WONCA INTERNATIONAL CLASSIFICATION COMMITTEE

Wonca International Classification Committee
2009 Annual Meeting
Florianopolis, Brazil
8-12 November, 2009

MEETING SUMMARY.

GOALS FOR FLORIANOPOLIS MEETING.

1. **Reach agreement on primary direction of WICC and next steps needed**
2. **Decide core issues for ICPC-3**
   (examples: numbering, X/Y,chapter revision(s), extent of prevention/RF)
3. **Create work plan for ICPC-3 revision**
4. **Identify leads and action plans for dissemination, training, Web presence**

WICC ACTION PLAN 2009-2010.

1. Work toward forming Primary Care Classification Consortium.

We will move forward to form a Primary Care Classification Consortium, an international non-profit organization that will provide primary care expertise to "all" classification and terminology efforts.
MK will lead in developing the structure and proposal for the Consortium in cooperation with Rich Roberts, the Wonca President-elect.
WICC executive will draft and circulate a document showing a possible structure for comment by WICC members. WICC executive will then send document to core Wonca executive to begin work on creating and identifying funding for the new organization.

2.1 Create the International Family Physician/General Practitioner Special Interest Group in IHTSDO.

WICC approved the agreement, which will create the IFP-GP SIG. A draft of a "governance" (quality assurance) process was reviewed and will be revised with input from Wonca Executive and IHTSDO leadership. We will nominate Nick Booth as leader of the SIG (which is what IHTSDO wants). Nick has agreed to serve in this role while remaining a member of WICC executive group.

2.2 The IFP/GP SIG will begin work on 2 projects.

The SIG will begin work on two tasks, already receiving preliminary approval from the IHTSDO Management Board: creation of a SNOMED Primary Care reference set of terms ("Primary Care Refset") and a map from this term set to ICPC-2.

3. Decisions made on ICPC-3 content and working process.

- Changes are to be made only where needed (not change for change sake)
- Additional capacity needed
- Important to fit ICPC-3 on to 2 pages–but flexible on size of the page.

- The possibility of local additions or adaptations to cover specific areas of morbidity of local importance was raised but not discussed extensively
- There will be a new coding structure so that there will be no re-use of codes.
- The new structure will be 2 alpha + 2 numeric.
- Meaning in second Alpha (example: type or is-a) was discussed but not decided
- Base decisions on new rubrics or other content on data wherever possible
- Preference is to merge chapters X and Y if feasible (no loss of clinical content)
- New content needed for risk factors/prevention
- Aim to complete ICPC-3 by November 2013

4. Actions to develop ICPC-3.

4.1 Genital chapter- lead Helena Britt

- HB to draft a revised combined X+Y chapter
- HB to supply WICC with a list of sexual health and sexual behavioural problems for consideration of where they should go in ICPC-3 (e.g. genital or psych).

4.2 Clinical findings – exploration only, lead Shin Fujita

- A small working group (TBA, including EF and GK) will look at clinical findings list created by Shin Fujita in Japan, and consider whether and how we could/should incorporate

4.3 Process codes – lead ?

- HB and GM keep up with Richard Madden's work in Australia on the newly developing ICHI so we can consider whether can integrate with this new system
- HB agreed to act as the 'contact person' for discussion of process but it felt that this area may have to wait until a little later in development of ICPC-3.
- The Working Group needs to reconvene. Interested members are HB, MKv, LL, EF.
- An electronic copy of IC-Process-PC will be circulated to WICC by MKv.

4.4 Risk factors - lead Kees van Boven

- KVB agreed to lead a working group (with Dutch Government funding possible) to coordinate with work by other groups such as WHO-FIC.
- First steps will be to bring together ideas on content and structure, and how would fit within ICPC-3
- Terminology and Structure WG White Paper on EHR structure (see below) will also provide ideas on structure of this information
- Interested members to include Ray and Laurent

4.5 The "patient side" – patient goals and preferences- lead Bob Bernstein (?)

- BB and MK to review ICNP and draft a White Paper for review

4.6. Metaclassifications—multimorbidity, case mix

- Individuals in WICC are free to explore working with Patricio on ACG-ICPC

- JG will ask SJ and Spanish colleagues to prepare report on the Spanish Experience with ICPC-ACG for presentation at Ghent meeting

4.7 Structure of information – lead Francois Mennerat

- FM will draft (with Structure WG members) a White Paper on data models and data structure for health records, to guide group in structuring additional content for ICPC-3

4.8 "Community care" (public health) content - lead Juan Gervas

- JG and AG to prepare White Paper on content for ICPC-3

4.9 Use cases for ICPC-3 - all

- Each member to think of use cases and send these to FM to assist in writing of White Paper on structure
- This will also provide content for rewriting chapter 3 of ICPC book for ICPC-3.

5. WICC website – lead Marc Jamoulle

WICC must have a maintained external site for dissemination and training, and an internal site for WICC work using Protégé or similar tools. At this point, the most practical solution is for WICC members to develop our own Website, then ask Wonca to create a link between the new WICC website and the official Wonca website. This implies that we (WICC) will take responsibility for the website, with no guarantee of financial support from Wonca.

ACTIONS:

- EF and MR will investigate with the Danish government whether the e-learning program can be translated into other languages, both in terms of content and technical aspects.
- WICC will ask Wonca webmaster to link the current http://trix.docpatient.net site to the main Wonca website.
- MJ will attempt to translate more of the http://trix.docpatient.net website into English
- MJ to take the lead on the website work, with JG, MDJ, EF, GM, AO as a Website Working Group
- Working group will be charged with advising WICC Chair on development costs (particularly for ICPC-3 and Protégé work).
- Working group will develop a formal project plan – including budget for website development.

6. WICC translations – lead Marten Kvist (MKv)

- MK will aks KITH to put text 2-pagers in KITH website to replace current link to a separate website
- MKv will ask Wonca regional offices if there is a translator who could identified in each region.
- HB will provide MKv with name of a potential contact for the Indonesian translation.

7. Conflict of interest statement and country reports – all

- JG will send out the format required for submitting Conflict of Interest (Declaration of Interests) reports, WICC members will complete and send to JG
- Country report required for all countires – to be sent to Ian Marshall

8. Working tools and process – all

- RS, AO to start to work with Protégé. HB to feed in some attributes used in Australia, others will supply ideas and explore working with Protégé (free download from Stanford University website)

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MINUTES of the MEETING

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Sunday 8 October: AM session
Chair: Mike Klinkman

Welcome and Introduction:
The Chair announced the opening of the 33rd annual meeting of WICC and welcomed old and new members. Gustavo Gusso, local host, welcomed the group to Florianopolis and Brazil.

Attendance:

Britt, Helena (Australia) - HB
Booth, Nick (UK) - NB
Boven, Kees van (The Netherlands) – KB
deJonghe, Michel (Belgium) – MDJ
Falkoe, Erik (Denmark) – EF
Gervas, Juan (Spain) -JG
Grimsmo, Anders (Norway) – AG
Gusso, Gustavo (Brazil) - GG
Jamoulle, Marc (Belgium) - MJ
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
Orsonio, Alejandro (Argentina) - AO (present for part of meeting)
Rosendal, Marianne (Denmark) - MR
Simkus, Ray (Canada) - RS
Verbeke, Marc (Belgium) - MV

Attendance by Skype (some sessions):

Bernstein, Bob (Canada) – BB
Fujita, Shin (Japan) – SF
Grimsmo, Anders (Norway) – AG
Kounalakis, Dimitirs (Greece) - DK
Marginaean, Marius (Romania) - MM

Observers and assistants:

Muniz, Patricio (Chile): from Johns Hopkins, working with ACG system

Apologies received from:

Rubina Ali (Pakistan)
Niels Bentzen (Denmark)
Susan Dovey (New Zealand)
Jan de Maeseneer (Belgium)
Tim Gardner (New Zealand)
Sebastian Juncosa (Spain)
Ian Marshall (Australia)
Kumara Mendis (Australia)
Roland Morgell (Sweden)
Jean Karl Soler (Malta)
Nuno Sousa (Portugal)
Martti Virtanen (Finland)
Gojimir Zorz (Slovenia)

Resigned from WICC:

Lloyd Michener (USA)

Approval of minutes:

Minutes from the 2008 Annual Meeting in Brasov, Romania were approved.

Roundtable Introductions, brief country reports, and priorities for meeting: All attendees. Meeting began with a roundtable session, where attendees reported on work in their countries, and their priorities for this meeting. (see collected written reports at WICC website)

Chair's Report: State of WICC 2009: Mike Klinkman

(See PowerPoint presentation at WICC Google site)
main points:

- The life and accomplishments of Henk Lamberts, with a collective moment of silence in tribute to his work
- ICPC as standard primary care classification in several countries
- Licenses purchased by Iceland and Greece
- The potential for full-scale implementation of ICPC in Brazil
- Need for continued focus on Africa, Latin America, and Asia

- External work with IHTSDO; reaching formal agreement to create the International Family Practice/General Practice Special Interest Group in IHTSDO, and agreement on a formal funded work plan to create the SNOMED-CT Primary Care reference set of terms and the SNOMED- ICPC-2 map in 2010-2011
- External work with WHO: appointment of Mike Klinkman as Primary Care Classification Liaison to WHO pending WICC approval, participation in ICD-11 task groups, participation in WHO-FIC, and the new ROADS initiative
- Review of agreements reached in Brasov on ICPC-3:
    - Need additional space, must improve risk factor/prevention, need some new rubrics, must decide whether to consolidate chs X and Y
    - Changes should be made based on use data, not opinion, where possible
    - No agreement on structure (alphanumeric) of ICPC-3
- Brasov agreements on working process:
    - Most basic work done in WorkingGroups
    - WGs report to WICC executive group
    - WG plus executive make decisions on content, structure, then full WICC reviews and ratifies
- Review of action steps from Brasov meeting (see "2008/9 Scorecard" in Appendix)
- The ICPC-3 "use case": diverse primary care needs and multiple use cases
- A proposed data model for ICPC-3
- The priorities for WICC work in 2010: ICPC-3 essential, then dissemination/training, maintenance, Web presence, and linkages to other classifications
- Current organization and budget for WICC – not adequate for needs
- "Expert volunteer committee" in world of professionals
- Posted budget of $20K USD, but no discretionary funding, and all expenses must relate to ICPC-3 work
- Options for changing WICC, already discussed with WICC Executive and Wonca Core Executive (see Basel Summary in Appendix for detail)
    - Sell ICPC – not viable
    - Find a business partner – not viable
    - Maintain status quo
    - Assimilate work into existing SDOs - WHO, IHTSDO, CEN
    - Create and charter an international "Primary Care Classification Consortium"
- Discussion of implications of each option.

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

Sunday 8 November: PM session
Chair: Mike Klinkman
AG attended by Skype

General discussion on option of forming Consortium:
Discussion led by Mike Klinkman and WICC executive.

The Consortium was formally defined as a group of people who work together to improve classification in primary care: an organisation, with a structure and Charter. The closest example would be IHTSDO.

AG comments to lead off session:

- General sense that Wonca Executive quite supportive of the concept of the Consortium but not clear whether able to or interested in raising funds to support it.
- AG has approached Norwegian Government regarding possible funding support for such a Consortium to develop ICPC-3. They expressed interest in talking to the other Nordic Countries regarding a possible funding approach: if one Government invited other Governments to a meeting, may get a Consortium approach with majority of Nordic countries (except Sweden).

Main points, comments, questions from general discussion:

- *Would ICPC-3 be free if a country contributes?* Need Wonca agreement on that, but that would be the aim. The overall goal is to make classification tools like ICPC free to users.
- *Timing?* First possible formal proposal to Wonca to form Coalition would be at Cancun
- *Number of countries?* As many as want to commit to ICPC-3. IHTSDO founded with 9 member countries
- Discussion on who would be responsible for finding the money to support. Some felt it should be Wonca's if Wonca is to be the convenor.
- General agreement that financial control would be with the Consortium –a healthy situation.
- *What happens if currently licensed countries don't want to contribute?* Agreed that that would be OK, that this represents moving forward, not asking for additional commitments for past products
- Agreed that discussions regarding creating, joining or funding the Consortium in each country MUST involve WICC individuals from within that country.
- It is likely that countries now members of IHTSDO would be most willing to contribute to the creation of the ICPC-3 standard.
- Agreed that invited countries need to have input to develop the Articles of Association for a Consortium.
- What does Wonca get out of it?
    - WICC (through the Consortium) would be able to develop and support the classification tools to improve primary care worldwide;
    - An opportunity to be the lead organisation for information management in primary care – for clinical, teaching, and research pruposes

Each WICC member in attendance was asked to state their opinion on whether we should move forward with the Consortium. There was unanimous agreement from all present (including AG on Skype) that the Consortium was a good idea and that we should move forward to establish such a Consortium.

Many members raised specific concerns in their comments, summarised here:

- This process needs individual contribution from members in their own country to work with the political process to raise the enthusiasm (GM).
- This could be a long process – and WICC cannot afford to wait for establishment of Consortium before working on ICPC-3. Currently available funds should be spent on development of ICPC-3 before the Consortium is formed (no budget freeze).
- WICC must have the opportunity to meet to discuss in the agreement in full and the Bylaws of the Consortium must reflect the four goals of WICC.
- Such a Consortium arrangement may reduce Wonca/WICC independence, since a Board made up of representatives of the contributing countries will want to have a say. WICC must keep its influence in the Consortium, to retain independence, ensure scientific quality and ethical application of its tools.
- WICC also needs to take care of the under developed countries – they need representation of some sort in the Consortium.
- This is definitely the best option, and realistic – all other options leave to extinction of this group - but this is going to be really hard.
- We need to maintain closer contact with the incoming Wonca President and we need a representative from Wonca Exec at our meetings to live and breathe these issues.
- It is a competitive market, many groups (SNOMED, ICPC, ICD) wanting money. May be difficult to raise funds for the Consortium. Perhaps they should get together and work out how they work together.

Discussion: Why would Wonca "give" ICPC to a Consortium?
[NOTE that this is in effect how IHTSDO was formed – by Snomed International giving the IP and rights for SNOMED to IHT]
NB: in the Consortium governance would remain with Wonca but the Consortium would have a supervisory board which would have influence on the direction of ICPC-3 – they are the users, and they currently have no control.
GM: we need Wonca branding. IHTSDO sees the value of this in the SNOMED – ICPC map. So we must retain Wonca branding and governance.

ACTION: It was unanimously agreed that WICC Executive should draft an initial model for such a Consortium and distribute this to WICC for comment, with a limited timeline for response. The reviewed draft version will then be forwarded to Wonca.

Monday 9 November: AM session
Chair: Mike Klinkman
Guest: Patricio Muniz

General discussion on IHTSDO and Terminology Work:
Presentation and discussion led by Nick Booth and Graeme Miller.

Agreement between Wonca and IHTSDO. General points.

- Agreement was signed in October, 2009 for a work plan to create 2 "products" - a family practice/general practice refset of SNOMED CT and a map between this primary care refset and ICPC
- Work is to be done by the Sydney group led by Julie and Graeme, funded by both NEHTA and IHTSDO
- Work will be done in phases:
    - First phase - formulate the methodology for collecting the data sets and the methods to be used for validating those data sets. There has been some collection of data from a number of different countries already.
    - Second phase - collect data sets from around the world showing the concepts used most frequently in primary care, convert the terms to SNOMED CT concepts, then amalgamate the term sets into a single refset of SNOMED CT concepts using the methods selected in the first phase.
    - Third phase - construct a rule based mapping from the refset to ICPC-2, then submit this draft mapping for review/testing/approval by individuals familiar with ICPC. Details of the testing were presented at the meeting.
    - Implementation guidelines and documentation of the products also must be developed.
- Funding from NEHTA is available because the Sydney group is working with NEHTA to develop an Australian subset of SNOMED CT. The two projects are complementary, and attention will be paid to ensure that funding for these two projects does not overlap. It is likely that the Australian refset will be completed first and will comprise one of the source data sets for the SNOMED FP/GP refset.
- This process will select usable terms from SNOMED CT that can be mapped to ICPC.
- The first product, the SNOMED FP/GP refset, will be freely available to all users in any country with a national licence to use SNOMED CT. IHTSDO has also decided to make SNOMED CT available at no charge to low-income countries.

General discussion about the agreement and proposed work plan.

- The group raised concerns about translation issues – whether the refset and map would be valid in languages other than English. It was pointed out that the translation would be based on the concepts rather than the current rubrics, and that IHTSDO has an active translation group that is well aware of issues related to translation of medical terminologies.
- Concerns were expressed about WICC and ICPC being locked into using SNOMED CT only as a terminology. A related concern was that ICPC be allowed to continue to develop independently of SNOMED CT. This agreement does not

lock any group into using ICPC with SNOMED, or tie ICPC development to IHTSDO or SNOMED. It is expected that ICPC will be used in conjunction with a terminology (whether SNOMED or another clinical terminology such as the Belgian 3BT) when recording at the granularity that is needed for individual patient care.

- Other clinical terminologies are in use in primary care in some countries: Finland has Duodecim, Belgium has 3BT, the Netherlands has the Dutch thesaurus, and other smaller-scale terminologies are in use with ICPC. These terminologies could also be professionally mapped to ICPC
- A.Orsonio commented based on his experience with the Spanish translation of SNOMED CT, his work as a consultant in this area, and his current work with the IHTSDO translation committee. His opinion is that SNOMED CT allows for a clear separation of the meaning from the term and this facilitates the translation into multiple languages.
- As part of the agreement between Wonca and IHTSDO, proper "clinical governance" is to be developed and carried out by Wonca and WICC. Much discussion occurred on this point, with several suggestions about process made:
    - The working group, WICC, and Wonca would have control over the content of the SNOMED FP/GP refset, but there would need to be some formal "stamp of approval" of the quality of its content from an international authority, which could be Wonca.
    - National Colleges of FP/GP could be asked to sign off on the refset
    - Each national SNOMED Release Centres could be asked to affirm the fitness for purpose of the refset.
    - IHTSDO recommends that the working group collaborate with the US National Library of Medicine (NLM), home of the UMLS and the Metathesaurus, to take advantage of the lexical tools that have been developed by the NLM. Kin Wah Fung should be the contact person, and needs to agree to collaborate. NLM could also serve as formal approval body.
    - Governance of the mapping of the SNOMED FP/GP refset to ICPC would be done internally by the Family Medicine Research Centre in Sydney and externally by the WICC/Wonca community through a separate process

ACTION: It was moved and seconded that WICC/Wonca proceed with the proposed work plan. The motion passed with 2 dissenting votes and one abstention. After further discussion, it was decided that specific governance issues could only be decided after the first phase of work was underway, which should be prior to the next WICC meeting. Suggestions from the discussion will be taken forward by N.Booth and G. Miller.

Following this discussion, the group again voted on the motion to proceed with the initial work plan. There was a unanimous vote to proceed with the initial work plan.

The press release from Wonca announcing the agreement between Wonca and IHTSDO, dated October 27, 2009, was tabled.

Monday 9 November: PM session
Chair: Francois Mennerat
Guest: Patricio Muniz

ICPC-2 Discussion, focused on clinical experience, clinical data.

Presentations on current use of ICPC-2.

1. Marianne Rosendal (Denmark): ICPC clinical usefulness

Presentation on the advantages of using ICPC and the current clinical use of ICPC-2 in Denmark.
Since 2007, 140 GPs use ICPC-2 on a regular basis, and they code in 60% of their consultation in average. Coded data are sent anonymously into a central database. Thanks to data structure with ICPC-2, the GPs can carry out quality assessment and find information useful for practice (guidelines…). ICPC-2 is integrated within most available medical software, along with all the attached criteria.

Described DAK-E website, which includes ICPC coding tools and audit systems for practices (Quality Improvement Unit at University of Southern Denmark). Examples of AF and hypertension with linked treatment and highlighted possible errors in management.

2. Mike Klinkman (US): ICPC: Clinical application at UMHS

Described the clinical application of ICPC-2 at UMHS (University of Michigan Health System). ICPC-2 is used, along with the Canadian ENCODE interface terminology, in practice software (Cielo Clinic) used alongside an EPR. It allows GPs to code the list of active health problems, and this problem list is linked to a clinical decision support "rules engine" that provides selected prompts and reminders for needed care for chronic problems. It remains difficult for clinicians, however, to structure the episodes of care with the current version of the software.

3. Gustav Kamenski (Austria): System being used in Austria with standardized terminology

The system is called Casugraphy, which is an Austrian classification of consultation results, originally described by P. Braun. It includes 318 items, and allows to check for avoidable dangerous outcomes (as differential diagnoses). Gustav would like to map it to ICPC-2.

4. Helena Britt (Australia): Multimorbidity in Australian General Practice – an emerging problem that we need to address in ICPC-3.

Report on a prevalence study on multimorbidity in Australia in which 289 GPs participated.
The analyses were made using both ICPC-2 and CIRS (Cumulative Index Rating Scale, including 12 categories). The study showed that around one third of the Australian population had multimorbidity. The prevalence was higher when using ICPC-2 than when using CIRS. Discussion followed on the problems of accurately coding for

multimorbidity. This is an excellent example of the use of research data to improve the quality of care.
ADDENDUM [from Tuesday 10 November PM session]: As a postscript to this presentation, HB stated she would be at the University of Sherbrooke in Canada and would discuss the mapping of ICPC to the CIRS system. It was decided this was not an official WICC item of business but would be reported in the Minutes.

5. Thomas Kuehlein (Germany): Content-EPR system and study in Germany.
Report of the CONTENT project, involving 38 GPs and 110,000 patients, highlighting the variance in management participation between practices, and the effects seen in the trial of use of evidence-based care.
The project was successful in changing physician behaviour in small groups in one specific instance on implementation of guidelines. GPs participated to a focus group and a descriptive study on the antibiotic treatment of cystitis. They could then verify that prescribing according to the guidelines did not generate many complications (failure rate: 6 %).

Multinational data on use of rubrics in ICPC.
Presentation and discussion led by Julie O'Halloran and Helena Britt.
Main points:

- Methodology of data collection: request for data coded in ICPC with frequency counts for individual rubrics
- Data have already been collected from more than 10 countries
- Data from developing countries are too scarce and still much needed. For example, in Rwanda, tuberculosis accounted for 25 % of health problems in the A chapter, compared to 0.3 % in developed countries.
- Helena Britt presented an initial analysis of data received with limited country input. (see slides); chapter S used as an example. Results are only food for thought at this point.
- Discussion followed regarding use and interpretation of the data.

Report of the update group.
Discussion led by Marianne Rosendal.
Main points:

- Report of several general problem areas that need to be corrected in ICPC-3
    - Problems with clinical findings, which are distributed in both components 1 and 7
    - Rubric inconsistencies (syndromes, infections in S chapter, skin problems around orifices)
    - Rubrics with low frequency- what should be done? Retire? Replace? Re-use rubric?
    - Several proposals for changes in specific rubrics (example: mumps from chapter D to A …)
    - Problematic issues in coding family planning/contraception, chronic kidney disease, metabolic syndrome

    - Some areas can not be improved given the constraints in ICPC-2 (risk factors, clinical factors, lack of space)
- Discussion of use and control of KITH website.

ACTION: instruct KITH to remove the notation "for testing" from the designation of the latest version of ICPC-2, Version 4.0, on the KITH site.

Thomas Kuehlein ended the session with a presentation on classifications from the GP perspective, featuring an audiovisual landscape.

Tuesday 10 November: AM session
Chair: Mike Klinkman
Guest: Patricio Muniz
AG, BB, MM, SF, and DK attended by Skype

ICPC and ICPC-3 work.
General discussion led by Kees van Boven.
See also: http://groups.google.co.uk/group/wicc-general/web/test-wicc-florianopolis-presentation-list?hl=en

Mike Klinkman gave introduction and overview of the agreements we reached at the Brasov meeting and the main decisions to be made regarding ICPC-3 structure and development.
Kees van Boven led discussion on each issue for decision.

1. Do we need a 2 pager?

- Discussion: do we need to decide this now, as it constrains further decisions? Even with extensions and changed structure, ICPC might still fit onto 2 pages. The 2- pager is a good overview tool for teaching and a very powerful tool for promotion of ICPC. It would be a good idea to create "local versions" of 2 pager, adapted to fit the local needs.
- **DECISION: we want in principle to have a 2 pager for ICPC-3**

***2. ICPC should be fit for "community care"*? (as distinct from general practice medical care)**

- Discussion: In principle, yes, but this needs to be tightly defined to keep the focus on primary medical care. Ambulatory care is different from community care, for example, in Argentina this includes aspects of sanitation etc. Why do we want to extend in this way and possibly destroy the idea of a 2 pager. We may need to include community concepts such as vaccination, but we need to guard against making a poorly cut down public health classification. Prevention is the major issue we are missing in ICPC, though the BEACH experience is that most issues are already provided for. The International Classification of Nursing Practice (ICNP) may provide content, and we could explore joint work. Which specific issues are we wishing to add – referral, collective education? There are country differences in how much community care is part of primary health care practice: for example, in the Netherlands vaccination is not part of GP role, whereas in France it is part of the GP role.
- Proposal for a new ICPC chapter addressing public health, followed by discussion about its content and overlap with existing classification. Proposal that we in principle include aspects of community care in ICPC.
- **DECISION: we need a white paper to clarify how to accommodate "community care" (public health) in ICPC-3. J Gervas and A Grimsmo volunteered to work on the White Paper.**

3. ***Change as little as possible in creating ICPC-3?***
   - Discussion:…. But change as much as is needed! Avoid change just for the sake of change, but some changes may be wise to make the new version readily recognisable as different to ICPC-3. The more change, the more we risk that current users would abandon ICPC or not upgrade to ICPC-3.
   - **DECISION: to change as little as needed, all proposed changes should be justified**

4. ***When can we have ICPC-3 ready (delivery date)?***
   - Discussion: We need a consortium to support the work, and that work alone will take 2 years. Revision is a 3 year process and we are therefore looking at 5 years from now. 5 years might coincide with ICD-11, but ICD-11 may well be delayed beyond its projected release date. 4 years is the most reasonable, to have ICPC-3 ready before ICD-11. Recall that the initial development of ICPC required about 10 years; this included prior ICHPPC work, then funded work and field trials from 1983-87. ICPC-2 took more than 4 years of volunteer effort.
   - **DECISION: Our aim is that ICPC-3 should be complete in 4 years, by November 2013, including field testing time. This is a very tight time line.**

5. ***Core features of ICPC (episode of care, etc) to remain unchanged?***
   - Discussion limited, as clear consensus.
   - **DECISION: No change**

6. ***Criteria for changing rubrics*?**
   - Discussion: Based upon relevance and prevalence (plus public health importance). Consensus and data. Taxonomic rules need to be followed, so this needs to be a criterion for changing rubrics. Do not change rubrics based upon urgent or expedient temporary public health issues (example: WHO breaking classification "rules" to create a separate code for H1N1 influenza) as these may be temporally transient (over the 10 year + lifetime of the classification. Do we need an explicit check list for criteria for changing rubrics, or do we simply need to restate the organising principles for ICPC? .
   - **DECISION: We will start with an open proposal of basic criteria to justify the proposed changes (no volunteer to create).**

7. ***What coding structure (alphanumeric) will be used?***
   - Discussion: Options proposed by WICC members over past year were reviewed. Clear consensus for the proposal of E. Falkoe/M.Rosendal, based on work by M. DeJonghe presented in Brasov, with 2 alpha/ 2 numeric structure. The second position alpha would specify "type" (infection, trauma, etc). This will be labeled 2A2N coding structure.
   - Paper describing 2A2N structure tabled: available at: http://groups.google.co.uk/group/wicc-general/attach/6103f540516dcf0e/Proposals+ICPC+structure+DK+2009.doc?hl=en&part=6&view=1

- Discussion on 2A2N proposal. Should we leave out structural information from the term (not use second alpha to specify type)? Current coding system is part of the structure of ICPC. We need to consider minimal change in the underlying concept of current codes, so that we avoid "partial reuse" of codes – in other words, keeping the same code but modifying its content to split off some content , as this will cause errors and create problems with backward compatibility. But many users remember the codes and use codes rather than terms during everyday practice (for example, in DK). This use case should be remembered.
- **DECISION 1: Proposal of J.O'Halloran/H. Britt withdrawn**
- **DECISION 2: We will adopt the 2A/2N structure for ICPC-3**

8. How do we accommodate risk factors?

- Discussion: We need more demographics formally collected. Epidemiology, genetics, environment, social culture, friends and teachers – the whole patient, and these might fit in as RFE or diagnosis, and are present in all ICPC chapters but not in a consistent way. Positioning of risk factors across all components is important. In paper or electronic use of ICPC, context is important. Risk factor as a structural class is important. How can we accommodate negation (the absence of a risk factor), which is increasingly reported in health care? Others prefer to omit negation from the ICPC model. We need as simple as possible a model for risk factors, as proposed in the 2A/2N structure proposal. In EMRs, users could add clinical management "tools" linked to the use of specific ICPC rubric fo rrisk factor. General consensus that improved handling of risk factors needs to be a core feature of ICPC-3. Risk factors can often be treated as episodes. Could we add risk factors as an attribute of a problem as proposed for ICD-11? Could we add risk factors in a new public health chapter for ICPC?
- **DECISION: We will delay a final decision on how to address risk factors. The terminology and EHR structure group will write a paper on EHR structure with particular reference to the place of risk factors, and this White Paper can guide our decision in the months ahead.**

9. X+Y chapters – should they merge?

- Discussion: Arguments pro and con have been circulated in the months before meeting, basic points are that gender is obtainable from the record, so not necessary to create codes-by-gender in different chapters, which creates complications in mapping. However, there is still a need to distinguish some concepts which are the same but behave differently in males and females.
- **DECISION: If feasible (no loss of clinical content), we will merge Chapters X and Y for ICPC-3.**

10. Include clinical findings in ICPC-3?

- Discussion: Clinical findings have "sneaked" into the classification in ICPC2/2R without formal discussion ("clinical findings refer to the "O" – objective findings - in the SOAP format). Some have wanted clinical findings for many years. How can these be classified? What is the point of including them in a classification, rather than as text elements in a record? - - Because there is a gap in standard

coding systems for clinical findings and this should be filled by ICPC. Is this not what terminologies like SNOMED-CT are for? This is not the purpose for a *classification.* Where would 3000 clinical findings go on the proposed ICPC-3 2 pager? We need to have the ability to record normal or abnormal findings. S. Fujita has been working on a classification of clinical findings for use in electronic records, and is willing to lead work to see if this is feasible.

- **DECISION: Shin Fujita will be asked to lead a group that will write a White Paper on the place to accommodate clinical findings in ICPC-3. WICC members will review the White Paper, and decide whether to move forward with this for ICPC-3.**

Tuesday 10 November: PM session
Chair: Mike Klinkman
Guest: Patricio Muniz

ICPC-3 work continued: development and classification tools for use by WICC.
General discussion led by Alejandro Orsonio.

This session began with a brief presentation on ontology tools by A. Orsonio:
There is knowledge in ICPC-2 that is not represented as structured knowledge, but as text, for example in the inclusion, exclusion criteria and in the alphabetic index to ICPC. It was suggested to move to a more structured way of storing this contextual information as clinical entities. WHO is also reviewing its approach to structuring the knowledge contained in ICD-10 in the update to ICD-11. One possible development tool is Protégé, an ontology editor developed at Stanford University. Protégé was demonstrated to the group.

Main points from discussion:

- The group discussed tools being developed by WHO for use in creatingICD-11, in particular the iCAT tool. This tool has been developed by the group at Stanford that developed Protégé. They have suggested that we could start with Protégé and move to iCAT when this is ready during the development of ICPC-3.
- WICC will need to make a decision about the tools we need to use for ICPC-3 development, but at present we don't have enough knowledge to make these decisions.

ACTION: Alejandro to provide the alphabetical index file from Protégé for the group to consider; interested members will review Protégé, other options. We will defer decision on which tool(s) to use at this time.

Adapting the ACG system to use ICPC.
Presentation by Patricio Muniz, Johns Hopkins University (patricio.muniz@jhu.edu; www.acg.jhsph.edu)

Ambulatory Care Groups (ACGs) use age, gender, diagnosis and treatment (ATC codes) data to generate predictive models of casemix groups and determine risk. They are applied

in the areas of health status monitoring, financing and payment, provider performance and high risk case organization. ICPC-2 is being incorporated into the ACG system, by mapping ICPC-2 to ICD-9-CM (this work is being done in Spain) and this is being checked against the ICPC-2 – ICD-10 map. The application of this will only be supported where an ICPC licence is in place. The Johns Hopkins staff are requesting assistance from WICC to validate this work from any existing databases containing sufficient utilization and ICPC data.

Main points from general discussion:

- Wonca core executive has met with the JHU lead (in Basel 9/09).
- WICC can neither approve nor disapprove of this work. Formal partnerships can only be negotiated with Wonca core executive.
- Individual WICC members are free to collaborate with the JHU team.
- At this point, there were no WICC members who indicated that they had appropriate data to be able to validate the work of the JHU team

ACTION: WICC members who have appropriate data to communicate with Patricio, and members were encouraged to identify other places appropriate data may be found, for example from Colleges or government sources. This collaborative opportunity will be supported as time and resources allow.

Process codes and ICPC-3.

General discussion led by Helena Britt.

Main points:

- Very little has happened with process codes since the last meeting.
- General discussion about whether process codes should be included as a core part of ICPC-3. Some processes (e.g. check-ups, immunisations, pap smears) may need to be included with the core group of process codes for ICPC-3 considering community care (public health) aspect of the core classification, with extra codes for more detail included in a separate classification or a supplemental "appendix" to ICPC.
- The use of ICPC process codes is, at present, limited to Australia, Belgium and the Netherlands.
- It was pointed out that removing the process codes from the core classification would create more room on the 2-pager for additional Component 1 and Component 7 content.
- The proposal for process coding submitted by E.Falkoe and M. Rosendal (tabled as part of the 2A/2N document) was discussed.
- General agreement that process codes should be an important part of ICPC-3. But how detailed this should be in the core version if ICPC-3, and whether we should consider ICHI, were not decided.
- The best positioning of process codes (in each chapter versus as separate chapter) is not clear
- It will be necessary to link to national terminologies
- WHO is developing ICHI, but its usefulness is not sure
- Consider re-drafting IC-Process-PC to supplement core ICPC-3

- Place or location of care may be important to include (home visit, e-visit, office, etc) in process classification (see IC-Process-PC)

ACTION: No decisions made after general discussion. The issues listed above should be considered by a Process working group to be re-created as part of ICPC-3 development.
ACTION: An electronic copy of ICPC-Process-PC will be circulated via the list by M. Kvist.

Patient preferences/goals and ICPC-3.
Discussion led by Mike Klinkman.
Main points:

- B. Bernstein has a system for including patient goals and targets with reminders in his EPR
- We need an understanding of what belongs in the taxonomy of patient goals as a first step toward incorporating this content into ICPC.
- This content might eventually fit as an "appendix", but probably does not fit within the core of ICPC-3.

Action: M.Klinkman and B. Bernstein, with assistance from the Structure working group, will investigate what is already available in this area that could be utilised.

Potential areas of collaboration in development of ICPC-3.
Discussion led by Mike Klinkman.
Risk factors and prevention
Kees van Boven stated that he and collaborators from the WHO-FIC group in the Netherlands have prepared a funding proposal to develop a risk factor classification. Richard Madden from WHO-FIC in Australia is also leading work on a risk factor classification.
ACTION: Helena Britt to facilitate communication between the two groups.

ICHI: The International Classification of Health Interventions, under development by WHO-FIC.
Work is proceeding slowly, but is a priority for WHO and WHO-FIC.
ACTION: Helena keeping in contact with Richard Madden.

Presentation:
MarcVerbeke (Belgium): Use of ICPC using the Belgian Thesaurus

Wednesday 11 November: AM session
Chair: Mike Klinkman

WICC Website.
Discussion led by Marc Jamoulle.
Main points:

- The current WICC Web presence is inadequate and unprofessional. Neither the official link for WICC on the Wonca website, nor the site developed by M. Margineau, have been updated for many years
- M. Jamoulle demonstrated his own website, developedin response to local need for training in ICPC (see http://trix.docpatient.net.)
- A Web-based e-learning program for training in ICPC for Danish GPs was demonstrated by M, Rosendal.
- T. Kuehlein presented his ICPC explanation pages in German, and offered to translate them into English to put on the website.
- General discussion on core content and layout of a fully-functional WICC website that would facilitate the collaborative work of WICC members.
- M. Jamoulle suggested developing a new ICPC website, with both a public website for external viewing and password-protected internal access for WICC members that could be used for the future development of ICPC-3
- We should also have for each full member, a short CV and a conflict of interest statement on the web site.
- A funding source is needed to develop this, but unless directly tied to ICPC-3 development it will likely not be funded by Wonca.

DECISION: At this point, the most practical solution is for WICC members to develop our own Website, then ask Wonca to create a link between the new WICC website and the official Wonca website. This implies that we (WICC) will take responsibility for the website, with no guarantee of financial support from Wonca.

ACTION: E. Falkoe and M.Rosendal will investigate with the Danish government whether the e-learning program can be translated into other languages, both in terms of content and technical aspects.
ACTION: WICC will ask Wonca webmaster to link the current http://trix.docpatient.net. Site to the main Wonca website.
ACTION: M. Jamoulle will attempt to translate more of the http://trix.docpatient.net. website into English
ACTION: M. Jamoulle is willing to take the lead for the website work, with support from G. Gervas, M. deJonghe, E. Falkoe, G. Miller, and possibly A. Orsonio as a Website Working Group.
ACTION: Working group will be charged with advising WICC Chair on development costs (particularly for ICPC-3 and Protégé work).
ACTION: Working group will develop a formal project plan for website development.

Nominations Committee.
Discussion led by Juan Gervas.
Two elected positions are available, each for 3 years.
One on the Executive Committee (currently held by Nick Booth)
One on the Nominations Committee (currently held by Juan Gervas).
Both were re-nominated for their positions. As there were no other nominations received, both were elected by acclamation.
ACTION:
Nick Booth elected to the Executive Committee for 3 year term.
Juan Gervas elected to the Nominations Committee for 3 year term.

Other discussion:

- J. Gervas will review WICC membership list in two weeks, to identify members who have not communicated with WICC in past year. This will be forwarded to the Executive for review.
- J. Gervas commented that the group needs new members to modify the age and sex distribution of the committee

ACTION: Nominations group will review ways to improve recruitment of interested and capable primary care classification experts.

Translations.
Discussion led by Marten Kvist.
Main points:

- New translations created since the last meeting included Icelandic, Italian and Slovenian translations.
- M.Kvist has not seen some of the translations listed as complete translations on the KITH website. Some have not been formally received and the information on the KITH website is not complete. The information on the KITH website does not state whether the translation is ICPC-1 or ICPC-2.
- There is a priority need to translate ICPC into Arabic. M. Kvist has had contact with Syria regarding translating the 2-pager, but the translation has not been made. M. Jamoulle had contact with someone from Tunisia about the Arabic translation, but this has not progressed. There may be alternate contacts in Tunisia or Morocco. Michael Kidd (Wonca executive member) has suggested that Dr Nabil Kurashi from the Eastern Mediterranean section of Wonca may assist.
- An Indonesian translation may be in progress, but status is not certain. There are plans to translate into Bengali and Tamil languages.
- General discussion reinforcing stated WICC policy for translation and validation, and suggestions for encouraging new translations.

ACTION: M. Kvist to ask Wonca regional offices if there is a translator who could be identified in each region.
ACTION: H. Britt will provide M. Kvist with name of a potential contact for the Indonesian translation.

Wednesday 11 November: PM session
Chair: Gustavo Gusso

Joint session with Brazilian General Practitioners, members of Brazilian Ministry of Health, and developers of EHR software products.

Thursday 12 November: AM session
Chair: Mike Klinkman

ICPC Bibliography
Discussion led by Graeme Miller.
Main points:

- T. Gardner moved during the past year, and had little time, so not a lot has been done on the Bibliography.
- G. Miller reviewed and added new publications in June 2009, but the bibliography needs an update to cover period from July 2009-present.
- The Bibliography needs to be more easily accessible. It is currently available on the FMRC web site. It needs to be put somewhere else at a later date. It also needs to be searchable.

ACTION: none.

Review of decisions and actions taken at meeting, action plan for WICC.
Discussion led by Mike Klinkman.

See WICC ACTION PLAN 2009-2010, at beginning of this document.

Next meetings for WICC.

1. Wonca World Congress 2010, Cancun

- M. Klinkman, M. Rosendal, K. van Boven will present, K. Mohan will attend.
- Group will consider presenting as Symposium on ICPC-3 issues

2. Annual WICC meeting, 11-15 October 2010, Ghent, Belgium

- On 16 October there is also a major celebration for Ghent
- M.Verbeke presentation on city and conference venue: international airport is in Brussels. Then train to Ghent – 40-45 minutes. WICC members will be picked up from the railway station in Ghent if we let them know.
- Discussion of when the working parties could meet during the scheduled meeting time. Suggested this should be on the 15th as the Terminology/Structure Working Party will all need to go to Canada for IHTSDO and not be available in Ghent on 15th.
- There is also a CEN meeting in Netherlands on 17th. Some may wish to attend

3. Options for WICC Annual Meeting 2011

- J. Gervas offered to host in Madrid: Sunday 16–Thursday 20 October were suggested dates**.**
- Also have unofficial offer from S. Juncosa to host in Barcelona at roughly same dates.
- General agreement that WICC should meet in Spain, J. Gervas and S. Juncosa will sort out location and dates.

4. Possible meetings at Wonca regional conferences

- Wonca executive have strongly encouraged WICC to meet at Wonca conferences so that WICC work can be highlighted and publicized for members
- Some WICC members will meet at Cancun, and will provide visibility and access to WICC for conference attendees
- Given current funding limitations, not feasible to expect WICC members to pay registration fees and travel for Wonca Conference, then have interrupted work time during meeting. The best option will be for Working Groups to meet at regional Wonca conferences – will provide time for face-to-face work as well as highlighting WICC presence.
- Terminology/Structure group can meet opportunistically at IHTSDO meetings.

Adjournment.

The Chair thanked all participants for their contribution to a very successful meeting.

Special thanks were given to Gustavo Gusso for his outstanding effort in organizing and hosting the meeting in Florianopolis, a beautiful and inspiring venue.

There being no further business, the 2009 WICC Annual Meeting was adjourned at 11.45 AM on 12 November.

APPENDIX

WICC 2008-09 Scorecard Summary of agreements on ICPC-3 from Brasov, and **s**tatus of action items agreed upon in Brasov

Basel Summary from meeting between Wonca Core Executive and WICC executive, September 2009

WICC 2008-09 Scorecard.

1. What we agreed in Brasov about ICPC-3.

- Difficult to agree on basic structure, given variation in use
- Primary needs
  - More space necessary (but how much?)
  - Improve risk factors and prevention
  - Add several new rubrics
  - Consider fusion of x-y chapters, revise P and Z
  - Create new maps to ICD and SNOMED,
  - Review all the rubrics in current version – to correct content
- Where possible, base decisions on data not opinion
  - begin with frequency of use in current applications
- **We also agreed on overall process of revision**
  - Working Groups continue in their roles
  - WG heads will meet together with WICC Exec to review WG recommendations
  - then reach consensus on basic structure and overall content
  - This consensus "blueprint" for ICPC will be presented to full WICC for discussion and approval

2. Scorecard on action items from Brasov.

Task	***status***
GENERAL	
WICC executive will continue to meet monthly	**DONE**
Helena Britt and Julie O'Halloran will develop and circulate a White Paper on "space" proposal to WICC members in 6 weeks time	**DONE**
Process and Risk Factor WGs will prepare White Papers	**DONE (in part)**
Mike Klinkman will propose to Wonca that WG Heads and Exec meet – funded by WONCA/WICC- in Hong Kong in April 09, and possibly in Basel in September 09	**DONE**
Mike Klinkman will prepare a white paper on the "ICPC blueprint" for Argentina/Brazil November 09 so we can make decisions	**NOT DONE**
ICPC Training	
Marc Jamoulle will head an ad hoc working group to investigate training resources (with Gojo, Gustavo, and Marius).	**DONE**

All members to provide Marc Jamoulle with concepts and materials used in their individual efforts at training.	**??**
WICC Website	
Mike Klinkman to make a formal proposal to Wonca Exec for Wonca site to formally host our web page.	**DONE (informal)**
Requirements for the website will include: education (online tutorials), documents that support education, updated contact details, links to KITH, and bibliography	**NOT DONE**
WICC will supervise and liase with the Wonca web designer.	**NOT DONE**
Maintenance of ICPC	
Anders Grimsmo will work with KITH on revising their proposal	**DONE**
Mike Klinkman will discuss funding support for maintenance function with Wonca core executive, as detailed in the ICPC-3 Business Plan and budget	**DONE (no answer)**
Translations	
Graeme Miller, Bob Bernstein, Mike Klinkman, Marten Kvist to examine existing contract wording and revise	**NOT DONE**
Translations database to be updated by Marten Kvist and re-published, All to forward information to Marten, and we will query Inge to see whether she holds a more current database	**NOT DONE**
Marten Kvist will be the contact person for translations, and enquiries about translations should be directed to him.	**DONE**

BASEL SUMMARY

Summary of meeting between Wonca Core Executive and WICC Executive
17 September 2009, Basel, Switzerland

Wonca Core Executive: Chris van Weel, President; Richard Roberts, President-Elect; Alfred Loh, CEO. Michael Kidd, Honorary Treasurer, was not able to attend.
WICC Executive: Mike Klinkman, Chair; Anders Grimsmo, Deputy Chair; Francois Mennerat; Nick Booth (by Skype connection). Helena Britt was unable to attend.

1. Wonca's current financial position

Since 2000, Wonca has transformed into a more professional organization with incorporation as Wonca International, creation of the Wonca Trust, and recovery from years of deficit spending. More recently, rapid expansion of Wonca, with the addition of new regions and member organizations primarily from less affluent countries, and increasing Wonca activity, with the establishment of new Working Parties and increasing engagement with WHO, have created new budget demands without sufficient funding. At the same time, the Wonca Executive have committed to reduce funding from industry. Wonca plans its budgets in 3-year cycles, from one triennial World Council/Conference to the next. The year of a World Conference typically represents the maximum revenue in the cycle because of levies from the World Conference. A summary of the current triennial budget is attached as Table 1 (all $ amounts are in U.S. dollars, USD). There are 13 Standing Committees (SC) and Working Parties (WP). *WICC has historically represented about one third of the total annual expenditures for SC & WP.*

The global recession and the decision of the Wonca Executive to reduce reliance on industry funding have created a significant budget challenge for Wonca. Virtually every area of discretionary spending had its budget cut in 2009. The Wonca Executive reduced its number of meetings from 3 to 1 per year. Some Working Parties have received no funds in 2009. WICC has been spared these budget cut backs.

Planning for the future, the Executive approved the GROW project, a strategic initiative to put Wonca on a more secure financial footing. The GROW committee made the following findings:

- It will not be possible to increase Member Organizations' Annual Dues to Wonca. The largest portion of dues comes from three countries (US $100,000; UK $40,000; Canada $30,000), which have reported that their own financial situations preclude additional contribution.
- Wonca swill have to look at other means to obtain resources to better support its activities and subsidiaries.
- The GROW proposals, if adopted by the World Council at its next meeting in May 2010, will require 3-5 years to implement.

For the next few years, budgets will be very lean and it is very unlikely that Wonca can increase support to WICC significantly or to any of its other Working Parties and

Committees. New ICPC licensing agreements may create some additional revenue, but that is speculative at this stage.

2. Wonca's commitment to WICC and ICPC

Working Parties have used a number of means to fund their activities and to create value for World Wonca. Some have put on workshops and conferences (Quality, Women), published monographs (Mental Health, Quality), conducted fund raising (Women), and so on. WICC is Wonca's oldest Working Party and has received funding for its activities since 1974. Records are readily accessible only since 1993 and show that since that time WICC has received $332,730 in funding support and generated $237,623 in revenues, mainly from license royalties from the 10 countries that have acquired ICPC since its first sale to Belgium in 2002 (see Table 2).

World Wonca does not have sufficient resources to alone provide all the funding needed for the development of ICPC-3 and will require partners to fund such an initiative. The Wonca Executive understand the value of and are committed to ICPC. The Wonca Executive view the work of WICC as a core part of the Wonca mission. It has demonstrated that commitment by funding WICC longer and more generously than any other Wonca Working Party. As important as funding have been the considerable efforts of the Wonca Secretariat and Executive to promote ICPC across the world. The development of ICPC-3 is a very high priority for Wonca, because of its potential value as a tool to describe the content of the practice of family doctors and to improve clinical care. The role of WICC is seen as the development and maintenance of ICPC and harmonization of ICPC with other classification and terminology tools. WICC's role in integration of ICPC into health information technology is developing but not clear, especially given the work of other Wonca entities such as the Working Party on Informatics. The oversight, financing, licensing, marketing, training, everyday use, and external relationships arising out of ICPC remain the responsibility of World Wonca and its Executive.

3. The current situation in health classification

Health care information technology is developing rapidly, with large organizations moving quickly to standardize classification and terminology tools. The speed with which this is moving makes it very difficult for a volunteer committee with few resources to effectively participate in classification development. **This is a major threat to the survival of ICPC as a mainstream classification.**

It is also clear that large organizations do not know how to develop classification and terminology tools that are fit-for-purpose for primary health care. That creates an opportunity for Wonca and WICC to influence or guide other organizations' efforts. WICC has taken the initiative to create formal relationships with IHTSDO and WHO to advance primary care agendas in each organization.

Current gaps in classification/terminology:

- Gap between developed and developing countries (EHR vs. none, the "information paradox" described by WHO)
- Gap between English-speaking and other language/culture (SNOMED's problem)
- Gap between primary and specialty care, family doctor and hospital, as exemplified by incompatibility of electronic record "solutions" for each setting
- Gap between patient (person) and doctor/hospital/health care system – seen in movement for patient-centered/person-based care
- Gap between competing health IT products (lack of interoperability, absence of data standards)

The time window for primary care to influence the development of classification and terminology standards will be very short – 2 to 3 years at most. WHO is assembling support to take the lead role in health IT for developing countries with the ROADS Initiative, and it will soon outpace the slow diffusion of ICPC into developing regions. In some developed countries, commitments to SNOMED-CT will obscure the need for data structure and standards that work in primary care. In other developed countries, concerns about the viability of ICPC may lead to adoption of ICD/WHO-FIC or SNOMED-based terminologies as standards. Other rapidly developing classification systems, such as Adjusted Care Groups (ACG) developed by Johns Hopkins University, use multiple classification sources (ICD, SNOMED, DSM, ICPC) to generate a more comprehensive snapshot of an individual's health status and health resource use. Work on ICPC-3 will proceed very slowly, if at all, without additional funding, and we are likely to miss this window of opportunity. At present, maintenance of ICPC-2 requires the primary attention and resources of WICC, in light of its status as the standard primary care classification in several countries.

4. Potential solution: creation of a Primary Care Classification Consortium

Several options for maintenance of ICPC-2 and development of ICPC-3 were prepared by Mike Klinkman in advance and served as the framework for the meeting discussion (see Appendix). Wonca Core Executive and WICC Executive agreed upon Option 5a as the preferred course of action:

Option 5a. Collaboration through a new consortium of national license holding states
Wonca creates a formal consortium, a "primary care expert group" with agreed working relationships with IHTSDO and WHO. The consortium would be chartered by Wonca. Its organizational structure and internal governance could be patterned after IHTSDO. It would be funded in large part by national Colleges or health ministries committed to national use of ICPC. In this model, WICC would serve as the consortium "expert group members" representing their country/College or region.

Members of this consortium would represent primary care classification in various forums. Members would serve in the IHTSDO GP/FP SIG, as TAG members in WHO, and as participants in the WHO-FIC working groups.

Discussion focused on how the Consortium would be organized. More detail is needed, but there was general agreement that this option should be explored.

5. Action steps

By end of October 2009 – Wonca and IHTSDO sign collaboration agreement. Wonca will seek guidance for consortium from IHTSDO on Articles of Incorporation.

By 7 November 2009 – Wonca Core executive presents to full Executive for approval.
IF APPROVED-

1. Draft Articles of Incorporation will be available by the time of the WICC annual meeting in Florianopolis on 8 November
2. Wonca Core Executive will take lead to approach countries in which ICPC is currently a national data standard, or where ICPC has widespread adoption, to give an "opportunity to invest" in the new Consortium.
3. WICC will identify a local champion in each of these countries, who can serve as primary contact for more detailed discussion and questions. Example: Anders Grimsmo in Norway. The first group of local champions will be identified at the WICC annual meeting in Florianopolis.
4. A more detailed time line for creation of the consortium and fundraising efforts will be developed by the end of 2009.

Table 1 - Summary of World Wonca current triennial budget (in US$)

	2007 actual Amount	%	2008 actual Amount	%	2009 budget Amount	%
Income						
Dues	315,188	33%	326,267	57%	320,400	66%
Industry	169,256	18%	138,593	24%	85,000	18%
Conference levies	271,456	28%	79,775	14%	51,000	11%
Royalties	141,653	15%	9,435	2%	22,500	5%
Other	64,422	7%	19,102	3%	4,500	1%
Total Income	961,975	100%	573,172	100%	483,400	100%
Expenses						
Secretariat & CEO	272,754	39%	302,045	42%	312,000	44%
Executive	192,259	28%	125,796	18%	100,000	14%
Regional development	20,409	3%	60,536	8%	37,500	5%
SC & WP	52,823	8%	67,889	9%	75,000	11%
WICC	***17,986***	***34%***	***23,292***	***34%***	***27,500***	***37%***
Publications/Website	127,245	18%	123,180	17%	94,500	13%
Others	32,923	5%	38,648	5%	87,100	12%
Total Expenses	698,413	100%	718,095	100%	706,100	100%
SURPLUS / (DEFICIT)	**263,562**		**(144,923)**		**(222,700)**	

Table 2 - Wonca International Inc
Records of Sale of ICPC2 National Licence

Countries	Licensee	Amount Billed	Date of Sale of Licence	Date of payment received
		US$		
Belgium	Belgian Government	$32,042	23-Jul-02	19-Aug-02
Norway	Directorate of Health and Social Affairs Norway	$21,478	15-Feb-04	29-Mar-04
Portugal	Portuguese Association of GP	$10,771	31-Mar-06	12-Jun-06
Switzerland	Swiss Society of General Medicine	$30,810	7-Jan-07	26-Dec-06
Finland	Association of Finnish Local and Regional Authorities	$15,800	10-Jan-07	16-Apr-07
Turkey	Republic of Turkey, Ministry of Health	$45,575	27-Aug-07 (revised on 23 May 08)	8-Jul-08
Brazil	Brazilian Society of Family & Community Medicine	$45,747	28-Sep-07	8-Jul-08
Iceland	Directorate of Health Iceland	$12,000	17-Dec-07	10-Jan-08
Denmark	Danish College of General Practitioners	$18,400	15-May-08	6-Jun-08
Georgia	ICPC National Licence sold to Georgia	$5,000	1-Apr-09	2-Jun-09
	Total sales as at September 2009 :	**$237,623**		

Appendix - Options for Wonca regarding ICPC maintenance and development.

Background notes for discussion with Wonca core executive 17 September.

Assumptions that need to be confirmed:
1. Wonca is committed to maintenance of ICPC-2 and development of ICPC-3 as a core activity that impacts quality of care, education, and research
2. Wonca is willing to provide international "governance" (accountability) for the quality of classification and terminology products related to primary care
3. Wonca is prepared to seek funding to support its classification activity

Option 1. Sell ICPC
If Wonca leadership does not consider classification part of its core mission, then it makes most sense for it to completely divest.

Option 2. Business partner
Wonca identifies a commercial partner (software vendor) or governmental consortium that invests in development of ICPC-3 in return for IP rights, then implements and markets the classification. Some Wonca/WICC members are funded to do the developmental work, likely in collaboration with experts from the funding bodies.
Maintenance and governance are provided by the partner. This will require withdrawal from our pending MOU with IHTSDO.

Option 3. Status quo, volunteer activity
WICC continues to work under its current structure, with committed volunteers working on maintenance of ICPC-2, updating of map(s), and minor changes or additions to ICPC to accommodate new diagnostic categories. As time and resources allow, Wonca/WICC members will work with classification experts from other organizations. ICPC-3 will be at most a minor update given the time and effort available from volunteers.

Option 4. Assimilation into SDOs
A subset of current WICC members is nominated to join the GP/FPSIG of IHTSDO and a similar Advisory Group of WHO, and participates as primary care content area experts in each organization as the next generation of classification and terminology products is produced. WICC continues to exist as a coordinating committee within Wonca to coordinate work of the expert groups and to advocate for needs of their own countries, but it does not produce new classification products. An ICPC-3 will not be produced, but there will be primary care-friendly versions of ICD-11 and SNOMED-CT.

Option 5. Collaboration with SDOs.
Wonca and WICC maintain independent existence while participating as primary care expert groups within IHTSDO and WHO. Work supported through the other organizations supplements work done on ICPC-3. Work done on ICPC is structured within Working Groups composed of experts who are funded to lead activity. Full WICC meetings serve to review and set direction for the work, and to coordinate with other

organizations. WICC requires additional funding resources to complete development of ICPC-3 and to "harmonize" with ICD-11 and SNOMED-CT.

Option 5a. Collaboration through a new consortium of national license holding states

As in Option 5, but WICC becomes a formal consortium, a "primary care expert group" with agreed working relationships with IHTSDO and WHO. This consortium would be chartered and funded by national Colleges or national health ministries who have committed to national use of ICPC. Expert group members would represent their country, region, or College. Governance agreements could be patterned after the IHTSDO model or the WHO Collaborating Centers model. Wonca could maintain oversight or partial "ownership", to be determined.

The primary care expert group will constitute a subset of the full (current) WICC. The work will proceed as in Option 5, with core work done on ICPC in Working Groups composed of experts who are funded to lead activity. The full WICC will include the expert group and less-involved members, much as it does now. WICC meetings will serve to review and set direction for the work, and to coordinate with other organizations. The additional funding resources necessary to complete development of ICPC-3 and to "harmonize" with ICD-11 and SNOMED-CT will come in large part from license holding members, but "pump-priming" funding from philanthropic sources will be needed.

The preferred option of WICC is Option 5 / 5a.

Option 5 is the closest match to the vision of the ICPC-3 Business Plan. Accomplishments to date have been in line with this option.

- creation of WICC Working Groups (most successful has been Terminology)
- MOU with IHTSDO
- submission by the GP/FP SIG of a work plan for SNOMED-CT refset and SNOMED-to-ICPC map
- closer collaboration with WHO-FIC
- successful negotiation for role of primary care classification liaison within WHO
- invitations to collaborate in health IT standards meetings (as in ROADS)

But we can not proceed from this point without identifying a funding source to support the work. We are stuck in development, as volunteer time is insufficient to enable sufficient thought or planning to settle on the necessary changes to include in ICPC-3, to carry out development and testing, and to create a plan for maintenance.

Here is one example of the importance of funding support. Several WICC members were invited to the WHO-FIC conference in Seoul in October, which has the theme of Primary Care, but they were expected to cover their own expenses as well as pay meeting registration fees. This precluded their attendance at a meeting where our visible presence would have had high impact. In contrast, WHO Collaborating Center members have funding support to cover this expense as their work is supported by health ministries or regional health authorities.

We request assistance from Wonca in approaching countries, Colleges, other philanthropic foundations, and commercial consortia to identify funding to support ICPC-3 development under Option 5/5a. We realize that we will likely need to create an internal governance structure for this effort that is more professional than what we have been able to create within WICC, and if option 5a is chosen we will need to create a completely new governance structure.