WHO-FIC Education Committee
WHO-FIC – IFHRO Joint Collaboration
Georgetown, Washington, D.C.
May 9-11, 2007

The Education Committee of the WHO Family of International Classifications (WHO-FIC) Network and the WHO-FIC Joint Collaboration with the International Federation of Health Records Organizations (IFHRO) held a working meeting on May 9-11, 2007 in Georgetown, Washington, D.C. The purposes of the meeting were to 1) advance work on the International Training and Certification Program for ICD-10 Mortality and Morbidity Coders, 2) receive reports on the project to pilot the program and examination for underlying cause of death coders and trainers, 3) prepare for the 15th Congress of the International Federation of Health Records Organizations, 4) address other Education Committee tasks and 5) make plans for the 2007 WHO-FIC Network meeting. Twenty-three persons from eight countries, representing collaborating centers, national and international organizations, participated in the meeting. A list of participants is included in Attachment 1.

Wednesday, May 9, 2007

1. Welcome and Introductions:

Marjorie Greenberg welcomed everyone to the meeting, introducing herself as Chair of the WHO-FIC Education Committee, and Sue Walker and Margaret Skurka as Co-chairs of the WHO-FIC – IFHRO Joint Collaboration (JC).

Marjorie made special mention of the diligence of Traci Ramirez (NCHS), whose administrative support preparing for this meeting was invaluable.

Participants introduced themselves.

2. Assignment of rapporteurs:

Wednesday, May 9 – morning	Patricia Wood
Wednesday, May 9 - afternoon	Tyringa Ambrose and Chris Sweeting
Thursday, May 10 - morning	Carol Lewis
Thursday, May 10 - afternoon	Cleo Rooney and Chris Sweeting
Friday, May 11 - morning	Kathy Giannangelo

3. Review of agenda and meeting objectives:

Marjorie invited participants to review the agenda (Attachment 2) and meeting objectives and asked for input:

- Sue Walker suggested adding an item; ***upcoming training sessions and workshops***
- Stefanie Weber suggested adding two items; ***the development of the Roster of Experts*** and ***other joint activities with the Implementation Committee***

- Marjorie Greenberg suggested adding an item; ***Health Metrics and the work of the WHO-FIC – IFHRO JC***

4. Review Education Committee Terms of Reference and 2007 Work Plan:

a. <u>Terms of Reference:</u>

Marjorie reviewed the Education Committee (EC) Work plan and Terms of Reference within the context of a presentation she intends to make at the IFHRO Congress in Seoul, Korea in May, 2007. Given the EC's role in supporting both ICD and ICF, there was discussion around the desirability of re-wording ICD item 11, support in the provision of a tool for self learning of ICD-10, and have it become a generic Committee function. Also discussed was specifying the "maintenance" of an inventory of existing educational materials and capacity.

[All of the changes to the Terms of Reference were made and presented to the participants on Friday morning - see Attachment 3]

b. <u>2007 Work Plan:</u>

Just prior to the discussion of the 2007 Education committee Work Plan, Dr. Kenji Shuto (Japan) asked if training and certification in the use of ICD-O-3 was part of the mandate of the Education Committee, generating a discussion.

- Apparently the International Association of Cancer Registrars (IACR) has some web-based training on ICD-0-3 classification and Marjorie suggested the idea of a subgroup to collaborate with the IACR folks.
- Amy Blum said that the National Cancer Registrars Association (NCRA) in the USA wants to establish an international exam. She believes the interest is there. AHIMA has a relationship with American cancer registries and has collaborated with NCRA on on-line training courses. Marjorie suggested a parallel with our program for mortality coders, to which Kathy added that our work could serve to establish a model that could be used to demonstrate an approach to classification training and international certification for all members of the WHO-FIC.
- Marjorie concluded that ICD-0-3 training and certification is certainly within the mandate of the WHO-FIC Education Committee. Further to that she proposed a possible session with IACR representatives at next year's mid-year meeting dedicated to ICD-0-3 education needs.

Action: Amy will chair this session to initiate discussions. Others expressing interest were Sue, Chris, Kenji and Joon.

Marjorie suggested that the Education Committee develop items for the 2007 Work Plan as the agenda is worked through and this should be pulled together in the summary session on Friday morning. (The updated work plan will be incorporated into the WHO-FIC Strategy and Work Plan.

5. **Review Joint Collaboration Terms of Reference and 2007 Work Plan:**

a. Terms of Reference:

- The membership of the Joint Collaboration (JC) is supposed to include three (3) IFHRO representatives. There have only been two (2) for quite a while but the IFHRO Executive is going to assign another IFHRO representative in May.
- WHO-FIC – IFHRO Joint Collaboration will be inserted everywhere "… Committee" is mentioned
- Functions 5, 6 and 7 were reviewed and it was decided to delete Function 7 and amend Function 6 to read "… process for certifying practicing and newly trained coders"
- mid-year meeting to be described as "face-to-face"

[All of the changes to the Terms of Reference were made and presented to the participants on Friday morning - see Attachment 4]

b. 2007 Work Plan:

- The 2007 Work Plan will be developed by a small group during the meeting and a draft document will be presented on Friday morning.

Stefanie Weber asked if IFHRO is interested in collaborating on the development of an international training and certification program for coders in ICD, ICF and ICD-O-3. Marjorie suggested that the ICF may require another Joint Collaboration (not this one) in order to get the right expertise. It was decided to leave ICF with the Education Committee for now. There was some discussion around the extent of the collaboration between the Education Committee and IFHRO, with reference to the first sentence of the JC Terms of Reference. It was concluded that collaboration on other classifications may actually require other "joint collaborations".

6. **Update on contract with AHIMA FORE to pilot and evaluate International Training and Certification Program:**

Kathy reminded everyone that the contract with AHIMA-FORE is to pilot and evaluate the International Training and Certification Program. She presented a progress report and reported that Sheryl Reyes, Administrative Assistant, is working very hard on this project.

a. Review and recognition of Training Materials

- The review of the Australian (NCCH) underlying cause of death training material has been completed and it is recommended as a standard for knowledge clusters 7 and 8.
- The review of the Korean underlying cause of death training material from various universities has been completed and recommended as a standard for knowledge clusters 3 – 9. Marjorie will announce both of these recommendations in her keynote address to the IFHRO Congress.
- The US (NCHS) underlying cause of death training material is with Sue for the second review and things are looking good. The U.S. also plans to develop materials for other clusters.

- INTERCOD has not been recommended as a standard at this time as it is felt that some updating is required.
- Some revisions to the Sri Lankan underlying cause of death training material have been recommended.
- South African and Portuguese (WHO CC for the FIC in Portuguese) mortality classification materials are still being reviewed.

The updated matrix of training materials received and under review is in Attachment 5.

Kathy named the current reviewer team [Margaret, Sue, Kathy, Amy, Roberto, Joon and Chris] and asked if anyone else would like to be added to the roster of reviewers. Margaret said that the new IFHRO representative will be a reviewer.

There was a discussion around the issue of newly-trained coders needing to have been trained in all components of the core curriculum. The current US and Australian material do not include material for all knowledge clusters and this raised the question, "does this mean that their newly-trained coders won't be able to qualify?" Patricia and Cleo felt that the main focus should be on the competency in underlying cause of death classification. Kathy deferred further discussion to the agenda item for the process for certifying newly-trained coders.

b. Solicitation of additional materials

Sue noted that we should continue to identify and encourage owners of materials to submit their courses for review by the Joint Collaboration.

c. Outreach to Coders and Trainers and solicitation of additional materials

Kathy reported that solicitation of potentially-interested parties thus far had been in the form of an informational letter signed by Marjorie, Sue and Margaret and distributed to Collaborating Centers and IFHRO member states. It had been hoped that the Collaborating Centers would assist with translation and distribution, but volunteer translators would be welcomed. Stefanie suggested that in some countries, it would be better if initial correspondence was between the JC and coders. After a coder has expressed interest, then the Collaborating Center could become involved.

The outreach to coders and trainers thus far has netted the following submissions:

- 33 interest forms
- 15 self-assessments
- 2 trainer applications
-

Sheryl Reyes responds to interested parties letting them know more about the program. She works at the AHIMA office 3 times per week and is committed to working a certain number of hours in order to take care of WHO-FIC Joint Collaboration business.

One avenue planned for solicitation of materials is the International Educators session during the afternoon of May 26th in Seoul, Korea. A flyer will be developed for distribution along with other information such as the JC brochure and interest form. Everybody attending the Congress

will have the opportunity to learn about the work of the Education Committee and the Joint Collaboration through various presentations throughout the Congress.

Other suggestions for solicitation:

- Marjorie agreed a link to the IFHRO site can be provided on the NCHS website (and vice versa);
- Provide information in various medical/HIM journals where coders will see it;
- when IFHRO countries are contacted, it could be suggested they place a notice in their journal;
- the Mortality Reference Group Forum is a great place to reach mortality coders;
- Education Meeting in Seoul;
- Robert Jakob will provide Kathy with the contact information from an interested party in Mexico.

Solicitation of training materials and coders interested in the international certification is a continuous process and will be ongoing.

7. Pilot testing of Underlying Cause-of-Death exam

Canada and Korea have completed pilot testing of the Underlying Cause of Death application, self assessment, and exam and Patricia and Joon shared their experiences with the group.

a. <u>Canada</u>

Two Statistics Canada employees sat for the coding exam – no provincial coders as yet. Patricia provided a casual refresher prior to completion of the exam to review underlying cause rules, etc. The students spent all of one workday (Wednesday, April 4, 2007, 800-1400 hrs) on the exam with a one hour break for lunch and one more hour of the following day (Thursday, April 5, 2007). The Canadians felt the second day would not have been necessary were it not for an unavoidable obligation that did not allow them to be as thorough as they would have liked on the initial sitting.

Both Canadian coders were successful with 93% and 96% scores. Both coders were trained on-the-job using NCHS materials and both had 2 years of experience assigning the underlying cause of death with previous training and experience in multiple cause of death coding.

Patricia pointed out that there were some editorial problems on the test itself as some of the examples had the multiple cause codes provided and another example had the duration missing, which affected the code assignment. There are 50 questions on the exam for coders and 60 on the exam for trainers. Patricia noted that it would be best to physically separate the 10 extra "trainer" questions from the rest of the questions on the hard copy exam as it became confusing for one of the coders to know exactly which examples to code. Patricia also suggested the actual rules applied be fine-tuned as there was some debate on one or two of them. One other quite problematic issue was the question of how exactly to rate the various parts of the exam. Prior to the test date, many email conversations were passed between Joon, Patricia and Cassia trying to work this out. A number of different scoring mechanisms were tried before finally settling on one that seemed to work the best.

The Canadian coders were very nervous at first but after encouragement from Patricia agreed to serve as our pilot test-takers and are most excited at their successful results. The students will not be able to travel to Seoul, but Patricia will provide a picture so they can be visible while receiving their certificates in absentia.

b. Korea

The Korean pilot test attracted much interest as it was also offered to coders who use Volume 2 rules to assign underlying cause from hospital records. At the beginning, a Task Force Committee (TFC) made up of KMRA members was organized to complete the large task of translation and verification of the exam and getting the information distributed to coders. It took three TFC members 3 days to complete the translation and an additional day for Joon to verify the material. Just to note, WHO guidelines mandate that there must be a 3-step process regarding translation of their endorsed materials – the first translation, a back translator to check and yet a third person to review once more. For the purposes of these exams in Korea, a 3rd person was not required because the WHO Volumes provided in the Korean language served as translation #1. One other note of interest in translation is that Korea chose to show both the English language version as well as the translated information on the exam. The Korean version of the ICD-10 is set out this way.

A one-day education program was provided for 320 trainees who had hopes of sitting for the exam. The final number of applicants ended up being 125, including 30 for both coder and trainer exams. The submitted self-assessments and applications had to be reviewed to assess eligibility, and only one applicant was not allowed to sit for the trainer's exam due to her insufficient experience teaching coding. Ultimately 23 people sat for the exam, 14 coders and 9 trainers and 10 of these 23 passed (receiving at least 80% correct scores)! It was noteworthy that 100% of those who code mortality data in their regular duties passed the exam while only 3 of the 14 hospital coders passed and 1 out of 3 instructors. Upon announcement of the successful certification of 10 Korean and 2 Canadian underlying cause of death coders, Education Committee members broke into spontaneous applause, thrilled at seeing the years of preparation and planning come to fruition!

There were some valid concerns noted in the Korean experience. A major concern among students was the length of time required to complete the exam. The exam took 6 hours on a Sunday with an extra hour provided for the trainer exam. Other concerns included the debate over some answers/rule selections on the answer key, trying to determine a definite scoring scheme, the workload required - too much work for one person overseeing the exam to complete, the need for better clarity of Volume II rules, and the fact that the decision tables were too thick to download. Joon also noted that there were three questions that nobody answered correctly; she can use similar questions when conducting another review session prior to the re-test to help clarify these types of instructions. The Mortality Reference Group (MRG), which helped develop the exam, would like to see these examples so the instructions can be reviewed and possibly clarified. There was concern among both Canadian and Korean colleagues that perhaps the self-assessment needs to be a bit more concrete – students interpret terms such as 'broad knowledge' differently. Joon noted that 2 students with the same exact level of experience and training assessed themselves differently.

Korea plans to re-administer the test in mid-November after providing further training. A number of those participants not passing the first attempt have already expressed an interest in re-taking the exam later this year.

Korea had planned to return the corrected exams to students but thought better of it since these questions can be used in a "pool" of examples from which questions can be randomly selected so that the exam will be different every time. The 10 trainer questions can also be part of this pool.

There was no fee for the pilot exam in Canada but a US$100.00 charge for the exam in Korea, which will be levied each time the person chooses to take the test. This matches what is done in the US morbidity arena. Joon noted that the fee did not seem to be a problem for anybody and covered the general administration for the exam.

c. <u>Further discussion about pilot exams and the process for certification</u>

As discussion continued, a question arose as to how long this certification would be valid. Committee members remembered that continuing education had been discussed before – perhaps valid for 2-3 years? For coders with a CCS (Certified Coding Specialist) in the USA, there is a self-assessment completed annually for coders to determine whether they are keeping up with the current trends in medicine. Possibly mortality could be every 5 years?

The committee discussed the concerns over the length of the exam. One suggestion was to reduce the number of questions. Overall, members wanted to be careful not to make it too easy and thus de-value the results. It is important to be sure all underlying cause rules are represented in the questions. Perhaps part of the stress resulted from coders with little experience attempting the test too soon. Another approach may be to administer the test in 3-hour increments, providing 25 questions, taking a break and then administering the last 25 questions.

There was interest in a number of other countries also trialing the pilot exam and then comparing those results with these initial experiences. Japan, the United States and the UK all offered to participate and will try to do so before the next Education Committee meeting in Trieste in October. The grading scheme decided upon by Joon, Patricia and Cassia can be used to assess these exams as well.

A Subgroup was developed to further assess the pilot test experience and address ways to solve some of the problems identified. Members will be:
Patricia (chair), Cleo, Donna Glenn, Cassia, Joon, Yukiko, Kathy (ex officio). Some of their duties will include:

- reporting at the meeting in late October regarding what they have discussed,
- offering revisions to the Pilot Exam itself to exclude the 3 problem questions, obtaining additional questions from the MRG,
- formalising the test administration procedures,
- re-verifying the marking scheme,
- considering the exam time elements and bringing recommendations to the meeting in October.

Kathy will interact with the group to get feedback; she will let them know what information she needs for the program evaluation.

The following questions were asked

- Who can retake the exam and how many times can they attempt it?
- Is there a window of opportunity in which practicing coders can take the exam?

After much discussion, it was concluded that although certain criteria will need to be met for any coder to complete the exam, a coder today will not lose the opportunity to eventually become certified as an underlying cause of death coder if they do not participate immediately.
Before sitting the exam, coders should:

- complete ICD-10 Training
- complete education in other country-specific areas such as legal issues and uses/users of data
- have coding experience (at least 1-2 years)
- complete the self-assessment.

Other exam requirements

- must be supervised during exam (their own supervisor or some other approved person must be responsible for administering exam)
- there will need to be a fee applied with the amount determined on a per country basis.

The pilot phase of testing will be extended through 2007 and results assessed. As far as the question of re-testing, it seemed okay for individual coders to make the decision about when they feel confident and ready. They can re-take as often as they wish, paying the fee each time. Eventually web-based training will be suggested / offered to those who fail in order to improve their chances for future success.

Another working group was organized to address the concern of how to certify trainers who have been involved in the development of the program up to this point. Perhaps an honorary certificate can be presented at Seoul. Members of the small group include: Donna Glenn, Chris, Marjorie, Kathy and Margaret.

The group next looked at a sample certificate to be presented to the successful candidates of the pilot exam and edits were made as the group discussed it. Some of the comments noted were that Underlying Cause needs to be stated and the acronyms need to be spelled out. The wording was finalized within the committee meeting.

Action: Kathy will work on the formatting of the final document.

The full Joint Collaboration then dispersed into small groups to work on various aspects of the Training and Certification program, to report back the following morning.

Thursday, May 10, 2007

The meeting reconvened at 9:05 a.m. with Sue Walker presiding.

8. Work Group reports

The session began with a presentation by each of the work groups that had met on the preceding day.

a. Joint Collaboration Work Plan for 2007-2008 – Sue Walker, Carol Lewis

A table outlining the 2007 – 2008 work plan was presented and accepted with minor modifications. See Attachment 6.

b. Pilot Examination Work Group – Patricia Wood, Cassia Buchalla, Donna Glenn, Joon Hong, Cleo Rooney, Yukiko Yokobori, Kenji Shuto, Emiko Oikawa, Ikuko Takatsuka

Action: The group identified a number of items for immediate action:

- By the end of next week, Joon will send each member of the work group the three questions that had posed problems in the pilot test in Korea
- Cassia will send the current exam to Japan so that translation can begin. (This has since been done.)
- Once she has translated the new questions that have answers, Cassia will send them simultaneously to the MRG and to the members of the work group to speed up the review process (This has since been done).
- Marjorie indicated that she can organize a conference call for the Work Group should one prove to be necessary.

c. Honorary Trainer Certification – Kathy Giannangelo, Marjorie Greenberg, Margaret Skurka and Christine Sweeting and Donna Glenn who participated in final discussion.

The group identified four specific criteria that the individual must meet in order to be awarded honorary certification. The candidate must have:

- authored approved underlying cause-of-death coding training materials
- two years experience in providing training in underlying cause of death
- worked on the pilot process to establish the examination
- ten years of extensive experience in coding underlying cause of death.

As a result of the general discussion, the first point was amended to read “authored or contributed to the development of approved underlying cause-of-death training materials.” The fourth criterion was deleted as it is a condition that could not be met by those for whom the designation was intended – many educators have not had the requisite amount of actual coding experience.

At present, only Sue Walker and Joon Hong are eligible for designation for the honorary certification as trainers and it is hoped that they can be recognized during the IFHRO Congress in Korea. The training materials developed in Brazil and the USA have not yet been approved thus precluding the trainers from those countries receiving the honorary designation. It may be that this could be finalized in the period before the IFHRO congress.

In the discussion, Robert Jakob asked if the proposal includes a threshold or standard for criteria that must be met? If not, the honorary designation might be interpreted as being self-serving. It was pointed out by several participants that the primary reason for the honorary designation was to allow participants in training courses to meet the criterion of having an approved trainer responsible for conducting the course.

Stefanie rightly pointed out that there are several individuals, such as Lars Age Johansson, whose direct involvement in reviewing the questions included in the examination make it unreasonable for them to sit the examination.

It was decided that the candidates for the honorary trainer certification should submit an application for review by the four members of the work group.

Action: Sheryl Reyes will send out the current application. Lars and other selected individuals will be invited by the co-chairs of the Joint Collaboration to submit applications.

The approved trainers will be on the roster with the honorary designation. The ultimate objective is to have not only approved training materials but also approved trainers.

9. Newly trained mortality coders

The objective of the training and certification program is to contribute to the best possible health of the population through the best possible health information to which knowledgeable coders and improved coding practice contribute.

At the Education Committee's meeting in Prague it was decided that an international examination was not feasible and that certification would have to be distributed based on training program best practices, including an examination. Now, however, with the successful experience of an international examination for existing underlying cause-of-death coders, the question of offering an international examination for all coders is being reconsidered. As pointed out by Cleo, such an international examination is possible for cause-of-death coding but not for morbidity coding because of the different rules and guidelines and the different national ICD modifications in use.

Marjorie suggested continuing with the self-assessment and perhaps adding examination questions for other modules, recognizing that the grading/marking might be harder.

Donna suggested that there should be an interval between the completion of training by the coder and the examination. Kathy reported that the booklet describing the AHIMA coding certification process contains the recommendation that the candidate have two years of coding experience before sitting the examination but if they feel ready they can take the examination before then.

Something similar might be included in the document describing the process and preparing people for the exam that Kathy plans to prepare.

There is a need for additional underlying cause-of-death questions and also for questions for other clusters.

10. Multiple cause of death coders

The participants discussed that currently there are no agreed-upon international rules for coding multiple causes of death to guide development of a training or certification program for these coders. However, several people felt that it might be useful to develop guidelines for users of multiple cause-of death data to improve the quality and comparability of analyses.

Action: Stefanie, Ruy, Donna Glenn, and Cleo agreed to work on this project with the MRG and report back at the 2008 mid-year meeting.

11. Morbidity coding internationally

Joint Chairs of working group: Christine Sweeting and Amy Blum

Chris Sweeting from the UK introduced the session, which she co-chaired with Amy Blum. She said that the purpose of the session was to get a feel from members present about

- how morbidity data was coded in each country
- the varied classifications in use, for example ICD-9, ICD-10, national and clinical modifications
- how training and accreditation of large numbers of coders in each country was or could be organised and funded
- how the Education Committee and Joint Collaboration could carry forward this work.

She pointed out that some international training was already available, for example from Sue Walker of the Australian WHO FIC CC, but that there was not the same international agreement on coding rules for morbidity that there was for mortality. The JC has begun the process to assess mortality coders, and will present the first certificates in Seoul later this month to coders who passed the international mortality coding exam. We have much further to go to establish international standards in morbidity coding.

It was agreed that the EC and JC should consider, under the heading of 'morbidity coding', coding of health services activity across a range of settings (hospitals, health centres, inpatient and outpatient, primary and secondary care, physicians' offices) and for a variety of purposes, including epidemiology, management and billing / reimbursement. The committee was not considering training for coding data from systems set up primarily to measure incidence and prevalence of disease (cancer registries, notification of infectious diseases, or health surveys).

Committee members presented information about coding and coder training in the USA, UK, Germany, Korea, Australia, Japan, Brazil and Canada. This included the diagnostic and procedure classifications used and whether 'main condition' or 'principal diagnosis' definitions

were used; and the expected level(s) of coding training and of education prior to working as a morbidity coder.

	Diagnostic classification	Procedure classification	Main condition or principal diagnosis for hospital inpatients	Settings
USA	ICD-9 CM	Several in use	PD	Inpatient, outpatient, Primary care Home visits
UK	ICD-10	OPCS-4	MC	Inpatient
Germany	ICD-10-GM	German Procedure coding system		
Korea	KCD-0 to KCD-4 (based on ICD-7 to ICD-10)	ICD-9-CM	MC since 1995	
Japan	ICD-10	DPC		
Brazil	ICD-10	Brazilian national classification	MC – reimbursement ? PD for public health	
Canada	ICD-10-CA Canadian Clinical Modification	CCI		
Australia	ICD-10-AM	ACHI	PD	Inpatient

a. <u>USA, Kathy Giannangelo, IFHRO/AHIMA</u>

In the USA, coding is carried out in a variety of settings (see table), each of which has its own definitions and standards. For inpatients, principal diagnosis, defined as 'that condition, determined after study, which occasioned the patient's admission', is used. New requirements to code secondary diagnosis and whether the condition was present at admission have recently been added. Only one diagnostic classification is used, ICD-9-CM, but several different procedure classifications are used. Coding, and the classification system used, are driven largely by the systems for reimbursement of health care providers by third party payers, including the use of DRGs for inpatient care. ICD-9-CM has been in use since 1979, and is updated annually. The move to ICD-10-CM has been resisted on the grounds of cost of redeveloping reimbursement and recording systems.

There are several levels of coder training, which lead to different qualifications. These include 2-year college programs for Health Information Technicians and 4-year programs for Health Information Managers. There are also 9-12 month 'approved coding programs', and very short,

concentrated programs ('boot camps') to train coders to work in single very specific settings, for example for reimbursement coding in a physician's office. There are many routes into coder training.

AHIMA offers a range of qualifications, Certified Coding Specialist (CCS, course plus two years experience), CCS-P (CCS for physicians' offices). Their most basic qualification is CCA, Certified Coding Associate, which requires a 9-month course and no experience. The American Academy of Professional Coders (AAPC) also awards coding qualifications, as do some other organizations. The processes and requirements for these qualifications vary.

b. UK, Chris Sweeting, EC/UK

Diagnostic coding is only required for hospital in-patients at present, but will be rolled out to hospital out-patients over the next few years, possibly also accident and emergency departments. The primary diagnosis, or main condition, based on the WHO definition, is required and all other conditions pertinent to the patient's care for that episode should also be coded. Coders assign codes based on all of the information in the in-patient record, but the doctor should check these codes on the discharge summary. The UK uses 'health care resource groups' rather than DRGs. HRGs classify similar conditions with similar resource requirements together. Most coders get a mixture of on-the-job training, NHS courses and self-teaching. There is a national qualification for coders based on an exam which is now in its tenth year. The marks required for a pass are kept high, to underpin improvements to data quality through better coding.

c. Germany, Stefanie Weber, DIMDI

In Germany, in-patient hospital diagnostic coding is done using the German Clinical modification, ICD-10-GM. Procedure coding is done through the OPS, a very refined classification of diagnostic and therapeutic procedures with about 24.000 codes. About 50% of the reimbursement of hospitals is done through DRGs as the reimbursement system is in a stepwise transition towards the new German DRG system. It will be 100% DRG reimbursement in all hospitals in 2009/2010 if things work out. .Both ICD-10-GM codes and OPS procedure codes are used to assign cases to DRG groups. Additionally there are separate coding instructions and guidelines for the use of codes in the DRG-system, which overrule the coding rules from volume 2. ICD-10-GM is also used for day cases and outpatients. The OPS is used mainly for hospital reimbursement but as well for day cases and some outpatients.

Coders are largely trained on the job. Health information managers have higher training in coding, document management and statistics. There are one and two year training courses, largely provided in the private sector. Many hospitals use doctors to do their own coding. Sometimes the codes assigned through a doctor are checked by a coder afterwards. Insurance companies check the coding before payment.

Almost all coding is done with the help of software solutions which are widespread in hospitals and outpatients clinics.

d. Korea, Joon H Hong, IFHRO

The official Korean version of the ICD is used for diagnostic coding. The Korean Government produced official translations of ICD-7 to ICD-10, which are called Revisions 0 to 4 of the

Korean Classification of Diseases. The current KCD-4 is the second to be based on ICD-10 and has been in use since 2003. For procedures, ICD-9-CM is used. Korea used 'prinicpal diagnosis' in KCD-2, based on ICD-9-CM, from 1979 to 1994. Since 1995, in KCD-3 and KCD-4, they have used 'main condition'. Doctors should record the 'main condition', but don't always do so.

Hospitals employ certified medical record and health information professionals. There are 2-year and 4-year educational programs for health record and health information managers. There has been a national certificate exam since 1985, for which education in classification of diseases and procedures is a prerequisite. National law requires that clinical coding is done only by certified medical record / information professionals. Eight credits of continuing professional education is required every year for medical record/health information professionals, but they do not have to re-sit exams.

e. Australia, Sue Walker, Australian CC

Hospital inpatient and day surgery cases are coded, but not out-patients or emergency room attendances (at this point in time). Coders code from the whole patient case notes, using the Australian clinical modification, ICD-10-AM, which is currently in its fifth edition. The principal diagnosis definition is used and all diagnoses and procedures relevant to the episode of care are coded. Four universities offer Health Information Management (HIM) courses which include coding in their curricula, some state governments also offer intensive, short courses, and distance based learning is available from the Health Information Management Association of Australia (HIMAA) and the Open Training and Education network. Coding is done both by trained HIM coders and non-HIM coders. For existing coders, the National Centre for Classification in Health (NCCH) offers update courses for each edition of ICD-10-AM, the Australian Classification of Health Interventions (ACHI) and the Australian Coding Standards (ACS), as well as annual coding workshops and a biannual coding conference. NCCH also offers short and customised courses for new coders who use the WHO version of ICD-10. The HIMAA education service offers courses at introductory, intermediate and advanced levels, and clinical coder certification. This Certification requires a minimum of four years' clinical coding experience in a hospital with a broad range of clinical services, completion of six coding assignments, and a two hour exam.

f. Japan, Yukiko Yokobori, Japanese CC

ICD-10 is used for coding in Japanese hospitals. The Japanese Hospital Association (JHA) provides a two-year distance training course for HIMs. There are also courses in universities, and some vocational colleges, but these must be recognised by the JHA. Ninety percent of applicants to take the certificate of the JHA are from hospitals, including some doctors and nurses. JHA is responsible for the curriculum which includes anatomy, physiology, terminology and ICD-10 coding. Health information managers code from the clinical discharge summary completed by doctors. HIMs discuss with the doctor when the main diagnosis appears to have been specified incorrectly. The first coding is sometimes done by the doctor, but checked by an HIM. Some hospitals use an automated coding system, particularly if they do not have a trained HIM. The Japanese Government developed a national system similar to DRGs, which is called the Diagnosis Procedure Combination (DPC). Many doctors are interested in this and have taken the JHA courses in coding and formed an ICD society. There are three organizations that relate to Health Information Management in Japan. Those are, the JHA, which provides training and accreditation of HIMs; the Japan Society of Medical Record Administrators (JSMRA), which is

the academic society for HIMs; and the professional association of HIMs. A resource based definition of 'Main condition' is used for in-patient coding.

g. Brazil, Cassia Buchalla, CC for Portuguese

Brazil presents its own 'information paradox', in that there is a huge amount of coded data available on the 11-13 million hospital discharges as well as outpatient visits each year, but the training of coders and use of coding standards vary a lot. CD ROMs of inpatient and outpatient data are distributed monthly and annually. Two systems of coding exist, one for statistics and public health including epidemiology of diseases, and one for payment. The coding for financial re-imbursement is taken seriously, but there is a very high turnover of morbidity coding staff and no career structure. The Portuguese language WHO FIC centre in Sao Paolo make ICD-10 training available, but most coders are trained on the job. In some areas, coders have been very well trained but the standard is very variable. There are a variety of different discharge forms available from which diagnoses and procedures are coded. Brazil has a national classification for procedures, for reimbursement purposes.

Ruy Laurenti offered some further observations about morbidity coding in Brazil: Carol Lewis provided the first national course for morbidity coders in Brazil many years ago. The Brazilian WHO-FIC centre tried four years ago to assess the consistency of morbidity data. They looked for inconsistencies in the main diagnosis codes by age, sex and for conditions not seen in Brazil. Less than one record per thousand failed these checks. However, there is no information available on how well the physicians specify diagnoses and there is no standardised discharge form used for statistical coding. Only publicly funded health care is coded and analysed, not the 30% that is privately funded. There is no recognised profession for health information management in Brazil. There used to be a professional society, but it lapsed when the founders retired. A new training course has been started recently, but the first students have not yet completed it.

h. Canada, Patricia Wood (with input from Lori Moskal at CIHI), North American CC

In Canada, in-patient, day case, emergency room and out-patient medical records are coded. Coders use the whole health record. They code diagnoses to the ICD-10-CA, the Canadian enhancement of ICD-10, and interventions to the Canadian Classification of Health Interventions (CCI), both of which are updated every three years. .

Several universities offer degree level courses in HIM, and community colleges offer HIM diplomas which cover coding and a range of related subjects. Courses are accredited by the CHIMA, which also administers an annual national exam to graduates of approved courses. CHIMA registration must be updated annually with evidence of continuing education and a fee of 230 Canadian dollars.

The Canadian Institute for Health Information (CIHI) maintains the annual Canadian Coding Standards for ICD-10-CA and CCI and an on-line coding query database. CIHI offers continuing morbidity classification training with face-to-face workshops, videoconference workshops and on-line courses.

Diagnosis Type (M)—Most Responsible Diagnosis (MRDx)

A Diagnosis Type (M) is the one diagnosis or condition that can be described as being most responsible for the patient's stay in hospital. If there is more than one such condition, the one held most responsible for the greatest portion of the length of stay or greatest use of resources (i.e. operating room time, investigative technology, etc.) is selected.

If no interventions have been performed select the first-listed diagnosis as the most responsible diagnosis.

If no definite diagnosis was made, the main symptom, abnormal finding or problem should be selected as the MRDx.

i. General Discussion about morbidity coder training and certification

Following this review of coding and training in countries represented at the meeting, participants went on to discuss what was already known about morbidity coding in other countries, what we still need to find out, and what should be the priorities for the Education Committee. Sue Walker reminded the meeting of the needs assessment carried out by the Education Committee, which she had presented at the WHO-FIC annual meeting in Reykjavik in 2004. She had the presentation with her and gave a brief overview of the findings of the survey.

There was some discussion about whether that survey should be repeated. There were several issues of relevance to the Education committee, for example:

1. Had countries that said they would implement ICD-10 soon done so yet? If not, what were the reasons and did they need help from the EC?

2. Were there countries that reported to the EC at this meeting that thought the EC could / should add value to the existing morbidity coding infrastructure in their country? For example, through a process for international recognition of training courses or materials?

3. Was there a way that the EC could help raise the status of morbidity coders, to address the problem of rapid turnover?

- Chris Sweeting said that the UK had introduced an improved career and pay structure for qualified coders based on the work of the Education Committee on skill levels and functions.
- Carol Lewis said there was a need to promote a grade structure and career progression with salaries based on experience and standards as well as initial qualifications.
- Amy Blum pointed out that there is a need to address the overall shortage of coders as well, and asked the participants for suggestions. She questioned whether an international certificate would help this.
- Kathy Giannangelo said that AHIMA had developed a career ladder, and was working on the career pathways to support this.
- Sue Walker said there might be problems in recommending a structure and levels which would require higher salaries within existing systems. This may be particularly problematic in small and developing countries.

Chris Sweeting said that the working group that she had co-chaired, had started from the question of how to certify morbidity coders, and whether a process similar to what had been done for mortality coders was possible. The group had moved on to the question of the relationship with existing national education and certification systems used in a range of countries. Coders who had completed a recognised course, or one given by a recognised trainer, should be able to achieve international accreditation. However, Sue Walker pointed out that there is also a need to support countries that don't have national qualifications or training programmes.

International standards for training are dependent on internationally agreed rules and standards for morbidity coding. The Education Committee should press the Morbidity Reference Group (MbRG) on the timing for these. We need the international rules, guidelines and definitions before we can really develop courses to support such standards. We can expect an update from the MbRG at the October WHO-FIC meeting. One of the urgent issues is how to recognise the excellent international training that is being provided by some WHO-FIC centres, notably the Australian Centre, before these standards have been agreed.

Action Marjorie Greenberg, as head of the Education committee will approach the MbRG to discuss these issues.

The meeting discussed what the Education Committee could do in the interim. It was suggested that:

- the EC could continue reviewing training material submitted by countries / national professional associations against the recommended core curriculum for morbidity coding training;
- IFHRO could carry out some work to identify which countries need such international courses; though we do have some of this information from the EC's needs assessment survey;

Action: Kathy Giannangelo agreed to provide a graphic based on the different skill levels and functions for coders developed by the Education Committee.

12. Dissemination

Actions:

- Marjorie will send an email to Centre Heads informing them that the Core Curriculum and Best Practices for Certifiers of Cause of Death have been posted on the Education Committee website
- Marjorie, Sue and Margaret will update the electronic version of the Joint Collaboration brochure by the end of July
- The JC brochure will be posted on the EC website
- Robert will follow up on distribution of the brochure on the WHO-FIC Network, which was developed by the EC
- Kathy is drafting a set of slides on the JC that can be used for outreach; she will circulate for review and comment

Friday 11 May

Marjorie Greenberg welcomed the group for the final day of the meeting. Additional attendees for today were Dr. John Hough from the National Center for Health Statistics, lead for ICF in the US and Lynn Bufka from the American Psychological Association, both ICF representatives on the Education Committee.

13. Finalisation of Terms of Reference

The Education Committee Terms of Reference revised on Wednesday were reviewed. Margaret next addressed the changes in the Joint Collaboration's Terms of Reference with attendees. After minor changes to the wording, both Terms of Reference were approved with modifications.

The draft Joint Collaboration's 2007-2008 Work Plan required task and time adjustments based on the previous day's decisions. Deliverables will be first grouped by underlying cause of death mortality coders as these tasks are of higher priority.

14. ICF updates and work with FDRG

Lynn updated the group on the status of the development of the professional manual for clinical implementation of the ICF. It is half finished and should be completed soon.

Cassia reported on the collaboration with the Functioning and Disability Reference Group (FDRG). There are 34 members with representatives from all WHO regions. The aim of Project 5: Education Material is to develop a suite of simple and accessible products made available on the WHO Web site which are suitable as an introduction to ICF and to follow up with one or more advanced courses for different ICF applications and audiences. Cassia described the progress thus far regarding steps one (collect information from the ICF INFO pilot project) and two (characterize the training materials that were reported in the pilot). For the development of an ICF core curriculum, the findings show that the uses for the ICF are varied, the users are varied, ethics and quality are very important aspects.

During the discussions, suggestions for going forward included:

- Use the work completed on the underlying cause of death core curriculum as a template for the work of the FDRG in the development of their core curriculum for ICF;
- Take a modular approach
    - Select the modules based on the individual and healthcare setting
    - Address levels – introductory and in depth
    - Set up as a matrix that shows the modules and to which groups they would be targeted.

Given the work that still needs to be done, e.g., having a developed core curriculum and the work involved in training material review, it was decided that having a draft of the basic training materials by October probably was not feasible.

Action: Over the next several months, Lynn, John, Catherine Sykes and Carol will work with Cassia to create the core curriculum. The draft will be circulated to the Education Committee for review and comments prior to the annual WHO-FIC Network meeting.

In the mean time, more ICF training materials will be solicited.

15. IFHRO Congress

Papers and presentations on the agenda for the upcoming 15th IFHRO Congress to be held in Seoul, Korea include:

- Saturday, 26 May WHO-FIC Education Committee, WHO-FIC – IFHRO Joint Collaboration meeting in the morning
    - EC Chair and JC co-chairs will present background information, discuss work plans and receive feedback from participants
- Saturday, 26 May IFHRO Global Health Record/Health Information Management Education Community meeting in the afternoon.
    - Content to be presented will focus on the audience, i.e., the educators, and will include the curricula, the process for becoming an approved trainer, and how training materials can be submitted;
- Sunday, 27 May IFHRO General Assembly;
    - Report from the WHO-FIC IFHRO Collaboration on the work of the JC by Marjorie, Sue/Margaret, Joon, and Kathy
        - Marjorie – introduction
        - Margaret – overview of the JC
        - Joon – Korean and Canadian pilots
        - Kathy – AHIMA/FORE contract
        - Sue – work going forward; what we would like IFHRO to do, e.g., consider the Korean process as a model for other medical record/health information management associations to use regarding the exam, promoting the program, solicitation of the training materials.
    - Breakout sessions in the afternoon include one on data quality where the work of the JC will be discussed
- Monday, 28 May
    - Keynotes by Marjorie Greenberg and Bedirhan Ustun
- Monday, 28 May, one of the concurrent sessions
    - The Joint Collaboration between IFHRO and the EC of the WHO-FIC Network by Sue Walker and Margaret Skurka
- Tuesday, 29 May
    - Educational Strategies for the WHO-FIC Network by Marjorie Greenberg
- Wednesday, 30 May
    - Closing ceremonies: Awarding of international underlying cause of death coder and trainer certificates by Marjorie Greenberg, Sue Walker, and Margaret Skurka

Other EC members who will participate in the Congress include Carol, Yukiko and Olafr Steinum. Additional activities during the 15th Congress include an international reception on

Sunday evening, a gala dinner on Tuesday night, and educational tours at various hospitals on Thursday.

16. 2007 WHO-FIC Network Meeting

Marjorie reported on plans for the 2007 WHO-FIC meeting in Trieste which had been discussed at the recent Planning Committee meeting in Odawara, Japan. Draft agenda items include:

- Pre-meeting tutorial - Training on the ClaML maintenance tool, either Saturday or Sunday
- Orientation session chaired by Marjorie on Monday morning
- Education Committee meetings on Monday from 1:30 – 3:00 and Wednesday from 9:00 – 10:30
    - One session will be devoted to the work of the JC and the other to the joint ICF project with the FDRG, depending on member availability. However, Marjorie also will solicit papers for a cross-cutting panel on best training practices.
    - Papers
        - Marjorie – the annual report
        - Sue and Margaret – the status of the JC work plan
        - Cleo – the second round of pilots
        - Cassia – the ICF FDRG work
        - Members of the EC who have performed training (Papers would be 2-3 pages describing the challenges, what worked and what didn't, best practices. Not all would be presented during the meeting)
            - Sue – training and train the trainers program in India, Brisbane and Micronesia
            - Chris – training in the Czech Republic
            - Cassia – train the trainers in Brazil
            - Elaine – possibly paper on work in South Africa
            - Geoff – training in South Africa (ICF)
        - Robert – Web based training update
    - Poster
        - Kathy – the work to date of the JC

Deadlines as reported by Robert are as follows:

- Imminent – Call for papers
- 30 June – Title and abstract (this subsequently was extended to July 15)
- 1 October – Final papers due

Marjorie encouraged those present to submit new abbreviations to her for inclusion in the revised WHO-FIC Abbreviations and Acronyms document.

New and updated FAQs are being documented through the outreach program. They will be posted on the IFHRO Web site.

Action:
Carol will work with Marjorie on updating the abbreviations document

17. Implementation Committee (IC) Update

Kenji presented on the work of the WHO-FIC Implementation Committee, including stimulation of regional networks, and how it coincides with the need for a number of educational initiatives. The EC foresees a closer working relationship in the next several years with the IC in order to work collaboratively on these initiatives.

18. Other training and relevant meetings

Sue reported that in 2008 an ICE on automating mortality statistics plenary meeting will be held. The focus of this meeting will be on improving mortality data in developing countries, demonstration of IRIS, certifier training, and e-learning initiatives.

After Seoul, the next meetings of the EC and JC will be held via conference calls scheduled tentatively for the end of June and in September.

19. Meeting closure

Marjorie asked if the group thought it appropriate to send a letter from the co-chairs of the JC to Sam Notzon in appreciation of his support. All agreed this should be done.

Action: Kathy will draft the letter for review and approval by Margaret, Sue and Marjorie. The letter will thank Sam for his support and acknowledge that without this, the progress to date would not have occurred. A status report on the program will be included.

Marjorie reminded the rapporteurs to be sure and note all action items clearly in the minutes. Electronic copies of the various sections should be e-mailed to Sue Walker no later than 24 May.

Marjorie thanked all attendees for their usual active participation in the meeting and wished everyone safe travel back home. The meeting was adjourned at 12:25 pm.

Attachment 1

Meetings of the Joint WHO-FIC - IFHRO Collaboration and WHO-FIC Education Committee
Washington, DC USA
May 9-11, 2007

Tentative List of Participants

Tyringa Ambrose
Medical Classification Specialist
CDC/National Center for Health Statistics
P.O. Box 12214
RTP, NC 27709
Ph: 919-541-3981
Fx: 919- 541-5211
Em: tla1@cdc.gov

Amy Blum
Medical Classification Specialist
CDC/National Center for Health Statistics
3311 Toledo Road, Room 2417
Hyattsville, MD 20782
Ph: 301 458-4106
Fx: 301 458-4022
Em: alb8@cdc.gov

Dr. Cassia Maria Buchalla
Assessor on ICD
WHO Collaborating Centre for FIC in Portuguese
Av. Dr. Arnaldo 715, Room 40
01246-904 Sao Paulo-SP-Brazil
Ph: 55 11 3061-7744
Fx: 55 11 3082-2920
Em: cmbuchal@usp.br

Lynn Bufka
Assistant Executive Director
Practice Research and Policy
American Psychological Association
750 First Street, NE
Washington, DC 20002
Ph: 202 336-5869

Fx: 202-336-5797

Em: lbufka@apa.org

Dr. Maria Teresa Cravo
Medical Doctor
WHO Collaborating Centre for the WHO Family of International Classifications in Portuguese
Rua Domingues de Sa 289/1001
Icarai-Niteroi-Rio de Janeiro, Brazil
Ph: 55 21 2299 9560
Fx: 55 21 2299 9561
Em:teresa.cravo@globo.com

Kathy Giannangelo
Director, Practice Leadership
AHIMA
11 Redbud Run
Springfield, IL 62707
Ph: 312 233-1520
Fx: 217 525-2871
Em: kathy.giannangelo@ahima.org

Donna Glenn
Branch Chief, MMCB
CDC/National Center for Health Statistics
P.O. Box 12214
RTP, NC 27709
Ph: 919 541-0999
Fx: 919 541-2471
Em: dgp2@cdc.gov

Marjorie Greenberg
Head, WHO CollaboratingCenter for the Family of International Classification for North America
CDC/National Center for Health Statistics
3311 Toledo Road, Room 2413
Hyattsville, MD 20782
Ph: (301) 458-4245
Fx: (301) 458-4022
Em: msg1@cdc.gov

Joon H. Hong
Chairperson of Task Force Committee for International Certification Exam for ICD 10 Coders
Korean Medical Record Association
Haitbitmaeul Apt. #2415-1301
Haengsindong, Duckyanggu, Goyangsi
Kyunggido, South Korea
Ph: 82-31-973-3663

Fx: 82-31-938-7696
Em: jhhong42@hotmail.com

Dr. John Hough
Statistican
CDC/National Center for Health Statistics
3311 Toledo Road, Room 2414
Hyattsville, MD 20782
Ph: (301) 458-4237
Fx: (301) 458-4022
Em: jph7@cdc.gov

Dr. Robert Jakob
Medical Officer
World Health Organization
20, Avenue Appia
1211 Geneva 27, Switzerland
Ph: 41 22 791 8577
Fx: 41 22 791 4894
Em: jakobr@who.int

Professor Ruy Laurenti
Full Professor
University of Sao Paulo
Av. Dr. Arnaldo 715, Room 40
01246-904-Sao Paulo-SP-Brazil
Ph: 55 11 3061-7747
Fx: 55 11 3083-4246
Em: laurenti@usp.br

Carol A. Lewis
Health Record Consultant
10201 Grosvenor Place, Apt 910
Rockville, MD 20852-4615
Ph: 301-493-2515
Fx: 301-493-2515
Em: calewis213@aol.com

Emiko Oikawa
Chief of Japan ICD Office
Statistics and Information Department
Ministry of Health, Labour and Welfare
1-2-2 Kasumigaseki
Chiyoda-ku, Tokyo 100-8916, Japan
Ph: 81 3 3595 2812
Fx: 81 3 3595 1670

Em: oikawa-emiko@mhlw.go.jp

Dr. Cleo Rooney
Medical Epidemologist
Office for National Statistics
Room D2/22
1 Drummond Gate
London SW1V 2QQ, England
Ph: 44 207 533 5254
Fx: 44 207 533 5320
Em: cleo.rooney@ons.gsi.gov.uk

Dr. Kenji Shuto
Director of Japan ICD Office
Statistics and Information Department
Ministry of Health, Labour and Welfare
1-2-2 Kasumigaseki
Chiyoda-ku, Tokyo 100-8916, Japan
Ph: 81 3 3595 2812
Fx: 81 3 3595 1670
Em: shuto-kenji@mhlw.go.jp

Margaret A. Skurka, MS, RHIA, CCS
Professor & Director, Health Information Management Programs
Indiana University Northwest
3400 Broadway
Gary, Indiana 46408
Ph: 219-980-6654
Fx: 219-980-6649
Em: mskurk@aol.com

Christine Sweeting
Clinical Coding Consultant
Christine Sweeting Clinical Coding Consultancy
6, Kennedy Gardens
Earley Reading Berkshire RG6 5RN England
Ph: + 44 118 966 9840
Fx: + 44 118 966 9840
Em: cesweeting@hotmail.com

Ikuko Takatsuka
Staff of Distant Training Division
Staff of the Japan Society of Medical Record Administration
13-3 Ichibanco Chiyodaku
Tokyo 102-8414 Japan
Phone: 81 3 3265 1281

Fx: 81 3 3265-1282
Em: takatsuka@jha-e.com

Sue Walker
Associate Director
National Centre for Classification in Health NCCH, School of Public Health
Queensland University of Technology
Victoria Park Road
Kelvin Grove Q 4059 Australia
Ph: + 61 7 3138 5873
Fx: +61 7 3138 5515
Em: s.walker@qut.edu.au

Dr. Stefanie Weber
Medical Classification Officer/Consultant
DIMDI – Deutsches Institut fur Medizinische
Dokumentation and Information –Deputy Head of WHO Collaborating Center for Medical Classifications in German
Waisenhausgasse 36-38a
50676 Cologne, Germany
Phone: 49 221-4724 485
Fx: 49 221 4724 444
Em: weber@dimdi.de

Patricia Wood
Mortality Classification Specialist
Health Statistics Division
Statistics Canada
Main Building, Room 2200, Section D
Ottawa, Ontario, Canada K1A 0T6
Ph: (613) 951-1648
Fx: (613) 951-0792
Em: patricia.wood@statcan.ca

Attachment 2

Draft Tentative Agenda
WHO-FIC Education Committee
WHO-FIC – IFHRO Joint Collaboration
Washington, D.C.
May 9-11, 2007

Wednesday, May 9

9:00 a.m.	Welcome Introductions Assignment of rapporteurs Review of agenda and meeting objectives	Marjorie Greenberg Education Committee Chair
9:30 a.m.	Review Education Committee Terms of Reference and 2007 - 2008 Work Plan	Marjorie Greenberg
10:00 a.m.	Review Joint Collaboration Terms of Reference and 2007 – 2008 Work Plan	Sue Walker Margaret Skurka Co-Chairs
10:30 a.m.	Coffee break	
10:45 a.m.	Update on contract with AHIMA FORE to pilot and evaluate International Training and Certification Program • Review and recognition of Training Materials • Solicitation of additional materials • Outreach to Coders and Trainers	Kathy Giannangelo
12:00 p.m.	Lunch	
1:00 p.m.	Continuation of AHIMA FORE update • Pilot testing of UCOD application, self assessment and exam o Translation issues o Exam for trainers • Deadline for practicing coders to challenge the exam	Kathy Giannagnelo Patricia Wood Joon Hong
3:00 p.m.	Award of first certificates in Seoul	JC Co-chairs
3:30 p.m.	Break	

4:00 p.m.	Development of Web-based training tool	Sue Walker Robert Jakob Donna Glenn
5:30 p.m.	Adjourn	
6:00 p.m.	Group dinner	

Thursday, May 10

9:00 a.m.	Welcome and Introductions Assignment of Rapporteurs Review of first day	Marjorie Greenberg JC Co-Chairs
9:30 a.m.	Development of process for certifying newly trained mortality coders	JC Co-Chairs Kathy Giannangelo
10:30 a.m.	Coffee break	
10:45 a.m.	Training for multiple-cause coding	Stefanie Weber
11:30 a.m.	Resource needs and potential funding sources	JC Co-chairs
12:00 p.m.	Lunch	
1:00 p.m.	Process for certifying practicing morbidity coders and trainers • Self assessment for coders • Application for trainers • Exam(s)	JC Co-chairs Chris Sweeting Amy Blum
3:00 p.m.	Break	
3:30 p.m.	Additional work on training certifiers of cause of death	Stefanie Weber et al
4:30 p.m.	Publicizing work of the Education Committee and Joint Collaboration • Brochures • Presentations and articles	EC Chair JC Co-chairs
5:30 p.m.	Adjourn	

Friday, May 11

9:00 a.m.	Welcome Assignment of rapporteurs	Marjorie Greenberg
9:15 a.m.	Report on collaboration with FDRG	Cassia Buchalla
10:00 a.m.	IFHRO Congress (May 26-31, 2007) • Papers and Presentations • JC Meeting	Marjorie Greenberg Margaret Skurka Sue Walker
10:45 a.m.	Break	
11: 00 a.m.	2007 WHO-FIC Network Meeting • Agendas • Papers • Orientation sessions, Tutorials • FAQ's and Abbreviations	EC Chair and JC Co-chairs
11:30 a.m.	Review of action items Future work plan	EC Chair and JC Co-chairs
12:30 p.m.	Adjourn	

April 5, 2007

Attachment 3

Terms of Reference
WHO-FIC Education Committee

Purpose

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

Background

The Subgroup on Training and Credentialing of the WHO-FIC Implementation Committee was established at the 1999 meeting of Heads of Collaborating Centres in recognition of:

- The critical role of education and training for the successful implementation, use and maintenance of a classification system and for the quality of data produced
- The opportunities for sharing and strengthening education and training in members of the Family of International Classifications through international efforts, and
- The resulting benefits for comparability of national and international statistics

The Subgroup was established specifically to:

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

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

Functions

The primary function of the Committee is to develop an integrated educational strategy for the International Classification of Diseases and the International Classification of Functioning,

Disability and Health. Other members of the Family of International Classifications will be considered as resources permit. The components of this strategy include the following functions:

1. Working with the Implementation Committee, assess the needs of users of the classifications, including those who provide source information, apply codes, conduct research or use the resulting data.
2. Identify the learning objectives for educational approaches.
3. Maintain an inventory of existing educational materials and capacity.
4. Make recommendations for learning content including development of core curricula
5. Make recommendations for best practices for promotion and delivery of educational material.
6. Develop and harmonize self-learning tools.

The components of the strategy for the ICD include the following tasks:

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

The components of the strategy for the ICF include the following tasks:

1. Liaise with Functioning and Disability Reference Group concerning applications and intended applications of ICF in order to identify educational needs and how to address them.
2. Identify the groups requiring education and training about ICF (e.g., coders, statisticians, epidemiologists, policymakers, administrators, relevant systems and program managers,

clinicians, survey developers, health sciences educators and students, consumers) the objective of the required education and the need for training trainers.
3. Catalogue, characterize (e.g., purpose, audience, content, language, availability, media and technology) and disseminate information on existing educational materials for ICF applications.
4. Create a database on educational products based on the Framework agreed by the Implementation and Education Committees and provide ongoing maintenance.
5. Review existing training materials and the mechanisms for their dissemination and identify best practices. Identify gaps and methods for filling them.
6. Provide advice on best practices to developers of ICF educational materials.
7. Explore the capacity of Collaborating Centres and Regional Offices for providing ICF education in WHO member states.
8. Explore the need for international certification of those trained to use ICF as a coding and classification system or of ICF training materials. Identify a support network or mechanism.
9. Identify approaches for assuring that training and certification are dynamic processes, responsive to changes in medical science, disability policy, technology, coding rules, etc. Explore different approaches to training, e.g., face-to-face, E-learning.

Structure and Working Methods

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

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

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

Preferably there should be a single Chair to emphasize the integration of WHO- FIC implementation.

The Subgroup should develop an annual work plan, which lists in detail aims, activities, deliverables, timelines and responsibilities for addressing the terms of reference.

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

Attachment 4

TERMS OF REFERENCE

WHO-FIC –IFHRO Joint Collaboration

Purpose

The purpose of the designated WHO-FIC-IFHRO Joint Collaboration is to carry out or oversee several major tasks under the Business Plan for the International Training and Certification Program for ICD Mortality and Morbidity Coders. The Joint Collaboration will evaluate and approve existing training modules for ICD coders against the standard curricula developed by the WHO-FIC Education Committee. The Joint Collaboration will identify "standard" core training packages from multiple approved sources. Having "standard" core modular training packages will result in more standardized education and training and better trained coders. Education and training materials identified as meeting the "standard" will be used by approved trainers or nationally recognized educational institutions when conducting ICD-10 training. Standardization will increase user confidence in the data for decision-making, resource allocation, and health planning. This standardization can ultimately lead to improvement in the health of the world's population.

Background

The WHO Family of International Classifications (WHO-FIC) Collaborating Centers and the International Federation of Health Records Organization (IFHRO) have been working together since 2000 to develop an international training and certification program. The overall goals of this program are to improve the quality of mortality and morbidity data and the status of ICD coders.

In October 2004, the IFHRO General Assembly and the WHO-FIC Network endorsed the program, which includes

- The development of international standard ICD-10 curricula for mortality (underlying cause of death) and morbidity coders,
- The identification of core modular training packages from multiple approved sources that meet the standard curricula.
- The development of specific modules if suitable existing materials cannot be sourced,
- The creation of a methodology by which educators and trainers are approved as meeting an international standard, and
- The identification of a process whereby coders can indicate completion of the required approved modules and thus be eligible to receive an international certificate.

The first phase of the Joint Collaboration's work is to establish an international certificate for underlying cause of death coders. This will be followed by a certificate for morbidity coders. The core curricula for training ICD-10 coders have been endorsed by both the WHO-FIC Network and IFHRO.

Membership:
The membership of the Joint Collaboration includes 3 nominated members from IFHRO and 3 members representing the WHO-FIC Education Committee. Lead individuals have been appointed from the IFHRO and from the WHO-FIC Education Committee.

Functions

1. To distribute questionnaires on ICD-10 Training Materials and to review responses.
2. To distribute request for submission of existing training materials for assessment against core curricula.
3. To assess submitted materials against the standard core curricula. The curricula are comprised of categories or knowledge clusters that represent broad domains of content.
4. To provide feedback to ICD educators and trainers regarding the adequacy of their materials and to encourage required modifications.
5. To determine a process whereby educators and trainers can be assessed against specific criteria.
6. To develop a process for certifying practicing and newly-trained coders, including promotion of availability and benefits of certification, methodology for submitting evidence of training, assessment methodology and issue of certificates.
7. To report progress to WHO-FIC Network and IFHRO membership on an annual basis.
8. To serve as a liaison with the WHO-FIC Education Committee on educational strategies for improving source documents---e.g. death certificates, health records.

Structure and Working Methods

The Collaboration has integrated membership as described above. In addition to the six official members, the Chair of the WHO-FIC Education Committee serves as an ex-officio member. Other members of the WHO-FIC Education Committee and IFHRO may serve on Collaboration working groups.

Working methods of the Joint Collaboration include e-mail, conference calls and face to face meetings, with at least one face to face meeting each year.

An annual work plan will be developed and presented to the face to face meeting of the Joint Collaboration in any given year. The annual work plan will list tasks, deliverables, timelines and responsibilities for addressing the items raised in the terms of reference.

May 11, 2007

Attachment 5

Matrix of ICD-10 Mortality and Morbidity Training Materials

Mortality Training Materials					
Materials	**Source of Submission**	**Purpose**	**Knowledge Clusters**	**Status**	
ICD-10 Coder Training Course	NCCH, Australia	Underlying Cause of Death	7. ICD 8. How to Code	First review completed (MS) Thank you letter sent? Received updated material 3/07. Second review completed (KG) Second letter sent	Recommended as standard
Manual for Training Mortality	WHO CC for the FIC in Portuguese	Underlying Cause of Death and Multiple Cause	3. General uses 4. Specific uses 5. Users 6. Sources of mortality data 7. ICD 8. How to Code 9. Quality assurance	First and second review not yet completed. Waiting for updated materials	
Medical record/health information management	Various universities in Korea	Underlying Cause of Death and Multiple Cause	1. Medical science 2. Legal/Ethical issues 3. General uses 4. Specific uses 6. Sources of mortality data 7. ICD 8. How to Code 9. Quality assurance	First review completed (HC) Thank you letter sent (KG). Second review completed by (JH)	Recommended as standard

Training materials	NCHS - US (also used by Canada)	Underlying Cause of Death	1. Medical science 7. ICD 8. How to Code 9. Quality assurance	First review completed by AB. No thank you letter sent Out for second review (SW)	
intercod	PAHO	ICD-10	1. Medical science 6. Sources of mortality data 7. ICD 8. How to Code	First review completed (RB) No thank you letter sent. Second review completed (KG)	Requires revisions
Training Coders in Med Rec Practice and ICD-10	Sri Lanka	Underlying Cause of Death	1. Medical science 2. Legal/Ethical issues 3. General uses 4. Specific uses 5. Users of mortality data 6. Sources of mortality data 7. ICD 8. How to Code 9. Quality assurance	First review completed (MS) Thank you letter attempted. E-mail bounce (MS) Second review completed (AB)	Requires revisions
ICD-10 Training	South Africa	ICD-10		First review complete	

Morbidity Training Materials

Materials	Source of Submission	Purpose	Knowledge Clusters	Status
ICD-10 Coder Training Course	NCCH, Australia	Morbidity	7. ICD 8. How to Code	
Medical record/health information management	Various universities in Korea	Morbidity - Korea	All clusters	First review completed (HC) Thank you letter sent (KG) Second review completed by (JH)
Coding Basics	American Health Information Management Association	Morbidity - US	All clusters except 8 and 9 (based on ICD-9-CM)	First review completed by SW Thank you letter sent (SW)
ICD-10-CA/CCI Classification Primer	Douglas Collage	Morbidity - CA	1. Medical science 4. General uses 8. ICD 9. How to Code	First review completed (MS) Thank you letter sent? Second review assigned (KG)
ICD-10-AM Training Materials	Health Information Management Association of Australia	Morbidity - AU	1. Medical science 4. General uses 5. Specific uses 6.Users 8. ICD 9. How to Code 10. Quality assurance	Received 3 booklets but not the complete program.
Textbook for Health Information Management	Japan Hospital Association	Morbidity - Japan	1. Medical science 2. Legal/Ethical issues 3. Healthcare data content and structure 4. General uses 5. Specific uses 8. ICD 9. How to Code	First and second reviews not completed

ICD-10-CA Training materials	Canadian Institute for Health Information	Morbidity - CA		Received only the descriptions of the courses, not the materials themselves.
ICD-10 Training	South Africa	ICD-10		First review complete (CS)

Attachment 6

Joint Collaboration Work Plan

Task	Responsibility	Time	Deliverables
Bi-monthly Conference calls	JC	ongoing	
Certification of coders	JC		Finalisation of exam process for existing UCOD mortality coders
		May-08	- questions
		May-08	- marking scheme
		May-08	- administration
		May-08	- fee
		Oct-07	Determine process for assessment of new mortality coders
		Oct-08	Determine process for morbidity coders - pending work of MbRG
		Oct-07	Determine process for development and mantenance of roster of experts/trainers - with IC
		Oct-08	Determine process for development and maintenance of roster of certified coders
		May-08	Determine process for maintenance of certification by mortality coders and trainers
Training	WHO & JC	on going	Continue to accept and review existing training materials
		on going	Feedback reviews to owners and developers and training materials
		Oct-08	Finalise web based training materials, solicit reviews and upload to WHO website, link to other relevant education sites
Agreement with AHIMA FORE	AHIMA & JC	May-08	Evaluate international training and certification program
		May-08	Continue soliciting ongoing financial support for the JC program
		ongoing	Continue administrative support for program
		ongoing	Continue outreach program to promote the JC work