SEA-HSD-308
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Regional Workshop of Trainers on the International Classification of Diseases (ICD)

Report of an Intercountry Workshop
Greater Noida, India, 3-7 September 2007

WHO Project: ICP HRH 000 XM 06

World Health Organization
Regional Office for South-East Asia

November 2007

Contents

Annexes

1. Introduction

An intercountry workshop of trainers on the International Classification of Diseases was held in Greater Noida, India, from 3 to 7 September 2007. The overall objective of the workshop was to build skills in the teaching and use of the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10); to review existing teaching activities and to create an understanding of the underpinning requirements for production of high quality coded morbidity and mortality data. The specific objectives of the workshop were:

(1) to review, discuss and share experiences on the current status and quality of implementation of the international classifications for coding of diseases and deaths,

(2) to review existing training modules, demonstrate and test existing training techniques,

(3) to adapt standard training modules for the Region and recommend a sequence for applying ICD-10 and other classifications of the WHO Family of International Classifications for the coding of morbidity, treatment procedures, health interventions and functional disability, and

(4) to draft outlines of country training plans for implementation of the classifications.

Twenty-one participants from nine Member countries of the Region attended the workshop (see list of participants in *Annex 1*). Also in attendance were workshop Facilitators from the National Centre for Classification in Health in Brisbane, Australia and from WHO Headquarters in Geneva as well as resource persons from Myanmar, Thailand and staff from the Evidence and Health Information Unit in the Regional Office.

2. Inaugural session

Dr Anton Fric, Regional Adviser for Evidence and Health Information, WHO-SEARO delivered a message on behalf of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region. Dr Samlee emphasized

that optimum use of the International Classification of Diseases was an important tool for data collection, analysis and dissemination in any country's health information system. Internationally-endorsed classifications ease the storage, retrieval, analysis and interpretation of data for decision making. He pointed out that there was a need to assess the quality of coding and generation of evidence from mortality figures and to identify ways and means to embark on coding of morbidity in the public as well as the private sectors. Dr Samlee said that this workshop was very timely since there was a need to follow-up the regional strategy for strengthening health information at the country level. This component of the national health information system required particular attention (for full text of the Regional Director's message, please see *Annex 2)*.

Following this, Dr Robert Jakob conveyed greetings from WHO Headquarters and outlined the importance of the use of the Family of International Classifications for the standardized collection of complete and comparable health information.

3. Technical sessions

3.1 Background to the training workshop

The workshop was organized to develop skills and knowledge of the participants so that they can train others to use the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) and to develop and deliver presentations to clinical staff responsible for documentation of health records and death certificates. While requesting nominations for the workshop, it was suggested that selected nominees should have knowledge regarding the use of ICD-10 to facilitate their participation. Dr Anton Fric noted that this workshop complemented the 2006 Regional Strategy for Improving Health Information Systems and was a precursor to an international workshop on health statistics reporting to be held in Kathmandu in September 2007. Use of ICD-10 for health records and death certificate reporting helped to standardize the collection of health information in countries across the Region, allowing national and international comparisons of the burden of morbidity and mortality. The workshop, structured to provide participants with some formal didactic learning sessions also facilitated the development of materials and plans and allowed country representatives to practice their skills through presentations. The workshop agenda is attached as *Annex 3*.

3.2 Uses of ICD-10 – Regional health situation and implications

On the first day, country representatives provided a brief update regarding the use of ICD-10 in their countries. Their reports are summarized below. (Detailed presentations are available in the attached CD).

Bangladesh

- ICD-10 mortality coding has been implemented since 2002 but does not represent full enumeration of deaths. Mortality data is only captured for inpatient deaths and coding is performed at 3-character level.
- For morbidity coding, outpatients, emergency department patients and inpatients are covered but there is under-reporting (as high as 59%) of all attendances and admissions. ICD-10 is used in sub-district hospitals in pilot areas only. There is a major problem with inappropriate reporting of diagnoses by doctors and lack of focal points responsible for coding at district level and above.
- There are no official posts for coders. Many clerical officers who have held these positions for a long time are now retiring and are not being replaced. There is a shortage of expertise relating to ICD and insufficient trained personnel.
- Even where ICD coding is performed, the resultant data are not used for management purposes. The government's programme implementation plan for the health sector highlights the importance of coding but there is no legislation or formal requirement to produce coded data.

Bhutan

- A Health Management Information System has been developed with a multisectoral management group representing donor agencies and other stakeholders. All medical record forms, system changes and the reliability/accuracy/validity of the data are the responsibility of a task force established by the management group. There is considerable parallel reporting to different donors for diseases such as malaria, TB etc.
- It is mandatory for doctors and health workers to record 3-character ICD codes. The National Referral Hospital uses a locally-printed book of the 3- character codes which was created in 2005. A short list of 88

disease groups has been printed on cards for other hospitals and basic health units. The latter has been used since 2003. If the coding has not been completed by the time patients are discharged from the hospital, when they attend the hospital pharmacy to receive discharge medications, they are returned to the ward until the coding is completed. Despite this, there is poor compliance by doctors who are overburdened with the high number of patients they attend.

- Only morbidity information is reported – there is no coding of mortality data although the WHO recommended medical certificate of cause of death is used. There is significant under-reporting of deaths of children below 8 years because there is no provision to claim against the national social insurance scheme for young children.
- There are plans to train medical record officers and medical record technicians and posts have been approved for these categories. There is already a process for training other categories of medical technicians through a two-year training programme and it is planned that medical record technicians will be trained to the same level and paid the same grade.

India

- The English language version of the ICD-10 was implemented in India in 2000 with coding performed at 3-character level. Directors of health services in all states and union territories have been advised to implement the ICD-10 but there is little uniformity in the way this has been done.
- For morbidity reporting, coding is performed locally and national morbidity statistics are reported for the public sector. Over 90% of public admissions are recorded. Outpatient reporting is less complete. Coding is the responsibility of coders and medical record officers.
- A national death registration process has been in place since 1969 under the auspices of the Ministry of Home Affairs. ICD-10 was implemented for mortality coding in 1999 and is the responsibility of the Registrar-General of India at national level and the Vital Statistics Division of the directorates of health at state level. In hospitals, the WHO Medical Certificate of Cause of Death is used but the level of registration is uneven across the states, ranging from 1% in Uttar Pradesh to 94% in Goa. 14.5% of deaths are medically certified. In some rural areas, verbal autopsy data are collected.

- The Central Bureau for Health Intelligence prints low cost sets of ICD-10 and also produces some coding software.

Maldives

- The Ministry of Health is responsibile for the interpretation and analysis of morbidity and mortality data and the training of coders. Mortality coding is done at this level.
- At the Indira Gandhi Memorial Hospital (IGMH), coding of both morbidity and mortality is performed and there is systematic recording, analysis, interpretation and comparisons of data collected at the central level. An annual statistical report is produced.
- An English language version of the ICD-10 is used. The browser version is used at the IGMH and the Ministry of Health but hard copy manuals are available at all atolls and health centres although coding is not done there.
- The Ministry of Health has a Health Information Management graduate to code the mortality data; coverage is estimated to be about 60% of all deaths. At the IGMH, there are four trained coders. A diploma course for coders is planned which will use the electronic version of the classification.

Nepal

- Prior to 1993, the Medical Record Unit was a part of the Epidemiology and Disease Control Division of the Department of Health Services. A Central Health Management Information system was established in that year and subsequently a Hospital Recording and Reporting system was introduced in 1995.
- Thirty seven recording and reporting tools are now used including a master register, OPD ticket, OPD register, hospital reporting tool (including 130 diseases with four character ICD-10 codes), an admission and discharge register and a tally sheet.
- Coding is taught at the B.P. Koirala Institute of Health Sciences (BPKIHS) and was introduced in 2000. The BPKIHS has developed its own coding software. Short training in coding and data management is also provided by the Central Health Management Information System (HMIS) staff. Currently, 107 hospitals send data to the central

HMIS and their Regional Health Directorate. While 31% code locally, the remaining cases are coded centrally to 3-character level using a short list of 130 disease groups. Raw data sheets and analyses are distributed monthly to hospitals/centres/divisions.

- ICD-10 data are carried in annual report of the Department of Health Services and are used mainly by researchers and students.
- Major problems include incomplete clinical documentation, need for additional reporting tools, lack of reporting from the private sector and lack of coding knowledge throughout the country.

Sri Lanka

- There are approximately 1000 medical record officers and medical record administrators, of whom around 600 have received formal training. Despite this, problems exist with poor quality morbidity data that is chronically late.
- Major problems with morbidity data are incomplete medical records, lack of final diagnosis reported by clinical staff, backlog in medical record departments and lack of medical record staff, poorly designed forms, attitude of medical officers and lack of trained coding personnel.
- Training in ICD-10 is provided by the National Institute for Health Sciences (NIHS) since 1998. The curriculum in coding and medical record practice was evaluated by WHO and the NIHS was recognized as a SEAR training centre. However, most training now is for local participants and not international students. The training consists of classes in medical terminology, medical record practice, computers and ICD-10 coding.
- For inpatient medical records ('bed head tickets'), a new electronic medical record system has been recently introduced. Doctors complete the final diagnosis and then enter the code using custom-built coding software. For outpatients, a similar system of record keeping is used but coding is done by doctors using the International Classification of Health Problems in Primary Care (ICHPPC) which is believed to better represent ambulatory cases.

Thailand

- A mortality statistics collection has been in place since the 1950s. ICD-10 was implemented in 1994 for both mortality and morbidity coding to the fourth-character level. In 2000, ICD coding for reimbursement purposes was introduced, using ICD-10-TM (Thai Modification). ICD-10-TM has been announced as a requirement for both morbidity and mortality coding from 1 April 2007 and is used in the Thai DRG system v4.0.
- While 98% of all deaths are coded, approximately 50% of these are ill defined. For morbidity, 70-80% of hospital admissions are included from the Ministry of Public Health hospitals. Error rates are high, at around 60%.
- There are an inadequate number of coders. Approximately 1200-15000 coders are employed, some trained at tertiary level and others with nursing or paramedical backgrounds attend a three-day course run by the Thai Health Coding Centre. Recently, a National Coder Certification programme has been implemented which tests coders at intermediate level (advanced level to come). Six of the thirteen medical schools include documentation and coding as part of their curriculum.
- The Thai Health Coding Centre (www.thcc.or.th) offers coding training with a workbook and answer book and e-learning materials, coders support, helpdesk and web board for coding queries.

Timor-Leste

- Morbidity and mortality data collection is very limited and coding is not (and has never been) performed.
- Two units within the Ministry of Health collect data and report causes of morbidity and mortality in groups of diseases, mainly of notifiable diseases. Leading cause of hospitalization and death is 'Other Diseases' which is a heterogeneous group of conditions that can't be specifically assigned to another group.
- Clinical documentation is poor and mostly prepared by nursing staff and not doctors. Because of the high percentage of overseas doctors that work in Timor-Leste for a limited period of time, there is little interest in improving this situation and few resources are devoted to it. There is very little knowledge about ICD in the country, few diagnostic facilities, poor diagnostic capacity and limited health staff skills.

- A computer system for reporting morbidity and mortality data is in the early stages of development but questions remain about who should code, when coding should be done and how to collect information about deaths that occur at home. Training in codings and access to coding books is required.

3.3 Challenges and opportunities for the Region

In a general discussion session, the following major challenges were identified:

- Lack of awareness on the role of coders and the importance of coding. This translates to underutilization of coded data for management purposes and to a lack of coding staff as funds are deployed to other areas seen as more important.
- Lack of sufficient coders as they are required to undertake multiple, unrelated roles.
- Lack of human and financial resources relating to the production of health information and a lack of training materials.
- Quality of coding is generally poor due principally to poor quality source documentation, poor verification of causes of death and reporting of ill-defined diseases.
- Lack of a culture of quality amongst coders. This also relates to a lack of recognition for the unique skills of coders and their contribution to the management of the health system through the production of coded data.
- Use of local short lists and local modifications of the ICD leading to incompatible data.
- Lack of involvement of the private sector in reporting health data leading to under-representation of the true burden of morbidity and mortality.

There are opportunities for improvement through:

- The development of medical record and coding committees to provide assistance to coders in negotiating improvements with clinical colleagues.
- Addition of educational materials about good documentation practices and the use of documentation for coding purposes to

the curricula for medical and nursing students. The resultant use of coded data would also raise the profile of coders and assist in their work being appreciated.

3.4 Audit of the completeness and accuracy of medical records

Participants were requested to bring copies of two or three de-identified medical records from local hospitals to the workshop. Only two countries did this and therefore additional medical records were sourced from hospitals around Delhi. The purpose for the request was to conduct an audit of the quality of the documentation of medical records and for participants to assess whether the records contained sufficient detail to code completely and accurately. (A copy of the data collection form used for the audit is at *Annex 4*.) Participants were taught how to use the audit tool and its purpose was explained and then each country group attempted to evaluate their records using this tool.

The purpose of this session was to enable participants to develop evidence of documentation problems that could be used by them to advocate for improvements. It is known that many problems that coders experience are caused by either a lack of sufficient documentation to assign specific codes, the documentation of symptoms rather than a formal diagnosis, the use of terms and diagnoses that are not compatible with the requirements of the ICD-10 or a complete lack of useful diagnostic information. When the resulting statistical data are produced it may be assumed that it is poor because the coding is erroneous. This may be one of the issues, but the quality of the documentation is also a major factor. Therefore, finding a way of quantifying these problems can be helpful.

Although formal results from each of the audits conducted were not presented, the general discussion that followed this experiential session indicated that major documentation quality problems existed. Participants indicated that they found the session useful and intended to take the sample audit sheet back to their own hospitals and health agencies to modify it to suit their local situation. Participants were also given a copy of a sample report produced as a result of a medical record audit and it was suggested that the production of something similar would be a useful outcome of any quality assessment that they conducted personally.

3.5 Work of the WHO Family of International Classification Network on education issues

Participants were informed about the work of the Education Committee of the WHO-FIC Network of Collaborating Centres, in conjunction with the International Federation of Health Records Organizations (IFHRO). IFHRO supports national associations and health record professionals to implement and improve health records and the systems that support them. It focuses on promoting the development and use of health records and health information in all countries and in improving healthcare through health information. The WHO-FIC are a network of WHO collaborating centres that work with WHO headquarters and regional offices to promote the development and use of classifications to support national and international health information systems, statistics and evidence around the world. The overall goals of the collaborative programme are to improve the quality of coded mortality and morbidity data and the status of ICD coders.

To date, the collaboration has focused on several projects. The first was the development of core curricula for courses that teach ICD coding for morbidity or mortality purposes. These curricula outline the knowledge clusters or subjects the members of the collaboration believe to be vital for any training programme for coders, whilst recognizing that some programmes may contain additional topics specific to the local situation in which they are taught. (A copy of the core curricula and information brochure regarding the Training and Certification Programme is available at *Annex 5).* The second project entailed the distribution of questionnaires on ICD-10 training to determine the availability of educational materials internationally that met one or more of the knowledge clusters outlined in the curricula. Next, the owners of the materials were asked if they would be willing to submit their materials for assessment against the standard core curricula. This assessment focuses on "The ICD and the How to Code" clusters, recognizing that these are the same wherever coding is performed. The authors of the materials are being contacted with the results of this qualitative assessment and are being encouraged to revise their materials in line with the recommendations made by the assessors. It was noted that the materials for Sri Lanka had been sent for review and that useful feedback to the material developers had been received. Other training materials were shared amongst participants during the workshop and information relating to the submission of the materials for review was provided. Through this part of the process it is hoped to standardize materials used for teaching ICD-10 coding and ensure there is a set of core topics covered comprehensively in every course.

The third project entailed development of a process to recognize the skills and abilities of trainers and educators who teach ICD-10 coding. The intention is to ensure that the educators and trainers who teach coding, using approved materials, are qualified to do so. Workshop participants were encouraged to bring this process to the attention of anyone who teaches ICD-10 in their own countries. Links to the IFHRO and Education Committee websites were provided for further information (www.ifhro.org, http://www.who.int/ classifications/committees/education/en/index.html)

It was generally agreed that this is important work and should be promoted throughout the Region. Of particular interest were the core curricula which were identified as an important pre-requisite to quality training and comparable coded data. A similar development for training medical record officers was thought to be useful.

3.6 Development of education sessions for clinical staff and future training plans

A session was devoted to considering the ways in which coding education can be provided and discussions were held about the most suitable methods. The general consensus was that workshop-style presentations with exercises and hands-on coding practice were the optimal way of teaching coding but that this method is resource intensive. Discussions were also held about the way to teach adult students which involves ensuring that they see the relevance and practical benefits of what is being taught in order to engage constructively in their learning.

Following this discussion and the previous documentation audit session, participants were given time to consider the development of materials and educational sessions for doctors and other clinical staff about coding and documentation and to consider the need for training for coders within their own countries. However, although the invitations to the workshop stipulated that attendees should have a good understanding of coding and coding issues, it was obvious that some participants had never coded and did not have the requisite background. A very short presentation on ICD-10 and on morbidity and mortality coding was therefore made to the participants prior to the country groups working to develop some of their own training materials and plans.

Each country group then presented their ideas to the other participants. The common themes and important issues that emerged from these presentations and the subsequent discussions amongst the group included:

- Any information session for clinical staff should seek to engage their interest very early in the presentation through providing some data of local relevance and use. Without this, interest levels will wane quickly and the session will be a waste of time.
- A good strategy is to complete a documentation and coding audit prior to an educational session or to provide copies of a clinician's own records as an example so that the information provided is of immediate local relevance. It should be ensured that clinical staff are aware of their responsibilities through the development and distribution of documentation standards and requirements. It should also be ensured that the uses of the coded data are highlighted.
- There is a need to advocate for high quality data and to market the importance of health data amongst policy and decision makers. These include stakeholders, funders and donor agencies which rely on the quality of the data.
- If coders or medical record officers are unwilling to make presentations or lack confidence, they should identify a local 'champion' who is a senior clinician or manager to advocate on their behalf amongst their colleagues.
- Training courses can be developed in a modular style so that only parts relevant to the audience are presented at any time – consider the needs of the audience. Do they need an overview only or do they need to learn to code?
- 'Cascade' training can work well in countries where coding is done at multiple levels. In other words, a small group of trainers are developed and provided with materials and skills to train others and then made responsible for the training of others in their hospital, region or province.
- There is a need for a realistic consideration of financial and human resource requirements and for materials and coding products.

4. Recommendations from the trainers' workshop

Participants made recommendations and proposed that consultations with relevant national authorities be held to discuss these issues. The recommendations were:

4.1 Engagement with the private sector

- Establish an advisory committee for ICD-10 implementation – including private sector representatives.
- Consider mandatory reporting as part of registration and licensing arrangements for private hospitals and health centres.
- Consider beginning with collection of coded data from sentinel sites if national private sector data collection is not possible.
- Invite involvement and participation in ICD training sessions of key representatives from the private sector.
- Consider involving national medical and nursing associations as a way of encouraging interest amongst clinical groups.

4.2 Coding workforce issues

- Obtain management support for coding and find local champions to advocate for coders.
- Consider regional need for a standardised curriculum and training on documentation and coding.
- Promote career development for coders by advocating for specific posts for coders, considering the existing staffing patterns in medical record departments.
- Seriously consider who should code – doctors, nurses, non-medical coders – what training is required for each group?
- Finalize the Regional Core Curriculum for training by using the draft discussed during the workshop and also curriculum used in some other SEAR countries (India, Sri Lanka, Thailand).

4.3 Improvements in clinical documentation

- Establish documentation standards for medical records and death certificates.
- Consider development of minimum data set and data standards – data collection processes and forms can be localized but all countries should collect similar minimum data so that comparable health information can be reported.
- Specify roles and responsibilities for documentation and coding.
- Establish committees to guide and support documentation and coding standards.

4.4 Uses of coded data

- Consider uses of health data – for example, who uses outpatient data and what is it used for? The uses made of coded data will determine the extent to which coding needs to be collected from all patients and at what level of specificity.
- Strongly encourage local and national use of the coded data and promote its benefits.

5. Closing session

Dr Sultana Khanum, Director Health Systems Development, WHO-SEARO, in her remarks at the final session of the workshop highlighted the importance of high quality coded data for the Region to facilitate planning and management of health issues.

Annex 1

List of participants

Bangladesh

Dr Wahidul Mowla
Deputy Program Manager
MIS-Health
Directorate General of Health Services
Mohakhali, Dhaka 1212

Mr Md. Ashraful Islam
Deputy Chief (Non Medical)
MIS-Health,
Directorate General of Health Services
Mohakhali Dhaka 1212

Bhutan

Mr Palden Lepcha
Medical Record Officer
Jigme Dorji Wangchuk National Referral Hospital
Thimphu

Ms Tshering Wangmo
Medical Record Technician
Gidakom Hospital
Thimphu

India

Dr Saudan Singh
Professor & Head of the Department
Community Medicine
VMMC & Safdarjung Hospital
New Delhi 110 029
E-mail: Saudan2k4@yahoo.co.in

Dr Bala Soudarssanane
Professor & Head of the Department
Preventive & Social Medicine
JIPMER
Puducherry 605 006
E-mail: drmybase@gmail.com

Dr D K Raut
Additional Director-General & Joint Director (TC & R)
Central Bureau of Health Intelligence
Directorate of GHS
New Delhi
E-mail: drdeepakraut@gmail.com

Dr Amarjit Kaur
Regional Director
Health & Family Welfare
Government of India
Chandigarh

Maldives

Ms Fathmath Azeema
Assistant Medical Record Officer
Indhira Gandhi Memorial Hospital (IGMH)
Male'

Ms Aishath Samiya
Assistant Director
Male'

Myanmar

Dr Thet Thet Mu
Deputy Director
Department of Health Planning
Nay-Pyi-Taw
E-mail: thetthetmu@gmail.com

Daw Khin San Myint
Assistant Director
Department of Health Planning
Nay-Pyi-Taw

Nepal

Mr Anil Thapa
Statistical Officer
Management Division
Department of Health Services
Teku
E-mail: anilthp@yahoo.com

Mr Nand Lal Shrestha
Medical Recorder Officer
Bheri Zonal Hospital
Nepalgunj

Sri Lanka

Dr Chandima P Abeysinghe
Medical Officer
National Institute of Health Sciences
Kalutara
E-mail: nihs@sitnet.lk

Dr Janaka Abeysirigunawardena
Medical Officer (Planning)
Health Information Unit
Ministry of Healthcare & Nutrition
No 385, Rev. Baddegama Wimalawansa Thero
Mawatha
Colombo 10

Thailand

Dr Wansa Paoin
Associate Dean
Faculty of Medicine
Thammasart University
Rangsi, Klong 1
Amphur klong Luang
Prathumthani province
E-mail: wansa@inet.co.th

Mrs Maliwan Yuenyongsuwan
Medical Statistician (ICD-10 Project Manager)
Bureau of Policy and Strategy
Office of the Permanent Secretary
Ministry of Public Health
Tiwanon Road
Nonthaburi 11000
E-mail: ied10@health.moph.go.th

Timor-Leste

Mr Fransisco Pereira do Rego
Head
Health Management Information System
Ministry of Health
Caicoli Road
Dili

Mrs Maria Hornay
Officer of Medical Record
Dili National Hospital
Dili

Resource Persons

Dr Sue Walker
Associate Director
National Centre for Classification in Health
School of Public Health Queensland
University of Technology
Brisbane, Australia
E-mail: s.walker@gut.edu.au

Dr Soe Myint
Deputy Director General
Department of Health Planning
Ministry of Health
Nay-Pyi-Taw
E-mail: usmyint@mptmail.net.mm

Dr Pornarong Chotiwan
Chulalongkorn University
Faculity of Medicine
Department of Social and Preventive Medicine
Bangkok
E-mail: Icd10th@hotmail.com

Dr Robert Jakob
Medical Officer (ICD)
Classification and Terminology
Information, Evidence & Research
WHO/HQ
E-mail: jakobr@who.int

WHO Secretariat

Dr Sultana Khanum
Director
Health Systems Development
E-mail: Khanums@searo.who.int

Dr Anton Fric
Regional Adviser
Evidence & Health Information
E-mail: Frica@searo.who.int

Dr Nihal Singh
National Professional Officer
Evidence & Health Information
E-mail: Singhn@searo.who.int

Dr Nirmal Kandel
JPP-Evidence & Health Information
E-mail: Kandeln@searo.who.int

Mr Ravinder Kumar
Administrative Secretary
Evidence & Health Information
E-mail: kumarra@searo.who.int

Annex 2

Message by the Regional Director, WHO South-East Asia Region

(delivered by Dr Anton Fric, RA EHI)

Distinguished Participants, Ladies and Gentlemen,

I have great pleasure in conveying greetings from Dr Samlee Plianbangchang, Regional Director, South-East Asia Region, to all the distinguished participants. Dr Samlee is unable to attend this workshop and I, therefore, have the honour to deliver his message.

I quote:

I extend a warm welcome to you all to the Regional Workshop of Trainers on International Classification of Diseases.

As we are aware, public health decision making relies heavily on the timely availability of sound data. The role of health information systems is to collect, analyze and disseminate such data. Reliable and timely health information is a vital element of health system development. The collection and analysis of relevant data to provide necessary evidence for assessing the development and performance of health systems at national and sub-national levels is the major role of any health information system. In this context, optimum use of the International Classification of Diseases becomes an important tool for data collection, analysis and dissemination in any country's health information system.

Internationally-endorsed classifications ease the storage, retrieval, analysis, and interpretation of data for decision making. They also allow the comparison of data within populations over time and between populations at the same point of time as well as the compilation of nationally consistent data, which is also important for international comparisons.

The Forty-third World Health Assembly endorsed ICD-10 in May 1990 and it came into use in Member States from 1994. For over a decade, countries in the South-East Asia Region have been applying ICD-10 for

coding mainly mortality in hospital settings and, to some extent, for non-hospital deaths in the community reported through surveys and vital registration. Only a few countries in the Region are coding clinical diagnoses of diseases and disabilities. Therefore there is a need to assess the quality of coding and generation of evidence from mortality figures and to identify ways and means to embark on coding of morbidity in the public as well as the private sectors. There is also an increasing demand for it from health insurance companies.

In view of this, many inter-country and national training courses on management of morbidity and mortality statistics, including appropriate use of medical records and expanded use of ICD-10 coding have been organized in the Region.

Distinguished participants, Ladies and Gentlemen,

The objective of this workshop is to contribute towards national efforts in improving morbidity and mortality coding of diseases and conditions. You will be reviewing and sharing experiences on the current status of the quality of implementation of international classifications for coding of diseases and deaths; reviewing training modules currently used in the countries; demonstrating and testing training techniques and adapting standard training modules for the Region and recommending a sequence of applying international classifications for coding morbidity and mortality.

It is expected that, after this workshop, we will have a network of experts who would be able to organize national and sub-national training activities in this important component of the health information system. Capacity-building for technical skills in this field is needed. We expect that, after this workshop, training activities at the country level would be intensified by using the regional training manuals reviewed during this workshop. All this should facilitate quality implementation of the international classification of diseases at the country level.

Finally, I would like to emphasize that this workshop is very timely due to the fact that, in August last year, the Fifty-ninth session of the WHO Regional Committee for South-East Asia endorsed the Regional Strategy for Strengthening Health Information Systems in SEAR countries. It identified 10 strategic areas, and all of them included proposed options and steps for implementation of the International Classification of Diseases. During the Regional Consultation on Mortality Statistics, organized in April 2007,

countries expressed a need to intensify quality implementation of the International Classification of Diseases.

Before concluding, I would like to welcome our resource persons from countries of our Region and also from the WHO Collaborating Centre in Australia and from WHO/HQ. I believe that your participation and sharing of your extensive experiences will help in achieving the objectives of this workshop.

I wish you success in your deliberations and a very pleasant stay in Noida. Unquote.

Annex 3

Agenda

Day 1, Monday 3 September 2007

0830-0900 hrs Registration

0900-0915 hrs Opening Session (*Anton Fric*)
Inaugural Remarks by the Regional Director
Introduction of participants
Announcements

0915-1015 hrs **Session 1: Overview of week's activities** (*Sue Walker*)
Introduction and context
- WHO Family of Classifications (Robert Jakob)
- What are the WHO-FIC and the WHO-FIC Network?
- What is coding? (Sue Walker)
- Morbidity coding – source documents

1020-1230 hrs **Session 2: Country presentations** (30 minutes per presentation including discussion, maximum 15 slides)
- Bangladesh
- Bhutan — *Country representatives*
- India

1330-1500 hrs **Session 3: Country presentations** (contd.)
- Indonesia
- Maldives — *Country representatives*
- Myanmar

1515-1715 hrs **Session 4: Country presentations** (contd.)
- Nepal
- Sri Lanka — *Country representatives*
- Thailand
- Timor Leste

Summary of day's discussions (*U Soe Myint*)

Day 2 Tuesday 4 September 2007

0900-1015 hrs **Session 5: Discussion about regional training experiences, country needs for training, difficulties and opportunities (flip chart notes)** – *Sue Walker and Country representatives*

1040-1230 hrs	**Session 6**
	WHO-FIC Education Committee – core curricula for coder training *(Sue Walker)*
	Joint collaboration with International Federation of Health Records Organisations *(Sue Walker)*
1330-1500 hrs	**Session 7**
	Coding in hospitals – responsibilities, rules and guidelines for morbidity coding *(Sue Walker)*
	Assessment of medical records and death certificates for coding purposes *(Robert Jakob)*
1515-1645 hrs	**Session 8**
	Small group work: Assessment of medical records and death certificates for coding purposes (to be completed as homework) – *Country representatives*
	Summary of day's discussions *(Pornarong Chotiwan)*

Day 3 Wednesday 5 September 2007

0900-1015 hrs	**Session 9**
	Teaching coding – *Sue Walker*
1030-1230 hrs	**Session 10**
	Teaching coding – *Sue Walker*
1330-1500 hrs	**Session 11**
	Teaching coding – *Sue Walker*
	Adult education techniques, planning lessons – *Sue Walker*
	Planning an education session for clinical staff about coding – *Sue Walker, Robert Jakob*
1515-1630 hrs	**Session 12**
	Small group work: development of an education session for clinicians/doctors about coding – *Country representatives*
	Summary of day's discussions – *U Soe Myint*

Day 4 Thursday 6 September 2007

0900-1015 hrs	**Session 13**
	Small group work: development of an education session for clinicians/doctors about coding – *Country representatives*

1030-1230 hrs **Session 14**

Small group work: development of an education session for clinicians/doctors about coding – *Country representatives*

1400-1500 hrs **Session 15**

Presentations of small group work outcomes (20 minutes per group, 5 minutes for discussion following each presentation)

- Bangladesh
- Bhutan *Country representatives*
- India

1515-1645 hrs **Session 16**

Presentations of small group work outcomes (20 minutes per group, 5 minutes for discussion following each presentation)

- Indonesia
- Maldives
- Myanmar *Country representatives*
- Nepal

Summary of day's discussions – *Pornarong Chotiwan*

Day 5 Friday 7 September 2007

0900-1015 hrs **Session 17**

Presentations of small group work outcomes (20 minutes per group, 5 minutes for discussion following each presentation)

- Sri Lanka
- Thailand *Country representatives*
- Timor Leste

1040-1230 hrs **Session 18**

Whole group discussion about presentations – *(Sue Walker)*

Development of country plans for future training *(Sue Walker)*

1330-1500 hrs **Session 19**

Development of country plans for future training (small group work – flip charts) – *Country representatives*

1515-1645 hrs **Session 20**

Presentations of country plans (10 minutes per group) – *Country representatives*

Summary of day's discussions – *Robert Jakob*

Conclusion of workshop – *Sue Walker, Anton Fric*

Annex 4

Medical record documentation audit

Criteria	UR Numbers																									Totals
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	
1. Identification completed on ALL pages (Minimum: MRN, First Name, Last Name, Date of Birth)																										
2. Documents in correct order																										
(a) MR number																										
(b) Chronological																										
3. Authentication of entries																										
(a) **Medical Officer**																										
Name																										
Date																										
Time																										
Designation																										
Signature																										
(b) **Nursing Staff**																										
Name																										
Date																										
Time																										
Designation																										
Signature																										
(c) **Allied Health**																										
Name																										
Date																										
Time																										
Designation																										
Signature																										
4. Use of black biro (RED for handwritten operation reports and allergies only)																										
5. No spare lines between entries																										
6. All corrections are made correctly - (Single line through incorrect entry with initials)																										
7. Legibility of																										
(a) Nursing notes																										
(b) Medical notes																										
(c) Allied Health notes																										
8. If pathology or Xray documented as done, report is in record.																										
9. All pathology & Xray reports filed correctly																										
(a) Reverse chronological order																										
(b) Duplicates removed																										
10. Alert notations used where appropriate and noted in red (Nil known may be in black).																										
11. Documented provisional diagnosis on admission																										
12. Notation every 24 hrs (acute admission) by																										
(a) Medical Officer																										

Criteria	UR Numbers																									Totals
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	
(b) Nursing Staff																										
13. Medical Officer physical examination and history documented on admission																										
14. For each drug ordered, medication sheet should contain:																										
(a) Medical Officer's printed name																										
(b) Signature																										
(c) Designation																										
15. (a) Front sheet completed																										
(b) Within 48 hours following discharge																										
(c) Dated																										
(d) Main diagnosis uniquely identified																										
(e) All required specificity documented																										
(f) Contains secondary diagnoses & operations if relevant																										
(g) signed																										
16. (a) Discharge Summary present																										
(b) Completed within 48 hours of discharge																										
(c) Summary contains main & other diagnoses																										
(d) Treatment on discharge documented																										
(e) Summary contains records of procedures and investigations																										
17. Follow-up arrangements documented																										
18. Written consent gained for procedures																										
19. Operation Report completed with Who / What / When /How																										
20. Anaesthetic report completed and dated																										
21. Unit and ward transfers noted																										
22.If death, death certificate completed																										
23. When Autopsy required a provisional anatomical diagnosis is documented.																										
Other issues:																										
24.																										
25.																										

Health information services
Continuous quality improvement programme

Date: July 2007

Study Title: Documentation Audit

Objective of Study:

- To assess the quality of documentation by medical staff in the medical records.
- To audit compliance with the RCH Documentation policy, and EQuIP criteria.
- To determine areas of documentation that require education/improvement.
- To investigate whether implementation of documentation education
- for medical staff is influential in improving documentation standards.

Criteria: Recent progress notes entries by medical staff.

Sample size: 120 records.

Exceptions: Admissions without any medical staff entries in progress notes.

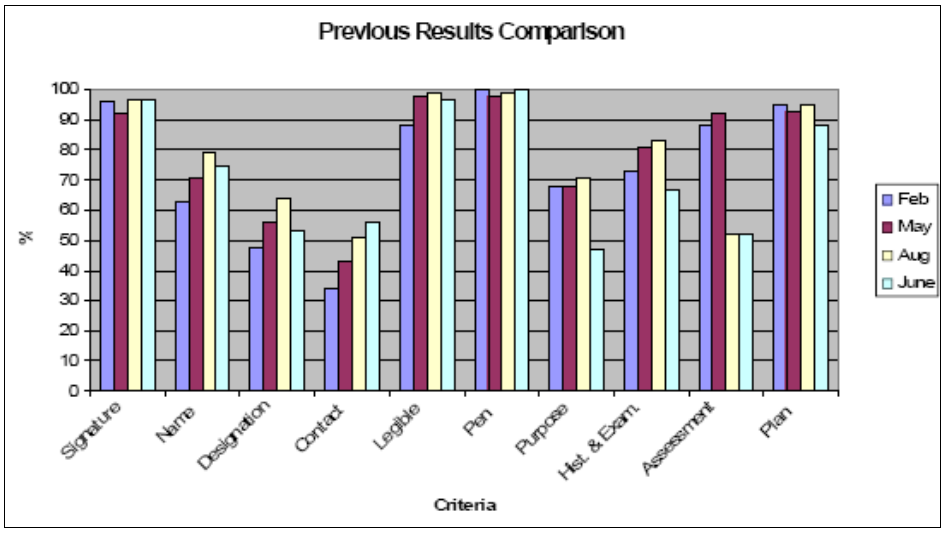
Method:

(1) Records were selected at random from recent discharges and coding shelves to ensure entries were recent.

(2) Medical staff entries from the most recent admissions were assessed on the 10 criteria below.

(3) Results were entered onto a spreadsheet, totalled, and a percentage obtained for each of the criteria audited.

Results: Comparison with previous results



The graph shows the results from the audit for each of the 10 criteria assessed. As the graph indicates, areas of concern are contact details, designation, purpose of entry and assessment.

Conclusions:

(1) Overall, the standard of medical documentation in progress notes has deteriorated.

(2) Criteria which demonstrated improved results were 'contact details' and 'pen/ink used'. Criteria with results that remained the same were 'signature' and 'assessment'. The remaining six criteria displayed a deterioration in results.

(3) Current documentation education is not effective.

Actions:

Short-term:

(1) Documentation education begun last year to be reactivated and a further education session to be provided to all medical staff.

(2) Re-distribute Good Clinical Documentation posters to be placed throughout wards of the hospital and in outpatient department.

(3) Continue distribution of 'Documentation Pack' (including copy of poster, laminated card with hints, and hospital documentation policy)

to all new medical staff during education session from Health Information Managers.

(4) Continue to provide education session for new medical staff during orientation.

(5) Continue regular auditing and feedback to medical staff regarding documentation.

Medium-term:

Formation of a working party to review medical documentation education and develop a more effective education process.

Follow up: Six months (January)

Completed by: Health Information Manager

Annex 5

Core curriculum
Underlying cause of death coders
including learning objectives

This core international curriculum describes entry-level requirements. Its purpose is to provide a basis for education to all countries.

Availability of resource materials and essential references needed for coding

- Full set of ICD-10 (Tabular List, Instructions, and Index current edition as updated by WHO)
- Periodic official WHO updates to ICD-10
- Medical dictionary
- Training materials relevant to core curriculum
- Drug references
- Abbreviation list
- Contact person to ask questions

1. Knowledge of basic medical science

Intent: To develop an understanding of medical terminology that will be encountered in cause of death statements, the structure and function of the human body and the nature of disease

- Medical terminology (A study of common medical terms related to major disease processes).
- Basic anatomy (A study of the structure of the human body utilizing a system approach).
- Basic physiology (A study of the functions affecting the human body).
- Concept of etiology and risk factors.

- Basic pathology (A study of the causes and nature and effects of diseases).

At the conclusion of this module, the coder should be able to:

- spell and define medical terms as well as explain the concepts of root/suffix/prefix word builds
- identify the normal structure and function of all human body systems
- name the typical causes, diagnosis, and treatment of common diseases
- define the concept of etiology and its relationship to risk factors
- state the nature and course of alterations in structure produced by etiological agents and mechanisms of the body.

2. Legal/Ethical issues relevant to the country in which coding is being done

Intent: To introduce legal and ethical issues applicable to health information, its collection and release

- Privacy and confidentiality principles (see appended proposed principles)
  - Use of person-identifiable information
  - Adherence to relevant laws and regulations
  - Access to person-identifiable information
- Release of information
- Professional ethics

At the conclusion of this module, the coder should be able to:

- apply policies and procedures for access and disclosure of personal health information
- utilize current laws and regulations related to health information initiatives
- release patient-specific data to authorized users
- practice and promote ethical standards of practice.

3. General uses of underlying cause of death data

Intent: To explain the purposes for which underlying cause of death data are collected and how they are used

- Context in which coding is done
- Purposes for coding
- Statistical outputs
- Evidence for health policy
- Planning and evaluating health services and programmes
- Medical and public health research
- Clinical education

At the conclusion of this module, the coder should be able to:

- list the common reasons of underlying causes for which data are collected
- describe the general uses of underlying cause of death data.

4. Specific uses of underlying cause of death data

Intent: To introduce the specific uses of coded mortality data

- Health situation and trend analysis
  - Leading causes of death
  - Definition of policies and priorities
  - Planning health programmes and services
  - Health indicators
  - Trend analyses
  - A critical element to identify:
    - Public health problems
    - Groups at risk
    - Needs of medical and sanitary research.

- Epidemiological surveillance (all listed causes)
  - First or main source of information for certain diseases
  - At local level, investigation of cases, disease control measures
  - Specific population groups/problems (e.g., maternal and infant mortality, adolescents, elderly)
- Evaluation in health
  - Quality of care
  - Outcomes of specific programmes
  - Different technologies.

At the conclusion of this module, the coder should be able to:

- enumerate specific uses for underlying cause of death data.

5. Users of mortality data

Intent: To explain the different groups and stakeholders who are users of mortality data

- Epidemiologists
- Statisticians
- Programme managers
- Actuaries
- Policy makers
- Researchers
- Demographers
- Educators and students
- International organizations (World Health Organization, United Nations)

At the conclusion of this module, the coder should be able to:

- name specific users of underlying cause of death data.

6. Sources of mortality data

Intent: To explain the roles of the different persons responsible for reporting data on the deceased and the sources of that data

- Providers of data (e.g., medical officers, coroners, medical examiners, funeral directors, and other informants)
- Source documents (e.g., death certificates, police reports, coroner reports, and other reports).

At the conclusion of this module, the coder should be able to:

- state the various roles of the individuals reporting data on the deceased
- relate the provider of data with the source
- verify completeness, accuracy, and appropriateness of data and data sources.

7. The International Classification of Diseases (ICD)

Intent: To develop an understanding of the ICD and to develop the knowledge and skills that are necessary to assign valid codes for causes of death

- Nomenclature and Classification
- International context
  - WHO Family of International Classifications
    - Reference Classifications (ICD and International Classification of Functioning, Disability and Health [ICF])
    - Derived and related classifications
- Standardization and comparability
- History of the classification
- Structure of classification
- Updating mechanisms of classification

At the conclusion of this module, the coder should be able to:

- distinguish a nomenclature from a classification
- describe the WHO Family of International Classifications and their relationships with each other
- discuss the history of the classification
- state the structure of the classification
- explain the classification's update process.

8. How to code

Intent: to provide detailed instruction and experience on how to apply the coding rules and assign codes

- How to use different volumes of the ICD
- Concept of underlying cause of death
  - Definition
  - International format of medical certificate of cause of death
- Rules, instructions and conventions for coding underlying cause of death
- Appropriate exercises in selection and coding

At the conclusion of this module, the coder should be able to:

- apply diagnosis codes using ICD-10
- adhere to current established guidelines in code assignment.

9. Quality assurance

Intent: To raise awareness about the various factors that influence the quality of coded data and describe techniques for assuring the highest quality data possible

- Quality of source documents
- Querying processes (e.g., sequencing on certificate, what and how to query)
- Editing and validation

- Timeliness, completeness and accuracy
- Responsibility for data quality
- Processes for accessing expert advice

At the conclusion of this module, the coder should be able to:

- conduct analysis to ensure documentation in the record supports the diagnosis
- validate coding accuracy using clinical information found on certificates
- resolve discrepancies between coded data and supporting documentation.

Core curriculum for morbidity coders

This international core curriculum describes entry-level requirements. Its purpose is to provide a basis for education for all countries. **There may be additional country-specific items such as education in the applicable procedure classification not listed here.**

Availability of resource materials and essential references needed for coding

- Full set of the ICD-10 (tabular list, instructions and index) (current edition as updated by WHO)
- Periodic official WHO updates to ICD-10
- Medical dictionary
- Training materials relevant to core curriculum
- Drug references
- Abbreviation list
- Contact person to ask questions

Knowledge clusters

Biomedical sciences

Intent: To develop an understanding of clinical knowledge through the study of the structure and function of the human body, pathophysiology, diagnostic and treatment modalities, and pharmacy therapy available for clinical management of patient care and to enhance professional communication in healthcare environments

- Medical terminology (A study of common medical terms related to major disease processes, diagnostic procedures, laboratory tests, abbreviations, drugs, and treatment modalities.)
- Basic anatomy and physiology (A study of the structure and function of the human body utilizing a system approach. Emphasis placed on the gross and microscopic anatomy as well as the physiology of the cell, skeletal system, skin and muscular system, nervous system, cardiovascular, respiratory, urinary, reproductive, endocrine, and digestive systems.)

- Pathophysiology/Disease process (A study of the disease processes affecting the human body via an integrated approach to specific disease entities, including the study of risk factors, etiology, manifestations, diagnosis and treatment of disease)
- Pharmacology (A study of the basic principles of drugs and their interactions)

Legal/Ethical issues relevant to the country in which coding is being done

Intent: To introduce legal and ethical issues applicable to health information, its collection and release

- Privacy and confidentiality principles (see appended proposed principles)
  - Use of person-identifiable information
  - Adherence to relevant laws and regulations
  - Access to person-identifiable information
- Release of information
- Professional ethics

Healthcare data content and structure

Intent: To introduce the generic components of the content, use and structure of healthcare data and data sets and how these components relate to primary and secondary record systems.

- Content of the health record
- Documentation requirements
- Healthcare record data sets
- Source documents

General uses of morbidity data

Intent: To explain the purposes for which morbidity data are collected and how they are used.

- Context in which morbidity coding is done
- Purposes for coding
- Statistical outputs
- Hospital disease indexing
- Evidence for health policy
- Planning and evaluating health services and programmes
- Medical and public health research
- Disease registries
- Clinical education
- Reimbursement, e.g., case mix funding

Specific Uses of Morbidity Data

Intent: To introduce the specific uses of coded morbidity data and health information appropriate to healthcare settings.

- Quality and utilization of healthcare services
- Quality assurance
- Utilization of healthcare services
- Healthcare clinical decision-making and communication
- Monitor outcomes
- Measure performance
- Health situation and trend analysis
- Leading causes of disease and injury
- Notifiable diseases
- Definition of policies and priorities
- Planning health programmes and services
- Public health
- Medical research
- Performance improvement activities

- Monitor service and resource utilization, analyze healthcare costs
- Health research and treatment development
- First or main source of information for certain diseases
- At local level, investigation of cases, disease control measures
- Specific population groups/problems (e.g., maternal and infant mortality, adolescents, elderly)
- Healthcare management and policy decision-making

Users of morbidity data

Intent: To explain the different groups and stakeholders who are users of morbidity data.

- Providers (e.g., clinicians, hospitals)
- Third parties (e.g., government, insurance)
- Epidemiologists
- Statisticians
- Programme managers
- Actuaries
- Policy makers
- Researchers
- Educators and students

Healthcare Delivery Systems

Intent: To provide an awareness of the organization, financing and delivery of healthcare services

- Organization of healthcare delivery
- Healthcare organizations
- Accreditation standards if any
- Licensure/regulatory agencies if any
- Payment and reimbursement systems if any

International Classification of Diseases (ICD)

Intent: To develop an understanding of the ICD and to develop the knowledge and skills that are necessary to assign valid diagnostic codes

- Nomenclature and Classification
- International context
  - WHO Family of International Classifications
    - Reference Classifications (ICD and International Classification of Functioning, Disability and Health [ICF])
      - Conceptual framework and structure of ICF
      - Complementary relationship between ICD and ICF
    - Derived and related classifications
- Standardization and comparability
- History of the classification
- Development of clinical modifications
- Structure of classification
- Updating mechanisms of classification

How to code

Intent: To provide detailed instruction and experience on how to apply the coding rules and assign codes

- How to use different volumes of the ICD
- Coding rules, instructions and conventions of ICD
- Coding Guidelines/standards
- Sequencing Guidelines
- Definition of main diagnosis, secondary diagnoses etc. as per volume II of ICD-10. Local definitions relevant to the country in which training is occurring such as principal diagnosis, other diagnoses
- Appropriate exercises in coding and sequencing

Quality assurance

Intent: To raise awareness about the various factors that influence the quality of coded data and describe techniques for assuring the highest quality data possible

- Quality of source documents
- Querying processes (e.g., sequencing of diagnoses/procedures, what and how to query)
- Editing and validation
- Timeliness, completeness and accuracy
- Responsibility for data quality
- Processes for accessing expert advice
- Clinical coding audit

Appendix

Proposed Confidentiality and Privacy Principles

The following recommendations are for organizations holding personal health data. Organizations and clinical coders should comply with the following principles:

- Justify the purpose – Every proposed use or transfer of person-identifiable information within or from an organization should be clearly defined and scrutinized, if possible prior to the collection of the data, with continuous uses regularly reviewed.
- Do not use person-identifiable information unless it is absolutely necessary. Person-identifiable information items should not be used unless there is no alternative. Knowledge and consent by the individual should be obtained where necessary.
- Use the minimum necessary person-identifiable information – where it has been considered that person-identifiable information is essential, each data item should be justified separately, with the aim of reducing identifiability.
- Personal health information should be as accurate and up-to-date as necessary for the purposes for which it is collected.
- Access to person-identifiable information should be on a strictly need to know basis. Only those coders who need access to person-identifiable information should have access to it, and they should only have access to the items they need to see. Both the amount and type of information collected are limited to what is necessary to fulfill the purposes identified.
- Everyone with access to person-identifiable information should be aware of their responsibilities. All coders should be fully aware of their responsibilities and obligations to respect confidentiality. Personal health information should not be disclosed for purposes other than those for which it is collected unless permitted by the country's confidentiality and privacy policies as articulated in law or regulation.
- Understand and comply with the law (Data Protection) of the respective country. Every use of person-identifiable information and data must be lawful and fully upheld by the coder.
- Liaise closely with Data Protection Manager (if in post), especially with reference to sending confidential information over the internet or via e-mail. Personal information should be protected with appropriate security safeguards.

➢

WHO Family of International Classifications (WHO-FIC) and International Federation of Health Records Organizations (IFHRO)

WHO-FIC - IFHRO JOINT COLLABORATION

Training and Certification to Promote High-Quality Data

Electronic Tools Committee is developing electronic versions of the ICD-10, a meta database of ICD-10 modifications and other electronic applications for the Family.

Family Development Committee develops protocol for accepting new classifications into the WHO-FIC and promotes data comparability.

Implementation Committee focuses on tracking, promoting and supporting implementation of the WHO-FIC in health information systems internationally. The Committee is assisting WHO in the compilation of guidelines, educational materials, tools and strategies useful to countries introducing Family members.

Mortality Reference Group identifies and solves problems related to interpreting and applying ICD-10 to mortality coding and classification.

Update and Revision Committee manages the process to update ICD-10 following submissions from the MRG, reference groups, collaborating centres, clinical groups, national health agencies and classification experts.

New Reference Groups: The Network has established three new reference groups on Morbidity, Functioning and Disability, and Terminology to improve international comparability of data.

Contact Information:
WHO-FIC Education Committee:
Marjorie S. Greenberg (msg1@cdc.gov)
Joint Collaboration:
Margaret Skurka (**mskurk@iun.edu**) **or**
Sue Walker (**s.walker@qut.edu.au**)

International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)

International Classification of Functioning, Disability and Health (ICF).

These Reference classifications are used in hospitals, health and community services, statistical agencies, and research to describe the morbidity, mortality and disability of individuals and populations.

WHO-FIC Network Committees

The WHO-FIC Network carries out its functions through a series of committees and reference groups:

WHO-FIC Education Committee

The aim of the WHO-FIC Education Committee is to ensure standardized, high quality coding of health data for comparability within and among WHO Member States. Activities focus on facilitating ICD-10 and ICF implementation by endorsing standardized educational materials and training and encouraging the development of best practices.

The WHO-FIC Network

The **WHO Collaborating Centres** for the **Family of International Classifications** (**FIC**) are an international network of expert centres in health classifications, coding and terminology development The principal role of the WHO-FIC network is to promote the implementation and use of the Family of International Classifications, with focus on two WHO reference classifications, the International Classification of Diseases (ICD) and the International Classification of Functioning, Disability and Health (ICF), in health information systems.
http://www.who.int/classifications/en/

IFHRO

The International Federation of Health Records Organizations (IFHRO) is a non-governmental organization (NGO) in official relations with WHO. IFHRO is a federation of health information organizations from different countries that come together to advance communications and understanding between health information professionals. A goal of IFHRO is to assist developing nations with improving their health information management practices.
www.ifhro.org

The Joint Collaboration

The WHO-FIC Education Committee and the IFHRO have established the Joint Collaboration to develop an international training and certification program to improve coding practice. The overall goals of this program are to improve the quality of mortality and morbidity data and the competence of ICD coders and thus their status. Through the work of the Joint Collaboration, health data at the national and international levels will be improved and the value of coded data and the professional coder will be more broadly recognized.

The International Training and Certification Program for ICD-10 Mortality and Morbidity Coders includes assessment of practicing coders, training of new coders and recognition of trainers. Those achieving a standard will be awarded certificates. For new coders, the international certificate will recognize successful completion of all modules in a core curriculum taught with approved materials by an approved trainer. International standard ICD-10 curricula for mortality (underlying cause of death) and morbidity coders have been developed by the WHO-FIC Education Committee and are the basis for a recognized training program. Acknowledging individual differences in health information systems in WHO Member States, the curricula focus on the basic needs of all coders in an international context.

The first phase of the 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.

Recognition of Training Materials

Providers of current training on mortality and morbidity coding can apply to have their curricula assessed by the Joint WHO-FIC – IFHRO Collaboration and recognized as meeting an international standard for coder training.

Approval will give coders confidence that their coding education program meets the benchmarks set by the WHO-FIC Education Committee and IFHRO for high-quality teaching and learning.

Recognition of Trainers

The Joint Collaboration is inviting experienced educators/coders to apply for recognition as approved trainers of new coders who wish to seek certification by the WHO-FIC-IFHRO partnership. Educators and trainers who meet this international standard will be included in a Roster of Experts on the IFHRO and Education Committee Web sites.

Coders

Both new and experienced coders are encouraged to seek certification. This is an opportunity to increase knowledge and proficiency, leading to higher quality national and international data, and to give recognition of the coders' skills.