not available with current ICPC rubrics such as "at risk for cardiovascular disease" or "genetic risk for cardiovascular disease"' (2) things we need to know when caring for a patient that are not of themselves episodes of care such as homelessness or social isolation, or history of exposure to asbestos.
- Much of our work as GPs in the near future will be in identifying and managing risk for individual patients, and we need to take leadership in defining what and how this will be integrated into practice. We can not do this without data, and we have to collect this data.
- Think of this NERI category as "things you need to know" when making clinical decisions in taking care of a patient or a population.
- Marc Verbeke has addressed this issue as part of a previous document for ICF implementation, the feasibility of ICF to address non-episode related issues reflecting clinical care – available to the group
- Some of the things that could be included are value-based or value-dependent. How or where do you draw the line?
- Should we go on with this line of work – "information for the GP record" in addition to ICPC? Is this a job for WICC?

ACTION: A NERI Working Group will replace the "risk factor" group and will be led by Sebastian Juncosa. The group will prepare a White Paper outlining this content area and identifying next steps in developing a NERI "classification" or terminology that can link to ICPC. This work can go on alongside ICPC-3 development.

<u>Chapter P and Z- Report of work of WHO Primary Care Consultation Group to ICD-11 Mental Health Classification.</u>
Presentation and discussion led by Mike Klinkman.

The work of this 10-member group, composed of 5 GPs and 5 psychiatrists, was presented. The group is charged with recommending the list of mental health conditions to be included as the ICD-11-PC mental health classification. This list is to be integrated with the full ICD mental health classification. MK is deputy Chair of this group and MR is a member. The draft list of 28 terms was presented, and compared to the rubrics included in Chapter P of ICPC-2. Differences and similarities in the lists of conditions were highlighted. One important issue is how to address somatization, as there has been much work by Marianne Rosendal and her research colleagues in defining the category of Body Distress Disorder (BDD) as an alternative to somatization / somatiform disorder. Another issue is the new formulation of anxiety – depression – anxious depression – distress disorder.

General discussion.

- Discussion on issues of sexuality or sexual function (homosexuality or promiscuity). Are they problems or risk factors? Sexual behaviour may or may not be a problem, may or may not be a symptom or disease. In many clinical settings we need to be able to code it if it is a problem- should we code it in chapter P or in the new chapter G?
- Over time, the boundary has changed for many mental health conditions on what is normal and what is abnormal, and ICD and DSM handle it differently .
- General discussion on the three classes of anxiety/depression/anxious depression ensued, with comments on these being parts of one spectrum and how this is addressed.
- General discussion on the topic of BDD and its main disorders, body distress syndrome and health preoccupation disorder - and the fact that these reflect the failure of ICD to accommodate symptom diagnoses.
- The division of sexual function disorder in the proposed ICD list into male and female was noted and commented upon: this is caused by political pressures.
- The group commented on the need to work on cross-links with ICD, and agreed to make a recommendation to Wonca executive to lobby WHO to include WICC members on all the TAGs created to guide ICD-11 development.
- The lack of a space for "suicide" in the ICD mental health chapter was noted.

ACTION: WICC will work with Wonca core executive to nominate WICC members to take part in the ICD development process, through membership in relevant TAGs and/or the creation of a Primary Care TAG.

Time for meetings of Working Groups.

Thursday, 14 October: AM session
Chair: Mike Klinkman

Working process for WICC on ICPC-3.
General discussion led by Mike Klinkman.

Discussion focused on related things: How should we break up the work with the ICPC-3 How can we organize the work? What tools do we have?

- To be decided: structure of codes, who will do chapter reviews, how to manage new suggestions, what to do about process codes, how to accommodate patient preferences, risk factors
- The work should be iterative
- We should start by translating the existing content in each chapters into the new 2A2N structure
- We should look at the proposals for changes forwarded in relation to ICPC-2, and assemble this in one place (the Update group was considered a good start point)
- The ICPC-2 update group and ICPC-3 development group have to be very well coordinated
- We will need web tools to support the work. Protege is a professional tool. Dropbox and/or Google groups might be easier to learn and use
- Teleconferencing is also a possibility to be explored- list servers function well for information exchange.
- We need a blueprint on how to do the work. Helena will write a draft proposal for instructions/specifications.
- There is work to be done to identify diagnostic content within the rag-bags that needs to become a separate rubric. Julie O'Halloran will work with others to do preliminary analysis of ragbag content from several countries
- The work with ICD-11 should be followed closely: the problem is the progress of ICD-11, which is uncertain
- Specific actions toward ICPC-3:
    - Chapter review: create a list of things that must be reviewed in each chapter and collect all new suggestions
    - Review codes to improve consistency of coding across chapters (examples of common issues: Fear of disease, Concern about appearance, Disability (currently -28 codes), Inconsistent use of concepts across chapters (e.g. polyps).

Update on WHO-ICD 11 progress.
Discussion led by Mike Klinkman.
Brief discussion on the status of the ICD revision. The formal working relationship between Wonca and WHO that has been negotiated has still not been completed or acted upon by WHO. Main features of the relationship were that Mike Klinkman would be named as the primary care classification liaison between Wonca and WHO and would serve on the revision steering group, that there would be primary care (Wonca) membership on relevant chapter-based Topic Advisory Groups (at present, Chris van Weel and Mike Klinkman are serving), and there had

been discussion about a primary care Topic Advisory Group that would advise on overall content issues. The revision process itself seems behind the posted schedule, and the TAGs have been slow to change their working process to be able to achieve the goal of building ontology into the ICD-11 structure.

Update on WHO-FIC

Discussion led by Laurent Letrilliart, Shin Fujita. Discussion focused on recent work of WICC members (Letrilliart, Fujita, Verbeke) on aspects of ICF and the feasibility of both limited (condition-specific) and general (whole-person) versions of ICF coding for primary care use. Further discussion occurred on options for integrating ICF or alternative method of functional status assessment into ICPC-3.

General discussion:

- Problems of attribution and interpretation of ICF coding again discussed – for example, how to separate whole-person function as assessed by ICF from condition-based functional assessment, or acute vs chronic problems and impact on scoring and interpreting scores
- Potential uses of ICF in describing specific body structures and impairment from injury, and difficulties in coding this level of detail, discussed
- The social utility of ICF was discussed (as determinant of social function)

ACTION: WICC members agreed that it is important to accommodate functional status measure(s) into ICPC-3. At the least, we will hold a place in the base classificiation by assigning an ICPC rubric to represent "functional status", and linking use of that rubric to ICF. Further work to identify options and propose a best solution will be led by Laurent Letrilliart and Shin Fujita.

Update on ISO-TC 215

Discussion led by Francois Mennerat.

The International Standards Organization has a number of technical committees responsible for determining standards for health informatics items. Francois Mennerat has worked with ISO TC 215 for several years as a French representative. TC 215 covers the area of primary care, and will be issuing recommendations related to primary care standards by October 2013. The TC 215 Working Party 3 has the task of creating a document standardizing concepts for continuity of care, a task that is of high importance to classification and data standards for primary health care. It is very important that Wonca/WICC have a formal representative to this organization who can actively participate in the work of TC-215.

ACTION: WICC will request Wonca Executive to name Francois Mennerat as the formal Wonca representative to ISO TC 215, and support his participation on the Committee.

Thursday, 14 October: PM session

Chair: Anders Grimsmo

Update on Wonca/IHTSDO work

Presentation and discussion led by Nick Booth.

This session began with a presentation of the relationship between terminology and classification, a brief description of the SNOMED terminology (see also http://www.informatics-review.com/wiki/index.php/snomed) and an outline of the 2 related work projects of the IHTSDO IFP/GP SIG chaired by Nick Booth and composed primarily of WICC members: creating a SNOMED-CT primary care reference set (refset) followed by mapping the SNOMED CT primary care refset to ICPC-2.

Graeme Miller and Julie O'Halloran presented more detail about the planned work projects (see PowerPoint slides).

General discussion on SNOMED-CT and work projects:

- In general, extremely difficult to directly link terminologies to each other, due to semantic differences in terms, so classifications can be valuable to provide link and interoperability. Classifications linked to terminologies can solve problems at individual patient record level by enabling specificity at the same time as grouping data into retrievable standard classes.
- Q – Will creating a smaller subset of SNOMED-CT limit our ability to work with other parts of the terminology? A – No, this will create a standard subset but any user free to add other SNOMED terms as needed locally
- As we learn more about how to work with primary care data, we can use the power of the computer to develop and refine terminologies; at that point we will not need an input classification, but an output classification
- SNOMED developers are not trying to replace or replicate natural language, current decision support protocols or tools, or classifications. What SNOMED-CT and this project offers is increased utility for primary care applications and use in primary care EHRs
- Q – how big will the refset be? A- will reduce from the current 250K terms in SNOMED-CT to likely 10-15K primary care terms, also expecting that some important terms will be missing from SNOMED-CT
- Q – Who will use this? A- Probably countries that have adopted SNOMED as their standard terminology for EHRs, as a reference terminology. The primary care refset could replace current cumbersome interface terminologies.

ACTION: IFP/GP SIG will begin work on the SNOMED-CT Primary Care refset. Goal is to complete a draft of the refset prior to the 2011 WICC meeting in Barcelona.

<u>Update on OpenMRS: a simple EHR application for developing countries</u>

Discussion led by Graeme Miller (see also PowerPoint slides).

OpenMRS is a very simple database designed to facilitate collection of specific disease data in developing countries, now extended to serve as a rudimentary EHR. It has been field tested in a few sites in Africa. The database was developed by a consortium in the US including Columbia University and the Regenstreif Institute, and provides a free and flexible Web platform for health workers in the field to upload data on health conditions. It currently uses ICD-10 as its diagnostic classification, and there have been reported problems in its use in the field related to the specificity of ICD-10. There are over 250 subscribers at present. WHO is considering

expanding its use in their Regional Access to Open Data Standards (ROADS) initiative focused on Africa.

Questions for WICC:

- Should we become involved in work to improve OpenMRS?
- Should we offer to supply ICPC (to replace ICD or map to ICD)? Would require Wonca to grant free license to use ICPC in the software
- Should we encourage IHTSDO to work with OpenMRS through the GP SIG?

General discussion:

- Q- What terminology does OpenMRS use? A -Not clear.
- Q- Does OpenMRS follow current ISO standards for health records? A- Developers say yes, but it is not clear.
- General interest in working with the Open MRS group, but we need more information about how it is used in field. Would be good to share their data on diagnoses in the field to help with ICPC-3 develeopment

ACTION: WICC will reach out to OpenMRS group to explore opportunities to work together to support EHR development. Graeme Miller will contact Wonca Executive to determine whether we can offer free ICPC license as a starting point.

<u>Update on KITH and ICPC-2e: recommendations for enhancement of electronic database</u>

Presentation and discussion led by Terje Sagen (KITH) (see also PowerPoint slides)

Terje Sagen presented the current database structure of ICPC-2e v 3.0. This does not refer to the structure of the codes, but the structure of the database files themselves. WICC needs to decide on basic rules and standards for the structure of the ICPC database files in accordance with the following basic questions: What are the high level requirements? What are the business rules? How are they documented?

The database model maintained by KITH keeps track of the ICPC version, changes to codes (for example, including new codes, updated codes, outdated codes), date and time stamps and a change log. Data in the ICPC-2 database Version 3.0 is currently not normalised. Commas are used as separators inappropriately, which means that the data is not machine-readable. There is no reference in the ICPC-2-R book (as the most recent publication of ICPC) about how terms are supposed to be separated, nor criteria for sorting order. There are 324 rows in the database that need to be corrected to overcome the use of commas as a delimiter.

TS recommended that elements are separated by semicolons, with commas only used within each individual element and that terms are listed as standalone terms (e.g. polyp of colon; polyp of rectum). Slashes (/) should also not be used as a separator. There is also an issue where the ICD codes listed are listed in groups (e.g. D74-76). For the purposes of database management this should be D74, D75, D76.

At the moment the exclusions don't represent what is in the original code text. There are no problems with the criteria field as this is free text. For the 'considers', TS recommends that terms are separated by semicolons and that terms are written as standalone terms. Another

recommendation is that the 'consider' gives a reference to the original code text. The ICD-10 reference should be expanded so that each ICD code is listed individually. The current version of ICPC-2 contains the map to an old version of ICD-10. WICC needs to determine which version of ICD is used for the map, and how this is updated.

Summary of recommendations from KITH:

- Normalise the ICPC database
- No constraints on field length (so "shorttext" descriptions of ICPC rubrics are no longer necessary and can be removed)
- Use semicolon as separator between elements
- Inclusions separates with semicolon
- Inclusions must be standalone terms
- Exclusions separates with semicolons
- Exclusions must refer to the original inclusion code text
- ICD-10 separates with semicolons
- ICD-10 is opened up so that each code is listed separately
- WICC needs to determine which version of ICD-10 will be used in the ICPC-ICD map
- ICPC-2 English 2-pager needs to be updated

ACTIONS: WICC agreed that KITH technical staff should undertake these recommended steps under the supervision of Terje Sagen and Anders Grimsmo. WICC members still need to determine which ICD-10 version will be used for mapping. The English ICPC-2 2-pager will be revised after this work is complete.

Friday, 14 October: AM session
Chair: Mike Klinkman

Update on ideas for effective training strategies in ICPC (issue carried forward from 2009).
General discussion, led by Mike Klinkman. WICC members discussed progress in disseminating or adapting successful ICPC training methods already used. Key points in discussion :

- Danish e-learning program (first presented at Florianopolis meeting), a self-directed on-line tutorial in ICPC use: copyright issues being sorted to allow translation into English.
- The Norwegian experience, focusing on broad education of the students, not only GP's, has been helpful to spread awareness of the classification. PowerPoint materials developed by Anders Grimsmo.
- "Brainstorming" and suggestions of how to carry out distance-based or virtual training-
    - bring all expertise into one virtual space, Internet site with all materials
    - construct a support group for people educating in ICPC
    - construct 2 min videos supporting learning
    - create YouTube videos instructing in use of ICPC
- In some areas, Internet methods will not work or will not be available, so we will still need hard-copy materials and face-to-face training capability – particularly in developing areas
- Participation in WONCA regional conferences can be very valuable – especially in the form of workshops introducing ICPC and providing basic training
- Is a CD with a half-hour tutorial sufficient to be an educated ICPC user? Some WICC members self-educated with the original book and no training
- After we have completed the changes in the on-line database at KITH, they will be able to do an instant print of a book form of ICPC: we can ask Wonca to allow us to print on-demand copies
- To fully train in use of ICPC, you have to teach both the classification itself and the episode of care model. The second one is far more complicated. But a training protocol must not make it seem as if you need months of training.
- Comments from a new user of ICPC: ICPC is not difficult. You do not need a lot of training. Circumstances of practice make it an indulgance to use it. It is a clumsy tool when in a tight time schedule.

ACTION: WICC members will continue to share materials, ad hoc training will continue for now.

Update on Translations.
Discussion led by Marten Kvist. Work continues on logging translations received for 2-pagers and full ICPC books. Communication with KITH to post translations improving, and process in place.

General discussion:

- Interest (but some confusion) in creating an Arabic translation, with key contact to be identified

- Vo Thanh Liem from Vietnam is proposing to begin work on a Vietnamese translation and will work with Marten Kvist and Marc Jamoulle

ACTION: Shabir Moosa and Marc Jamoulle will start working with interested WICC members to stimulate interest in new translations, with Marten Kvist continuing to serve as lead and coordinator.

Review of Action Items for 2010-2011.

Discussion led by Mike Klinkman, who displayed a list of action items from this meeting to date, as well as a few items carried forward from the 2009 meeting. After general discussion, the items included in the Action Plan at the beginning of this document were agreed upon by WICC members as the Action Plan for 2010-2011.

Final session: question and answer session with Wonca Executive representative Chris van Weel (immediate Wonca Past President).

General discussion, beginning with opening remarks by Chris van Weel to present Wonca's congratulations on a successful meeting and on the developing relationships between WICC and international organizations in the classification field. His 4 main points were:

1. Maintenance of a valuable PC property in ICPC-2 is essential
2. ICPC-3 is also essential for the future of the discipline
3. Go for the NERI concept to expand the capacity to capture primary care information
4. More and more collaboration with others (ICD, SNOMED, IHTHSDO) will be necessary

Question and answer session:

- Q - There have been some difficulties in licensing processes, with open source tool developers, lack of follow through with individual people who want to explore ICPC in their own context , lack of response of CEO to requests for license for ICPC , and many then come to WICC (Chair) with their question. A - traditional policy is that ICPC is free of use for research purpose, license use for day to day use in the EMR; Wonca is experimenting with subscribing for use and getting updates, and to get more flexible.
- Q - As more countries have ICPC, the responsibility for WICC becomes greater. Until now WICC is a voluntary organization, and it is more and more difficult to meet the added responsibility. How can we professionalize WICC? What are the possibilities from Wonca? A- Wonca Core Executive believes it is a task of Wonca to support more professional work, as in the relationship with SNOMED and other organizations. But WICC will need to communicate effectively with Wonca leadership.
- Q - Will a subscription model for ICPC generate more income (than a one-time license fee)? A - The idea is from an operational perspective instead of a financial one, to support ongoing work with subscription revenue.
- Q – Might it not be a good idea to let governments invest in a social project by freely distributing ICPC in the field by licenses/subscriptions? For example, in Thailand ICF is being used in the practice of "oral autopsies" because it is has been distributed free of charge, even though it is a poor tool for that purpose. And in the Netherlands, ICPC-1 is still in use as it has not required purchase of a national license. A – the challenge is making this issue concrete and understandable for Wonca to address. WICC must

communicate the problems and issues clearly to Alfred Loh, as CEO, and the Executive committee.

- Responses by WICC members - concrete problems include:
    - International standard map SNOMED-ICPC – a problem if we can not enforce license for ICPC along side SNOMED.
    - Malaysia - could be granted a simple research purpose license for free to test a simple flat doc of ICPC
    - Philippines : OpenMRS opportunity that bypassed general/family medicine because of license issues: preventing work with an open-source tool to serve developing countries
- Q - ICD 11 has a primary care component. If my (developing) country already has a license for ICD-11, how could I stimulate them to get ICPC? A – The advantage of ICPC is that it is a better fit for primary care. ICPC is much more than a classification of diseases. The person-centered information that is addressed by the NERI group is a perfect example of that. ICPC is a good tool for primary care development
- Q - Could you give us some more information on the consortium? Why did Wonca only approach national Colleges to ask for funding to support a consortium? A - No classification tool in isolation; if the goal is to develop primary care, its tools must not be made in isolation but in conjunction with hospital care, and that will take much effort. After the Cancun Wonca Council meeting (spring 2010),it was decided to first go the members. Wonca going directly to a government (those who have bought the license) would bypass the colleges, and as a first step this would be a problem.
- Q - Would WICC be a better "child" of Wonca if it would meet at the same time as other WONCA meetings? A – There are pros and cons. Protected time is important. But demonstrations or workshops at Wonca conferences will make the work of WICC less theoretical and put it within the whole context of primary care. WICC Chair attendance at Wonca Council meetings would also be valuable.
- Response: ICPC sessions and WICC presentations already exist at some WONCA conferences.

Adjournment:

The Chair thanked Chris van Weel and Wonca executive for their time and interest in WICC, and thanked all participants for their contribution to a productive meeting.

Special thanks were given to Marc Verbeke for his work in planning and coordinating the meeting, to Jan de Maeseneer for his leadership and support of the meeting, to Pauline Boeckxstaens and Diego Schrans for their assistance in coordinating the meeting, and to Marc Jamoulle for his hosting of the welcoming all-group dinner at his home.

There being no further business, the 2010 WICC Annual Meeting was adjourned at 11:50 am on 15 October 2010.