Wonca International Classification Committee
2011 Annual Meeting
Barcelona, Spain
3-7 October, 2011

MEETING SUMMARY.

GOALS FOR THE BARCELONA MEETING.

1. **Complete corrections and finalize content of ICPC-2e**
2. **Approve the work plan for the IHTSDO FP/GP SIG: completion of a SNOMED-CT primary care refset, and SNOMED refset- ICPC map**
3. **Engage WHO in active collaboration on the primary care content for ICD-11, and harmonization with ICPC**
4. **Agree on a set of common "work tools" for classification maintenance, translations, and internal and external communications.**

WICC ACTION PLAN 2011-2012.

1. Complete "statement of interests" (conflict of interest statements) for all members.
Responsible: Juan Gervas. Due Date: 11/11

2. Update working group actions (group lead: Kees van Boven)
2.1 Will use ClaM and ClaM browser for Update work to test its usefulness
Responsible: Kees van Boven. Due Date: Now
2.2 WICC members will post comments on ICPC 2 4.2 *beta* to browser
Responsible: All. Due Date: 11/1/11
2.3 Update group will collate comments, post ICPC 2 4.2 with agreed changes to KITH
Responsible: Kees van Boven. Due Date: 12/1/11
2.4 Update group will review items without consensus, report back at 2012 Annual Meeting
Responsible: Kees van Boven. Due Date: 9/12

3. Process working group actions (group lead: Erik Falkoe)
3.1 Will post proposed inclusion-exclusion criteria to browser
Responsible: Erik Falkoe. Due Date: 11/1/2011
3.2 WICC will post comments on criteria to browser
Responsible: All. Due Date: 12/1/2011
3.3 Process group will collate comments, post criteria to KITH browser
Responsible: Erik Falkoe. Due Date: 1/1/2012

4. Complete and circulate "coding recommendations" document to guide users of ICPC
Responsible: Thomas Kuehlein. Date: TBA

5. Risk factor working group (lead: TBA)
5.1 Proposal for "risk factor" labeling will be circulated to WICC for comment
Responsible: Mike Klinkman. Due Date: 1/1/2012

5.2 WICC will post comments - ? Through Google groups?
Responsible: All. Due date: ongoing

5.3 A small working group will review, prepare final document for review and adoption at 2012 meeting
Responsible: All. Due Date: 9/2012

6. WHO collaboration proposal for work on ICD-11, harmonization with ICPC. Planned action items:
Identify initial cohort of WICC group members
Review content in ICD-11 alpha, suggest additions
Train WICC group members in iCAT
Create primary care TAG
Give WICC control over constructing "primary care view" in ICD-11
WICC will work to create primary care view of ICF
Responsible: Mike Klinkman. Due Date: Ongoing

7. Further planning for Primary Care Classification Consortium: planned action items
Prepare document for review by Wonca executive
Approach Colleges with WHO/ ICPC-3 work plan
Work with Wonca executive on management and transition to Consortium
Responsible: Mike Klinkman. Due Date: Ongoing

8. Prepare list of budget requests for Wonca review for 2012 budget cycle
Responsible: Mike Klinkman, others. Due Date: 11/1/11

9. Continue with IHTSDO FP/GP SIG work plan (as reviewed in meeting)
Responsible: Graeme Miller, Nick Booth. Due Date: ongoing

10. Circulate existing Spanish work on ACG-ICPC to orient WICC to issues in integrating ICPC with ACG
Responsible: Sebastian Juncosa, Juan Gervas. Due Date: ASAP

11. WICC executive will explore collaboration opportunities with ACG International
Responsible: Mike Klinkman. Due Date: 1/1/2012

12. Begin pilot field studies for ICF (examples from minutes)
Responsible: TBA. Due Date: ongoing

13. WICC executive will approach Wonca executive to advocate for translation of ICPC into high-priority languages (ex: Arabic)
Responsible: TBA. Due Date: 12/31/11

14. WICC executive will approach Wonca executive regarding proposed PH3C website
Responsible: Mike Klinkman. Due Date: 11/11

15. **Public launch of PH3C website**

Responsible: Marc Jamoulle. Due Date: 1/1/2012

16. Work tools for 2011-2012 were agreed upon:
Update group will work with ClaM, check out iCAT when available
Country leads will interface with Update group via browser
Google groups will be used for general work, internal communication
Responsible: All. Due Date: ongoing

17. Circulate "ICPC-3" blueprint draft
Responsible: Mike Klinkman, WICC executive. Due Date: 1/1/2012

Wonca International Classification Committee
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MINUTES OF THE MEETING.

GOALS FOR THE BARCELONA MEETING.

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Monday 3 October: PM session.
Chair: Mike Klinkman

Welcome and Introduction:
The Chair announced the opening of the 35th annual meeting of WICC and welcomed members and observers. Sebastian Juncosa, local host, and Josep Basora, President of SemFYC (Catalan GP association), welcomed the group to Barcelona and provided practical information about the meeting and venue.

Attendance: 22 members, 11 observers, 1 guest (Wed 5 Oct).
Members present:

Bernstein, Bob (Canada) – BB
Britt, Helena (Australia) - HB
Booth, Nick (UK) - NB
Boven, Kees van (The Netherlands) – KB
Falkoe, Erik (Denmark) - EF
Gardner, Tim (New Zealand) - TG
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
Letrilliart, Laurent (France) – LL
Mennerat, Francois (France) – FM
Miller, Graeme (Australia) – GM

Mohan, Krishna (India) – KM
Simkus, Ray (Canada) - RS
Soler, Jean Karl (Malta) - JKS
Zorz, Gojimir (Slovenia) - GZ

Associate members present:

Baricevic, Ines (Croatia)
Boeckxstaens, Pauline (Belgium)
Buono, Nicola (Italy)
Moosa, Shabir (South Africa)
Petrazzuoli, Ferdinando (Italy)
Schrans, Diego (Belgium)

Observers present:

Bhend, Heinz (Switzerland)
Landsberg, Gustavo (Brazil)
Pinto, Daniel (Portugal)
Savolainen, Tuija (Finland)
Vrca Botica, Marija (Croatia)

Guest present (Wednesday, 5 October):

Jakob, Robert (WHO Classification Unit, Geneva)

Apologies received from:

Bentzen, Niels (Denmark)
deJonghe, Michel (Belgium)
de Maeseneer, Jan (Belgium)
Dovey, Susan (New Zealand)
Fujita, Shin (Japan)
Marginean, Marius (Romania)
Marshall, Ian (Australia)
Mendis, Kumara (Australia)
O'Halloran, Julie (Australia)
Orsonio, Alejandro (Argentina)
Rosendal, Marianne (Denmark)
Sagen, Terje (Norway)
Verbeke, Marc (Belgium)

Not present:

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

Approval of minutes:

Minutes from the 2010 Annual Meeting in Ghent were 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) and a review of the process for members to submit a Declaration of Interest were presented by Juan Gervas, head of the Nominations Committee.

WICC History and Mission:

Discussion led by WICC executive.
A brief review to orient new members and attendees to the mission and history of WICC was led by Helena Britt
(NOTE: formal WICC mission statement and summary document listing all WICC meetings and main products produced by WICC available at WICC website, www.p3hc.org).

Chair's Report: State of WICC 2010:

Presented by Mike Klinkman**.** (See PowerPoint presentation at WICC website)
Main points:

- Currently 41 members from 25 countries
- Increasing numbers of observers, including some from under-represented areas
- ICPC use in 2011 – slowly expanding in new areas (Brazil) and inquiries from some commercial firms
- Review of 2010 meeting and status of work on each of Action Plan items: in general, items related to ICPC-2 maintenance completed, ICPC-3 on hold due to resource constraints
- Impressions of observers at 2010 meeting:
    - WICC must develop partnerships with business, technology suppliers
    - It's very difficult to overcome barriers to use even simple health IT solutions
    - Practising clinicians' needs are not the same as health authorities' needs (implications for "standards" choice)
    - ICPC is very much disease-focused
    - There is a steep learning curve for ICPC, and training needs are huge
- External work with IHTSDO and WHO proceeding as planned and approved
- Described prior decisions on next generation of classification tools and data structure in which they will fit, and constraints in moving forward
- Review of state of finances: process for applying for funds from Wonca executive, unfunded funding requests, and consequence of limited progress in classification development
- Status of planning toward goal of forming Primary Care Classification Consortium
- Overall plan and goals for this meeting
    - Complete corrections and finalize content of ICPC-2e
    - Approve the work plan for the IHTSDO FP/GP SIG - completion of a SNOMED-CT primary care refset, and SNOMED refset- ICPC map
    - Engage WHO in active collaboration on the primary care content for ICD-11, and harmonization with ICPC
    - Agree on a set of common "work tools" for classification maintenance, translations, and internal and external communications.

Session ended with general discussion of items in the report.

Tuesday 4 October: AM session
Chair: Mike Klinkman

THEME: INTERNAL WORK ON ICPC.

<u>ICPC-2 Update work</u>

Presentation and discussion led by Kees van Boven.
The work of the Update working group since the 2010 Annual meeting was presented. All requests for corrections in content and mapping were collected and reviewed by the group over the past several months, and proposed changes were listed for review and approval at this session. KvB presented the proposed new version, ICPC2e v4.2x beta.
General discussion was held. The work of the group was in principle agreed to with comments incorporated as agreed by the full Committee.

Actions: The full Committee approved thefollowing actions.

1. **The change period is open for 1 further month; WICC members were encouraged to review ICPC2ev4.2x beta on browser and comment on any remaining questions or issues**
2. **Comment period will be closed on 1 November 2011**
3. **The Update group will review and post items that do not have agreement for final comment.**
4. **On 1 December 2011 the draft final version will posted for comment.**
5. **On 1 Jan 2012 the final version will be posted and sent to KITH.**
6. **Unresolved issues will be held over for discussion by Update group and resolution during 2012.**
7. **The Update group is open for new members, but working size of 8 is ideal.**

The Update working group was congratulated for its work during the year, and given a mandate for continued operation to resolve current content issues and work to improve Process classification (see below).

Kees van Boven next demonstrated the classification working tool CLAM, used by the Update group during 2011. CLAM was developed at Radboud Univeristy in Nijmegen, and was offered on trial to the Update group. Under terms of the agreement, CLAM can be used by a limited number of WICC members for 3 years for free. For continued use beyond that point, a one-time license fee of $3000 will be charged.

General discussion on CLAM.

- Can we export CLAM output to another classification management tool, or similar software? In general, YES, but not tested for all tools.
- WICC may need to budget $3000 from its limited budget in future, not sure how many users this will cover. May need to negotiate reduced price.
- Cost may be covered by the EU project "*Transform*" : WICC member Jean Karl Soler is a lead in that project and will check this.

Action: Update working group will continue to work with CLAM in 2011-2012.

<u>Guidelines on how to use ICPC (“classification use rules”)</u>

Presentation and discussion led by Thomas Kuehlein.

This discussion topic was scheduled to improve clarity in presentation of classification work, and to improve consistency in coding in field use of ICPC. General recommendations:

- it is best to use the word “class” for an entity, not “rubric”
- three levels of classes for diagnoses – level A should never be used twice (DM, MS), level B would be unlikely to be used twice (such as 2 cancers in the same organ system), level C is unrestricted
- component 1 classes can be used more than once, for the start of each new episode of care
- components 2-6 should never be used as an episode title at all

Several rules were proposed to improve consistency of recording component 7 diagnoses.

1. only use a class once if defined pathophysiology, or described syndrome that is recurrent or chronic (ex: diabetes, multiple sclerosis)
2. recurrent infectious diseases (ex: UTI) should always be coded as a new episode [general discussion followed with dissent]
3. classes including diseases that may occur at different sites should be coded only once (ex: glaucoma, arthritis, diabetic retinopathy) [general discussion followed with dissent]
4. exacerbations and recurrences should be coded in the main episode (ex: exacerbations of COPD, recurrences of malignancies or some infections like herpes zoster)
5. complications of a disease should be coded as a new episode if the complication is clinically important (ex: diabetic retinopathy, glomerulonephritis) [general discussion followed with dissent]
6. in residual classes, the class code of the episode can be used more than once if it is a different disease in the same class (ex: A77 “viral disease other/NOS”, A76 “viral exanthema, other”)

Tuesday 4 October: PM session
Chair: Mike Klinkman

<u>Continued discussion: guidelines on how to use ICPC (“coding rules”)</u>

Thomas Kuehlein led a general discussion on further development of this content.

General discussion on ICPC coding rules.

- The primary goal is to give guidance about how to use the classification in an EHR - implementation instructions, guiding principles
- Is there a difference between diagnosis in problem list, and in an episode of care? We need a clear recommendation
- Coding events can be stigmatizing when using psychiatric terms. For example, a schizophrenic reaction that occurs ONCE in a lifetime is not schizophrenia
- Should we create a general recommendation for the EHR problem list and make the episode of care idea more explicit in our recommendation for use of ICPC? What is the link between structure and terminology? In Australia, the practice accreditation process is a driving force to push vendors to make better products, should we follow this approach?
- Should we make recommendations for how a “good” EHR should present problems... examples given included ACE –induced cough, penicillin allergy, schizophrenia

- EHR structures are significantly different one from another. The terminology does not have to drive coding in a record that has separate categories for events or different types of information (example – allergies). In an episode based record the terminology DOES drive categories.
- To be widely adopted, ICPC must be useful in clinical practice. In Denmark both the problem list (active episode) AND encounter list are required of vendors and users can filter by episode.

Action: A small group of WICC volunteers will work with Thomas Kuehlein to develop a publishable White Paper on this topic, will revised these proposed rules, and will report back to the full WICC.

Revising and updating process component of ICPC.

Presentation and discussion led by Erik Falkoe.

A few members of the Update group have updated process codes with inclusion criteria and cross references for several reasons: to improve reliability of coding, to guide precise and granular mapping to other classifications and terminologies, to enable overview of relevant processes to the clinical situation, and to inspire the process components for ICPC 3. As an example, in Denmark they send ICD-10 codes to hospitals and get coded hospital discharge summaries in ICD-10, so they must map them back to ICPC in the GP record. The initial draft version of the revised process component, with inclusion and exclusion criteria, was presented for discussion.

General discussion on the draft:

- All splits need a ragbag
- Need Swedish input (they have worked on a process classification)
- Discussion of whether classes must be linked to specific Chapter in ICPC, as in ICPC-2. At this point, general consensus that all remain in chapter A, but there are clearly advantages and disadvantages. If using native ICPC and following original manual coding process it is easier to use chapters.
- More granularity is clearly needed... we should extend it even further in next revision.
- How should we classify HOSPITAL information or things done OUTSIDE the practice? There is no standard for whether this is the PATIENT's record, the HOSPITAL/SYSTEM's record, or the GP's work record. How do we import and aggregate process information coming from multiple sources? Without losing information? Can outside procedures be entered as "test results", or in some other standard way?
- In the Maltese database, prescriptions, examinations, and advice comprise 85% of all process codes used. Data from many countries should inform decisions re granularity. Degree of granularity depends on the size of the database - practice, region, nation? We need a full discussion about it
- What about other procedure terminologies or classifications? How do they link? This is really about ICPC-3. In many countries the GP does MORE than a European office based GP so we need more content.
- In many advanced primary care settings, the solo GP is no more – replaced by multi-disciplinary clinics that offer increased range of practice based interventions. Can we – and should we – accommodate this?

Action: The full Committee approved the following actions.

1. **Accept inclusion/exclusion criteria for process codes.**
2. **Comments from WICC members proposing changes or corrections to criteria to be submitted by 12/1/2011**
3. **Erik Falkoe will lead group to review, make final corrections, publish at KITH by 1/1/2012**
4. **expansion, chapter specificity, other issues to be addressed by working group then presented for review at 2012 meeting**

Prevention and screening classes in ICPC-2e

Discussion led by Thomas Kuehlein.
All preventive services currently coded in A98, but prevention not a component 7 diagnosis and not always best located in chapter A.
The group discussed a proposal to relocate primary prevention procedures FROM A98 TO several specific processes in component 2, in appropriate system chapters, and to allow their use as episode titles.

General discussion on the proposal.

- Where does prevention end? For example, treatment of hypertension is actually prevention of stroke – how can you accommodate “prevention” that is not a screening procedure?
- Q. What is the clinical purpose of this proposal? A. Political, to allow counting of screening done by GPs
- This is similar to Marc Verbeke's proposals for use of A98 in the past; risk factors fit with the concept of NERI (Non Episode-Related Information) discussed at Ghent as part of the ICPC-3 information model. GPs are moving beyond treatment of acute disease to management of risk, and this does not require an episode model.
- GPs can have more than one A98 episode.
- In Portugal A98 is used repeatedly for the same patient, from childhood immunizations to pap tests, and leads to large and heterogeneous class. We need better discrimination than a single code. If double coding to use prevention _40, then what do we do with _44?
- Some advocated collecting A98 WITH a process code (double coding), so that retrieval of “prevention” is easier. That may lead to double-counting of preventive activities if not done carefully.
- We will create a different problem by going to all process codes and losing the aggregated A98. If we move away from A98, we will need to retire the code, and this will cause problems.
- In practice using the episode of care and procedures in a Belgian EHR, one major problem is that prevention must be disease specific. This falls apart with multimorbidity.
- Process codes as episodes can create problems. For example, in Malta, for occupational health purposes, used to use “Post Operative” as symptom label for episode but could not tell what operation. Now they code the problem first and the operative code separately.

Action: The group decided that no changes were needed at this point. Those with most at stake in change (for example, HB, JKS, AG) can talk together and develop specific recommendations that could be implemented with ICPC-3.

The group next discussed a proposal to assign a different color on the multicolored ICPC 2-pager to disease codes that are also “risk factors”. Examples include hypertension, overweight, diabetes. A related proposal was to assign an “attribute” of risk factor to the disease code to allow retrieval of “risk factors” from an ICPC clinical database.

General discussion on the proposal.

- This is moving from classification to politics – assigning “risk factor” status can be arbitrary and almost certainly will be political. General agreement with this comment.
- This is a step forward in moving to a data model that can structure data to serve multiple purposes – but there is no need to change the classification to accomplish this purpose.
- If we adopt this proposal, it will be very important that all ICPC users assign risk factor status or attribution in the same way so that our governments are aware of what we do and international comparisons can be valid. General agreement with this comment.

Action: the full Committee decided further work on risk factor attribution would be valuable. A next step is to propose which codes would need these attributes. A small group can be formed to start this process.

Wednesday 5 October: AM session

Chair: Mike Klinkman

THEME: EXTERNAL WORK - WITH OTHER ORGANIZATIONS.

ACG International

Discussion led by Mike Klinkman.
ACG (Ambulatory Care Groups) International is a business unit within the Johns Hopkins Bloomberg School of Public Health that develops and maintains ACG case-mix products that are marketed worldwide. ACGI has been interested in developing an ambulatory care/primary care case-mix tool based on ICPC, and did some work on this in Spain several years ago. At the Florianopolis WICC meeting in 2009, Patricio Muniz from ACGI attended, presented work to date, and WICC decided to collaborate informally with the group.
A Memorandum of Understanding (MoU) between ACGI and Wonca was completed and signed in early 2011 without the involvement of WICC. However, the MoU contains no commitment, only a simple intention to collaborate. There are no specific plans to proceed with joint ventures at this time.

General discussion on the Wonca-ACGI relationship.

- Q. Did Wonca put funds aside to support that collaboration? A. Not seen in the Wonca budget for 2011 or 2012.
- Q. What are the implications for ICPC-3? A. Unknown.
- A recent example was given of a situation in which an ACGI representative discouraged government/MOH purchase and use of ICPC, promoting ICD instead.
- In general terms, the ACG case-mix system marketed to health insurance funds is a proprietary and closely-guarded methodology. This is at odds with our preference to create open-source classification tools to encourage wide dissemination.
- Although the initial developers have spoken positively about ICPC, there has been an historic reluctance to accept the episode of care data structure of ICPC. It is not clear how this would affect a joint working relationship to develop ICPC-based ACGs.
- We should try and set up a mechanism by which Wonca, WICC and ACG can develop primary care-oriented ACGs. The ACG group clearly needs the longitudinal data that we alone could provide to develop an ICPC-based ACG grouper.
- We need to investigate how the ACG group could support the 'Consortium' to come.

Action: The WICC executive will explore collaboration opportunities with ACG International and report back to the full Committee at the 2012 meeting.

IHTSDO: Work of the GP/FP SIG to harmonize SNOMED-CT and ICPC.

Presentation and discussion led by Graeme Miller on behalf of the Terminology working group.
As mentioned in prior meetings, the IHTSDO has chartered a General Practice/Family Practice Special Interest Group chaired by WICC member Nick Booth and including several WICC members. The SIG has been given responsibility to develop primary care content for SNOMED. Funding to support the specific technical work has been provided by IHTSDO , and given after a selective tender process to the Family Medicine Research Centre of the University of Sydney. The 2 deliverables in this contract

include: (1) a General Practice Reference Set (refset) of terms (abbreviated as GPRS); and (2) a map of the GPRS to ICPC – based on the most recent versions of both GPRS and ICPC-2 available at the start of the mapping process. SNOMED-CT already has local extensions, such as SNOMED-CT-AU. This project's purpose is to "create links between the SNOMED-CT GPRS and international classifications used in the the GP/FM environment" (ICPC).

Specific data elements to be covered by GPRS content include:

1. Reasons for encounter
2. Problems/diagnoses (Health issue, as defined in the European standard EN 13940-1 " Health informatics – system of concepts to support continuity of care – Part 1: basic concepts")
3. "Sub-refsets" (groups of symptoms, signs, diseases, family history, allergies, ADRs, results, procedures, administrative processes), where they are used in a problem list (i.e. as a health issue)
4. SNOMED CT hierarchies (Finding/disorder, Procedure/intervention, Observable entities)

The GPRS and ICPC mapping project is divided into three distinct phases: (1) requirements gathering and method (9 months); (2) build phase (6 months); and (3) testing and validation phase (6 months) For Phase 1, requirements were gathered and reported in a formalised manner (in the style of the IHTSDO Quality Assurance Framework) that allows measurement and assessment of them against a quality metric, and prepare the GPRS and the ICPC mapping in line with a defined set of objectives and expectations. The group is at present between Phases 1 and 2. The first drafts of the GPRS and of the map to ICPC-2 will be available around July/August 2012. Volunteers will be sought in the second half of 2012 to validate the map and test the products.

Once this work is completed, the GPRS will be made freely available to those with a valid SNOMED-CT licence, and the GPRS - ICPC2 map will be made freely available only to those with both SNOMED-CT and ICPC2 licences. Vendors will be provided with an implementation guide.

General discussion was held. Clarifications of the work plan were incorporated into the above text.

Action: the full Committee approved the work done by Terminology working group members on this project, and support its ongoing work under the leadership of Nick Booth and Graeme Miller over the next year.

Wednesday 5 October: PM session

Chair: Mike Klinkman
Guest: Robert Jakob, WHO Classification Unit

<u>WHO: Collaboration on ICD-11 / Harmonization with ICPC.</u>
Presentation by Robert Jakob (WHO).
Discussion led by Robert Jakob and Mike Klinkman.
The primary topic for discussion is how WICC/Wonca can collaborate with WHO in the development of ICD-11 to make primary care more visible. ICD-11 must be ready by 2015. It will be part of a new "framework" (flower diagram) including all of the WHO-FIC approved classifications. Development of the classification is making use of an internet platform (iCAT) involving all users and expert groups.

Main goals for the revision:

- Move beyond a "causes of deaths" list
- Evolve into a coherent classification that can serve multiple purposes (mortality, morbidity, primary care, clinical care, research, public health) with consistency and interoperability across these different purposes
- Serve as an international and multilingual reference standard scientifically and for communication between clinical providers
- Function within an EHR
- Compatibility with other reference classifications of WHO-FIC

ICD is supposed to have definitions. In ICD-11 all entities will have a definition (beyond inclusion, exclusion criteria) that can be both human readable and machine readable. The list of attributes is specified in the ICD-11 content model. Definitions are key descriptions of the meaning of the category in human readable terms- to guide users. They will be compatible with the content model and will be consistent across the whole classification. Topic advisory groups (TAGs) focus on specific content areas (chapters within ICD). Details about the content model and the descriptors ("clinical phenotype") are available at the WHO ICD-11 website.

Currently there is a developmental "alpha" version of ICD-11, accessible via the internet. In May 2012 the beta-version will be released for field testing. Several aspects of development to date were illustrated, including use cases, the relationship to SNOMED terms, proposed "linearizations" to supply reduced sets of terms for specific use cases, and changes to address the former "dagger and asterisk" and localization/etiology problems.

The internet tools to support this work were shown, including the open access internet platform / comment system, and the limited access iCAT tool.

General discussion on the ICD-11 development process and Wonca-WHO collaboration.

- Discussion whether ICD remains a classification or is becoming a terminology/thesaurus, with the example of multiple coding in oncology or mortality, difficulties of primary cause analysis versus multiple cause analysis. For morbidity registration, multimorbidity reporting is difficult. The WHO MM subgroup works together on this along with the quality and safety group.
- Q. Is severity of disease taken into account in ICD-11? A. Yes and No. There is an available space in the content model that allows the entry of severity (example: kidney failure in 5 stages based on GFR)
- WHO staff have entered some ICPC 2 entities into the alpha-draft of the ICD-11 system to see whether they can be meaningfully linked
- What about the symptom diagnoses that at times account for up to 50% of the patient encounters in primary care? Cooperation between ICPC and ICD should focus on this particular aspect.
- GPs who might want to use ICD 11 in primary care to record symptoms , symptom diagnoses, and social problems would have much difficulty using ICD as their sole classification. ICD does not represent the complete domain of PC. But WHO wants to try to

achieve this aim with WICC's assistance, through linearization of their diagnostic content and chapter 21.

- The basic thing is not to impose one class on another. Define a "common box" together , then build links to other classification serving other purposes.
- Discussion of the purpose and perspective (orientation) of ICD – is it to represent the perspective and domain of the clinician, the policy-makers and statisticians, or the patient,…? Suggest that ICD does not represent the patient. ICPC reflects the clinician's perspective, and the patient's to a lesser degree. Classification needs to address needs of public health but also the phenotype of disease.
- Agreement on the smallest entities is essential for qualitative data registration.
- Definitions will improve the time consuming process of cross referencing and mapping.
- General concerns about usability of ICD-11 in primary care, especially in symptoms, social problems and processes. WHO is open to suggestions from WICC for ICD-11 in this regard.
- Q. In a rapidly changing world, how do you see maintenance of the linkages between ICD-11 and SNOMED? A. A technical group is working on those linkages.
- Some members would put ICPC in the center of the flower diagram presented by RJ.
- Q. How do you see the representation of GP's In the ICD subgroups. GPs would have an uneasy position as single members of a specialist topic group. A. ????
- Primary care accounts for over 50% of health care, and has a majority position within healthcare and society. But it has a minority position within WHO-FIC and the ICD revision process. This leads to a bias toward specialist care. It needs to be addressed by WHO.
- Where does person-centeredness fit in the WHO process?

The session closed with Robert Jakob expressing WHOs interest in working together to create a plan for integrating primary care into the ICD-11 process, and to harmonize ICD and ICPC. Specific action steps were agreed upon in the Friday 7 October AM session.

Results of WICC Election.

Discussion led by Juan Gervas.
Candidates for WICC Executive: Francois Mennerat and Thomas Kuehlein. Francois was elected.
Candidates for Nominations Committee: Laurent Letrilliart and Gustavo Gusso. Gustavo was elected.

Juan informed the group that the Nominations Committee will soon make a proposal for virtual membership in WICC. Those who have been serving as Associate Members may become full Members after two years. Observers are encouraged to apply for Associate Membership.

Thursday 6 October: AM session
Chair: Anders Grimsmo

ICF Working Group.

Discussion led by Laurent Letrilliart.

WICC members (LL, MV, PB) have accumulated considerable experience working with ICF. ICF is a core classification in WHO-FIC. ICF has 4 levels of codes and four dimensions. In ICF one can have a semi quantitative scale from -4 to +4 to indicate limitations to ability. Laurent has used ICF in relation to sick-leave research, in that project using three of the dimensions - body, activities and environmental factors. The main findings from that study were: (1) 3 minutes were required to code ICF for each encounter, (2) health problems were more important than functional and contextual factors on the length of the sick-leave; (3) doctors need better training to assess functional problems/status; and (4) ICF can be used for outcome.

Based on his work to date, Laurent recommended that functional and contextual data should become a part of ICPC-3.

General discussion on ICF.

- ICF has both a framework and codes. While it is quite common to use subsets of the codes, it is important to also know the framework. It fits well with the way GPs work and think, but it is hard to put it together with ICPC. It is difficult to measure by patient self-assessment as it is not a questionnaire.
- In documenting with the SOAP scheme, ICF can be used to better describe objective findings
- ICPC-3 might contain a component with functional and contextual data, and ICF is a candidate for that component.

Further general discussion on collaboration with WHO on ICD-11.

- It is important for WICC to find out how far the work with ICD has come and the tools that they use.
- We should follow up the "invitation" to contribute to the work with ICD11 to find out the reality about it.
- We should request there be a TAG for primary care.
- The primary care working group in IHTSDO is responsible for primary care content in SNOMED: we should have a similar relationship with WHO.

Translations working group.

Presentation and discussion led by Marten Kvist.

Little work has been done over the past year. ICPC is translated into 35 languages (counting both ICPC-1 and ICPC-2). It is used in 29 countries, possibly in several more. It is a national standard for classification in five countries (PG, NL, BE, DK and NO). 12 countries have paid national licenses. In many countries the "medical care" language is English and not the native language, so not all countries will need native-language translations. We should ask Wonca exec to advertise ICPC in their meetings to get to know better where it is used and the translations. Marten reviewed the relative sizes of language groups that do not have an ICPC translation, and recommended that for many reasons an Arabic translation should be given priority. He also recommended that WICC

should find a way to make the ICPC book available electronically, and that each translation should be imported into CLAM and made available through KITH.

General discussion was held, supportive of the recommendations made by Marten.

Action: WICC executive will approach Wonca executive to advocate for translation of ICPC into high-priority languages (eg: Arabic)

<u>General discussion on collaborative tools for classification work.</u>
Discussion led by Mike Klinkman.
Heinz Bhend reported on the ICPC-FIRE-project he leads in Switzerland. The project involves over 60 GPs and 500,000 encounters, with a need to collect and make use of common data using internet-based collaborative tools. The project has developed a website that includes a WIKI, demonstrated during the session. The collaborative approach improves coding and retrieval and can be fed forward to software vendors for updates, so users can implement a home grown terminology that includes preferred terms used by the GP.

General discussion of this approach.

- General recognition of the need for natural GP language implementation into responsive system – this is one way of doing this, but it requires an attentive group of people to respond to requests for additional preferred terms.
- there are 4 levels of terminology: short-cut keyword, local term, official synonyms, preferred term. The ideal system would have all in an easy-to-use interface/implementation.
- In the mature ICPC-2-Plus system used in Australia there are very few new requests for terms, but most requests for new terms are from inter-professional groups with need to code, in standardised way, concepts not covered in ICD/ ICPC/other systems to date. This is an issue for update group/ICPC-3 development/ functional status group.
- Keyword coding or “electronic cheat sheets” have a high potential for biasing data entry.
- The balance between local terms or labels and an international standard description is difficult if using international WIKI approach. Some blend of international standardization and local modification/customization is needed, and how/who governs?

General discussion was extended to collaborative tools for use by WICC.

- Currently no common system in use for collecting recommendations for changes.
- WICC could adopt country based collection method. WICC members collect suggestions, collate, then send on to Update or appropriate group or to KITH
- WICC could possibly use WHO's ICAT tool . WHO has offered to teach some of WICC how to use, can then decide on its usefulness.
- WICC could continue to test CLAM.

Action. The full Committee agreed on the following steps.

1. **The Update group will work with CLAM, and will check out iCAT when available**
2. **Country leads will interface with Update group via browser**
3. **Google groups will be used for general work, internal communication**

<u>ICPC Implementation and Training Issues.</u>
Discussion led by Mike Klinkman.
Presentation by Shabir Moosa on training issues for ICPC from experience in his project in South Africa. The clinical setting was a nurse-dominated multidisciplinary team approach to primary health care, with community care workers giving care after brief training. The data collection required for the project was cumbersome, and included extensive social and demographic information. Some of these data overlap areas in which ICPC could be useful, other areas point to areas in which domain coverage could improve, some are not related to ICPC (demographics).

General discussion was held on implications for training in ICPC, to be carried forward to session of Friday 7 October.

Thursday 6 October: PM session

Travel to Mataro for
Catalan Society of Family and Community Medicine Congress.
WICC presentations at the Congress:
Miller/ O'Halloran/Booth: An international approach to the implementation of SNOMED CT in Family/General Practice
Kuehlein: Encoded knowledge in an operating adhocracy - About the usefulness of ICPC for the primary care physician
Letrilliart: Expectations of French GPs for research in primary care: Which themes, domains and types?
Boeckxstaens/ Schrans/ Verbeke/ Matthys/ Mennerat/ Elwyn/ Kuehlein: The International Classification of Primary Care (ICPC) as a reason for encounter classification – A proposal for its extended use to classify intentions, concerns and expectations (ICE)
Van Boven: Do Unexplained symptoms predict anxiety or depression in Primary Care?
Klinkman/Van Weel: A conceptual model for person-centered diagnosis in general medical practice.
Soler: Interoperability between terminologies and classifications in primary care
Jamoulle/ Roland/ Vander Stichele/ Roumier/ Estievenaert/ Matskanis/ Latignies/ Romain: LOCAS + project, first dive into the world of semantic web
Gusso: In search for a system that decode medical world
Britt/ Harrison/ Miller: Prevalence and patterns of multimorbidity in Australia

Friday 7 October: AM session
Chair: Mike Klinkman

<u>ICPC Implementation and Training Issues (continued).</u>
Discussion led by Mike Klinkman.

Gustavo Landsberg (observer) presented a novel method using photographs to illustrate problems that may be coded using ICPC. In his experience, it provided a very successful method to engage doctors in learning ICPC terms as well as the role that context/ personal interpretation plays in recognition and assignment of codes.

General discussion was completed on training issues for ICPC, without specific action taken.

<u>Review of meeting and action plan for 2011-2012.</u>
Discussion led by Mike Klinkman.
Review of GOALS for meeting, all accomplished.
Review of overall goals for WICC. ICPC-3 is on hold, but not forgotten. Funding proposals from 2011 reviewed, decisions made on which to re-submit for 2012. Priorities include: KITH maintenance work, ICPC field study in South Africa, support for purchase of classification management software, WHO and IHTSDO harmonization work, ISO liaison work, and support to subsidize travel for observers/members from developing countries to 2012 meeting.

General discussion was held on priorities for work in 2011-2012, focusing on the WICC-WHO collaboration. Specific points included:

- Possible WHO collaboration items - review ICD-11 alpha and suggest additions, train WICC in iCAT, create primary care TAG, give WICC control over construction of a `primary care view' in ICD-11 (explicit mapping ICPC/ICD as lateral proposal – to keep up visibility), WICC will work to create primary care view of ICF. If all ICPC classes are embedded within ICD, we can then provide the ICPC overview – linearisation work.
- We need WHO to understand that fundamental change in ICD is needed to provide an adequate view of primary care.
- For ICF, we need to work on what GPs can put into use as contextual tools in daily work. Non disease specific measures, to deal with patient (not disease) specific outcome measures. Could explore placing in NERI, or placing in `O' of SOAP in data model, or mapping Wonca COOP charts to ICF. Another option might be to develop questionnaire for asthma/ diabetes ICF work.
- Members need to submit country reports. These were formally sent to Ian Marshall, now should be collated and submitted to Wonca News. The group decided on a 100-word summary, followed by a longer description that could be assembled and submitted to an academic journal. WICC needs a volunteer to coordinate this process.
- Jean Karl Soler described the Transform project, a funded EU project examining patient safety, e-records, decision support , and other aspects of health IT, and asked for collaborators in this work from within Europe.
- Bibliography: send papers , citations, pdfs to Tim Gardner, who is willing to lead the work of updating and maintaining the ICPC/WICC on-line bibliography.

Action: the full Committee approved 17 action plan items for 2011-2012. [Listed in opening section of meeting minutes].

Other miscellaneous actions:
A formal letter to thank retired Committee members for their service will be drafted by Mike, to be signed by WONCA President .

Next meeting:
To be hosted by Nicola Buono, Ferdinando Petrazzuoli, and Jean Karl Soler in Italy, near Naples. Preliminary dates include first/second week of October. Final dates to be arranged.

2013 meeting candidates - Hyderabad, India or South Africa.

Adjournment:
The Chair thanked all WICC members and observers for their many contributions to a productive meeting.
Special thanks were given to Sebastian Juncosa and Ines Barea for their outstanding work in planning, coordinating, and hosting this meeting, and to SemFYC for their support and provision of meeting space.

There being no further business, the 2011 WICC Annual Meeting was adjourned at 11:35 AM on 7 October 2011.