Message from the Director

Welcome to the ICD Revision Conference.

October 2017: A major milestone towards the finalization of the 11th Revision of the International Classification of Diseases. Hundreds of individuals and institutions have greatly contributed to the revision process over several years. Web platforms have been created to seek broad inputs from around the world. Multiple technical committees have been intensively working to find the best solutions for complex problems. Financial resources from core and voluntary contributions of Member States and special organizations, especially the Japan Hospital Association, made it possible to make steady progress. This week, WHO is proudly releasing the 2016 version of the ICD-11 for Member State comments at the Tokyo ICD Revision Conference.

This is an historic moment. In 2015, the UN adopted a new agenda for sustainable development, the Sustainable Development Goals (SDGs) 2016-2030. The broad agenda with its 17 goals, 169 targets and over 200 indicators, covers economic, social and environmental dimensions of development. Cause-specific mortality targets and indicators abound. Consequently, as noted in the recent WHO World Health Statistics report1, there is even stronger demand for quality country mortality statistics.

The SDGs also embrace innovation such as the huge opportunities provided by information and communication technology. The ICD revision aims to make full use of these advances, improving the ease of use and quality of statistics.

ICD currently serves a broad range of country data needs. Many countries have systems that rely on the ICD for mortality and morbidity data and health financing. Recent country health events, especially the Ebola, Zika, and Yellow Fever outbreaks, have only served to highlight the serious need to strengthen current health information through the use of the ICD as the international standard.

This is therefore a critical time for ICD. ICD must continue to serve global statistics needs such as those of the SDGs, as well as multiple data needs in modern health systems, whilst adapting for future data needs which, at this point, we can only imagine.

We welcome at this ICD Revision Conference a wide representation of Member States from Asia-Pacific, Africa, the Americas, Europe, and the Middle East. WHO is releasing the ICD-11 at this conference for Member State comments. As we receive feedback from Member States on future data needs and approaches, work will continue in 2017 to refine the ICD-11 appropriate for Member State use, and lead to a release in 2018. I trust you enjoy the conference, and would like to thank our hosts, Japan, and the wide network of Member State representatives and stakeholders who have contributed to the development of the ICD-11.

Dr Ties Boerma, WHO.

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ICD: An International Resource

The International Classification of Diseases (ICD) has been a valuable international resource for more than a century. ICD-1 was endorsed in 1900; ICD-10 was endorsed in 1990. Over its period of evolution, ICD content has been periodically updated to reflect new scientific knowledge, with functionality adapted to suit contemporary data and statistical needs. In its present form, ICD is the modern international standard national and international mortality and morbidity statistics, and is used widely in health systems for data and financing needs.

The International Statistical Classification of Diseases and Related Health Problems, Eleventh Revision (ICD-11) has been an ambitious, complex and multiphase project. The focus has been to deliver health information for the 21st century, to reflect advances in medical and scientific knowledge, make improvements to design and function of the classification, and make full use of information technology.

The ICD Revision: Recent Developments

In the initial phases of ICD-11 development, global experts were mobilized and grouped into specialty Topic Advisory Groups (TAGs) focused on specific disease domains. These groups were tasked to develop and review classification content for specific chapters and cross-cutting disease domains in the ICD.

Development of ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS) commenced in 2013, with the task to create a classification for statistical purposes from the rich and diverse material developed by the TAGs.

2015 and 2016 have seen significant progress for the ICD-11 MMS.

| Review of the ICD-11 | • In early 2015, WHO commissioned and published an external review of the development process, which provided further recommendations about the management and development of ICD-11 MMS.  
| | • In particular, the review recommended a second phase that primarily focused on completing a stable version of the ICD-11 that could be used for mortality and morbidity statistics.  
| | • WHO implemented the recommendations, increased the technical staffing and management, and established an expert task force to support the development process. By January 2016, more than 5000 proposals had been processed in the beta version draft.  
| Formation of the Joint Task Force | • In March 2015, the Joint Task Force for Mortality and Morbidity Statistics was formed, and has proven invaluable to the development of the ICD-11 MMS over this period.  
| | • During 2015 and 2016, this hardworking Task Force met four times face-to-face to provide expert advice on improvements to the structure and content of the ICD-11-MMS, considering decisions from both the mortality and morbidity use case perspectives.  
| | • In the lead up to the Tokyo Revision Conference, the Task Force has met monthly to support revision progress. In the week before the conference, this Task Force met five times to ensure readiness of the ICD-11 for Member State comment. |
| Executive Board | • In May 2016 during the World Health Assembly Executive Board, Member States discussed the importance of the ICD, and the progress of ICD-11.  
| | • Member State feedback emphasized how valuable ICD remains to all Member States, and noted the good progress that had been made since 2015. |
ICD-11 Advances

The ICD-11 has been developed for a rapidly evolving environment for health data, an environment that differs markedly to the previous ten revisions. Data handling tools are dramatically different, as are the expectations of data users, who seek to extract robust data at granular as well as aggregate levels to enable a broad range of reporting for population health, health program and health financing.

ICD-11 for Mortality and Morbidity Statistics

The ICD-11-MMS includes categories for mortality and morbidity statistics at national and international levels, including diseases, disorders, injuries and external causes, signs and symptoms, risk factors, reasons for contact with health services, and information relevant to primary care and patient safety. The ICD-11-MMS is subdivided into chapters by etiology, body systems, and other.

<table>
<thead>
<tr>
<th>Chapter Updates</th>
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<tbody>
<tr>
<td>• Classification of cancer and benign tumours is better aligned with contemporary progress in cancer research and cancer classification systems (as for cancer registries) and clinical staging. Additional information on the type of tumour tissue is now included.</td>
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<tr>
<td>• The infectious diseases chapter has been updated to reflect improved knowledge.</td>
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<tr>
<td>• Chapters on diabetes, hypertension, maternal conditions, dementia, injuries, and accidents have also been updated to reflect progress, as well as to solve classification problems that existed in ICD-10.</td>
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<table>
<thead>
<tr>
<th>New Data Options</th>
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<tbody>
<tr>
<td>• New to the ICD are added coding options for anatomy, histopathology, causal agents, and severity stages.</td>
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<tr>
<td>• Diagnostic categories used in traditional medicine have been included as a new chapter within ICD-11, based on traditional medicine practices now commonly used in China, Japan, Korea, and elsewhere. Particular attention will be given to testing this chapter in integrated health care settings in various countries.</td>
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<table>
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<tr>
<th>Improved Breadth and Depth of Information</th>
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<tbody>
<tr>
<td>• In the ICD-11 MMS, information can be given more breadth through the use of extension codes or through clustering entities to provide more detail.</td>
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<tr>
<td>• In the future, the foundation will allow for the production of different versions that present the diseases from the perspective of a single specialty.</td>
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<tr>
<th>ICD-11 Multilingual Features</th>
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<tbody>
<tr>
<td>ICD-11 is designed to support multilingual use. The underlying technology facilitates consistent translations, and adding synonyms to match the medical terminology. Translations of the classification can benefit from the existing tools such as the browser, coding tool, print generation and web services</td>
</tr>
</tbody>
</table>

ICD-11 Foundation

The ICD-11 Foundation is an important component of the ICD-11 architecture, since it contains all entities for diseases, disorders, injuries, external causes, signs, and symptoms in a network of relationships. Code sets may be created from the Foundation, with the most important of these the ICD-11 for Morbidity and Mortality Statistics outlined above.

The Foundation supports the better use of the ICD in an informatics environment. It enables rapid searching by software and services for the best matching term. This search capability is exemplified by the ICD-11 Coding Tool, and in the future may be used on mobile devices. The Foundation will also enable linkages to other terminologies, such as SNOMED CT. Maps to and from ICD-10 are maintained on the same infrastructure.

The ICD-11 Foundation enables a range of improved management options for the ICD:

- The Foundation supports the maintenance of current knowledge and content.
- The ICD-11 Foundation can support classifications to work together seamlessly across future patient information, allowing greater congruence with other classifications, including primary care, specialty health care, and functioning.
Traditional Medicine

The Traditional Medicine (TM) chapter is a new chapter within the ICD-11 MMS. It provides for the first time an internationally agreed standard list of diagnostic categories to identify and report on TM conditions. The TM chapter can be used as a coding tool for statistical and administrative purposes as well as a tool for facilitating clinical decision-making, research and education.

Standardized and international comparable data on TM diagnosis and encounters is needed because utilization of TM is on the rise globally; and TM products and practice are a global phenomenon with growing economic importance.

The scope of the chapter covers traditional medicine conditions that originated in ancient China and are now commonly used in China, Japan, Korea and elsewhere around the world (Module I). This TM chapter (Module I) constitutes the formative step for the integration of TM into a classification with standards used in conventional medicine ICD. Additional modules classifying other prominent forms of TM may be developed in the future provided that certain requirements (e.g. existing national classification and terminology standards and use cases) are met.

The chapter is a mirror of clinical practice and reality. The TM chapter categories were derived or reference from:

- National Clinical Modifications of ICD
  - e.g. Korean ICD version, KCD-7 Disease Codes of Korean Medicine;
- National TM Classifications
  - e.g. Chinese TCM classification GB 95/97, Japanese Kampo Medicine Code Set;
- Regional Terminologies
  - e.g. WHO International Standard Terminologies on Traditional Medicine in the Western Pacific Region;
- The chapter also represents the most common diagnoses used by TM practitioners in Europe and US;
- Expert groups of TM clinicians using the existing classifications listed above to achieve consensus on standard terminology.

The TM chapter is being developed in parallel to the revision of other ICD-11 chapters. The TM chapter is using the same classification development principles and tools (e.g. Content Model, iCAT, ICD-11 Browser) applied in other ICD chapters. The TM chapter is also undergoing translation in multiple languages, international peer review and pilot testing. Chapter development, the peer review and field-testing is organized as an international process involving traditional medicine clinicians, researchers, academics and classification experts from around the world.

As with other ICD chapters, the TM chapter is neither judging nor endorsing the scientific validity of any TM practice or the efficacy of any TM intervention. As a tool for classifying, diagnosing, counting, communicating and comparing TM conditions it will also assist research and evaluation to assess the efficacy of TM.
Explore the ICD-11

Visit the WHO Consultation Desk

During the Conference, the WHO consultation desk will be open near Room B7 to discuss the content and advances of ICD-11 and demonstrate the ICD-11 browser and coding tool. The desk will be staffed by WHO expert staff, and will be open immediately before the conference and during lunch breaks.

ICD-11 Browser

The ICD-11 Browser is a web site that allows users to browse the classification and see the content of the ICD-11. The ICD-11 Browser includes references to ICD-10, a user guide, and help buttons for individual features.

How to use the browser:

At the top of the browser is a browser bar with the search functionality and a drop-down menu Info that provides access to additional information, as well as the User Guide, and the coding tool (see next section).

- The ICD-11 Browser is equipped with a powerful searching functionality. The search will show matching entries in a hierarchical view while you type.
- In the content section of the browser, the classification hierarchy is shown on the left side of the browser screen. Users can access the next level of detail in the hierarchy by clicking on the small arrow.
- The right side of the screen shows detail of the category or groups that can be chosen by clicking on the hierarchical view. This shows inclusions, exclusions, index terms.

Users can browse the ICD-11 2016 content here:
http://apps.who.int/classifications/icd11/release

ICD-11 Coding Tool

ICD-11 Coding Tool is software designed to help users of ICD-11 search and find categories within the ICD-11. Users can access the coding tool through the ICD-11 browser bar.

- While typing a word, the system will use word completion and word suggestion to provide a word list.
- Matching categories and groups will appear in the hierarchy and be sequenced as listed in the ICD-11 for Mortality and Morbidity Statistics.
- In addition, a summary view of chapters is provided. Users can further refine the result list by including or excluding chapters from the results by removing the checkmark at the chapter title, or clicking on the chapter label.
Next Steps

The ICD-11 will be finalized for release in 2018. Before finalization, WHO will undertake a process of consultation and quality assurance on the classification.

<table>
<thead>
<tr>
<th>Member State Comments</th>
<th>WHO is now seeking Member State comments to inform ICD-11 finalization. WHO invites Member States to coordinate and provide comments in three main areas:</th>
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<tbody>
<tr>
<td></td>
<td>• Features and Structure of the ICD-11;</td>
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<td></td>
<td>• Implementation needs;</td>
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<td></td>
<td>• Future data needs.</td>
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<tr>
<td></td>
<td>The ICD-11 website will be open for Member State comments at the end of the Revision Conference. Member State comments can be provided at <a href="http://www.who.int/classifications/icd/revision">http://www.who.int/classifications/icd/revision</a></td>
</tr>
<tr>
<td></td>
<td>Feedback and comments received will be collated into feedback over the course of 2017 on ICD-11, and will be presented in a final report on ICD-11 at its 2018 release.</td>
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<tr>
<td></td>
<td>The Website will be open to receive comments until 31 March 2017.</td>
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</tbody>
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<tr>
<th>Quality Assurance</th>
<th>During 2017, ICD-11 finalization will be delivered through a comprehensive Quality Assurance approach:</th>
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<tbody>
<tr>
<td></td>
<td>• WHO Collaborating Centres and other partners will be conducting quality assurance exercises on the ICD-11-MMS in 2017.</td>
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<td>• Quality assurance will inform further decision making of the Joint Task Force for MMS at two meetings in 2017, and will improve the functionality of the ICD-11-MMS.</td>
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</tbody>
</table>

| New Governance          | • During 2016 and 2017 the Medical and Scientific Advisory Committee (MSAC), comprised of experts selected by WHO will be formed, to advise on scientific content for the ICD-11, and management of the ICD-11 Foundation |

Keep Up to Date:

The latest information on the ICD-11 can be found at http://www.who.int/classifications/icd/revision/en/
## Agenda Overview

### Wednesday 12 October

**Morning**
09:30 - 12:00  
Opening Ceremony  
*Including:*
- **Keynote Presentation** - Margaret Chan, World Health Organization  
- **The ICD for Global Health** - World Health Organization panel  

For full agenda, please see Opening Ceremony Booklet

**Afternoon**
14:00 – 16:30  
Traditional Medicine Side Event

### Thursday 13 October

**Morning**
09:30 - 13:00  
Health information in the new era  
The ICD Revision process  
- ICD-11 2016 Release for Member State Comment  
- Launch of the Medical and Scientific Advisory Committee (MSAC)

**Afternoon**
14:00 – 17:30  
ICD-11 advances and use  
*Side Sessions:*
- Future Data Needs and the Family of Classifications  
- Global Data Developments for Women’s and Children’s Health

**Evening**
18:00  
Gala Dinner

### Friday 14 October

**Morning**
09:30 - 13:00  
Traditional Medicine  
Health Financing  
ICD-11 Informatics and Tooling  
*Side sessions:*
- Mental Health  
- Leaving No-One Behind

**Afternoon**
14:00 – 16:00  
ICD Way Forward  
Meeting Closure
### Wednesday 12 October

**Opening Ceremony**

Health Information in the New Era

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>8:30 – 09:30</td>
<td>Registration</td>
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<tr>
<td>09:00</td>
<td>Convene for Opening Ceremony</td>
<td>Hall A</td>
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**Opening Ceremony**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>09:30</td>
<td>Opening Ceremony and Official Remarks</td>
<td>(please see Opening Ceremony Booklet)</td>
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<table>
<thead>
<tr>
<th>Time</th>
<th>Keynote Presentation: Margaret Chan</th>
<th>World Health Organization</th>
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<tr>
<td>10:30</td>
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**Break**

**Opening Sessions**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>11:00</td>
<td>Presentation from International Hospital Federation</td>
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<tr>
<td>11:30</td>
<td>ICD for Global Health: World Health Organization panel</td>
<td>Facilitator: Ties Boerma, WHO</td>
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<td>ICD-11: Better information for health - James Harrison, Flinders University</td>
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<td>ICD-11: Capturing the advances in medical knowledge – Stefanie Weber, German Institute of Medical Documentation and Information (DIMDI)</td>
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<td></td>
<td>Getting ICD ready for the future (informatics) - Christopher G. Chute, Johns Hopkins University School of Medicine</td>
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</tbody>
</table>

**Break**
### Wednesday 12 October (Side Event)

#### Developing and using a common language for counting Traditional Medicine conditions

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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</thead>
<tbody>
<tr>
<td>14:00 – 15:30</td>
<td>Opening remarks</td>
</tr>
<tr>
<td>Room G610</td>
<td>Dr. Margaret Chan, World Health Organization</td>
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<tr>
<td></td>
<td>* Introductory remarks by H. Sato, Japan Liaison of Oriental Medicine (JLOM)</td>
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<tr>
<td></td>
<td><strong>Panel presentations</strong></td>
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<tr>
<td></td>
<td>Moderators: Kenji Watanabe &amp; Rosemary Roberts, ICTM PAG Members</td>
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<td></td>
<td>- The case for better TM data to support implementation of the WHO TM Strategy - Zhang Qi, WHO</td>
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<td></td>
<td>- ICD-11 TM chapter (Module 1) – development, features, and maintenance arrangements - Nenad Kostanjsek, WHO</td>
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<td></td>
<td>- Japan: Current state of TM information and prospects for using the ICD-11 TM chapter - Hiroshi Sato, Japan Liaison of Oriental Medicine (JLOM)</td>
</tr>
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<td></td>
<td>- Moving towards implementing the ICD-11 TM chapter in China - Lessons learned from implementing a national TM diagnostic classification system (GB 95/97) - Wang Xiaopin, State Administration for Traditional Chinese Medicine (SATCM)</td>
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**Break**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>14:00 – 17:00</td>
<td>Using TM Code sets of the Korean Disease Classification (KCD) – What difference does it make for the Korean Health System - Nam Jeomsoon, Ministry of Health and Welfare of the Republic of Korea</td>
</tr>
<tr>
<td>Room G610</td>
<td>Potential benefits and uses of the ICD-11 TM chapter for clinical research - Peter Fisher, Royal London Hospital for Integrated Medicine</td>
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<td></td>
<td>Joint Morbidity coding with TM and other ICD chapters - Rosemary Roberts, ICTM PAG Member</td>
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<td></td>
<td>Prospects of using the ICD-11 TM chapter in comparative effectiveness research - Charlie Xue, Chinese Medicine Board of Australia</td>
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<td></td>
<td>Classifications of other forms of TM: Ayurveda - P.N. Ranjit Kumar, Ministry of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH)</td>
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</tbody>
</table>

**Conclusion**
# Thursday 13 October

## Main Conference

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Moderator/Location</th>
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<tbody>
<tr>
<td>8:30 – 09:30</td>
<td>Registration. Visit the WHO Consultation Desk</td>
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<tr>
<td>9:30 – 10:45</td>
<td>Room B7</td>
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<tr>
<td></td>
<td>Session: Health information in the new era</td>
<td>Moderator: Stefanie Weber, DIMDI</td>
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<td></td>
<td>Global data priorities: the role and value of ICD</td>
<td>Ties Boerma, WHO</td>
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<td></td>
<td>Data Challenges for the Sustainable Development Goals</td>
<td>Raj Mitra, United Nations Department of Economic and Social Affairs (UNDESA)</td>
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<tr>
<td></td>
<td>The RELACSIS agenda in Latin America and Caribbean region</td>
<td>Gerardo de Cosio, WHO AMRO</td>
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<td></td>
<td>ICD in Japan: lessons from implementing ICD-10</td>
<td>Kei Mori, Ministry of Health, Labour and Welfare of Japan</td>
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<td></td>
<td>Panel Discussion</td>
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<tr>
<td>11:15 – 12:30</td>
<td>Session: The ICD Revision Process</td>
<td>Moderator: Ties Boerma, WHO</td>
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<tr>
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<td>ICD-11 Use Case</td>
<td>Stefanie Weber, DIMDI</td>
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<tr>
<td></td>
<td>ICD-11 Design Process</td>
<td>James Harrison, Flinders University</td>
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<tr>
<td></td>
<td>ICD-11 Business Model and Future Governance</td>
<td>Christopher G. Chute, Johns Hopkins University Naoko Tajima, The Jikei University</td>
</tr>
<tr>
<td></td>
<td>Panel Discussion</td>
<td></td>
</tr>
<tr>
<td>12:30 – 14:00</td>
<td>ICD-11 2016 Release for Member State Comment and launch of the WHO ICD-11 Medical and Scientific Advisory Committee</td>
<td>Ties Boerma, WHO</td>
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</tbody>
</table>

**Break**

Visit the WHO Consultation Desk
### Thursday 13 October (continued)

<table>
<thead>
<tr>
<th>14:00 - 15:30</th>
<th>Session: ICD-11 advances and use</th>
<th>Moderator: Robert Jakob, WHO</th>
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</thead>
<tbody>
<tr>
<td>Room B7</td>
<td>Infectious diseases</td>
<td>Olafr Steinum, Nordic Centre for Classifications in Health Care</td>
</tr>
<tr>
<td></td>
<td>Neoplasms</td>
<td>Sherri De Coronado, National Cancer Institute (NCI)</td>
</tr>
<tr>
<td></td>
<td>Skin</td>
<td>Robert Chalmers, University of Manchester School of Medicine</td>
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<tr>
<td></td>
<td>Diabetes</td>
<td>Naoko Tajima, The Jikei University School of Medicine</td>
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<td>Allergy</td>
<td>Luciana Tanno, University Hospital of Montpellier</td>
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</tbody>
</table>

### Side Session: Future Data Needs and the Family of Classifications

**Room G510**

**Chair:** Jenny Hargreaves, Australian Institute of Health and Welfare

**Rapporteur:** Alarcos Cieza, WHO

**Opening Presentation:** Jenny Hargreaves, Australian Institute of Health and Welfare

**Global Policy – the need to improve data for rehabilitation:** Alarcos Cieza-Moreno, WHO

**Future data needs from a terminology perspective:** Jane Millar, International Health Terminology Standards Development Organisation

**The Importance of Classification Data for Understanding Ageing Populations in Japan:** Reiko Hayashi, National Institute & Population and Social Security Research of Japan

**United Kingdom: data needs for an ageing population:** Myer Glickman, Office for National Statistics

**The Way Forward:** Alex Ross, WHO

**Discussion**

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**Break**

**16:00 - 17:30**

<table>
<thead>
<tr>
<th>Room B7</th>
<th>Session: ICD-11 advances and use (continued)</th>
<th>Moderator: Robert Jakob, WHO</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Injuries and External Causes</td>
<td>James Harrison, Flinders University</td>
</tr>
<tr>
<td></td>
<td>Dementia</td>
<td>Paulo Caramelli, Federal University of Minas Gerais</td>
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<td></td>
<td>Quality and Safety</td>
<td>William Ghali, University of Calgary</td>
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<td></td>
<td>Primary Care</td>
<td>Olawunmi Olagundoye, World Organization of Family Doctors</td>
</tr>
<tr>
<td></td>
<td>Discussants</td>
<td>Olafr Steinum, Nordic Centre for Classifications in Health Care Gunnar Hendrikssen, Nordic Casemix Centre</td>
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</tbody>
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**Side sessions**

### Future Data Needs and the Family of Classifications

**Chair and Rapporteur:** Jenny Hargreaves, Australian Institute of Health and Welfare

This side session will focus on future data needs and use of a system of classifications, particularly focused on rehabilitation and ageing.

- **Opening Presentation:** Jenny Hargreaves, Australian Institute of Health and Welfare
- **Global Policy – the need to improve data for rehabilitation:** Alarcos Cieza-Moreno, WHO
- **Future data needs from a terminology perspective:** Jane Millar, International Health Terminology Standards Development Organisation
- **The Importance of Classification Data for Understanding Ageing Populations in Japan:** Reiko Hayashi, National Institute & Population and Social Security Research of Japan
- **United Kingdom: data needs for an ageing population:** Myer Glickman, Office for National Statistics
- **The Way Forward:** Alex Ross, WHO
- **Discussion**

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### Global Data Developments for Women’s and Children’s Health

**Chair:** Raj Mitra, United Nations Department of Economic and Social Affairs

**Rapporteur:** Doris Chou, WHO

This session will focus on current and future global actions to improve data for women’s and children’s health.

- **Developing a global data strategy and Integrating ICD into monitoring frameworks:** Doris Chou, WHO
- **How ICD can improve data:** Professor McCaw-Binns, University of the West Indies
- **Improving data across the continuum of care:** Anneke Schmider, WHO

**Panel:** Development of new approaches: improving morbidity, primary care and mortality data through digital health technologies.
## Friday 14 October

### Main Conference

<table>
<thead>
<tr>
<th>Time</th>
<th>Session: Integrated Medicine: Traditional Medicine chapter</th>
<th>Moderator: Charlie Xue</th>
<th>Side Session: Leaving No-One Behind (detail below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:30 – 10:30</td>
<td>Opening statement</td>
<td>Zhang Qi, WHO</td>
<td>Room G510</td>
</tr>
<tr>
<td>Room B7</td>
<td>Written message from Tu Youyou, Nobel Prize Laureate for Medicine 2015, China</td>
<td></td>
<td>Chair and Organizer: Raj Mitra, UNDESA</td>
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<tr>
<td></td>
<td><strong>TM and the ICD-11 TM Chapter</strong></td>
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<tr>
<td></td>
<td>Zhang Qi, WHO</td>
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<td></td>
<td>The statistical use case - reporting TM conditions in China</td>
<td>Wang Xiaopin, State Administration of Traditional Chinese Medicine</td>
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<td></td>
<td>The reimbursement use case in Korea</td>
<td>Nam Jeomsoon, Ministry of Health and Welfare of the Republic of Korea</td>
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<td></td>
<td>Traditional Medicine in Japan</td>
<td>Teiji Takei, Ministry of Health, Labour and Welfare, Japan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The utility of the ICD-11 TM Chapter for integrated health care setting in Europe</td>
<td>Peter Fisher, Royal London Hospital for Integrated Medicine</td>
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</tr>
<tr>
<td>10:30 – 11:15</td>
<td>Session: ICD for health financing</td>
<td>Stefanie Weber, DIMDI</td>
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<tr>
<td>Room B7</td>
<td>ICD-11 for health financing</td>
<td>Anneke Schmider, WHO</td>
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</tr>
<tr>
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<td>ICD in casemix systems</td>
<td>Martti Virtanen, Nordic Casemix Centre</td>
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<td>Role of ICD in health systems financing</td>
<td>James Downie, Independent Hospital Pricing Authority</td>
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<tr>
<td></td>
<td>Panel Discussion</td>
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</tbody>
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### Break

<table>
<thead>
<tr>
<th>Time</th>
<th>Session: ICD-11 Informatics and Tooling</th>
<th>Moderator: James Harrison, Flinders University</th>
<th>Better Data for Mental Health (detail below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:45 – 12:45</td>
<td>Overview and ICD-11 Foundation Component</td>
<td>Christopher G. Chute, Johns Hopkins University School of Medicine</td>
<td>Room G510</td>
</tr>
<tr>
<td>Room B7</td>
<td>ICD-11 tools for implementation and maintenance</td>
<td>Mark Musen, Stanford University School of Medicine</td>
<td>Chair and Rapporteur: Geoffrey Reed, WHO</td>
</tr>
<tr>
<td></td>
<td>ICD and automated coding</td>
<td>Stefanie Weber, DIMDI</td>
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<td></td>
<td>The Role of SNOMED CT</td>
<td>Don Sweete, IHTSDO</td>
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<td></td>
<td>Panel Discussion</td>
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</tbody>
</table>

### Visit the WHO Consultation Desk
## Friday 14 October (continued)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session: ICD-11 way forward</th>
<th>Moderator: Dr Ties Boerma, WHO</th>
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<td>14:00 – 15:30</td>
<td>Rapporteurs: Side sessions and Posters</td>
<td>Alarcos Cieza-Moreno, WHO</td>
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<tr>
<td></td>
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<td>Doris Chou, WHO</td>
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<tr>
<td></td>
<td></td>
<td>Raj Mitra, UNDESA</td>
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<tr>
<td></td>
<td></td>
<td>Geoffrey Reed, WHO</td>
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<tr>
<td></td>
<td></td>
<td>Kenji Watanabe, Keio University</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nenad Kostanjsek, WHO</td>
</tr>
<tr>
<td></td>
<td><strong>Main Features and Next Steps:</strong> the Member State perspective</td>
<td>JTF Task Force Panel:</td>
</tr>
<tr>
<td></td>
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<td>James Eynstone-Hinkins, Australian Bureau of Statistics</td>
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<td></td>
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<td>Robert Anderson, Centers for Disease Control and Prevention</td>
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<td></td>
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<td>Jenny Hargreaves, Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td></td>
<td><strong>Member State Observations</strong></td>
<td>Invited Member States</td>
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<tr>
<td>15:30 – 16:00</td>
<td>Closing Remarks: The Way Forward</td>
<td>Ties Boerma, WHO</td>
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<td></td>
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<td>Kei Mori, Ministry of Health, Labour and Welfare of Japan</td>
</tr>
</tbody>
</table>

### Side sessions

**Leaving No-One Behind**

<table>
<thead>
<tr>
<th>Time</th>
<th>Chair and Rapporteur: Raj Mitra, UNDESA</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:30 – 10:30</td>
<td>This session will highlight momentum for better civil registration and vital statistics data, including ICD-coded data, and challenges to be addressed into the future</td>
</tr>
<tr>
<td></td>
<td><strong>Leaving No-One Behind:</strong> Pali Lehohla, Statistics South Africa</td>
</tr>
<tr>
<td></td>
<td><strong>ICD Implementation Challenges and Next Steps:</strong> Yukiko Yokobori, Japan Hospital Association</td>
</tr>
<tr>
<td></td>
<td><strong>Challenges and Opportunities for better data:</strong> Hongyi Xu, WHO</td>
</tr>
<tr>
<td></td>
<td><strong>Country Perspectives: interactive session</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Closing Remarks</strong></td>
</tr>
</tbody>
</table>

### Better Data for Mental Health

<table>
<thead>
<tr>
<th>Time</th>
<th>Chair and Organizer: Geoffrey M. Reed, WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:45 – 13:15</td>
<td>This side session will provide an opportunity to explore in greater depth the approach for mental and behavioural disorders and categories relevant to suicide deaths in the ICD-11.</td>
</tr>
<tr>
<td></td>
<td><strong>Field studies for ICD-11 Mental and Behavioural Disorders:</strong> Global scope and the Japanese example, Shigenobu Kanba, The University of Kyushu</td>
</tr>
<tr>
<td></td>
<td><strong>A new model for schizophrenia and other primary psychotic disorders in the ICD-11:</strong> Proposals and field testing, Wolfgang Gaebel, University of Dusseldorf</td>
</tr>
<tr>
<td></td>
<td><strong>Disorders due to substance use and addictive behaviours in the ICD-11:</strong> Meeting the needs of Member States, Member of Ministry of Health Delegation, Mexico</td>
</tr>
<tr>
<td></td>
<td><strong>Improving data collection and data quality for suicide deaths:</strong> How the ICD-11 supports global and national public health objectives, James Eynstone-Hinkins, Australian Bureau of Statistics</td>
</tr>
<tr>
<td></td>
<td><strong>Panel discussion, questions and answers</strong></td>
</tr>
</tbody>
</table>
International Classification of Diseases for Morbidity and Mortality Statistics, 11th revision (ICD–11 MMS)

Version for Member State comment

This special edition of ICD–11 has been prepared for the ICD–11 Revision conference in Tokyo, 2016. The ICD–11 for Member State comment shows all the features, structure and content of ICD–11, so that Member States can provide their comments.

The booklet provides some basic information about ICD–11 and shows its high-level structure.

Contents:

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   1.2 ICD–11 Coding Tool 6
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1 Access ICD–11 online

http://www.who.int/classifications/icd/revision/
or directly at
http://apps.who.int/classifications/icd11/release
(The QR code can be used instead)

1.1 Browse the ICD–11

The ICD–11 Browser is a web site that allows users to browse the classification and see the content of the ICD–11. A category or grouping can be accessed using the search engine, or browsing the tree. The ICD–11 Browser also shows references to ICD–10, has a user guide, and help buttons for individual features.

At the top of the browser is the bar with the search functionality, a link to the coding tool (described in the next section) and a drop-down menu Info that provides access to additional information, such as the User Guide, the ICD–11 revision website, or a very simple map from ICD–10.

In the content section of the browser, the classification hierarchy is shown on the left side of the browser screen. The next level of detail in the hierarchy is accessed by clicking on this symbol ➤.

The right side of the screen shows the detail of the category or group that is selected in the hierarchical view. It will show inclusions, exclusions, index terms and a reference to ICD–10.

The ICD–11 Browser is also equipped with a powerful searching functionality. The search will show matching entries in a hierarchical view while typing.

An advanced search functionality allows filtering of a search. For example, a search can include titles only, or inclusions only, or all fields.

Display help text by clicking on the small question marks 🎨.

Figure 1 showing the browser with ‘essential hypertension’ selected and displaying its features.
For users that need to access additional features, the browser software also produces print versions, maps to and from ICD-10, and provides a multilingual translation interface. Special versions will be available for databases as well as web services, including unique reference identifiers (the ‘Foundation ID’).

1.2 ICD–11 Coding Tool

The ICD–11 Coding Tool is an online software that helps coders find the most appropriate codes for conditions by entering terms into the search field. The coding tool is accessed through the browser. The tool works by searching while the user types. It generates (and dynamically updates) three different outputs:

**Word list**
While typing a word, the system tries to anticipate the term that is being searched for. If a term is completed, followed by a ‘space’, the system will show related keywords.

**Destination entities**
The second output is matched entities. This output is sorted by how closely the text entered matches the phrase in ICD. Destination entities can also be grouped by using the ICD hierarchy. The matching categories and groups will appear in the hierarchy sequenced the way they are listed in the ICD–11 for Mortality and Morbidity Statistics.

**Chapter distribution**
This area gives a summary view and identifies in which chapter the results are found. The result list can be further refined by including or excluding chapters from the results. This is done by removing the checkmark at the chapter title, or clicking on the chapter label.

![Figure 2 showing the ICD–11 Coding Tool with the results of a search for the term 'hypertension'](image)
2 ICD–11 for Mortality and Morbidity Statistics at a Glance

ICD–11 for Mortality and Morbidity Statistics is the reference set of categories for international reporting.
ICD–11 has categories for disorders, injuries, external causes, signs and symptoms, risk factors, and reasons for contact with health services.
The design of categories and groupings suits the needs of mortality and morbidity statistics at national and international levels. Its new content addresses needs of primary care, and quality and safety better than ICD–10.
ICD–11 has been updated scientifically and has new features that did not exist in earlier versions of ICD, such as integration into electronic reporting environments and multilingual support.

2.1 New terminology

Foundation
The foundation is a complex network of knowledge that resides in a database and holds all the information necessary to generate print versions of the tabular list and the alphabetical index. It also includes information needed to develop Specialty Code sets.
The figures show the relationship between foundation and ICD–11 for Mortality and Morbidity Statistics.

Figure 3, sample of the foundation

The foundation includes detailed information that is linked in multiple relationships. It also contains the instruction for production of the ICD–11 for Mortality and Morbidity Statistics. The left side of the figure 3 shows the tree structure while the right side shows the relationships. Figure 4 shows the rendering of the above part of the foundation in the format of the ICD–10 MMS.

Figure 4, sample of the ICD–10 MMS
**Stem code**

Stem codes are codes that can be used alone. They are found in the tabular list of the ICD–11 for Mortality and Morbidity Statistics. Stem codes may be entities or groupings of high relevance, or clinical conditions that should always be described as one single category. The design of stem codes makes sure that in use cases that require only one code per case, a meaningful minimum of information is collected.

**Extension code**

Some users and settings are interested in reporting more detail than is included in a stem code. This additional detail can be coded using an Extension Code. Extension codes can never be used without a stem code, but are used together with the stem codes to define the full detail of a reported disease.

The 2D3Z for ‘Malignant Neoplasm of breast, unspecified’ is the Stem Code. An extension code can be added for laterality, or specific anatomy in order to describe in more detail the location.

---

Figure 5 showing the guidance given in the ICD–11 browser for possible code combinations on the example of ‘Malignant neoplasms of the breast, unspecified’.
Cluster coding (postcoordination)
Stem codes can be used together with extension codes, or with other stem codes, to fully describe one diagnosis. In this case, codes will be associated by a mechanism called ‘cluster coding’. In ICD–10, the dagger-asterisk system was used to classify diseases together with their manifestations. In ICD–11, this concept was replaced by the coding of a category together with optional or mandatory additional information in a predefined way.

A diagnosis of a ‘Breast cancer of the areola of the left breast’ would be coded in a cluster that looks like

2D3Z/XB21/XC42

(2D3Z is the ‘malignant neoplasm of the breast, unspecified’; XB21 is ‘left’; XC42 is ‘areola’).

There are other ways of marking a group of codes that describe a single diagnosis. These alternative methods depend on the national technical infrastructure.

‘Code also instructions’ inform the user about mandatory additional information which has to be coded in conjunction with certain categories because that additional information is relevant for primary tabulation. The ‘code also’ statement marks the categories that should be used in conjunction with the indicated second code(s). However, in some instances they may be a reason for treatment in their own right, where aetiology is unknown, and the code is reported alone.

‘Use additional code, if desired’ instructions inform the user about optional additional detail that can be added for a particular diagnosis.

2.2 Coding scheme
The coding scheme in ICD–11 for Mortality and Morbidity Statistics has changed compared to ICD–10. The following section illustrates the new coding scheme.

The chapters are numbered with Arabic numbers.

<table>
<thead>
<tr>
<th>Number</th>
<th>Chapter Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Certain infectious or parasitic diseases</td>
</tr>
<tr>
<td>02</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>03</td>
<td>Diseases of the blood or blood-forming organs</td>
</tr>
<tr>
<td>04</td>
<td>Diseases of the immune system</td>
</tr>
<tr>
<td>05</td>
<td>Endocrine, nutritional or metabolic diseases</td>
</tr>
<tr>
<td>06</td>
<td>Mental or behavioural disorders</td>
</tr>
<tr>
<td>07</td>
<td>Sleep-wake disorders</td>
</tr>
<tr>
<td>08</td>
<td>Diseases of the nervous system</td>
</tr>
<tr>
<td>09</td>
<td>Diseases of the eye or ocular adnexa</td>
</tr>
</tbody>
</table>
The first character of the code always relates to a specific chapter. This means that the code range of a single chapter always has the same character in the first position. Numbers in the first position identify the chapters 01 to 09. Letters in the first position identify the chapters 10 to 27. For example:

Chapter 02 - Neoplasms all codes start with ‘2’, as 2D3Z ‘Malignant neoplasms of breast, unspecified’

Chapter 11 - Circulatory system all codes start with ‘B’, as BA00 ‘Essential hypertension’

The coding scheme always has a letter in the second position to differentiate ICD–11 codes from ICD–10 codes.

ICD–10: J11 Influenza, virus not identified
ICD–11: 1E93 Influenza, virus not identified

The coding scheme for categories has 4 characters, and there are 2 levels of subcategories.

Example

<table>
<thead>
<tr>
<th>GD90 Kidney failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>GD90.1 Acute kidney failure</td>
</tr>
<tr>
<td>GD90.2 Chronic kidney disease</td>
</tr>
<tr>
<td>GD90.21 Chronic kidney disease, stage 1</td>
</tr>
<tr>
<td>GD90.22 Chronic kidney disease, stage 2</td>
</tr>
</tbody>
</table>

2.3 Other general features

Definitions
Categories of the ICD–11 for Mortality and Morbidity Statistics may have a short description and a long definition labelled ‘additional information’. The ‘short description’ is a characterization (maximum of 100 words) of the entity that states things that are always true about a disease or condition and necessary to understand the scope of the rubric. The ‘short description’ appears in the tabular list of the ICD–11 for Mortality and Morbidity Statistics. The long ‘additional information’ is the full definition, without length restriction, including detailed information that appears in only the foundation component.

Special tabulation lists
Special tabulation lists of the ICD–11 for Mortality and Morbidity Statistics include the Startup Mortality List (SMoL), the list for verbal autopsy, and infectious diseases by agent. Additional special tabulations can be added, as required.
3 ICD–11 MMS List of Chapters and Blocks

Please note that the codes are not final.
CHAPTER 01

Certain infectious or parasitic diseases

Code range starts with 1A00

Exclusions: Infections of the fetus or newborn

List of blocks in this chapter:

- Gastroenteritis and colitis of infectious origin
  - Bacterial intestinal infections
  - Bacterial foodborne intoxications
  - Viral intestinal infections
  - Protozoal intestinal infections
  - Gastroenteritis and colitis without specification of infectious agent
- Predominantly sexually transmitted infections
- Mycobacterial diseases
- Sepsis due to certain bacteria
- Certain staphylococcal or streptococcal diseases
- Pyogenic bacterial infections of the skin or subcutaneous tissues
- Certain zoonotic bacterial diseases
- Other bacterial diseases
- Human immunodeficiency virus disease
- Viral infections of the central nervous system
- Dengue
- Other arthropod-borne viral fevers
- Other viral haemorrhagic fevers
- Influenza
- Viral hepatitis
- Viral infections characterised by skin or mucous membrane lesions
- Certain other viral diseases
- Mycoses
- Malaria
- Certain protozoal diseases
- Helminthiases
- Pediculosis, acariasis or other infestations
- Human prion diseases
CHAPTER 02

Neoplasms

Code range starts with 2A00

List of blocks in this chapter:

- Neoplasms of brain or central nervous system
  - Neoplasms of brain
  - Neoplasms of spinal cord, cranial nerves or other parts of the central nervous system
  - Neoplasms of the meninges
- Neoplasms of haematopoietic or lymphoid tissues
- Malignant neoplasms, except of lymphoid, haematopoietic, central nervous system or related tissues
  - Malignant neoplasms, stated or presumed to be primary, of specified sites, except of lymphoid, haematopoietic, central nervous system or related tissues
    - Malignant mesenchymal neoplasms
    - Malignant neoplasms of lip, oral cavity or pharynx
    - Malignant neoplasms of digestive organs
    - Malignant neoplasms of middle ear, respiratory or intrathoracic organs
    - Malignant neoplasms of skin
    - Malignant neoplasms of peripheral nerves or autonomic nervous system
    - Malignant neoplasms of retroperitoneum, peritoneum or omentum
    - Malignant neoplasms of breast
    - Malignant neoplasms of female genital organs
    - Malignant neoplasms of male genital organs
    - Malignant neoplasms of urinary tract
    - Malignant neoplasms of eye or ocular adnexa
    - Malignant neoplasms of endocrine glands
  - Malignant neoplasms of ill-defined or unspecified primary sites
  - Metastatic malignant neoplasms, except of lymphoid, haematopoietic, central nervous system or related tissues
    - Metastatic malignant neoplasm to lymph nodes
    - Metastatic malignant neoplasm to thoracic or respiratory organs
    - Metastatic malignant neoplasms to digestive system
- Metastatic malignant neoplasm to retroperitoneum or peritoneum
- Metastatic malignant neoplasm to other sites
- In situ neoplasms, except of lymphoid, haematopoietic, central nervous system or related tissues
- Benign neoplasms, except of lymphoid, haematopoietic, central nervous system or related tissues
  - Benign mesenchymal neoplasms
  - Benign non-mesenchymal neoplasms
- Neoplasms of uncertain behaviour, except of lymphoid, haematopoietic, central nervous system or related tissues
- Neoplasms of unknown behaviour, except of lymphoid, haematopoietic, central nervous system or related tissues
CHAPTER 03

Diseases of the blood or blood-forming organs

Code range starts with 3A00

Exclusions:
- Complications of pregnancy, childbirth and the puerperium (JA00-JB63.Z)
- Diseases of the immune system (4A00-4D0Z)
- Certain conditions originating in the perinatal or neonatal period (KA00-KC6Z)
- Injury, poisoning or certain other consequences of external causes (NA00-ND4Z)
- Human immunodeficiency virus disease (1D40-1D4Z)
- Endocrine, nutritional or metabolic diseases (5A00-5D56)
- Congenital malformations, deformations and chromosomal abnormalities (LA00-LE2Z)
- Clinical manifestations of the blood or blood-forming organs
- Neoplasms of haematopoietic or lymphoid tissues
- Symptoms, signs or clinical findings of blood, blood-forming organs or the immune system

List of blocks in this chapter:
- Anaemias and other erythrocyte disorders
- Coagulation defects, purpura or other haemorrhagic or related conditions
- Diseases of spleen
CHAPTER 04

Diseases of the immune system

Code range starts with 4A00

**Exclusions:**
- Complications of pregnancy, childbirth and the puerperium (JA00-JB63.Z)
- Neoplasms (2A00-2G6Z)
- Developmental anomalies (LA00-LE2Z)
- Organ specific autoimmune disorders
- Symptoms, signs or clinical findings of blood, blood-forming organs or the immune system

**List of blocks in this chapter:**

- Primary immunodeficiencies
  - Primary immunodeficiencies due to disorders of innate immunity
  - Primary immunodeficiencies due to disorders of adaptive immunity
- Acquired immunodeficiencies
- Non-organ specific systemic autoimmune disorders
- Organ specific autoimmune disorders
- Autoinflammatory disorders
- Allergic or hypersensitivity conditions
  - Allergic or hypersensitivity disorders involving the respiratory tract
  - Allergic or hypersensitivity disorders involving the eye
  - Allergic or hypersensitivity disorders involving skin or mucous membranes
  - Allergic or hypersensitivity disorders involving the gastrointestinal tract
  - Anaphylaxis
  - Complex allergic or hypersensitivity conditions
- Immune system disorders involving white cell lineages
- Certain disorders involving the immune system
CHAPTER 05

Endocrine, nutritional or metabolic diseases

Code range starts with 5A00

Exclusions: Transitory endocrine or metabolic disorders specific to fetus or newborn (KB30-KB3Z)

Complications of pregnancy, childbirth and the puerperium (JA00-JB63.Z)

Symptoms, signs or clinical findings of endocrine, nutritional or metabolic diseases

List of blocks in this chapter:

- Endocrine diseases
  - Disorders of the thyroid gland or thyroid hormones system
  - Diabetes mellitus
  - Other disorders of glucose regulation or pancreatic internal secretion
  - Disorders of the parathyroids or parathyroid hormone system
  - Disorders of the pituitary hormone system
  - Disorders of the adrenal glands or adrenal hormone system
  - Disorders of the gonadal hormone system
  - Certain disorders of puberty
  - Polyglandular dysfunction
  - Other endocrine disorders

- Nutritional disorders
  - Undernutrition
  - Overweight, obesity or specific nutrient excesses

- Metabolic disorders
  - Inborn errors of metabolism
  - Disorders of metabolite absorption or transport
  - Disorders of fluid, electrolyte or acid-base balance
  - Disorders of lipoprotein metabolism or certain specified lipidaemias
  - Other metabolic disorders

- Postprocedural endocrine or metabolic disorders
CHAPTER 06

Mental or behavioural disorders

Code range starts with 6A00

Inclusions: Disorders of psychological development
Exclusions: Disappearance or death of family member (QF71)
             Normal grief (QF73)
             Mental or behavioural disorders associated with disorders or diseases classified elsewhere
             Mental or behavioural clinical manifestations
             Sleep-wake disorders
             Sexual dysfunctions
             Gender incongruence

List of blocks in this chapter:

- Neurodevelopmental disorders
- Schizophrenia or other primary psychotic disorders
- Mood disorders
  - Bipolar or related disorders
  - Depressive disorders
- Anxiety and fear-related disorders
- Obsessive-compulsive or related disorders
- Disorders specifically associated with stress
- Dissociative disorders
- Bodily distress disorder
- Feeding or eating disorders
- Elimination disorders
- Disorders due to substance use or addictive behaviours
  - Disorders due to substance use
    - Disorders due to use of alcohol
    - Disorders due to use of cannabis
    - Disorders due to use of synthetic cannabinoids
    - Disorders due to use of opioids
• Disorders due to use of sedatives, hypnotics or anxiolytics
• Disorders due to use of cocaine
• Disorders due to use of stimulants including amphetamines, methamphetamine or methcathinone
• Disorders due to use of synthetic cathinones
• Disorders due to use of caffeine
• Disorders due to use of hallucinogens
• Disorders due to use of nicotine
• Disorders due to use of volatile inhalants
• Disorders due to use of MDMA or related drugs, including MDA
• Disorders due to use of dissociative drugs including ketamine and phencyclidine [PCP]
• Disorders due to use of other specified psychoactive substances
• Disorders due to use of unknown or unspecified psychoactive substances
• Disorders due to use of non-psychoactive substances
• Disorders due to addictive behaviours
• Impulse control disorders
• Disruptive behaviour or dissocial disorders
• Personality disorders and related traits
• Paraphilic disorders
• Factitious disorders
• Neurocognitive disorders
• Mental or behavioural disorders associated with pregnancy, childbirth and the puerperium, not elsewhere classified
• Mental or behavioural disorders associated with disorders or diseases classified elsewhere
• Mental or behavioural clinical manifestations
• Secondary mental or behavioural syndromes
CHAPTER 07

Sleep-wake disorders

Code range starts with 7A00

List of blocks in this chapter:

- Insomnia disorders
- Sleep-related movement disorders
- Hypersomnolence disorders
- Sleep-related breathing disorders
- Circadian rhythm sleep-wake disorders
- Parasomnia disorders
- Disorders of the sleep-wake schedule
- Certain specified sleep disorders
CHAPTER 08

Diseases of the nervous system

Code range starts with 8A00

Exclusions:
Endocrine, nutritional or metabolic diseases (5A00-5D56)
Complications of pregnancy, childbirth and the puerperium (JA00-JB63.Z)
Certain conditions originating in the perinatal or neonatal period (KA00-KC6Z)
Injury, poisoning or certain other consequences of external causes (NA00-ND4Z)
Injuries of the nervous system
Neoplasms of the nervous system
Cerebrovascular diseases
Structural developmental anomalies of the nervous system
Syndromes with central nervous system anomalies as a major feature (LC50)
Human prion diseases
Symptoms, signs or clinical findings of the nervous system

List of blocks in this chapter:
- Movement disorders
- Neurological disorders with neurocognitive impairment as a major feature
- Multiple sclerosis or other white matter disorders
- Epilepsy or seizures
- Headache disorders
- Spinal cord disorders excluding trauma
- Motor neuron diseases or related disorders
- Disorders of nerve root, plexus or peripheral nerves
- Diseases of neuromuscular junction or muscle
- Cerebral palsy
- Nutritional or toxic disorders of the nervous system
- Disorders of cerebrospinal fluid pressure or flow
- Injuries of the nervous system
- Neoplasms of the nervous system
- Paraneoplastic or autoimmune disorders of the nervous system
- Disorders of autonomic nervous system
• Disorders of consciousness
• Other disorders of the nervous system
• Infections of the nervous system
• Paralytic syndromes
• Postprocedural disorders of the nervous system
CHAPTER 09

Diseases of the eye or ocular adnexa

Code range starts with 9A00

Exclusions:
- Certain conditions originating in the perinatal or neonatal period (KA00-KC6Z)
- Certain infectious or parasitic diseases (1A00-1K2Z)
- Complications of pregnancy, childbirth and the puerperium (JA00-JB63.Z)
- Endocrine, nutritional or metabolic diseases (5A00-5D56)
- Injury, poisoning or certain other consequences of external causes (NA00-ND4Z)
- Neoplasms of the eye or ocular adnexa
- Reasons for contact with the health care system
- Contusion of eyeball or orbital tissues (NA06.3)
- Foreign body in multiple parts of external eye (NC30.3)
- Oculocutaneous albinism (EE20)
- Symptoms, signs or clinical findings of the visual system
- Structural developmental anomalies of the eye, eyelid or lacrimal apparatus

List of blocks in this chapter:
- Disorders of the ocular adnexa or orbit
  - Disorders of eyelid or peri-ocular area
  - Disorders of lacrimal apparatus
  - Disorders of orbit
- Disorders of the eyeball – anterior segment
  - Disorders of conjunctiva
  - Disorders of the cornea
  - Disorders of the anterior chamber
  - Disorders of the anterior uvea
  - Functional disorders of the pupil
  - Disorders of lens
- Disorders of the eyeball – posterior segment
  - Disorders of sclera
  - Disorders of the choroid
  - Disorders of the retina
• Disorders of the vitreous body
• Disorders of the eyeball affecting both anterior and posterior segments
• Disorders of the visual pathways or centres
• Strabismus or ocular motility
• Glaucoma or glaucoma suspect
• Disorders of refraction or accommodation
• Disorders of vision or visual functioning
• Certain specified postprocedural disorders of eye or ocular adnexa
CHAPTER 10

Diseases of the ear or mastoid process

Code range starts with AA00

**Exclusions:**
- Complications of pregnancy, childbirth and the puerperium (JA00-JB63.Z)
- Certain infectious or parasitic diseases (1A00-1K2Z)
- Certain conditions originating in the perinatal or neonatal period (KA00-KC6Z)
- Injury, poisoning or certain other consequences of external causes (NA00-ND4Z)
- Neoplasms (2A00-2G6Z)
- Endocrine, nutritional or metabolic diseases (5A00-5D56)
- Structural developmental anomalies of the ear
- Symptoms, signs or clinical findings of ear or mastoid process

**List of blocks in this chapter:**
- Diseases of external ear
- Diseases of middle ear or mastoid
- Diseases of inner ear
- Disorders with hearing impairment
- Disorders of ear, not elsewhere classified
- Postprocedural disorders of ear or mastoid process
CHAPTER 11

Diseases of the circulatory system

Code range starts with BA00

Exclusions:
- Certain infectious or parasitic diseases (1A00-1K2Z)
- Certain conditions originating in the perinatal or neonatal period (KA00-KC6Z)
- Congenital malformations, deformations and chromosomal abnormalities (LA00-LE2Z)
- Complications of pregnancy, childbirth and the puerperium (JA00-JB63.Z)
- Injury, poisoning or certain other consequences of external causes (NA00-ND4Z)
- Endocrine, nutritional or metabolic diseases (5A00-5D56)
- Neoplasms of the circulatory system
- Developmental anomalies of the circulatory system
- Certain specified rheumatic heart diseases
- Symptoms, signs or clinical findings of the circulatory system
- Functional vascular disorders of the skin

List of blocks in this chapter:
- Hypertensive diseases
- Hypotension
- Ischaemic heart disease
- Diseases of coronary artery
- Pulmonary heart disease or diseases of pulmonary circulation
- Pericarditis
- Acute or subacute endocarditis
- Heart valve disease
- Diseases of the myocardium or cardiac chambers
- Cardiac arrhythmia
- Heart failure
- Cerebrovascular diseases
- Diseases of arteries or arterioles
- Diseases of veins
- Disorders of lymphatic vessels or lymph nodes
- Infections of the circulatory system
- Postprocedural disorders of circulatory system
CHAPTER 12

Diseases of the respiratory system

Code range starts with CA00

Exclusions: Endocrine, nutritional or metabolic diseases (5A00-5D56)
            Congenital malformations, deformations and chromosomal abnormalities (LA00-LE2Z)
            Injury, poisoning or certain other consequences of external causes (NA00-ND4Z)
            Certain conditions originating in the perinatal or neonatal period (KA00-KC6Z)
            Certain infectious or parasitic diseases (1A00-1K2Z)
            Complications of pregnancy, childbirth and the puerperium (JA00-JB63.Z)
            Neoplasms of the respiratory system
            Developmental respiratory diseases
            Symptoms, signs or clinical findings of the respiratory system
            Pulmonary heart disease or diseases of pulmonary circulation
            Sleep-related breathing disorders

List of blocks in this chapter:

- Upper respiratory tract disorders
- Certain lower respiratory tract diseases
- Lung infections
- Lung diseases due to external agents
- Respiratory diseases principally affecting the lung interstitium
- Pleural, diaphragm or mediastinal disorders
- Certain diseases of the respiratory system
- Respiratory failure
- Postprocedural respiratory disorders
CHAPTER 13

Diseases of the digestive system

Code range starts with DA00

Exclusions:
- Endocrine, nutritional or metabolic diseases (5A00-5D56)
- Injury, poisoning or certain other consequences of external causes (NA00-ND4Z)
- Neoplasms (2A00-2G6Z)
- Certain infectious or parasitic diseases (1A00-1K2Z)
- Complications of pregnancy, childbirth and the puerperium (JA00-JB63.Z)
- Digestive system disorders of fetus or newborn
- Symptoms, signs or clinical findings of the digestive system or abdomen

List of blocks in this chapter:

- Diseases or disorders of orofacial complex
- Diseases of oesophagus
- Diseases of the stomach or the duodenum
  - Diseases of stomach
  - Diseases of duodenum
  - Ulcer of stomach or duodenum
- Diseases of small intestine
- Diseases of appendix
- Diseases of large intestine
- Diseases of anal canal
- Diseases of liver
- Diseases of gallbladder or biliary tract
- Diseases of pancreas
- Diseases of peritoneum
- Diverticular disease of intestine
- Ischaemic vascular disorders of intestine
- Hernia
- Inflammatory bowel diseases
- Functional gastrointestinal disorders
- Postprocedural disorders of digestive system
CHAPTER 14

Diseases of the skin

Code range starts with EA00

Inclusions:
- Diseases of the epidermis
- Diseases of the dermis
- Diseases of the epidermal appendages
- Diseases of subcutaneous tissue
- Diseases of cutaneous vasculature

Exclusions:
- Cutaneous complications of diabetes mellitus
- Tophaceous gout (FA25.31)
- Rheumatoid nodule with erosion (FA20.12)
- Tophaceous gout (FA25.31)
- Hairy leukoplakia (DA11)
- Symptoms, signs or clinical findings involving the skin

List of blocks in this chapter:
- Certain infections or infestations affecting the skin
  - Certain viral infections affecting the skin
  - Certain bacterial infections affecting the skin
  - Certain fungal infections affecting the skin
  - Certain parasitic infections or infestations affecting the skin
  - Infestation of the skin by ectoparasites
  - Miscellaneous specified infections affecting the skin
- Inflammatory dermatoses
- Metabolic or nutritional disorders affecting the skin
- Genetic, chromosomal or developmental disorders affecting the skin
- Psychological, psychiatric, sensory or neurological disorders affecting the skin
  - Disturbances of cutaneous sensation
  - Psychological or psychiatric conditions affecting the skin
  - Neurological conditions affecting the skin
- Disorders of the epidermis or epidermal appendages
  - Disorders of epidermal keratinization
• Disorders of skin colour
• Disorders of hair
• Disorders of the hair follicle
• Disorders of eccrine sweat glands or sweating
• Disorders of the nail or paronychium
• Disorders of epidermal integrity
• Disorders of the dermis or subcutis
  • Disorders of cutaneous connective tissue
  • Histiocytic-granulomatous disorders of the skin
  • Benign dermal lymphocytic infiltrations or proliferations
  • Disorders of subcutaneous fat
• Disorders of cutaneous blood or lymphatic vessels
• Dermatoses of the head, neck or oral cavity
• Dermatoses of genital or perianal regions
• Dermatoses of pregnancy or of the newborn or infant
• Skin disorders provoked by external factors
• Cutaneous complications of diabetes mellitus
• Skin disorders associated with diabetes mellitus
• Adverse cutaneous reactions to medication
• Postprocedural disorders of the skin
CHAPTER 15

Diseases of the musculoskeletal system or connective tissue

Code range starts with FA00

Exclusions: Injury, poisoning or certain other consequences of external causes (NA00-ND4Z) Endocrine, nutritional or metabolic diseases (5A00-5D56) Complications of pregnancy, childbirth and the puerperium (JA00-JB63.Z) Certain infectious or parasitic diseases (1A00-1K2Z) Temporomandibular joint disorders (DB88) Certain conditions originating in the perinatal or neonatal period (KA00-KC6Z) Neoplasms of the musculoskeletal system Monogenic autoinflammatory syndromes Non-organ specific systemic autoimmune disorders Symptoms, signs or clinical findings of the musculoskeletal system Structural developmental anomalies of the skeleton Syndromes with connective tissue involvement as a major feature (LC58) Syndromes with skeletal anomalies as a major feature (LC54)

List of blocks in this chapter:

- Arthropathies
- Conditions associated with the spine
- Soft tissue disorders
  - Disorders of muscles
  - Disorders of synovium or tendon
  - Miscellaneous specified soft tissue disorders
- Osteopathies or chondropathies
- Other disorders of the musculoskeletal system or connective tissue
- Postprocedural musculoskeletal disorders
CHAPTER 16

Diseases of the genitourinary system

Code range starts with GA00

Exclusions:
- Injury, poisoning or certain other consequences of external causes (NA00-ND4Z)
- Endocrine, nutritional or metabolic diseases (5A00-5D56)
- Complications of pregnancy, childbirth and the puerperium (JA00-JB63.Z)
- Certain infectious or parasitic diseases (1A00-1K2Z)
- Contact with health services for reasons associated with reproduction
- Predominantly sexually transmitted infections
- Symptoms, signs or clinical findings of the genitourinary system

List of blocks in this chapter:
- Diseases of the female genital system
- Diseases of the male genital system
- Disorders of breast
- Diseases of the urinary system
- Other disorders of the genitourinary system
- Postprocedural disorders of genitourinary system
CHAPTER 17

Conditions related to sexual health

Code range starts with HA00

Exclusions: Paraphilic disorders
Adrenogenital disorders
Predominantly sexually transmitted infections
Assault: Sexual maltreatment (PH00.7)
Contraceptive management (QA81)

List of blocks in this chapter:

- Sexual dysfunctions
- Sexual pain disorders
- Gender incongruence
- Changes in female genital anatomy
- Changes in male genital anatomy
CHAPTER 18

Pregnancy, childbirth or the puerperium

Code range starts with JA00

Exclusions:
- Postpartum necrosis of pituitary gland (5A41.1)
- Obstetrical tetanus (1C72)
- Injury, poisoning or certain other consequences of external causes (NA00-ND4Z)
- Gestational trophoblastic diseases
- Contact with health services for reasons associated with reproduction

List of blocks in this chapter:
- Abortive outcome of pregnancy
- Oedema, proteinuria, or hypertensive disorders in pregnancy, childbirth, or the puerperium
- Obstetric haemorrhage
- Certain specified maternal disorders predominantly related to pregnancy
- Maternal care related to the fetus, amniotic cavity or possible delivery problems
- Complications of labour or delivery
- Delivery
- Complications predominantly related to the puerperium
- Certain specified obstetric conditions, not elsewhere classified
CHAPTER 19

Certain conditions originating in the perinatal or neonatal period

Code range starts with KA00

**Inclusions:** conditions that have their origin in the perinatal period even though death or morbidity occurs later

**Exclusions:**
- Endocrine, nutritional or metabolic diseases (5A00-5D56)
- Congenital malformations, deformations and chromosomal abnormalities (LA00-LE2Z)
- Neoplasms (2A00-2G6Z)
- Injury, poisoning or certain other consequences of external causes (NA00-ND4Z)

List of blocks in this chapter:

- Infections of the fetus or newborn
- Fetus or newborn affected or suspected to be affected by maternal factors or by complications of pregnancy, labour or delivery
- Disorders of newborn related to length of gestation or fetal growth
- Birth injury
- Digestive system disorders of fetus or newborn
- Respiratory disorders specific to the perinatal or neonatal period
- Cardiovascular disorders present in the perinatal or neonatal period
- Haemorrhagic or haematological disorders of fetus or newborn
- Transitory endocrine or metabolic disorders specific to fetus or newborn
- Disorders involving the integument of fetus or newborn
- Disturbances of temperature regulation of newborn
- Neurological disorders specific to the perinatal or neonatal period
- Genitourinary system disorders specific to the perinatal or neonatal period
- Other disorders originating in the perinatal period
CHAPTER 20

Developmental anomalies

Code range starts with LA00

Exclusions: Inborn errors of metabolism (5C50-5C8Z)

List of blocks in this chapter:

- Structural developmental anomalies
  - Structural developmental anomalies of the nervous system
  - Structural developmental anomalies of the eye, eyelid or lacrimal apparatus
  - Structural developmental anomalies of the ear
  - Structural developmental anomalies of the face, mouth or teeth
  - Structural developmental anomalies of the neck
  - Structural developmental anomalies of the respiratory system
  - Structural developmental anomalies of the circulatory system
  - Structural developmental anomalies of the diaphragm, abdominal wall or umbilical cord
  - Structural developmental anomalies of the digestive tract
  - Structural developmental anomalies of the liver, biliary tract, pancreas or spleen
  - Structural developmental anomalies of the urinary system
  - Structural developmental anomalies of the female genital system
  - Structural developmental anomalies of the male genital system
  - Structural developmental anomalies of the breast
  - Structural developmental anomalies of the skeleton
  - Structural developmental anomalies of the skin
  - Structural developmental anomalies of the adrenal glands
- Multiple developmental anomalies or syndromes
- Chromosomal anomalies, excluding gene mutations
  - Complete trisomies of the autosomes
  - Duplications of the autosomes
  - Polyploidies
  - Complete monosomies of the autosomes
  - Deletions of the autosomes
  - Uniparental disomies
• Imprinting errors
• Balanced rearrangements or structural markers
• Sex chromosome anomalies
• Conditions with disorders of intellectual development as a relevant clinical feature
CHAPTER 21

Symptoms, signs or clinical findings, not elsewhere classified

Code range starts with MA00

Exclusions: Certain conditions originating in the perinatal or neonatal period (KA00-KC6Z)
Clinical findings on antenatal screening of mother (JA80)

List of blocks in this chapter:

- Symptoms, signs or clinical findings of blood, blood-forming organs or the immune system
  - Symptoms of blood, blood-forming organs or the immune system
  - Clinical findings in blood, blood-forming organs or the immune system
- Symptoms, signs or clinical findings of endocrine, nutritional or metabolic diseases
  - Symptoms of endocrine, nutritional or metabolic diseases
  - Results of function studies of the endocrine, nutritional or metabolic diseases
- Symptoms, signs or clinical findings of speech or voice
  - Symptoms, signs or clinical findings involving speech or voice
- Mental or behavioural symptoms, signs or clinical findings
- Symptoms, signs or clinical findings of the nervous system
  - Symptoms or signs involving the nervous system
  - Clinical findings in the nervous system
- Symptoms, signs or clinical findings of the visual system
  - Symptoms or signs involving the visual system
  - Clinical findings of the visual system
- Symptoms, signs or clinical findings of ear or mastoid process
  - Symptoms or signs involving the ear or mastoid process
- Symptoms, signs or clinical findings of the circulatory system
- Symptoms, signs or clinical findings of the respiratory system
  - Symptoms or signs involving the respiratory system
  - Clinical findings in the respiratory system
- Symptoms, signs or clinical findings of the digestive system or abdomen
  - Symptoms or signs involving the digestive system or abdomen
• Clinical findings in the digestive system
• Symptoms, signs or clinical findings of the skin
  • Symptoms, signs or clinical findings involving the skin
• Symptoms, signs or clinical findings of the musculoskeletal system
  • Symptoms or signs of the musculoskeletal system
  • Clinical findings in the musculoskeletal system
• Symptoms, signs or clinical findings of the genitourinary system
• General symptoms, signs or clinical findings
  • General symptoms
  • Finding of microorganism resistant to antimicrobial drugs
  • Clinical findings in specimens from other specified organs, systems and tissues
• Ill-defined and unknown causes of mortality
CHAPTER 22

Injury, poisoning or certain other consequences of external causes

Code range starts with NA00

Exclusions:
- Stress fracture, not elsewhere classified (FB53)
- Pathological fracture, not elsewhere classified (FB54)
- Certain specified obstetric trauma (JB23)
- Malunion of fracture (FB50)
- Birth injury (KA70-KA8Z)
- Nonunion of fracture (FB51)

List of blocks in this chapter:

- Injuries to the head
- Injuries to the neck
- Injuries to the thorax
- Injuries to the abdomen, lower back, lumbar spine or pelvis
- Injuries to the shoulder or upper arm
- Injuries to the elbow or forearm
- Injuries to the wrist or hand
- Injuries to the hip or thigh
- Injuries to the knee or lower leg
- Injuries to the ankle or foot
- Injuries involving multiple body regions
- Injuries to unspecified part of trunk, limb or body region
- Effects of foreign body entering through natural orifice
- Burns
  - Burns of external body surface, specified by site
  - Burns of eye or internal organs
  - Burns of multiple or unspecified body regions
- Frostbite
- Harmful effects of or exposure to noxious substances
- Injury or harm arising from surgical or medical care, not elsewhere classified
- Other or unspecified effects of external causes
CHAPTER 23

External causes of morbidity or mortality

Code range starts with PA00

List of blocks in this chapter:

- Unintentional Causes
  - Transport injury events
  - Falls
  - Exposure to object
  - Exposure to person, animal or plant
  - Exposure to weapon
  - Unintentional Drowning or submersion
  - Threat to breathing
  - Exposure to thermal mechanism
  - Unintentional harmful effects of or exposure to noxious substances
  - Unintentional privation, neglect or maltreatment
  - Unintentional exposure to other or unspecified mechanism
  - Exposure to forces of nature
  - Sequelae of unintentional external causes
- Intentional Self Harm
- Assault
- Undetermined intent
- Operations of war or armed conflict
- Legal intervention
- Causes of healthcare related harm or injury
  - Drugs medicaments or biological substances associated with injury or harm in therapeutic use
  - Surgical or other medical devices associated with injury or harm in therapeutic use
  - Surgical or other medical procedures associated with injury or harm in therapeutic use
  - Other aspects of care associated with injury or harm
  - Mode of injury or harm associated with a surgical or other medical device
  - Mode of injury or harm associated with a surgical or other medical procedure
  - Mode of injury or harm associated with exposure to a drug, medicament or biological substance
CHAPTER 24

Factors influencing health status or contact with health services

Code range starts with QA00

List of blocks in this chapter:

- Factors influencing contact with the health system
- Factors influencing health status
  - Factors associated with finances
  - Factors associated with drinking water or nutrition
  - Factors associated with the environment
  - Factors associated with employment or unemployment
  - Factors associated with education
  - Factors associated with social or cultural environment
  - Factors associated with health behaviours
  - Factors associated with social insurance or welfare
  - Factors associated with the justice system
  - Factors associated with relationships
  - Factors associated with absence, loss or death of others
  - Factors associated with assault or other harmful or traumatic events
  - Factors associated with fear
  - Factors associated with upbringing
  - Factors associated with impairments of body structure
  - Difficulty or need for assistance with activities
  - Concern about body appearance
CHAPTER 25

Codes for special purposes

Code range starts with RA00

List of blocks in this chapter:
- International provisional assignment of new diseases of uncertain aetiology
- National provisional assignment of new diseases of uncertain aetiology
Extension codes

Code range starts with XA00

List of blocks in this chapter:

- Severity Scale Value
- Temporality
- Aetiology
- Topology Scale Value
- Specific Anatomic Detail
- Histopathology
- Dimensions of external causes
- Dimensions of injury
- Consciousness
- Substances
  - Chemicals
  - Medicaments
- Diagnosis code descriptors
- Capacity or context
CHAPTER 27

Traditional Medicine conditions - Module I

Code range starts with TA00

List of blocks in this chapter:

- Traditional medicine disorders\(^{(TM)}\)
  - Organ system disorders\(^{(TM)}\)
    - Liver system disorders\(^{(TM)}\)
    - Heart system disorders\(^{(TM)}\)
    - Lung system disorders\(^{(TM)}\)
    - Kidney system disorders\(^{(TM)}\)
  - Other body system disorders\(^{(TM)}\)
    - Skin and mucosa system disorders\(^{(TM)}\)
    - Female reproductive system disorders\(^{(TM)}\) (including childbirth)
      - Menstruation associated disorders\(^{(TM)}\)
      - Pregnancy associated disorders\(^{(TM)}\)
      - Puerperium associated disorders\(^{(TM)}\)
      - Other female reproductive system associated disorders\(^{(TM)}\)
    - Bone, joint and muscle system disorders\(^{(TM)}\)
    - Eye, ear, nose and throat system disorders\(^{(TM)}\)
    - Brain system disorders\(^{(TM)}\)
  - Qi, blood and fluid disorders\(^{(TM)}\)
  - Mental and emotional disorders\(^{(TM)}\)
  - External contraction disorders\(^{(TM)}\)
  - Childhood and adolescence associated disorders\(^{(TM)}\)
- Traditional medicine patterns\(^{(TM)}\)
  - Principle-based patterns\(^{(TM)}\)
  - Environmental factor patterns\(^{(TM)}\)
  - Body constituents patterns\(^{(TM)}\)
    - Qi patterns\(^{(TM)}\)
    - Blood patterns\(^{(TM)}\)
    - Fluid patterns\(^{(TM)}\)
• Essence patterns\textsuperscript{(TM)}
• Organ system patterns\textsuperscript{(TM)}
  • Liver system patterns\textsuperscript{(TM)}
  • Heart system patterns\textsuperscript{(TM)}
  • Spleen system patterns\textsuperscript{(TM)}
  • Lung system patterns\textsuperscript{(TM)}
  • Kidney system patterns\textsuperscript{(TM)}
• Meridian patterns\textsuperscript{(TM)}
  • Main Meridian patterns\textsuperscript{(TM)}
  • Extra Meridian patterns\textsuperscript{(TM)}
• Six stage patterns\textsuperscript{(TM)}
• Triple energizer stage patterns\textsuperscript{(TM)}
• Four phase patterns\textsuperscript{(TM)}
  • Defense phase patterns\textsuperscript{(TM)}
  • Qi phase patterns\textsuperscript{(TM)}
  • Nutrient phase patterns\textsuperscript{(TM)}
  • Blood phase patterns\textsuperscript{(TM)}
• Four constitution medicine patterns\textsuperscript{(TM)}
  • Large yang type patterns\textsuperscript{(TM)}
  • Small yang type patterns\textsuperscript{(TM)}
  • Large yin type patterns\textsuperscript{(TM)}
  • Small yin type patterns\textsuperscript{(TM)}
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<td>C301</td>
<td>WHO-FIC in Primary Care</td>
<td>Hanmer, Hargreaves, et al</td>
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<td>Line coding pilot testing ICD-11 MMS</td>
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<td>C307</td>
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<td>Solbrig, Liu, Jiang</td>
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ICD-11

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<td>C311</td>
<td>ICD-11 MMS Traditional Medicine Chapter International Peer review</td>
<td>Espinosa, Kostanjsek, Ito, Lee, Xu, Zhang</td>
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<td>C701</td>
<td>The ‘Family’ paper revision and WHO-FIC in the ICD-11 era</td>
<td>Hanmer, Hargreaves, Macpherson</td>
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<td>C703</td>
<td>The WHO-FIC Implementation Database</td>
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Primary Care classification was discussed at both the WHO-FIC 2015 annual meeting and the FDC mid-year meeting held in Conegliano in May 2016.

**Introduction**

The Family Development Committee (FDC) has identified Primary Care as an important use case for the WHO-FIC classifications, as a component of the Committee work item 'Integration of the Family'. Primary Care classification was discussed at both the WHO-FIC 2015 annual meeting and the FDC mid-year meeting held in Conegliano in May 2016.

**2016 Mid-year meeting discussions**

**Overview of the activities of the ICD-11 Primary Care Task Team (PCTT):**

The PCTT has been focusing on producing a standard mapping between the International Classification of Primary Care (ICPC) and ICD-11 Primary Care (ICD-11-PC) in both directions. A similar agreed mapping exists between ICPC-2 and ICD-10. In addition, the PCTT is considering the requirements for primary care classification, to ensure that the requisite primary care concepts are available in ICD-11.

- The PCTT has to date focussed on the high-resource setting in its analyses. It was noted that there is a risk of too much detail in the high-resource setting version, but not enough detail in a low-resource setting version.
- The Committee agreed to maintain a watching brief over this work.

**The Primary Care use case and options for classification:**

The example of diagnosis coding was presented. Options for diagnosis coding could include:
- ICPC only,
- ICD-11-PC (ICD-11 primary care linearization) only,
- ICD-11-MMS (ICD-11 mortality and morbidity statistics linearization) only
- or combinations of ICPC and/or ICD-11-PC and/or ICD-11-MMS, depending on local requirements and available resources.

- It was noted that the use of linearization/s of ICD-11 would facilitate interoperability of primary care classification with classification at other levels of health care.

**2016 Mid-year meeting (cont)**

**Primary care in the Family:**

Background was provided on the importance of primary care having its own classification, and how the FDC could support development of a primary care classification.

Further work on guidance for primary care classification, and the role of the FDC in such work, was proposed.

- It was noted that ICPC is a related classification in the WHO-FIC for 'reason for encounter'. Whether or not a future classification should include 'reason for encounter' needs to be answered by defining the primary care use case.
- General principles for primary care classification are required. Since no information on general principles for a Primary Care classification were identified, it was agreed that some principles for a primary care classification should be drafted.
- There were examples in some countries where ICD-10 is being used for primary care. In order to capture 'reason for encounter', a concept not included in ICD-10, a free-text field was utilised for this information instead. The German, Nordic and Thai collaborating centres confirmed their use of ICD-10 for primary care.
- It is necessary to ensure that core family members, including ICD-11, reflect primary care concepts adequately.

The role of the FDC in such a process requires clarification.

Members in the meeting were in favour of the FDC maintaining a watching brief over this aspect of work on WHO-FIC classifications.

- It was proposed that a poster on guidance for primary care classification, and the role of the FDC in such a development, should be prepared for the WHO-FIC 2016 annual meeting in Tokyo.
- Members of a working group for this task were identified.
- The co-chairs of the PCTT should be consulted on the poster.

**Principles for classifications**

**Initial proposals for discussion: Principles/guidelines for Health Classifications to support Primary Care:**

- Ensure that the limited scope of primary care services can be accurately recorded. Aim for a limited range of high quality data.
- Define the scope clearly. Consider which aspects of primary care should be included (e.g. diagnoses/ symptoms, functioning, interventions).
- Consider interoperability between primary care classification/s and the related classification/s used at other levels in a health system, to ensure integrated recording and reporting of health conditions and related services.
- Take account of classifications in use or planned for use at other levels of a health service.
- Ensure that the classification is suited to manual or electronic implementation.
- Ensure that the classification is suited for use by health service personnel other than specialist coders.
- Take account of the cost of acquisition and implementation of the classification/s on a large scale.
- Learn from national and international experiences of using health classifications, including ICD-10, to support primary care.
- Learn from national and international experiences of developing and/or using classifications in low-resource settings, since primary care services are often low-resource settings.

**Conclusions**

FDC work on primary care classifications within the WHO-FIC is ongoing. It is complementary to the activities of the ICD-11 Primary Care Task Team. An FDC working group on primary care classification has been identified to facilitate progress.

**Acknowledgements**

The inputs of members of the FDC to the work on primary care classification are gratefully acknowledged.
Abstract: In 2016 generic testing of the ICD-11 MMS is focused on line coding pilot testing of approx. 420 diagnostic terms (representing 5% of current ICD-11 MMS Chapter categories). The poster provides an overview of the test design, procedure and instruments. Furthermore the poster outlines key features of the envisaged data analysis and gives a summary of the current implementation status.

Objectives and approach
The pilot testing objective is to assess selected ICD-11 MMS components in terms of reliability (consistency), goodness of fit (accuracy) and feasibility (usability) for basic morbidity coding as well as ascertain the comparability between ICD-10 and ICD-11.

Furthermore, the pilot testing aims to examine the testing process and instruments in order to determine where improvements are needed before starting with more comprehensive testing envisaged for 2017.

Finally, the pilot testing intends to gradually build-up ICD-11 knowledge and coding skills among participating coders. This will ensure that testing of the full ICD-11 MMS as envisaged for 2017 is done by ICD-11 trained coders. In turn this will help to reduce the bias of having well trained ICD-10 coders assessing the new ICD-11.

Procedure and instruments

**Step 1: Identification and preparation of diagnostic term set for morbidity coding.** WHO has identified a diagnostic term set representing 5% of current ICD-11 MMS Chapter categories (approx. 420).

All diagnostic terms used in the pilot testing are pre-coded in ICD-11 and ICD-10 by an expert group consisting of FT Center Coordinators and members of the WHO Education and Implementation Committee. The expert consensus on the code assignment (gold standard) will serve as the reference against which the level of agreement between different coders will be measured.

The diagnostic term set is uploaded on the web-based platform (ICD-FIT) on which all testing activities will be conducted and managed.

**Step 2: Identification and registration of coders and coordinators on the ICD-FIT platform.** Each Field Test (FT) Center participating in the pilot testing will identify a min. of 5 experienced (morbidity) coders.

The FT Centre will also identify a FT Center Coordinator and a FT Site Coordinator. WHO will invite the FT Center Coordinator to register on the ICD-FIT platform. Subsequently the FT Center Coordinator will invite the FT Site coordinator(s) and coders to register on the ICD-FIT platform and complete the Participant Information Form (PI-Form).

**Step 3: Training of coders.** The FT Center Coordinator will arrange for ICD-11 familiarization and training of coders using the ICD-11 Training Manual and corresponding slide sets as reference material. The training will include familiarization with ICD-11 MMS, its tooling environment and coding rules base. Coder will undergo guided and unguided coding of case examples and will be familiarized with pilot test protocol and the ICD-FIT platform.

**Step 4: Coding of diagnostic terms on the ICD-FIT platform.** Assignment of coders. The FT Center Coordinator or FT Site Coordinator will assign the diagnostic terms to each of the coders using the ICD-FIT platform.

For each of assigned diagnostics term coders will complete an electronic ICD-11 and ICD-10 Code Assignment Form. After completing the code assignments for all diagnostic terms coders will fill an Evaluation Form.

Data analysis

**Data analysis:** For the compiled data set analysis will focus on:

- Percentage distribution of coders agreement with the gold standard of the ICD-11 and ICD-10 code assignment for each diagnostic term.

The proposed algorithm for the distance calculator is using a five point scale:
- If actual coding and gold standard are equal, the distance is 0
- If actual coding and gold standard are siblings, the distance is 1
- If actual coding and gold standard are cousins, or actual coding is a niece or nephew of gold standard, the distance is 2
- If actual coding and gold standard are second cousins, the distance is 3
- If actual coding and gold standard have a relationship greater than the second cousin, but they are in the same chapter, the distance is 4
- If actual coding and gold standard are in a different chapter, the distance is 5

- Cross-tabulation of coders level of agreement in the ICD-11 and ICD-10 code assignment with appropriate covariates (e.g. age, years of coding experience, ICD-11 familiarization and training).

- Basic descriptive statistics including frequency distribution, measures of central tendency of encountered coding time, accuracy and usability disaggregated by appropriate covariates (e.g. age, years of coding experience, ICD-11 familiarization and training).

Implementation status

As of August 2016 line coding pilot testing of the ICD-11 MMS English version is conducted in 11 Countries. Preparation are also under way to pilot test the ICD-11 MMS Spanish version in 7 Spanish speaking countries. It is expected to complete the line coding pilot for the ICD-11 MMS English version by September 2016 in preparation for the ICD Revision Conference in Tokyo.
Describing the impact of a disease on functioning: Coding functioning properties in ICD-11

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Abstract

Recognising the merits of using ICD together with aspects of functioning, WHO introduced functioning properties (FPs) as part of the record structure of the ICD-11 as a way of describing the most likely functions impacted by selected ICD-11. FPs are represented by selected ICF categories from the activities and participation component. Since their presentation at the 2015 WHO-FIC Network Meeting and in light of the available collaboration with members of the Functioning Disability Reference Group (FDRG) the instructions for coding coding FPs have been revised. After extensive review, the RSG-SEG made recommendations that were discussed with the Joint Task Force (JTF). This poster presents the results of fTAG’s joint effort with selected FDRG experts, the RSG-SEG recommendations, and the JTF feedback during a July meeting in Queensland (Australia).

Specification of FPs

Three possibilities for specifying the FPs for a given disease/disorder:

- All ICF block codes from all the A&P chapters*

- Tailored set of FPs reflecting the Brief ICF Core SetsA for specific diseases/disorders which can also be combined for multi-morbid situations

- 23-item set = 21 FPs based on the ICF Rehabilitation SetB + d1
to cover the Understanding & Learning Impact and d3 to cover the Communication impact

*Sanctioning rules dictate which combination of codes are allowed or not allowed. Users are not required to use ICF Core Sets, and users can choose an FP even if it is not included in the ICF Core Set.

Introduction

Recognising the merits of considering functioning information with ICD, WHO introduced functioning properties (FPs) as part of the ICD-11 content model.

FPs are selected categories derived from the ICF component of activities and participation (A&P) that can be used to describe the potential impact of a specific disease/disorder on a person’s functioning in daily life (such as toileting) and various life areas (such as work and employment).

To gain a more complete description of a person’s functioning in interaction with the health condition and contextual factors, relevant items from the ICF, in addition to the ICD, would need to be recorded.

Instructions for Coding Functioning Properties (FPs) Reviewed by RSG-SEG

- All ICF block codes from all the A&P chapters*
- Tailored set of FPs reflecting the Brief ICF Core SetsA for specific diseases/disorders which can also be combined for multi-morbid situations
- 23-item set = 21 FPs based on the ICF Rehabilitation SetB + d1
to cover the Understanding & Learning Impact and d3 to cover the Communication impact

*Sanctioning rules dictate which combination of codes are allowed or not allowed. Users are not required to use ICF Core Sets, and users can choose an FP even if it is not included in the ICF Core Set.

Codings in ICD-11

The functioning Topic Advisor Group (fTAG) developed instructions on how to code FPs as a first step to introduce the community of ICD users functioning as an essential component of health. Since presenting the coding instructions for FPs at the 2015 WHO-FIC Annual Meeting and in light of the available collaboration with members of the Functioning Disability Reference Group (FDRG), the coding instructions have undergone significant revisions.

After extensive review of the revised instructions, the RSG-SEG made recommendations that were discussed with the Joint Task Force (JTF) at the Queensland meeting mid-July 2016.

Response to RSG-SEG Recommendations on Coding FPs

- All ICF block codes from all the A&P chapters*
- Tailored set of FPs reflecting the Brief ICF Core SetsA for specific diseases/disorders which can also be combined for multi-morbid situations
- 23-item set = 21 FPs based on the ICF Rehabilitation SetB + d1
to cover the Understanding & Learning Impact and d3 to cover the Communication impact

*Sanctioning rules dictate which combination of codes are allowed or not allowed. Users are not required to use ICF Core Sets, and users can choose an FP even if it is not included in the ICF Core Set.

Conclusion

Discussions about FPs have come a long way since their inception in 2010. There are still several issues to resolve in terms of coding, however, the inclusion of FPs in ICD-11, including in the Mortality/Morbidity release, has been legitimised by the support given by RSG-SEG and JTF. The true test of the FPs’ utility and feasibility in ICD-11 will be the field trials with ICD users.

To allow more time for gathering fTAG input and more thorough exchange with ICF experts within the WHO-FIC community, the fTAG response will be presented at the WHO-FIC Annual Network Meeting in Japan.
Introduction

In March 2016, WHO invited the AIHW, as the ACC, to participate in a pilot test on ICD-11. The pilot test would involve the AIHW, as the ACC, conducting the pilot test in Australia on WHO’s behalf (as Field Trial Centre (FTC)), on the use of ICD-11 for basic morbidity coding. Other countries’ collaborating centres were similarly invited. The pilot test methodology involves finding, from a pre-determined list of diagnostic terms (about 420 or 5% of ICD-11-MMS), the relevant code of interest in both ICD-11 for Mortality and Morbidity Statistics (ICD-11-MMS) (using the Coding Tool) and the ICD-10 (using the online browser).

WHo’s aims for the pilot test are to:
• Assess selected components of ICD-11 in terms of reliability (consistency), goodness of fit (accuracy) and feasibility (usability) for basic morbidity coding.
• Ascertain the comparability between ICD-10 and ICD-11.
• Examine the testing process and instruments in order to determine where improvements are needed before starting more comprehensive testing.

The AIHW received in-principle support to participate in the pilot test from the Australian Health Classifications Advisory Committee (AHCAC) – a committee established to assist and advise the AIHW in relation to the WHO’s work to develop ICD-11 and other international health classifications. In addition to the WHO’s aims, the following aims were identified as being additional outcomes from the pilot test for Australia:
• Determine the usefulness of the pilot test for future (more extensive) field testing of ICD-11 in Australia.
• Evaluate the educational and implementation needs of Australian participants for future field tests of ICD-11 in Australia.
• Inform decision making as to whether ICD-11 will be a suitable product for use for morbidity coding in Australia.

The AIHW undertook to complete the pilot test in four phases:
1. Preparation
2. Undertake Testing
3. Analysis of Results
4. Reporting of Results

Abstract

The Australian Institute of Health and Welfare (AIHW) as the Australian Collaborating Centre (ACC) for the World Health Organization Family of International Classifications (WHO-FIC) was invited to participate in the WHO’s ICD-11 pilot test during 2016. The Australian aims for participating in the test were to a) determine the usefulness of future field tests in Australia; b) evaluate educational and implementation needs of Australia for field tests; and c) inform decision making on the use of ICD-11 as a morbidity tool in Australia. The Australian testing was planned in four phases, including 1) Preparation; 2) Undertake testing; 3) Analysis of results; and 4) Reporting of Results.

Phase 1: Preparation

During the preparation phase, discussions were held with WHO to understand the exact requirements for the pilot test and to confirm that these requirements were achievable by/in Australia.

Clarification was sought on the materials to be provided by WHO, such as the Field Testing Training Manual, and any other requirements that participants would need. The anticipated timing for the field test activities was also clarified with the WHO, although it was noted that this was subject to change.

The WHO provided access to, and a live demonstration of, ICD-FiT, the web-based platform through which all information for the pilot test is to be entered and analysed.

Participants

The AIHW recruited 9 health classification experts from Australia and sought permission from WHO to invite 2 health classification experts from New Zealand. New Zealand representatives are included in the ACC, and New Zealand uses ICD-10-AM (ICD-10 Australian modification) so it was considered appropriate to extend the pilot test invitation to New Zealand.

All participants had minimal (if any) prior exposure to ICD-11 and represented different sectors, including public and private hospitals and government.

Pre-test coding exercise

To enable participants to become familiar with the pilot test protocols, a pre-pilot test coding exercise was undertaken. Participants assigned ICD-10 and ICD-11-MMS codes to up to 23 test cases using all of the pilot test materials - ICD-FIT, the Coding Tool, ICD-11-MMS beta browser and ICD-10 browser.

The AIHW undertook this exercise in two parts. The first part was with a core group of participants with some, but limited knowledge of ICD-11, to enable the AIHW to assess educational needs of the participants on the pilot test materials. An information teleconference was held with this group, where a test case was coded and participants could ask questions. Outcomes from this process informed education delivery for the second group (with no prior knowledge of ICD-11) with whom a similar teleconference was held. Teleconferences were also held upon completion of the pre-test coding exercise to ascertain feedback and learnings from the entire group.

Participation in expert consensus

All FTCs participating in the pilot test were asked to confirm the WHO’s selection of ICD-11-MMS and ICD-10 codes for the list of 420 diagnostic terms. Consensus on codes amongst FTCs provided the reference against which the level of agreement between participants was measured. The AIHW also participated in this exercise.

Phase 2: Undertake Testing

This phase involved the participants assigning ICD-11-MMS and ICD-10 codes to the list of diagnostic terms, as provided by WHO.

Participants also indicated whether the codes found were optimal, that is, whether there was an exact match of code to diagnostic statement, or whether there was any ambiguity in the codes they found for selection.

Phase 3: Analysis of Results

This phase will occur during October 2016 after testing is complete. Only the Australian results will be analysed as results from other FTCs will only be accessible by WHO.

Feedback will be sought via teleconference from the Australian participants to ascertain their experiences in undertaking the pilot field test.

The AIHW will discuss the Australian results with WHO and provide any feedback or lessons learnt through coordinating the pilot test in Australia.

Acknowledgements

The AIHW gratefully acknowledges the voluntary participation by the health classification experts in this pilot test.
Pretest for the ICD-11 Field Trial in Japan

Authors: Hiromitsu Ogata¹, Yoko Sato¹, Naoko Tomita¹, Kei Mori², Hiroshi Mizushima¹

¹National Institute of Public Health, Wako, Japan
²Ministry of Health, Labour and Welfare, Tokyo Japan

Abstract. A pretest (preliminary investigation) as a simulation of the ICD-11 Field Trial was carried out to reveal the problems in the Field Trial implementation in Japan. The results of this pretest showed some of the detailed issues for the implementation of the actual Field Trial. In particular, it was found that the exact translation of the web and the protocol is important.

Introduction

It needs to be systematically field tested in the world to assess the accuracy or the relevance of ICD-11. In previous ICD revisions, Field Trials were limited in scope and conducted to facilitate the transition between the old and the new classification system after the revision. Nevertheless, learning from these past experience, the Field Trial has been found to be very useful in the revision process. The purpose of this study is to carry out a pretest (preliminary investigation) as a simulation of the ICD-11 Field Trial, and to reveal the problems in the Field Trial implementation in Japan.

Methods & Materials

Based on the draft version of the WHO protocols, the pretest was conducted according to the following process; 1) submission of the protocol for review by ethical review committee, 2) translation of reference guide, 3) selection of case summaries, 4) translation of questions, 5) implementation of the pretest (basic questions, bridge coding and reliability). 3 coordinators and 7 raters (4 clinicians and 3 coders) participated in this pretest. Participants were selected from three national centers (National Center for Child Health and Development, National Center for Global Health and Medicine, National Hospital Organization Kyushu Medical Center). Case summaries were selected from three fields such as cancer, childhood diseases and lifestyle-related diseases.

Results

Some sections of the ICD-11 have changed largely their classification structure, therefore the reviewers pointed out that some parts of structures are too complicated and that some mistakes were found within the classification. There is a need for detailed lectures on the revised classification and its usage. Also, some terms and definitions used in the assessment form of the ICD-11 Field Trial protocol seem to be confusing.

This pretest was carried out using paper documents. For the ICD-11 draft version and the instructions of ICD-11 coding, the English versions were used. Therefore, there was some confusion for reviewers. These problems could be solved to some extent by developing web environment before the ICD-11 Field Trial starts.

Conclusions

The results of this pretest showed some of the detailed issues for the implementation of the actual Field Trial. In particular, it was found that the exact translation of the web and the protocol is important.

Acknowledgements

We gratefully acknowledge the collaboration of coordinators and raters of three national centers (National Center for Child Health and Development, National Center for Global Health and Medicine, National Hospital Organization Kyushu Medical Center). This work was supported by Health Labour Sciences Research Grant.

Table 1: An example of results

<table>
<thead>
<tr>
<th>(Sample code Q704 in ICD-10)</th>
<th>Rater ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridge-Coding Primary diagnosis</td>
<td>Q704 Q704 Q704</td>
</tr>
<tr>
<td></td>
<td>ICD-10</td>
</tr>
<tr>
<td>2nd primary diagnosis</td>
<td>ICD-10 ICD-11</td>
</tr>
<tr>
<td>Alternative diagnosis</td>
<td>ICD-10 ICD-11</td>
</tr>
<tr>
<td>Time required for coding(m)</td>
<td>5 10 5</td>
</tr>
<tr>
<td>Reference for ICD-11 code</td>
<td>Web Web Web</td>
</tr>
<tr>
<td>Difficult to code</td>
<td>Yes No No</td>
</tr>
<tr>
<td>(Reason for difficult)</td>
<td>No “search function”</td>
</tr>
<tr>
<td>Ease of use of ICD-11</td>
<td>Normal High High</td>
</tr>
<tr>
<td>Self-confidence for coding</td>
<td>High High Normal</td>
</tr>
<tr>
<td>Discrepancy</td>
<td>No No No</td>
</tr>
</tbody>
</table>

Figure 1: Process of the pretest
**Abstract**

Internal Medicine Topic Advisory Group (IM-TAG) conducted a coding exercise for testing practicality of new structure of ICD-11 in September 2015. The participants of the exercise conducted coding of 61 sample cases and reported length of time and difficulties of the coding of each case. This exercise indicated that the new structure proposed by the IM-TAG could be considered to be practical use. However, it revealed that it is necessary to make further improvement of the structure for the everyday use of ICD-11.

**Methods & Materials**

During the Face-to-Face meeting, a coding exercise was conducted using 61 sample cases developed by WGs: 20 cases from Endocrine WG, 7 cases from Hepatology & Pancreatobiliary WG, 24 cases from Haematology WG, and 7 cases from Respiratory WG. Members of WGs who participated in the meeting were also participated in the coding exercise (Table 1). Using sample cases, the participants conducted coding exercise of the assigned cases and they reported the length of time for the coding of each case.

<table>
<thead>
<tr>
<th>Table 1: List of IM-TAG member participated in the 7th IM-TAG Face-to-Face meeting</th>
</tr>
</thead>
</table>

**Discussion**

This exercise indicated that the new structure proposed by the IM-TAG could be considered to be practical use. However, it revealed that it was necessary to make further improvement in some areas of structure for the everyday use of ICD-11. We also found that the Coding Tool was useful for seeking appropriate code efficiently. The Tool was well accepted by the participants. ICD-11 should achieve not only clinical validity but also practicality for the everyday coding. The coding exercise could achieve both validity and practicality of the ICD-11.

**Introduction**

In the alpha phase of the ICD-11 revision process, the structural changes have been developed by the Topic Advisory Groups (TAGs) and working groups (WGs). In the Internal Medicine TAG (IM-TAG), the structural changes were developed by the WGs in collaboration with clinical experts and classification experts. As ICD-11 should be used for the everyday coding at the time of its launch, IM-TAG conducted a coding exercise using sample cases for testing practicality of new structure in the 7th IM-TAG Face-to-Face meeting held in Tokyo on 29th and 30th September 2015 (Figure 1).

They also reported the difficulties of the coding for each case. The Coding Tool developed by WHO was used for this exercise.

**Results**

All 61 cases were coded correctly by the participants, even though all participants were clinical experts rather than coding specialists. There were variations as for the length of time and difficulties of the coding. Sixteen out of 61 cases (26.2%) were assessed as the “difficult” for the coding by participants (Figure 2). The average time for coding was approximately 2.5 minutes per case whereas it took more than 15 minutes for the coding of some cases (Figure 3).

**Figure 1: Coding exercise in the 7th IM-TAG Face-to-Face meeting in Tokyo (29th and 30th Sep 2015)**

**Figure 2: Difficulties of coding for each sample case**

**Figure 3: Length of time of coding for each sample case (minutes)**
The collaboration of the Spanish-speaking countries in the 11th revision of ICD (ICD-11)

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(2) Alonso Gelabert, Arnaud; Canala Soler, Jaume; Conejo Gómez, Carolina; Conesa, Artur; del Río Mata, José; Estrada Sabadell, Maria-Dolors; Ferrer Ivars, Rosario; Gelabert Colomó, Gemma; González Gómez, Adelaida; Hernández-Cortés, Anna; Laxe García, Sara; Linanes Fernandez, Luis F.; López Cabanas, Maria José; Martínez Reina, Alfonso; Molina Puyo, Purificación; Romero Serrano, Ramón; Salazar Pou, Maria del Mar; Vivanco Hidalgo, Rosa M.

Abstract In 2015 the Collaborating Centers and National Reference Centers for the WHO-FIC in the Americas and in Barcelona (PAHO/WHO-FIC network) started working with PAHO in the ICD-11 revision. A total of 109497 (update in 02/August/2016) entities in ICD 11 Beta Draft were translated and the preparation of field testing has also started. This poster share experiences and challenges faced in this process.

Introduction

Background. The Collaborating Centers (CCs) for the WHO-FIC in Venezuela (CEVECE), Mexico (CEMECE) and Argentina (CACE), the National Reference Centers (CNRs) in Cuba (CECUCE) (under designation), Chile and Colombia, and the Collaborating Center in Barcelona (CC-BCN) (under designation) have formed the PAHO/WHO-FIC Network.

They also are part of the RELACoSIS (Latin American and Caribbean Network to Strengthen Health Information Systems).

ICD-11 revision. Since 2015, the PAHO/WHO-FIC Network has started a collaborative translation of the ICD-11 Beta draft to better contribute to the ICD revision and participate in the field testing. This work is coordinated by the Health Analysis & Information Unit (CHA/HA) at the Pan American Health Organization (PAHO/WHO).

This poster aims to share the progress made and challenges faced in this process.

Methods & Materials

Plan the work and work the plan.

1) Commitment. This activity has brought an overload of work to the CCs, so the solid commitment from their members with the improvement of health statistics was the key to carry it out in a successful way.

2) Regular virtual meetings: every two weeks, a virtual meeting was held to follow up progress of the collaborative translation, exchange experiences, to reach a common understanding of the process and to discuss technical documents and be updated with the global advances and plan.

3) Experienced team of translators. Members of the CCs were responsible for the translation of the platform. Difficult terms were discussed by the group.

4) Development of technical materials

Results

Other key elements were also translated and technical materials were developed such as platform (CEMECE), a Reference Guide and ICD-11 Field Testing Training Manual (PAHO), tutorial for collaborative translation (CACE), a tutorial for online coding (CEVECE), and scientific article (All).

The knowledge built in this experience will allow the PAHO/WHO-FIC Network to help other Spanish-speaking countries in the 2017 phase of the ICD-11 field testing and the process of transition from ICD-10 to ICD-11.

Lessons learned

Some strengths:

• Honoforic activity.
• Enable teamwork and sharing of knowledge and experiences.
• Commitment - one year of intense work together despite of thousands of kilometers distance and time zone difference.
• In the process of translation the CCs have made an effort to find a neutral language to be used in all Spanish-speaking countries.
• Have information on the ICD-11 features.

Some limitations:

• No funds assigned for this activity.
• Overload of work for CCs.
• Frequent changes in the ICD Beta draft after translation, platform and delays in the field testing.
• Vocabulary innovations with no correspondence in Spanish.

ICD-11 implementation. Looking to the future.

The ICD-11 will provide the users with more detailed and specific codes in addition to the inclusion of the new ones that can have a positive impact on health statistics. Alignment with other classifications is welcome. Its readiness to be used with electronic health records is a plus.

On the other hand, some important issues have to be addressed in the implementation process:

• To adjust the current status of data collection and health statistics in the radical changes in the ICD-11 would determine a large period of time to train people, implement or review information technology, etc. The costs of these changes needs to be evaluated.
• The digital gap. ICD-11 is intended to be used in a digital environment. However, coders in many Spanish-speaking countries in the Americas use mostly the print version of the ICD-10. Will ICD-11 determine a change in the coders’ job profiles?

Acknowledgements: To all colleagues who collaborated voluntarily on this project. Special thanks to Nenad Kostanjsek and Can Celik (WHO).
Spanish version of the ICD-11 beta draft: the experience of the CC-BCN (Spain)

Authors: Estrada MD1,2 on behalf of the Spanish volunteers group of the CC-BCN (Spain)*
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Abstract
The WHO-FIC Network is developing the ICD-11 in response to align the demands of the classification with the latest scientific evidence and to meet user requirements. Among the different activities related to this developments, they offer a possibility of participation in field trials. It is in this context that the CC-BCN (Spain) is actively participating, especially on the Spanish translation of the ICD-11 beta draft (“Traducción solidaria”). With the aim of describing the specific characteristics of the Spanish volunteers and identifying possible barriers and facilitators, the CC-BCN (Spain) has conducted a cross-sectional study using an electronic survey.

Objective
To describe the main characteristics of the Spanish volunteer group from the CC-BCN (Spain) who have participated in the Spanish translation of the ICD-11 beta draft, as well as to identify some barriers and facilitators in order to improved future translations.

Method

- A cross-sectional descriptive study by online survey has been carried out in 2016 (from 20th June to 29th July), only from a sample of the CC-BCN (Spain) volunteers (N=19 people, in total)
- The survey had 45 items (closed-ended and open-ended questions) distributed in eleven domains: 1) identification of the participant, 2) demographic characteristics, 3) educational background, 4) level of knowledge about WHO FIC, 6) lack of ICD-11 beta draft numerical codes, 7) IT translation platform training, 8) Burden of platform usage and translation by itself, 9) translation tools, 10) Internet connections and 11) Personal motivation & Satisfaction.
- Question Monkey platform was used for designing and descriptive analysis of the results.

Main results

Results 1. Description of the participants

- Women and men: 9 women and 5 men
- Age: 10 people were born before 1968
- The highest educational level reached: University studies (n=13), Professional studies (n=6)
- Years of professional activity: 10 years +
- Level of English: Low (n=4), Middle (n=10), High (n=5)
- ICTs usage skills: Low (n=5), Middle (n=10), High (n=4)
- Level of IT translation platform usage: Low (n=3), Middle (n=9), High (n=7)
- Time since the highest educational level has been reached: 10 years +
- Difficulty in translation tasks: Low (n=1), Middle (n=9), High (n=5)
- Difficulty in handling translation platform: Low (n=3), Middle (n=6)
- Difficulty in translation tasks: Low (n=1), Middle (n=9)
- Level of satisfaction after participating: middle (n=7), high (n=7)
- Would you recommend it? Yes (n=14)

Results 2. WHO FIC

- Identification of the main professional activity: University Hospital (n=9), Catalan Government (n=2), Community (n=2), Research Institute (n=1) and Medical student (n=1)
- Autonomous Community of Spain: Catalonia (n=6), Andalucía (n=2), Castilla Mancha (n=1), Valencia (n=2) and Murcia (n=1)
- Level of knowledge about WHO FIC tools: Low (n=6), Middle (n=10), High (n=4)
- Training materials: video tutorials (n=5), power-point (n=3), informative emails (n=5)
- Type of training: individual (n=8), group (n=6), both (n=2)
- Has received training: Yes (n=14)
- Training method: Skype (n=2), face-to-face meetings (n=5), mix means (n=6)
- Difficulty in handling translation platform: Low (n=8), Middle (n=10)
- Difficulty in translation tasks: Low (n=3), Middle (n=6)
- Experience of the CC-BCN (Spain): 10 people - 9 women and 5 men
- Would you recommend it? Yes (n=14)

Results 3. Topics related with the Spanish translation and IT translation platform

- Personal motivation & satisfaction: Yes (n=14)
- Training method: Skype (n=2), face-to-face meetings (n=5), mix means (n=6)
- Personal motivation & satisfaction: Yes (n=14)
- Difficulty in handling translation platform: Low (n=8), Middle (n=10)
- Difficulty in translation tasks: Low (n=3), Middle (n=6)
- Experience of the CC-BCN (Spain): 10 people - 9 women and 5 men
- Would you recommend it? Yes (n=14)

Results 4. Personal motivation and satisfaction

- Participation motivation: WHO project (n=13), International collaborative project (n=10), IT platform involved (n=4); other (n=4)
- Level of motivation: Low (n=2), Middle (n=8), High (n=7)
- Interest in obtaining an accreditation certificate: Yes (n=14)
- Would you recommend it? Yes (n=14)

Results 5. Barriers & facilitators

- Barriers: Having a coordinator
- Facilitators: Easy access to ICD-11 beta draft (browser)
- Previous knowledge of FIC tools, medical terms and English language
- Automatic translation tools (light icon and “copy & paste” option
- Having a coordinator
- Easy access to ICD-11 beta draft (browser)
- Previous knowledge of FIC tools, medical terms and English language
- Automatic translation tools (light icon and “copy & paste” option

Discussion

- Limitations: recall bias, small sample, some redundant questions, limitations of using online surveys and non-anonymous survey.
- In conclusion, the good feedback from our participants will encourage further contributions in the next steps of ICD-11 field trials.

*Spanish volunteers group from the CC-BCN (Spain)

Arnau Alonso, Jaume Canela, Carolina Conejo, Artur Conesa, José del Río, Maria-Dolors Estrada, Rosario Ferrer, Gemma Gelabert, Adelaida González, Anna Hernández-Cortés, Sara Laxe, Luis Linares, Mario José López, Alfonso Martínez, Mireia Miquel, Purificación Molina, Ramón Romero, María del Mar Salazar Pou, Rosa M Vivanco.
ICD-11: Road to linearization

Author: Cordero C.
Collaborating Center for the WHO-FIC in Venezuela (CEVECE), Statistics and Health Information, Ministry of Popular Power for Health; Caracas, Venezuela

Abstract

Given the technological advances in the health-disease event the need to provide new vision to the family of international classifications, the creating the term linearization as a given every affection comprehensive approach by presenting the user in location devices and / or arises systems. The dynamic orientation and clinic ICD-11 according to our times is evident.

Background

Since ancient times man has had the need to measure disease and death as indicators of the health of people and based on that public policies established in order to improve the quality of life of human beings; another need is to compare health and the phenomenon of disease in the population: born so the family of international classifications.

Bertillón list presented in Paris, 1900 during the First International Conference on the revision of the "International List of Causes of Death" its creator Jacques Bertillon, french statistician, with contributions from Marc D’Espine, swiss statistician and William Farr, english physician.

Therefore this list is assumed in consensus by the countries for the classification of diseases, with periodic updates that allowed its optimization as detailed below:

<table>
<thead>
<tr>
<th>REVISIONS</th>
<th>YEAR OF THE CONFERENCE THAT ADOPTED</th>
<th>YEARS OF USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-1</td>
<td>1900</td>
<td>1900-1909</td>
</tr>
<tr>
<td>ICD-2</td>
<td>1909</td>
<td>1910-1920</td>
</tr>
<tr>
<td>ICD-3</td>
<td>1920</td>
<td>1921-1929</td>
</tr>
<tr>
<td>ICD-4</td>
<td>1929</td>
<td>1930-1938</td>
</tr>
<tr>
<td>ICD-5</td>
<td>1938</td>
<td>1939-1948</td>
</tr>
<tr>
<td>ICD-6</td>
<td>1948</td>
<td>1949-1957</td>
</tr>
<tr>
<td>ICD-7</td>
<td>1955</td>
<td>1956-1967</td>
</tr>
<tr>
<td>ICD-8</td>
<td>1965</td>
<td>1968-1978</td>
</tr>
<tr>
<td>ICD-9</td>
<td>1975</td>
<td>1979-1992</td>
</tr>
<tr>
<td>ICD-10</td>
<td>1989</td>
<td>1993- Present</td>
</tr>
</tbody>
</table>

The translation process of ICD-10 Spanish language was commissioned by WHO to CEVECE and started in 1983, culminating in 1989, when it is presented at the International Conference for the Tenth Revision of the International Classification of WHO diseases.

The linearization allows a comprehensive presentation of each condition, reducing ambiguity and gaining specificity.

The clinical approach to ICD-11 will allow a greater understanding of the FCI by health personnel.

The immediate challenge of the DC network is in the training and dissemination of ICD-11 for the strengthening of the countries in FCI.

Learned lessons

- The linearization allows a comprehensive presentation of each condition, reducing ambiguity and gaining specificity.
- The clinical approach to ICD-11 will allow a greater understanding of the FCI by health personnel.
- The immediate challenge of the DC network is in the training and dissemination of ICD-11 for the strengthening of the countries in FCI.
Structured Representation of Diagnostic Criteria and Compositional Expressions

Harold R. Solbrig, Hongfang Liu, Guoqian Jiang
Mayo Clinic, Rochester, MN, USA

Abstract
In this presentation, we will describe our efforts in developing and evaluating automated methods for converting textual clinical diagnostic criteria in a structured format based on the Quality Data Model (QDM). In addition, we collaborated with the IHTSDO development community to define the SNOMED CT Expression Constraint Language (ECL). We anticipate incorporating the ECL into the ICD-11 tooling when the SNOMED/ICD-11 mapping project resumes.

Table 1
An example of textual diagnostic criteria for diabetes mellitus.

<table>
<thead>
<tr>
<th>Criteria for diabetes mellitus.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1: An example of textual diagnostic criteria for diabetes mellitus.</td>
</tr>
</tbody>
</table>

Introduction
Diagnostic criteria are one of main parameters specified in the ICD-11 content model for describing an ICD-11 category. However, constructing standard and computable clinical diagnostic criteria is a challenging research field in the clinical informatics community. We at Mayo Clinic have previously explored the methods and tools converting the Quality Data Model (QDM)-based diagnostic criteria into Semantic Web Rule Language (SWRL). In this presentation, we will describe our efforts in developing and evaluating automated methods for converting textual clinical diagnostic criteria in a structured format based on QDM. We demonstrated that Our NLP-based computational framework is a feasible and useful solution in developing diagnostic criteria representation and computerization.

Methods & Materials
We used a clinical Natural Language Processing (NLP) tool known as cTAKES to detect sentences and annotate events in diagnostic criteria. We developed a rule-based approach for assigning the QDM datatype(s) to an individual criterion, whereas we invoked a machine learning algorithm based on the Conditional Random Fields (CRFs) for annotating attributes belonging to each particular QDM datatype. We manually developed an annotated corpus as the gold standard and used standard measures (precision, recall and f-measure) for the performance evaluation.

Data Collection: our diagnostic criteria were collected from a number of sources, including medical textbooks, journal papers, documents issued by professional organizations (such as the World Health Organization [WHO]), and the Internet. Table 1 shows an example of textual diagnostic criteria for diabetes mellitus.

Table 1: An example of textual diagnostic criteria for diabetes mellitus.

<table>
<thead>
<tr>
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<tbody>
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</tbody>
</table>

Compositional Expressions
The SNOMED CT to ICD-11 mapping project required a formal language that could be used to select and perform logical operations on SNOMED CT concept identifiers. We collaborated with the IHTSDO development community to define this language, the SNOMED CT Expression Constraint Language (ECL), which is now an official IHTSDO standard. We created a formal specification of the in the Z notation which was used to verify the consistency and completeness of the language. We then implemented an ECL parser and interpreter based on ANTLR and Z that can be used to transform ECL into corresponding SQL queries against the IHTSDO Release Format 2 (RF2) tables. We anticipate incorporating the ECL into the ICD-11 tooling when the SNOMED/ICD-11 mapping project resumes.

Figure 1: An Integrated Framework for Representing Diagnostic Criteria in QDM.

Figure 2: A web application for converting individual diagnostic criteria into QDM/HQMF XML.

From the implementation perspective, we chose the two most common types of diagnosis evidence, Symptom and Laboratory Test, to perform our experiment in this study. The evaluation results indicated that the framework and methods we designed and developed are feasible to represent diagnostic criteria in a standard and computable way.

Acknowledgements
This work is supported in part by funding from the caCDE-QA (U01 CA180940) , and PhEMA (R01 GM105688).

WHO Academic Collaborating Centre at Mayo Clinic

WHO - FAMILY OF INTERNATIONAL CLASSIFICATIONS NETWORK ANNUAL MEETING 2016
8-12 October 2016
Tokyo, Japan

C310
Abstract
In preparation for the release of the Traditional Medicine (TM) Chapter as part of the overall ICD-11 MMS in Tokyo at the ICD Revision Conference, the TM Chapter has undergone a stringent quality analysis process. A major component of the analysis was a three-month international peer review of the whole chapter.

The international peer review of the ICD-11 MMS TM Chapter successfully enhanced its content, structure, and terminology, despite the challenge of being a pioneering activity for the international TM community. Constructive technical and cross-cultural communication ensured a smooth process. Discussions among experts substantiated with rationale and references provided input of significant quality and quantity.

The importance of terminology harmonization as well as conceptual equivalence of key technical terms was highlighted. Also the need for continued communication within and beyond the TM community was shown to be of paramount importance in order to explain the classification requirements such as for instance including ‘system’ for organs in a TM context; ‘disorder (TM)’ or ‘pattern (TM)’ in each TM entity in order to identify them systematically.

In preparation for the release of the Traditional Medicine (TM) Chapter as part of the overall ICD-11 MMS in Tokyo at the ICD Revision Conference, the TM Chapter has undergone a stringent quality analysis process. A major component of the analysis was a three-month international peer review of the whole chapter.

The peer review results were then compiled into proposals for enhancing content, structure, and terminology of the TM Chapter. The proposals were discussed and decided upon in an editorial working group meeting in July, and processed by WHO in August.

Introduction
In 2010, WHO started the international classification of traditional medicine (ICTM) project. A major output developed for inclusion within ICTM has been the classification of the diagnostic categories used in the traditional medicine (TM) that originated in ancient China and are now commonly used in China, Japan, Korea and elsewhere around the world. This classification represents a unified set of harmonized traditional medicine disorders and patterns from national classifications from China, Japan and Korea, different in each country according to their specific diagnostic approaches.

The TM Chapter has undergone a stringent quality analysis process and in particular a three-month international peer review of the whole TM chapter. Between January and March of 2016, 142 TM experts from China, Japan, Korea, USA, Australia, and Europe - grouped in multinational teams of 5 to 10 experts interacting on the WHO Review Platform - reviewed 470 TM chapter entities with their respective title, definition, inclusion and exclusion terms. The TM chapter entities were reviewed in terms of their accuracy, clarity, uniqueness, level of specificity, consistency, correct placement, conciseness, clinical applicability, research utility as well as possible overlap between categories, out of scope entities, and any omissions.

The peer review results were then compiled into proposals for enhancing content, structure and terminology of the TM Chapter. The proposals were discussed and decided upon in an editorial working group meeting in July, and processed by WHO in August.

Review process
The WHO Review Platform enabled TM experts to carry out their review online at their convenience and importantly offered experts the possibility to interact within their multinational team for each assigned review item in order to discuss their inputs with the objective of reaching a consensus statement.

Conclusions
The following typical situations occurred:

Example #1: Agreement among experts

Example #2: Discussion leading to consensus on enhancement

The peer review results were then compiled into proposals for enhancing content, structure and terminology of the TM Chapter. Overall 435 proposals were generated, split into 3 lists to facilitate analysis:
- List 1: proposals (285) for which there was agreement among reviewers, or minor content edits;
- List 2: proposals (95) for which there was disagreement among reviewers, or major content edits;
- List 3: any proposal (55) to edit the structure of the TM Chapter

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Authors: Espinosa S 1, Kostanjsek N 1, Ito M 2, Lee R 3, Xu W 4, Zhang Q 1

1World Health Organization, Geneva, Switzerland
2Kyoto University, Japan
3Korea Institute of Oriental Medicine, Republic of Korea
4Shanghai University of TCM, People’s Republic of China

International Peer review

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Use case for Traditional Medicine in Japan - Morbidity data classified by joint use of ICD-

Authors: Masato IZUTSU1, Kenji WATANABE1,2, Shuji YAKUBO1,2, Michio ITO1,2, Takao NAMIKI1,2, Kei MORI1

Affiliation, Location

1Collaborating Centre for the WHO-FIC in Japan, 2Japan Liaison of Oriental Medicine

Abstract

World Health Organization (WHO) commenced to develop International Classification of Traditional Medicine (ICTM) in 2010 and the development was focused on traditional medicine practice used in China, Japan and Korea (one of the Traditional Medicine practice in Japan is called as "Kampo Medicine"). In this poster, we show the tentative morbidity data which are classified by joint use of Western Medicine (WM) chapter and TM chapter in ICD-11 Beta Draft by using health insurance claims.

Introduction

Traditional Medicine is an important form of health care for many people across many regions. The use of safe and effective traditional medicine practice and products can make an important contribution to national and individual health care and the promotion of health equity. However, there was no international platform that allows the harmonization of data for clinical, epidemiological and statistical use. In order to overcome such lacking, World Health Organization (WHO) commenced to develop International Classification of Traditional Medicine (ICTM) in 2010 and the development was focused on traditional medicine practice used in China, Japan and Korea (One of the Traditional Medicine practice in Japan is called as "Kampo Medicine"). Part of ICTM was evolved by integrating national standards in these countries and then is to be included into chapter 27 "Traditional Medicine Conditions – Module 1" in ICD-11.

The aim of this study is to create morbidity data in Japan, which are classified by joint use of Western Medicine (WM) chapter and TM chapter in ICD-11 Beta Draft.

Data source

Ministry of Health, Labour and Welfare (MHLW) performs "Survey of Medical Care Activities in Public Health Insurance" to obtain the basic data for health insurance policy by identifying the situation of recipient of health care including the contents of health intervention, the situation of diseases and injuries, the contents of prescription etc. In order to conduct this survey, MHLW gathered health care claims data.

In principle, there are 3 categories in health care claims (medical claim, dental claim and pharmaceutical claims). We use data from medical claim and pharmaceutical claims since there are data on age, sex, use of "Kampo" drug, diagnosis (according to ICD-10) and specialty of each medical institution (e.g. internal medicine, surgery, gynaecology etc.).

Mapping table between Pattern (TM) and "Kampo" drugs

One of the greatest features of "Kampo" medicine is that each "Kampo" drug is corresponds to "pattern" in traditional medicine. Japanese society of oriental medicine has completed the mapping table.

Morbidity data classified by joint use of ICD

We estimated the number of usage of "Kampo" drug by sex, age, diagnosis and specialty of medical institutions. And then, by using mapping table showing "kampo" drug-to-pattern (TM) correspondence, we created morbidity data in TM.

Results

Table 1. 10 leading patterns (TM) by sex, in morbidity: Japan, 2016

<table>
<thead>
<tr>
<th>Rank</th>
<th>Male</th>
<th>Pattern (TM)</th>
<th>Female</th>
<th>Pattern (TM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>TC59</td>
<td>Medium (Excess/Deficiency) pattern (TM)</td>
<td>TC59</td>
<td>Medium (Excess/Deficiency) pattern (TM)</td>
</tr>
<tr>
<td>2</td>
<td>TC52</td>
<td>Heat pattern (TM)</td>
<td>TC52</td>
<td>Heat pattern (TM)</td>
</tr>
<tr>
<td>3</td>
<td>TC55</td>
<td>Deficiency pattern (TM)</td>
<td>TC55</td>
<td>Deficiency pattern (TM)</td>
</tr>
<tr>
<td>4</td>
<td>TC53</td>
<td>Cold pattern (TM)</td>
<td>TC58</td>
<td>Moderate (Heat/Cold) pattern (TM)</td>
</tr>
<tr>
<td>5</td>
<td>TC58</td>
<td>Moderate (Heat/Cold) pattern (TM)</td>
<td>TC53</td>
<td>Cold pattern (TM)</td>
</tr>
<tr>
<td>6</td>
<td>TC81</td>
<td>Fluid disturbance pattern (TM)</td>
<td>TC81</td>
<td>Fluid disturbance pattern (TM)</td>
</tr>
<tr>
<td>7</td>
<td>TC61</td>
<td>Qi stagnation pattern (TM)</td>
<td>TC71</td>
<td>Blood stasis patterns (TM)</td>
</tr>
<tr>
<td>8</td>
<td>TC60</td>
<td>Qi deficiency pattern (TM)</td>
<td>TC62</td>
<td>Qi reverse flow patterns (TM)</td>
</tr>
<tr>
<td>9</td>
<td>TC54</td>
<td>Excess pattern (TM)</td>
<td>TC60</td>
<td>Qi deficiency pattern (TM)</td>
</tr>
<tr>
<td>10</td>
<td>TC60</td>
<td>Kidney qi deficiency pattern (TM)</td>
<td>TC61</td>
<td>Qi stagnation pattern (TM)</td>
</tr>
</tbody>
</table>

Table 2. 5 leading patterns (TM) by age-group, in morbidity: Japan, 2016

<table>
<thead>
<tr>
<th>Age</th>
<th>Pattern (TM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>TC52, TC59, TC54, TC53, TC58</td>
</tr>
<tr>
<td>10-19</td>
<td>TC52, TC59, TC54, TC53, TC58</td>
</tr>
<tr>
<td>20-29</td>
<td>TC52, TC59, TC54, TC53, TC58</td>
</tr>
<tr>
<td>30-39</td>
<td>TC52, TC59, TC54, TC53, TC58</td>
</tr>
<tr>
<td>40-49</td>
<td>TC52, TC59, TC54, TC53, TC58</td>
</tr>
<tr>
<td>50-59</td>
<td>TC52, TC59, TC54, TC53, TC58</td>
</tr>
<tr>
<td>60-69</td>
<td>TC52, TC59, TC54, TC53, TC58</td>
</tr>
<tr>
<td>70-79</td>
<td>TC52, TC59, TC54, TC53, TC58</td>
</tr>
<tr>
<td>80-</td>
<td>TC52, TC59, TC54, TC53, TC58</td>
</tr>
</tbody>
</table>

Table 3. 5 leading patterns (TM) by specialty, in morbidity: Japan, 2016

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Pattern (TM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>Surgery</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>Dermatology</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>Others</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
</tbody>
</table>

Table 4. 10 leading patterns (TM) by chapters in ICD-10, in morbidity: Japan, 2016

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Pattern (TM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>II</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>III</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>IV</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>V</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>VI</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>VII</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>VIII</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>IX</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>X</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>XI</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>XII</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>XIII</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>XIV</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>XV</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>XVI</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>XVII</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>XVIII</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
<tr>
<td>IX</td>
<td>TC59, TC52, TC51, TC54, TC53</td>
</tr>
</tbody>
</table>

Conclusions

We created the tentative morbidity data in TM. The feature of this study is to show the cross-tabulation table according to both of WM chapter and TM chapter in ICD. Although there were still some technical problems to create morbidity data in TM, this results could show the usefulness and possibility of practical use of TM chapter in ICD-11. We hope our study could help enhance understanding of TM widely.

Acknowledgements or Notes

The authors thank members of JLOM for their technical advise on creating mapping table and statistical table.
Abstract

As a new Chapter in ICD-11, the TM Chapter is subject to international field testing. A feasibility study has been conducted to pilot field test the clinical utility of TM ICD-11 codes. A mixed methods approach was adopted, including a survey of practitioner views on the TM ICD-11 codes; a coding process of case studies to establish inter-rater reliability; and a survey of coders experiences of using TM ICD-11 codes to explore conceptual and operational issues with the codes.

In 2010, WHO started a collaborative project to produce an international classification of traditional medicine (ICTM). As part of the ICTM project the diagnostic categories used in the traditional medicine (TM) that originated in ancient China and are now commonly used in China, Japan, Korea and elsewhere around the world have been classified for inclusion as a chapter within ICD. These classification rubrics represent a unified set of harmonized traditional medicine diagnoses from national classifications from China, Japan and Korea, different in each country according to their specific diagnostic approaches.

As a new Chapter in ICD-11, the TM Chapter will be subject to international field testing.

Primary objective:

To pilot field test the clinical utility of TM ICD-11 codes.

Methods & Materials

To achieve the aims of the study a mixed methods approach was adopted, including a survey of practitioner views on the TM ICD-11 codes ('Basic Questionnaire'); a coding process of case study vignettes to establish inter-rater reliability between the coding of TM ICD-11; and a survey of coders experiences of using the TM ICD-11 codes to explore practitioners’ perspectives on conceptual and operational issues related to the codes.

Four European Field Trial sites participated in the field testing. Led by the Royal London Hospital for Integrated Medicine (lead contact Dr Peter Fisher), field trial sites included the Charité University Hospital Berlin, Germany (lead contact Professor Benno Brinkhaus); Tromso University, Norway (lead contact Professor Vinjar Fonnebo); and the Hospital Campo di Marte, Italy (lead contact Dr Elio Rossi).

Survey of practitioner perspectives on draft TM ICD-11 codes:

Online 'Basic Questionnaire' developed focussing on practitioner familiarity with western medicine ICD codes; perceived value of TM ICD-11 codes; and conceptual and operational issues related to TM ICD-11 codes. Member organisations of European Traditional Chinese Medicine Association agreed to participate. 14 TM associations agreed to distribute the survey link, spanning 12 European countries.

127 TM practitioners completed the survey. 83 (65.4%) were female, 44 (34.6%) male, with the overwhelming majority being white/caucasian (n=117, 92.1%). Participants had a range of ages, lengths of time practicing TM, and knowledge and experience of using the current ICD system.

Key findings included:

- The theoretical backgrounds predominantly used to guide diagnosis in clinical practice included Traditional Chinese Medicine (89.0%); Five Element (41.7%); western medical (33.1%); and Japanese style (11.8%).
- 47.2% strongly agreed/agreed TM ICD codes provides a meaningful way to classify “traditional medicine (of ancient Chinese origin) disorders and patterns”; 38.0% neither agreed or disagreed; 14.8% disagreed/strongly disagreed.
- TM ICD codes perceived as being most useful for reporting and health statistics (79.6% very useful/useful); conducting TM research (71.2%) and communication with conventional practitioners (66.9%).
- 77.0% felt the distinction between TM Disorders and Patterns was clear.
- 41.3% strongly agreed/agreed their patients’ diagnoses could be represented within the TM ICD codes; 43.3% neither agreed or disagreed; 15.4% disagreed/strongly disagreed.
- 93.1% felt that there were no categories in the ICD-TM Chapter which were misplaced and should therefore be moved to another section.
- 47.1% of participants felt TM practitioners could easily learn to use the TM ICD codes; 45.9% didn’t know; and 7.1% didn’t think they would be easy to learn.

Coding of case study vignettes: Case study vignettes were provided to the WHO ICTM project by China, Japan, and Korea. 5 case study vignettes selected to represent TM Disorders and Patterns frequently seen in clinical practice within Europe (based on the findings from the survey). Each field trial site identified 6 traditional acupuncturists to participate in the coding exercise (24 acupuncturists in total). Acupuncturists provided with case study vignettes and asked to code according to the TM ICD-11. Thus far responses have been received from 13 participants. The inter-rater reliability will be analysed using a Fleiss’ Kappa test.

Survey of acupuncturists participating in coding of case study vignettes:

Acupuncturists participating coding phase additionally completed a questionnaire relating to the clinical utility of the TM ICD-11 codes. Analysis is ongoing.

Conclusions

Survey findings indicate European TM practitioners perceive the TM ICD-11 codes as valuable, conceptually accurate, and easy to learn. Analysis of inter-rater reliability and survey of acupuncturists participating in coding of case study vignettes will be completed late summer 2016. The findings will be published in peer reviewed medical/Complementary and Alternative Medicine academic journals.

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Dual Diagnosis of Traditional Chinese Medicine and Western Medicine in China

Authors: Lianghua Zu, Danbo Dou*
Center for International Classification Research on Traditional Medicine Clinical Conditions and Service Evaluation, SHUTCM, Shanghai, China

Abstract
The article aims to introduce the background, related policies, achievements and significance concerning the application of dual diagnosis by traditional Chinese medicine (TCM) and Western medicine (WM) in China. Based on this dual diagnosis mode, China has been actively involved in seeking for the best treatment scheme for patients, improved diagnostic and treatment capabilities of clinicians and provided more effective associated information and inspirations for researchers as well as greatly contributed to the mutual progress of traditional Chinese medicine and Western medicine.

Methods & Materials
Since 2000, the SATCM has selected 100 TCM hospitals from more than 2,000 TCM hospitals throughout China based on the principle of stratified cluster random sampling to build a monitoring network focusing on all data from the first page of TCM inpatient medical records. From 2001 to 2010, the monitoring center has accumulated more than 2.4 million the first page records, which included TCM diagnoses (including TCM disease diagnoses and pattern diagnoses) and Western medicine diagnoses. The TCM diagnoses are according to the national classification standards of TCM diseases and patterns (GB95 and GB97). And as all the TCM hospitals in China have to use the dual diagnosis mode, a huge amount of data could be collected and used for health statistics, health decision-making, scientific research and other fields.

Results

1 Health Statistic
The first pages of inpatient medical records of almost 2500 TCM hospitals all over the country are all required to use the standard of GB95/97, which is also part of China’s national health statistics.

And the monitoring data from the 100 collected hospitals often has been used to do more detailed analysis. For example, the statistic of commonly used diagnosis. The most commonly used TM and WM medicine diagnosis in 2401731 cases which have WM diagnosis, TCM disease diagnosis and TCM pattern diagnosis during 2001-2010 in 100 monitored hospitals are as follows.

<table>
<thead>
<tr>
<th>TCM disease</th>
<th>TCD(GB95/97)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wind stroke diseases</td>
<td>BNG080</td>
<td>174278</td>
</tr>
<tr>
<td>Fracture diseases</td>
<td>BGG000</td>
<td>160435</td>
</tr>
<tr>
<td>Vertigo disease</td>
<td>BNG070</td>
<td>133777</td>
</tr>
<tr>
<td>Cough diseases</td>
<td>BNF010</td>
<td>102416</td>
</tr>
<tr>
<td>Heart pain with chest impendiment disease</td>
<td>BNX020</td>
<td>88356</td>
</tr>
</tbody>
</table>

Chart 1: The top five most commonly used TCM disease diagnosis

<table>
<thead>
<tr>
<th>TCM pattern</th>
<th>TCD(GB95/97)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qi stagnation and blood stasis pattern</td>
<td>ZYVXK0</td>
<td>333416</td>
</tr>
<tr>
<td>Dampness-heat pouring downwards pattern</td>
<td>ZBMRD0</td>
<td>90731</td>
</tr>
<tr>
<td>Dual deficiency of qi and yin pattern</td>
<td>ZYYV30</td>
<td>73619</td>
</tr>
<tr>
<td>Liver and kidney yin deficiency pattern</td>
<td>ZZGS40</td>
<td>61097</td>
</tr>
<tr>
<td>Qi deficiency and blood stasis pattern</td>
<td>ZYVXM0</td>
<td>61087</td>
</tr>
</tbody>
</table>

Chart 2: The top five most commonly used TCM pattern diagnosis

<table>
<thead>
<tr>
<th>WM Diagnosis</th>
<th>ICD-10 Code</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral Infarction</td>
<td>I63.902</td>
<td>112759</td>
</tr>
<tr>
<td>Lumbar intervertebral disc extrusion</td>
<td>M51.202</td>
<td>67529</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>I25.101</td>
<td>59445</td>
</tr>
<tr>
<td>Mixed Hemorrhoids</td>
<td>I84.102</td>
<td>58971</td>
</tr>
<tr>
<td>Non-insulin-dependent diabetes mellitus</td>
<td>E11.901</td>
<td>37876</td>
</tr>
</tbody>
</table>

Chart 3: The top five most commonly used WM diagnosis

Conclusions
Clearly, through dual diagnosis, a mass of diagnosis and treatment associated data of traditional Chinese medicine and Western medicine have been accumulated which will exert tremendous impacts on the fields of health care, management, health economy, education, etc. China’s dual diagnosis has experienced several decades’ exploration, and China has made full training of dual diagnosis knowledge to traditional Chinese medicine doctors from the course setting of traditional Chinese medicine university education. In The Dual Diagnosis Mode is very meaningful in terms of whether patient safety, medical quality or management, but the efforts needed to make are obvious to all. At present, only hospitals of traditional Chinese medicine can strictly implement the Dual Diagnosis in China. Hopefully, after the launch of traditional medicine chapters of ICD-11, the Dual Diagnosis Mode can be extended to a wider range of medical institutions.

Acknowledgements or Notes
*Corresponding author
US Experiences Smooth Transition to ICD-10-CM/PCS

Authors: Sue Bowman, Donnamarie Pickett
American Health Information Management Association, Centers for Disease Control and Prevention, USA

Abstract
After years of debate and multiple delays, the US finally implemented ICD-10-CM and ICD-10-PCS on October 1, 2015. Despite warnings of major financial losses, massive volumes of claims rejections, and huge drops in coding productivity, the transition was smooth and uneventful. This poster will analyze the US implementation experience, explore the reasons for the successful transition, and offer lessons learned for adoption of new clinical code sets in the future.

Background
On October 1, 2015, ICD-10-CM (diagnoses) and ICD-10-PCS (procedures) were implemented in the US. ICD-10-CM was implemented by all healthcare providers in all settings and ICD-10-PCS was implemented for hospital reporting of inpatient procedures. The transition impacted all healthcare providers, payers, software vendors, and billing services.

Prior to that date, predictions of severe consequences included financial and business operation disruptions, cataclysmic financial losses, closures of physician practices, lack of access to care, and dramatic drops in productivity and accuracy.

ICD-10 Transition
The ICD-10-CM/PCS transition has gone very smoothly and has been widely characterized as a "non-event." All industry sectors invested significant time and resources in financing, training, and implementing changes to systems, workflow processes, and clinical documentation practices. Free or low-cost educational programs, tools, and resources, many designed specifically for small and rural providers, were widely available. The Centers for Medicare and Medicaid Services "Road to 10" initiative was specifically designed to address the needs of small physician practices.

Claims denial and rejection rates have been on track with pre-ICD-10 rates. In some cases, claims denial rates declined after implementation, possibly due to closer attention being paid to coding accuracy. There were even reports of a decline in the use of "unspecified" codes and increased coding accuracy as compared to ICD-9-CM. Systems vendors have also reported few problems.

Even physicians, the group expected to be most adversely affected, experienced a seamless transition, with only minor productivity declines or payment delays.

While some specialties have been hit harder with coding and documentation challenges than others, well-designed electronic health records (EHRs) have supported coding and documentation requirements through robust code search tools and documentation prompts.

ICD-10-CM/PCS training and clinical documentation improvement strategies paid off. There has been little or no impact on coding accuracy. While many saw an initial productivity decline, some did not. Productivity declines were less than 20% for many providers, with widespread reports of rapid improvement within just a few months after the transition. Organizations that took a strong approach to training, performed ample dual coding, and had robust clinical documentation improvement programs experienced less impact on productivity. The use of computer-assisted coding technology may have also mitigated productivity losses.

Some transition issues have occurred, but they have not been widespread and most have been minor or quickly resolved. Increased medical necessity denials for certain services have been reported, primarily due to incorrectly-translated payment policies. Other identified post-transition issues include:
- Systems errors
- Incorrect claims edits
- Clinical documentation deficiencies
- Increased physician queries
- Inadequate physician education
- EHR code look-up tools that led to incorrect codes

Organizations that failed to prepare properly in advance experienced the most problems.

Impact of Delays
ICD-10-CM/PCS implementation was delayed twice, due to concerns about industry readiness, costs, and administrative burden. The cost of a one-year delay was estimated to be as high as $6.8 billion, or a 30% increase in implementation costs.1

Delays were disruptive and costly for all stakeholders, as well as to healthcare delivery innovation, payment reform, public health, and healthcare spending.

Many organizations that were behind in their preparations did not take advantage of the additional time offered by the delays.

Lessons Learned
Industry-wide collaboration was key to a successful transition, including close public-private partnerships to improve communication and expand the availability of education, tools, and resources.

Extensive outreach, education, resources, and technical assistance, tailored to different audiences, are essential to ensure a successful transition to a new code set. Simple tools that make the change easy and affordable for providers with scarce time and resources are needed.

Clear implementation milestones and metrics should be established in order to measure progress and assess readiness.

Organizations should take advantage of the additional time provided by a delay and not slow preparation efforts.

Conclusions
The smooth transition can be attributed to extensive planning, education, preparation, and systems testing, effective communication, and industry-wide collaboration.

While it’s still too early to judge the impact of ICD-10-CM/PCS on quality of care and healthcare costs, better data have already been seen in areas where major differences exist between ICD-9-CM and ICD-10-CM, such as obstetrics.

ICD-10-CM/PCS will modernize and expand the capacity of US healthcare organizations to keep pace with changes in medical practice and healthcare delivery by providing higher-quality information for measuring service quality, outcomes, safety, and efficiency. Better data produced by ICD-10-CM/PCS are critical to supporting new healthcare delivery and payment models designed to improve quality of care, increase efficiencies, lower costs, and reward value. It is hoped that the US experience will provide useful insight and pathway toward ICD-11 implementation.

The ‘Family’ paper revision and WHO-FIC in the ICD-11 era

Authors: Lyn Hanmer¹, Jenny Hargreaves², Brooke Macpherson³

Abstract

A key work area of the Family Development Committee (FDC) is to develop the WHO-FIC as an integrated and comprehensive suite of classifications. A focus of this work is the review and revision of the 2007 ‘World Health Organization Family of International Classifications: definition, scope and purpose’ paper (also known as the Family paper), which is in progress. As the ICD-11 Revision develops, the Family is also changing; the FDC have therefore pursued producing an additional document, to complement the 2007 Family Paper, focused on the WHO-FIC reference classifications and their potential (joint) uses in the ICD-11 era. This poster summarizes the work of the FDC on these documents.

Introduction

The 2007 World Health Organization Family of International Classifications: definitions, scope and purpose paper (also known as the Family paper) describes the Family, principles of classification and the processes of adding, updating and maintaining classifications in the Family.

The Family is currently described as including the three reference classifications ICD, ICF and ICHI, as well as related classifications ICPC, ATC, IFC, ISO 9999 and ICNP, and classifications derived from the ICD for oncology, mental and behavioural disorders, dentistry and stomatology and neurology.

The Family paper was authored in 2007 by Richard Madden, Catherine Sykes and Bedirhan Üstün, with inputs from the Family Development Committee (FDC): http://who.int/entity/classifications/en/FamilyDocument2007.pdf

It was agreed at the 2010 WHO-FIC Network meeting that the FDC should revisit the paper for redrafting. Since then, the FDC has discussed how the paper should be revised to reflect current approaches to classification development and, in particular, the work on the ICD-11 revision.

The initial suggested changes to the structure of the paper were reported via a poster at the Barcelona annual network meeting in 2014. A number of other issues have been discussed by the FDC since that time, including the purpose of the paper; its intended audience and whether its focus should be on the current or future WHO-FIC.

While these issues are still under discussion, the FDC have pursued the creation of a shorter document focused on the reference classifications in the ICD-11 era, to coincide with the ICD-11 Revision Conference in October 2016.

2015 WHO-FIC Network Annual Meeting Discussions

A number of issues and questions were presented to inform discussion at the FDC sessions in Manchester in 2015.

Purpose of and audience for the paper?

The Committee considered that there are many purposes for which the Family Paper could be written, but multiple versions addressing each of these is not required. Instead, one version should be written and if required, other papers could be derived from it.

Reference and derived classifications

As ICD-11 is structured with a foundation layer from which a number of linearizations can be drawn, the FDC discussed whether such linearizations should be regarded as reference or derived classifications? The answer may be informed by whether there will be specific procedures by which a linearization is approved. If it is endorsed by the World Health Assembly, does this automatically give a linearization reference status?

This issue is still under discussion.

Related and neighbour classifications

The FDC considered whether the relationships of ‘related’ classifications to the Family are changing in the ICD-11 era. This may affect the criteria for inclusion of non-WHO classifications into the Family.

Whether to introduce the relationship ‘neighbour’ into the Family is still under discussion.

Focus of the paper – should it be on the current situation or the future?

The Committee considered it was important to reflect the current position of classifications, their issues and potential solutions, and also what the Family may look like in an ICD-11 era.

Acknowledgements

The FDC Co-Chairs thank Huib ten Napel for his contributions to the small working group on the short document and the FDC members for their contributions to the short document and the Family paper revision.

Author affiliations

¹South African Medical Research and WHO-FIC South Africa Collaborating Centre, FDC Co-Chair.
²Australian Institute of Health and Welfare and Australian Collaborating Centre, FDC Co-Chair.
³Australian Institute of Health and Welfare and Australian Collaborating Centre, FDC Secretariat.

2016 Mid-year Meeting Discussions

In parallel with the revision of the Family paper, it was decided that the FDC would produce another shorter, more focused document on the reference classifications in the ICD-11 era, to complement the 2007 Family paper. This document will be presented for comment at the 2016 WHO-FIC Network meeting in Tokyo.

Discussions over the content and structure of the revised Family paper also continued. Small groups worked on assigned sections of the Family paper and made suggestions for updates to the order and wording of content. Unresolved issues were also discussed and new issues for consideration were reported.

The issues were grouped under the following headings:

Governance: the Family paper should consider the respective responsibilities for the classifications between the WHO and the Network, and for those classifications not-governed by the WHO.

Use cases: they need to be clearly defined and described; some classifications focus on the person while others focus on care – this should be addressed in the paper. Use of the classifications together should also be covered.

Multi-professional: all of the reference classifications are provider-neutral. Should this be a criterion for all classifications within the Family?

Foundation: the role and nature of the foundation needs to be described, as does its maintenance and governance. Linkages between linearizations and foundations also need to be clearly defined and described.

Content of the short document

Following the 2016 mid-year meeting, a small working group was formed to progress the short document.

Proposed content and structure:

1. Introduction
   a. What is the Family in the ICD-11 era?

2. Scope, conceptual framework and structure of the Family in the ICD-11 era
   a. Reference classifications
   b. Speciality classifications

3. Use of the WHO-FIC and other health-related classifications

4. Governance and management

5. Technical foundations of the Family
   a. ICD-10 era
   b. ICD-11 era
Universal Health Coverage (UHC) is a global WHO initiative to ensure that everyone who needs health services is able to receive them, without experiencing financial hardship. The Family Development Committee (FDC) has been assessing the extent to which the WHO-FIC can potentially be used to support measuring progress towards UHC. In 2015, UHC was included as a target under the United Nations’ Sustainable Development Goals (SDGs). The FDC undertook to assess the usefulness of the WHO-FIC in measuring progress towards the targets for the Health goal in the SDGs, as an extension to the work on universal health coverage.

**Introduction**

The Family Development Committee (FDC) has been assessing how the WHO-FIC can potentially be used to support measuring progress towards the WHO’s UHC initiative. UHC is the ability for all people to receive quality health services they need, without being exposed to financial hardship.

In June 2015, the World Health Organization and World Bank released Tracking Universal Health Coverage: First Global Monitoring Report. In this report, eight core tracer health service coverage indicators were chosen to report progress towards UHC; chosen as they involve health interventions from which every individual should benefit and because recent, comparable data are available.

Under their respective groups, the eight core tracer indicators are:

**Reproductive and newborn health**
1. Family planning
2. Antenatal care
3. Skilled birth attendance

**Child immunization**
4. Three doses of diphtheria, tetanus and pertussis (DTP)-containing vaccine

**Infectious disease**
5. Antiretroviral therapy (ART)
6. Tuberculosis (TB) treatment

**Non-health sector determinants**
7. Improved water sources
8. Improved sanitary facilities

Previous work by the FDC has involved the identification of codes in the WHO-FIC relevant to the indicators proposed to monitor progress towards UHC. The work also helped to identify potential areas of improvement for the WHO-FIC.

As reported in poster C710 in Manchester, the results have shown that for many indicators, codes of potential relevance were able to be identified and in some cases, joint use of the classifications would be required.

In 2015, the UN General Assembly adopted the Sustainable Development Goals (SDGs) as the new development agenda, superseding the Millennium Development Goals. There are 17 SDGs including one for Health “to ensure healthy lives and promote well-being for all at all ages”. Each SDG is associated with a set of targets (169 overall); the SDG on Health has 13 targets, of which UHC is one.

The focus of the FDC’s work has shifted to begin to consider how the WHO-FIC could be used to support reporting against the Health goal of the SDGs, as an extension of the work related to UHC, and given the importance of the SDG initiative.

**Discussion and Next Steps**

The FDC agreed that ICHI and ICD could be useful in the monitoring of many of the Health targets. The ICF may also be useful, but only for selected targets.

The Committee suggested the following actions as potential next steps for this work plan item:

- To consider the Global Reference List of 100 Core Health Indicators as another WHO indicator initiative that could be supported by the WHO-FIC, or could inform WHO-FIC development. An initial assessment of the Global Reference List indicated the need for further work to make the list more readable and user-friendly.

**References**

One of the achievements within the EIC Strategic Work Plan, is the establishment of the WHO-FIC Implementation Database which at the moment is up and running since 2014. Gradually the Implementation Database will be filled with information on the level of implementation of the WHO classifications, such as the ICD and the ICF. In future there will also be the possibility to inform the world-community about the International Classification of Health Interventions (ICHI) which is under development at the moment. The Implementation Database feeds into the Global Health Observatory, where the content of the Database can be browsed on the level of implementation of ICD and ICF on a country level.

The WHO-FIC Implementation Database is of great importance to support the WHO-member states with information about the level of implementation of WHO Classifications and the availability of relevant material within each WHO-region or -country. The content of this posters explains the ins-and-outs of the Implementation Database.

Abstract

The WHO-FIC Implementation Database is of great importance to support the WHO-member states with information about the level of implementation of WHO Classifications and the availability of relevant material within each WHO-region or -country. The content of this posters explains the ins-and-outs of the Implementation Database.

Introduction

One of the achievements within the EIC Strategic Work Plan, is the establishment of the WHO-FIC Implementation Database which at the moment is up and running since 2014. Gradually the Implementation Database will be filled with information on the level of implementation of the WHO classifications, such as the ICD and the ICF. In future there will also be the possibility to inform the world-community about the International Classification of Health Interventions (ICHI) which is under development at the moment. The Implementation Database feeds into the Global Health Observatory, where the content of the Database can be browsed on the level of implementation of ICD and ICF on a country level.

The WHO-FIC Implementation Database is a web-based platform for collection and dissemination of general information on the implementation of the WHO Family of International Classifications (WHO-FIC), including the International Classification of Diseases (ICD), the International Classification of Functioning, Disability and Health (ICF), the International Classification of Traditional Medicine (ICTM), and others in WHO Member States. The platform is a tool that is mainly meant to collect data within the database. This database is then used to generate data into information for the WHO Global Health Observatory (GHO). Although it is a data-entry tool, it can also be used by focal points to browse though the already available data by every person interested.

Where can information be found?

The information is presented in a similar structure as within the survey of the WHO FIC Implementation Database. In the GHO the content of the Implementation Database is visualized. This underlines the difference between the both; one for the input of data, the other as the output of information.

Where does data come from?

The data comes from the 194 WHO member states, where focal points are, or are in the process of being appointed by the ministries or comparable responsible institutes for the maintenance of WHO classifications or management of health care information. The process is coordinated by the six WHO Regional Offices and the WHO-FIC Education and Implementation Committee (EIC). The EIC has established an annual cycle and call for updates in June and August. All WHO-FIC Collaborating Centres are expected to update or check the content of the Database as part of their Centre’s Workplan. All six Regional Offices are striving to expand on the number of countries which do not have a WHO-FIC Collaborating Centre to inform the Database.

Acknowledgement

We wish to acknowledge the Dutch Ministry of Health (VWS) for funding the development of the Implementation Database as part of the Dutch Partnership Program.
For information: huib.ten.napel@rivm.nl
## WHO-FIC Network Annual Meeting 2016 and ICD-11 Revision Conference
### 8-12 and 12-14 October 2016; Tokyo, Japan

<table>
<thead>
<tr>
<th>SATURDAY</th>
<th>SUNDAY</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
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<td><strong>MRG</strong>&lt;br&gt;(Room E)</td>
<td><strong>URC ICD</strong>&lt;br&gt;(Room B)</td>
<td><strong>ITAG</strong>&lt;br&gt;(Room E)</td>
<td><strong>URC ICF</strong>&lt;br&gt;(Hall B7)</td>
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<td><strong>Joint MMS Task Force</strong>&lt;br&gt;(OPEN - Hall B7)</td>
<td><strong>FDC</strong>&lt;br&gt;(Room G510)</td>
<td><strong>ICD Revision Conference</strong>&lt;br&gt;(Hall B7)</td>
</tr>
<tr>
<td>17:00</td>
<td><strong>Joint MMS Task Force</strong>&lt;br&gt;(CLOSED - Room B)</td>
<td><strong>WHO Meeting of HQ and Regional Advisors</strong>&lt;br&gt;(CLOSED - Room G510)</td>
<td><strong>Speakers &amp; Chairs Session</strong>&lt;br&gt;(CLOSED - Room G510)</td>
<td><strong>Gala Dinner</strong></td>
<td><strong>Break</strong></td>
<td><strong>Break</strong></td>
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<tr>
<td>Saturday, 8 October 2016 - MORNING</td>
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<tr>
<td><strong>Room B - FDRG</strong></td>
<td><strong>Room E - MRG</strong></td>
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<tr>
<td><strong>1. Introduction and Background – FDRG Co-Chairs</strong></td>
<td>1. Procedural issues (co-chair elections; MRG meeting time)</td>
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</tr>
<tr>
<td>a. Co-chairs welcome</td>
<td>2. URC issues need discuss ahead of URC sessions (TBD after URC voting/comments reviewed)</td>
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<tr>
<td>b. Appointment of rapporteurs</td>
<td>3. New issues MRG requested to examine</td>
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<tr>
<td>c. Brief introductions by participants</td>
<td>4. (MRG2016 Inconsistencies in vol 2 issue; O10.0 vs O10.9)</td>
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<tr>
<td>d. Confirmation of the agenda and minutes of Bangkok meetings</td>
<td>5. Table group review</td>
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<tr>
<td>e. Matters arising</td>
<td>(e.g., TG2014_030 DS from D70 to C349; TG2014_034 P60 tables; PS25 Q2; TG2014_093 Systemic connective tissue disorders; TG2015_075 Indexing related to coronary embolism issue; TG2014_074 Add maybe for I4299; TG2015_001 Heart failure linkage; TG2015_009 J841, J848 and J849 causal tables; TG2015_022 Acme maybe I64 or I61 due to H-codes; TG2015_026 LMC A099 and K519; TG2015_039 DS in both directions tangent; TG2015_054 Review DS of F03; TG2015_052 I4299 due to E752; TG2015_075 Immune disorders not accepted as due to anything else; TG2012_005 Review/develop code sets Anaemia; TG2015_072 Causal tables for vascular dementia; TG2015_073 How to interpret “with”; TG2016_003 Sequence and radiation; TG2016_004 A572 vs J449; TG2016_005 A66 examples; TG2016_006 K631 vs K650; TG2016_008 G319 vs W80; TG2016_009 Q651 vs G409; TG2016_012 K318 vs M45; TG2016_015 K519 vs E778; TG2016_016 J819 vs K562; TG2016_017 K631 vs M644; TG2016_018 G20 vs W80; TG2016_019 G459; TG2016_020 Another epilepsy question; TG2016_021 J449 &amp; I694; TG2016_026 I259 and K264; TG2016_027 I361/I371 and I270/I279; TG2016_028 I64 &amp; M13-M19; TG2016_029 M68 due to E10-14; Aortic valve stenosis, mitral valve stenosis email end of apr discussion)</td>
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<tr>
<td>2. Election of co-chairs 2016-2018 – Molly Meri Robinson Nicol</td>
<td>6. Ongoing work MRG deliberating about</td>
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<tr>
<td>3. WHO: Evolution of Functioning Information Needs – Alarcos Cieza</td>
<td>(e.g., PS11 Q3 Bronchitis and duration; TG2012_005 Decide which morphologies coded to C80; TG2013_001 Can FMD be the underlying cause of IHD; PS27 Q11 Bullying; PS27 Q13 Expand trivial list; PS27 Q14 URC 2061 Respiratory tract infection; PS27 Q24 A99/I469; TG2014_051; PS27 Q35 Nordic N9; MRG2014_037 Exclusion for all infectious diseases acquired after birth; MRG2015_002 Doubts about badly certified deaths; MRG2015_004 Use of I15; MRG2015_008 Conditions considered to increase risk of malignancy test; MRG2015_014 P95; TG2014_044 Nordic N2 Hyperbilirubinemia; MRG2015_022 How to handle perinatal certificate; MRG2015_023 Suggestions about heart failure; TG2014_089; MRG2015_026 R63 anorexia is not ill defined; TG2014_089; MRG2015_027 Add most advanced for drug dependence to secondary conditions; TG2014_089; MRG2015_028 K746+ B16-B19; TG2014_089; MRG2015_029 DS I33 to I34-I37; TG2015_017 DS question from table group; URC 0318; PS15 Q17 Congenital anomalies due to chromosome abnormality; MRG2015_037 Indexing codes for types of leukemia and lymphoma with less specificity; MRG2015_039 New short list for mortality; MRG2015_042 Request to modify wording in 5.8.2; TG2014_050 Complications of hypertension; MRG2015_043 R95 questions; MRG2015_044 ICD-PM; TG2014_067; TG2015_055 G909 DS Q909 and review Q909; MRG2015_046 Inconsistencies found in volumes; MRG2015_047 Instruction 4.3.5 malignant neoplasms A (b); MRG2015_051 Instructions flow; MRG2015_050 Diabetic embaphrophath; MRG2016_005 Unspecified HIV; MRG2016_008 GHB disappeared; MRG2016_009 Conflict in linkage; TG2015_069 I739/I702; I702/I739; TG2016_022 Other senility issues (SEND2-SENM2_LAI); MRG2016_011 Victim of extreme weather)</td>
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<tr>
<td>4. Informing the ICF Ontology – Andrea Martinuzzi</td>
<td>7. Open mike: Any requests from floor to topics needing MRG attention</td>
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<tr>
<td>a. Use cases</td>
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<td>b. Term beating</td>
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<td>c. Next steps</td>
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<tr>
<td>5. ICF Updates – Jennifer Jelsma &amp; Janice Miller</td>
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<td>11:30</td>
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</table>
**WHO-FIC Network Annual Meeting - October 2016**

**Saturday, 8 October 2016 - AFTERNOON**

<table>
<thead>
<tr>
<th>Time</th>
<th>Room B - FDRG</th>
<th>Room E – MRG and mTAG</th>
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<tbody>
<tr>
<td>14:00 – 15:30</td>
<td><strong>6. Ongoing Projects</strong></td>
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<tr>
<td></td>
<td>b. mICF – Olaf Kraus de Carmago</td>
<td>2. Development of critical infrastructure and implications for mortality coding</td>
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<td></td>
<td>c. ICF Education.org portal – Catherine Sykes</td>
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<td></td>
<td>d. Informing rehabilitation outcomes and indicators – Catherine Sykes</td>
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<tr>
<td>14:00 – 15:30</td>
<td><strong>7. Strategic Work Plan 2016-2017 – FDRG Co-Chairs</strong></td>
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<tr>
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<td>a. Overview of key meeting outcomes and plans for the forthcoming year.</td>
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<td>b. New Projects?</td>
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<tr>
<td></td>
<td>i. Coder Training for ICF</td>
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<td>ii. Rehabilitation Outcomes Monitoring</td>
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<td>iii. ICF for Hospital Statistics</td>
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**16:00 – 17:30 WHO-FIC Council (Conference Hall)**

1. **Welcome**
   - Anneke Schmider, Project Lead, Health Data Standards and Informatics, World Health Organization
   - Kei Mori, Head of the WHO-FIC Collaborating Centre in Japan

2. **Council Co-Chairs and WHO Secretariat – Official Opening**
   - Jenny Hargreaves and Lynn Bracewell, WHO-FIC Network Advisory Council Co-Chairs

3. **Reports from the Regional Advisers**
   - a. Hongyi Xu – Regional Office for Africa, WHO
   - b. Ivo Rakovac – Regional Office for Europe, WHO
   - c. Dr Vilma Gawryszewski – Regional Office for the American / Pan American Health Organization, WHO
   - d. Mark Landry – Regional Office for South-East Asia, WHO

4. **Conduct of the Network Paper Updates**

5. **State of the Network and Network Re-design**

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WHO-FIC Network Meeting 2016 and ICD Revision Conference – Master Agenda
<table>
<thead>
<tr>
<th><strong>Room B – URC ICD</strong></th>
<th><strong>Room E – fTAG</strong></th>
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<tbody>
<tr>
<td><strong>9:30 – 11:00</strong></td>
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</tr>
</tbody>
</table>
| 1. Welcome           | 1. Welcome / Introductions / Appointment of rapporteurs  
|                      | Gerold Stucki, fTAG Co-Chair  |
| 2. Approval of agenda| 2. Manchester Meeting Minutes  
|                      | Melissa Selb, fTAG Managing Editor  |
| 3. Confirmation of membership and attendance | 3. Review of activities since Manchester Meeting  
|                      | Melissa Selb  |
| 4. Voting of URC Co-Chairs | 4. Updates on Coding Instructions on functioning properties incl.  
|                      | recommendations from RSG-SEG and Joint Task Force (JTF)  
|                      | Melissa Selb & Molly Meri Robinson Nicol, WHO  |
| 5. Report and Update on work plan |                  |
| 6. Ratification/discussion of URC ICD-10 worksheets:  
| 6.1. Ratification of accepted ICD-10 proposals |                  |
|                      |                  |
| 6.2. ICD-10 proposals for discussion |                  |
|                      |                  |
| **11:30 – 13:00**    |                  |
| 5. Presentation of current coding instructions relevant to functioning properties  
|                      | Melissa Selb  |
| 6. Question & Answer Round on coding instructions relevant to functioning properties  
|                      | Solvejg Bang and John Melvin, fTAG members  |
| 7. Update on chapter on Factors influencing health status and contact with health services  
|                      | WHO representative  |
| 8. What are the next steps  
|                      | Gerold Stucki  |
**WHO-FIC Network Annual Meeting - October 2016**

### Sunday, 9 October 2016 - AFTERNOON

<table>
<thead>
<tr>
<th>Room B – URC ICD</th>
<th>Room E - EIC</th>
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<tbody>
<tr>
<td><strong>14:00 – 15:30</strong></td>
<td>6.3. ICD-10 proposals for discussion</td>
</tr>
<tr>
<td><strong>U. Vogel</strong></td>
<td>1. Welcome &amp; Introductions - Huib Ten Napel &amp; Yukiko Yokobori</td>
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<tr>
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<td>2. Election of co-chairs 2016-2018 - Nenad Kostanjsek</td>
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<td></td>
<td>3. Bangkok Mid-year Meeting Minutes - Huib Ten Napel</td>
</tr>
<tr>
<td></td>
<td>4. Update on EIC SWP - Yukiko Yokobori</td>
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<tr>
<td></td>
<td>5. EIC SWP 01: Implementation Database</td>
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<tr>
<td></td>
<td>a. Update on WHO-FIC Implementation Database/s - Huib Ten Napel</td>
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<tr>
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<td>b. Improvement of the question - Carol Lewis and Joon Hong</td>
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<td>6. EIC SWP 02: ICD-11</td>
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<td>b. Field Trial Activities – WHO</td>
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<td>c. Field Trial in Korea – Seulkyung Baek</td>
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<td>d. ICD-11 training material - Vera Dimitropoulos</td>
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<td>e. Country feedback from ICD-11 line coding pilot testing - Olafr Steinum &amp; Norway CC</td>
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<tr>
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<td>f. Transition and Implementation Guidance</td>
</tr>
<tr>
<td><strong>16:00 – 17:30</strong></td>
<td>6.4. ICD-10 proposals for discussion</td>
</tr>
<tr>
<td><strong>U. Vogel</strong></td>
<td>7. Any other ICD-10 business</td>
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### Room B – JTF (CLOSED)

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<thead>
<tr>
<th>Room B – JTF (CLOSED)</th>
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<tbody>
<tr>
<td><strong>18:00 – 19:00</strong></td>
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<tr>
<td>1. Review of the Revision Conference Agenda</td>
</tr>
<tr>
<td>a. Role of the JTF</td>
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<tr>
<td>2. Review of the technical work to date</td>
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<tr>
<td>a. ICD-11-MMS release for Member State Comment</td>
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<tr>
<td>3. Communication</td>
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<tr>
<td>a. Key Messages for Network Stakeholders and Member States</td>
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</table>

**WHO-FIC Network Meeting 2016 and ICD Revision Conference – Master Agenda**
## WHO-FIC Network Annual Meeting - October 2016

### Monday, 10 October 2016 - MORNING

<table>
<thead>
<tr>
<th>Room B7 – URC ICF</th>
<th>Room G510 - mbTAG</th>
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<tbody>
<tr>
<td>9:30 – 11:00</td>
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</tbody>
</table>
| 8. Confirmation of ICF voting members and attendance | 1. Introductions
| 9. Minutes of Manchester, 2015 meeting |   Syed Aljunid and Donna Pickett
| 9.1. Matters arising out of minutes | 2. ICD-11 Status
| 10. Report and Update on work plan | MbTAG’s Work Progress (including chapter review work that was done)
| 11. Ratification/discussion of URC ICF worksheets: | Morbidity Coding Rules
| 11.1. Ratification of accepted/rejected ICF proposals | JLMMS
| 11.2. ICF proposals for discussion | 3. MbTAG Future Work Plan and Timeline
| 12. Any other ICF business | |
| *J. Jelsma* | |

<table>
<thead>
<tr>
<th>Room B7 – JTF (CLOSED)</th>
<th>Room G510 - ITC</th>
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<tbody>
<tr>
<td>11:30 – 13:00</td>
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</tbody>
</table>
| 4. ICD Governance      | 1. Introductions
|   a. Transitioning from ICD-10 to ICD-11 | *Karen Carvell and Vincenzo Della Mea,*
|   b. MSAC and CSAC     | *ITC Co-Chairs*
| 5. Platforms and Browsers: ICD-11, ICHI | 2. Manchester Meeting Minutes
|                       | *Jun Nakaya, ITC Secretary*
| 6. Election of ITC Co-Chairs | 3. Highlight of activities since Manchester Meeting
|                         | *Karen Carvell and Vincenzo Della Mea,*
| 7. Platforms and Browsers: ICD-11, ICHI | 4. Election of ITC Co-Chairs
|                       | *Can Celik, WHO liaison*
|                       | *Can Celik, Vincenzo Della Mea* |
### Monday, 10 October 2016 - AFTERNOON

<table>
<thead>
<tr>
<th>Time</th>
<th>Room B7 – JTF (CLOSED)</th>
<th>Room G510 – ITC</th>
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<tbody>
<tr>
<td>14:00</td>
<td>5. Quality Assurance</td>
<td>6. CLaML Revision proposals</td>
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<tr>
<td></td>
<td>a. JTF Role</td>
<td>[Vincenzo Della Mea (for Stephanie Weber)]</td>
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<tr>
<td></td>
<td>b. Processing of “Interim Proposals”</td>
<td>7. OMICs – update on standardization with ICD</td>
</tr>
<tr>
<td>15:30</td>
<td>6. Long term plans</td>
<td>[Jun Nakaya]</td>
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<td></td>
<td>a. from October 2016 to May 2018</td>
<td>8. Harmonization Activities – ICF Ontology</td>
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<tr>
<td></td>
<td>b. tasks for the JTF</td>
<td>[ICD-11 integration with Terminologies]</td>
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<td>c. future meeting planning</td>
<td>9. Poster Presentation</td>
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<td>[TBD]</td>
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<td>10. ITC 2016-2017 Workplan</td>
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<td>[Karen Carvell and Vincenzo Della Mea]</td>
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<tr>
<th>Time</th>
<th>Room B7 – JTF (OPEN)</th>
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<tbody>
<tr>
<td>16:00</td>
<td>7. Live Demos</td>
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<td>a. Implementation of Post-Coordination</td>
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<td>b. Coding using ICD-11</td>
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<tr>
<td>17:30</td>
<td>8. JTF Report</td>
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<tr>
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<td>a. Progress over the last 18 months</td>
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<td>9. Network Feedback</td>
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<td>a. Identification of concerns, outstanding issues, and challenges</td>
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<td>Time</td>
<td>Agenda Item</td>
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<tr>
<td>9:30</td>
<td>JTF Feedback</td>
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<td>11:00</td>
<td>Next Steps</td>
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## WHO-FIC Network Annual Meeting - October 2016

**Room B7 - Poster Session – Moderators: Jennifer Jelsma and Francesco Grippo**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Title</th>
<th>Presenters</th>
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<tbody>
<tr>
<td>9:30-9:35</td>
<td>C401</td>
<td>US Experiences Smooth Transition to ICD-10-CM / PCS</td>
<td>Sue Bowman and Donnamarie Picket</td>
</tr>
<tr>
<td>9:35-9:40</td>
<td>C402</td>
<td>Reviewing progress in civil registration and vital statistics (CRVS) in selected countries of the Southern African Development Community (SADC)</td>
<td>Jané Joubert, Debbie Bradshaw, and Lyn Hammer</td>
</tr>
<tr>
<td>9:40-9:45</td>
<td>C404</td>
<td>Benefits of Collaborative SNOMED CT to ICD-10 Mapping</td>
<td>Hazel Brear and Kathy Giannangelo</td>
</tr>
<tr>
<td>9:45-9:50</td>
<td>C301</td>
<td>WHO-FIC in Primary Care: approaches to effective use</td>
<td>Lyn Hammer, Jenny Hargreaves, and Brooke Macpherson</td>
</tr>
<tr>
<td>9:55-10:00</td>
<td>C304</td>
<td>ICD-11 Pilot Testing – The Australian Experience</td>
<td>Jenny Hargreaves, Brooke Macpherson, Miriam Lum On</td>
</tr>
<tr>
<td>10:00-10:05</td>
<td>C306</td>
<td>Internal Medicine TAG Coding Exercise of ICD-11</td>
<td>Toshio Ogawa, Emiko Oikawa, Masato Izutsu, Kaori Nakayama, Kei Mori, Naoko Tajima, and Tomoaki Imamura</td>
</tr>
<tr>
<td>10:05-10:10</td>
<td>C312</td>
<td>Use Case for Traditional Medicine in Japan – Morbidity data classified by joint use of ICD</td>
<td>Masato Izutsu, Kenji Watanabe, Shuji Yakubo, Michiho Ito, Takao Namiki, and Kei Mori</td>
</tr>
<tr>
<td>10:10-10:15</td>
<td>C314</td>
<td>Dual Diagnosis of Traditional Chinese Medicine and Western Medicine in China</td>
<td>Lianghua Zu and Danbo Dou</td>
</tr>
<tr>
<td>10:15-10:20</td>
<td>C501</td>
<td>Use of WHO-DAS 2.0 in the Netherlands</td>
<td>Daphne van Hoeken, Coen van Gool, Huib ten Napel, and Hans w. Hoek</td>
</tr>
<tr>
<td>10:25-10:30</td>
<td>C508</td>
<td>Mexico Experience in the Training of ICF</td>
<td>Diana Avendaño, Patricia Nilda Soliz, Manuel Yañez, and Amanda Navarro</td>
</tr>
<tr>
<td>10:35-10:40</td>
<td>C514</td>
<td>ICF Implementation in Italy: regional policies and national needs</td>
<td>Lucilla Frattura and Pietro Malara</td>
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<tr>
<td>10:40-10:45</td>
<td>C601</td>
<td>ICHI Alpha 2016 - Development</td>
<td>Richard Madden, Albrecht Zais, Megan Cumerlato, Andrea Martinuzzi, Ann-Helene Almborg, Nicola Fortune, and Nicole Rankin</td>
</tr>
</tbody>
</table>
6.  C&RG Reports
   a. Jenny Hargreaves and Lyn Hanmer  Family Development Committee (FDC)
   b. Huib ten Napel and Yukiko Yokobori  Education and Implementation Committee
   c. Ulrich Vogel and Jennifer Jelsma  Update and Revision Committee (URC)
   d. Karen Carvell and Vincenzo della Mea  Informatics and Terminology Committee (ITC)
   e. Lars Age Johansson and Francesco Grippo  Mortality Reference Group (MRG)
   f. Andrea Martinuzzi and Catherine Sykes  Functioning and Disability Reference Group (FDRG)

7.  Confirm actions of Committees and Reference Groups
   g. ICD-10 updates
   h. ICF updates
   i. ICHI Proposals

8.  Strategic Work Plan – Compilation and Cooperation between Committees and Reference Groups
   Jenny Hargreaves and Lynn Bracewell, WHO-FIC Network Advisory Council Co-Chairs

9.  Meeting evaluation
   j. Feedback from participants
   k. What went well
   l. What could be improved
   m. Assessment of the network meeting design
   n. Additional comments, suggestions

10. 2017 & 2018 Network meetings

11. Other business
### WHO-FIC Network Annual Meeting - October 2016

**Wednesday, 12 October 2016 - AFTERNOON**

<table>
<thead>
<tr>
<th>Time</th>
<th>Room G510 - FDC</th>
<th>Activity</th>
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<tbody>
<tr>
<td>14:00</td>
<td></td>
<td>1. Welcome and Introductions, including minutes from previous meetings</td>
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<td><em>Jenny Hargreaves and Lyn Hanmer, FDC Co-Chairs</em></td>
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</table>
| 15:30 |                 | 2. FDC-SWP 02 Integration of the Family and FDC-SWP 03 Applications of the WHO-FIC  
|       |                 |  Primary care use case  
|       |                 |  *Presentation of the poster “The WHO-FIC in Primary Health Care settings: Approaches to effective use” and group discussion.* |
| 16:00 |                 | 3. FDC-SWP 02 Integration of the Family and FDC-SWP 03 Applications of the WHO-FIC  
|       |                 |  Revision of the Family Paper  
|       |                 |  *Presentation of the poster “The Family paper in the ICD-11 era” and group discussion.* |
| 17:30 |                 | 4. FDC-SWP 05 Assess the need for additional members of the Family to fill gaps in information  
|       |                 |  *A presentation of the poster “Determinants of health in the WHO-FIC” and group discussion* |
|       |                 | 5. FDC-SWP 04 Universal Health Coverage and the Sustainable Development Goals  
|       |                 |  *Presentation of the poster “Use of the Family of International Classifications in monitoring Universal Health Coverage” and group discussion* |
|       |                 | 6. FDC-SWP 01 Assist WHO in the development of ICHI  
|       |                 |  *Update on ICHI development activities and governance* |
|       |                 | 7. Other business  
|       |                 | a. Co-Chair Elections  
|       |                 |  *Coordinated by WHO* |

WHO-FIC Network Meeting 2016 and ICD Revision Conference – Master Agenda