Annual Report 2013

The Collaborating Centre for the WHO-FIC in Japan
Preface

Two years have passed since the designation of the Collaborating Centre for the WHO-FIC in Japan by WHO Regional Director for the Western Pacific in September two years ago.

The WHO-FIC Collaborating Centre in Japan has an exceptionally rare structure among WHO-FIC Collaborating Centres in that it is a conglomeration of five organizations and moreover, from both the public and private sectors, namely, the Ministry of Health, Labour and Welfare’s Japan ICD Office, whose director is the Centre Head, the National Institute of Public Health, the National Cancer Center, Japan Hospital Association/Japan Society of Health Information Management, and Japan Society for Oriental Medicine. By taking advantage of this special feature of our Centre and continuing to collaborate among our organizations, we intend to work together for the development of international classifications in Japan.

This annual report is the Centre’s second report since its inception. It contains, among others, the activities of our member organizations in the past year (Sep.2012-Aug.2013), evaluation of those activities, issues and challenges, and discussions with other WHO-FIC Collaborating Centres.

I hope it will gain wide readership for better understanding of the activities of our Centre.

Lastly, I would like to sincerely thank those of you who made efforts to assist with the running of the Centre and ask for your continued support.

Nobuyoshi Tani
Head, Collaborating Centre for the WHO-FIC in Japan
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Part I. Activities in Japan

1. Activities of Japan ICD Office, Policy Planning Division, Statistics and Information Department, Ministry of Health, Labour and Welfare

Japan ICD Office is a government organization to which the Director of the Collaborating Centre for the WHO-FIC in Japan belongs. By developing and implementing statistical classifications in Japan, Japan ICD Office performs the core activities of the Centre.

(1) Implementation of ICD-10 (2010 version) in Japan

As the current ICD in use in Japan is based on ICD-10 (2003 version), expeditious implementation of the 2010 version of ICD has been one of the ICD Office’s priorities in the last few years.

As in last year, the office continued to work with the Statistics and Information Department’s Vital, Health and Social Statistics Division, which has jurisdiction over vital statistics in Japan, to adjust the schedule for implementation of the 2010 version. We also continued to answer inquiries about ICD updates to the 2010 version (such as conceptual changes of leukemia, lymphoma, and nephritis, and introduction of staging and etiological classifications).

The Statistics Act stipulates that implementation of the Japanese version of ICD as a statistical classification in Japan to be based on a proclamation by the Ministry of Internal Affairs and Communications. Therefore, implementation of the 2010 version requires modification of the existing proclamation by the Ministry of Internal Affairs and Communications. To deliberate on the modification of the proclamation, the Expert Group on Classification of Diseases, Injuries and Causes of Death was established under the Statistics Committee of the Ministry of Health, Labour and Welfare’s Social Security Council, with the approval of the Statistics Committee. Japan ICD Office selected the members of the expert group.

The deliberations are set to begin in November 2013.

(2) Management of ICD Expert Committee

To continually examine the contents of ICD and disseminate Japan’s views on them, the Expert Committee on Classification of Diseases, Injuries and Causes of Death (ICD Expert Committee) was established in 2006, under the Statistics Committee of the Social Security Council, as an investigative body. ICD Expert Committee investigates and discusses technical matters related to ICD implementation, revision, and update.
Its membership is based on recommendations by 29 ICD-related scientific societies in Japan.

The committee met twice in the last one year in November 2012 and March 2013, as shown below.

- The 13th Meeting of the Expert Committee on Classification of Diseases, Injuries and Causes of Death
  Date and Time: November 16 (Fri.), 2012  14:15-16:15
  Place: Ministry of Health, Labour and Welfare, Common Meeting Room No.9
  Agenda: 1. Selection of chair
  2. Developments concerning ICD revision
  3. Implementation of ICD-10 (2010 version) in Japan
  Reference: [http://www.mhlw.go.jp/stf/shingi/2r9852000002omby.html](http://www.mhlw.go.jp/stf/shingi/2r9852000002omby.html)  (Japanese text only)
  Minutes: [http://www.mhlw.go.jp/stf/shingi/2r9852000002r6l8.html](http://www.mhlw.go.jp/stf/shingi/2r9852000002r6l8.html)  (Japanese text only)

- The 14th Meeting of the Expert Committee on Classification of Diseases, Injuries and Causes of Death
  Date and Time: March 27 (Wed.), 2013  15:00-17:00
  Venue: Ministry of Health, Labour and Welfare, Ad-hoc Meeting Room No.3
  Agenda: 1. Developments concerning ICD revision
  2. URC proposals
  3. Updates to ICD-O-3
  Reference: [http://www.mhlw.go.jp/stf/shingi/2r9852000002yipa.html](http://www.mhlw.go.jp/stf/shingi/2r9852000002yipa.html)  (Japanese text only)
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In addition, the committee members provided their respective expertise in response to inquiries made in relation to URC voting for 2013.

(3) Use of teaching materials for ICD implementation

The ICD Office publishes the introductory guide “ABC of ICD” for residents annually. Together with “Manual for Writing Death Certificates” published by the Vital, Health and Social Statistics Division, we published some 10,000 copies of the guide and distributed
them to 870 hospitals designated for training residents and other related institutions in March 2013.

The contents of each publication are as follows:

- Contents of “ABC of ICD” (published March 2013)
  1. What is International Classification of Diseases (ICD)?
     Outlines of ICD
  2. Uses of ICD in Japan
     Surveys using mortality and morbidity classifications and other uses
  3. Classification System of ICD-10 (2003 Version)
     Explanation on the structure and meaning of 3- to 5-character codes
  5. Difference between ICD and Medical Terminologies
     The meaning of ICD as a statistical classification
  6. Coding Examples
     Explanation on the methods of coding using “atopic asthma” and “pulmonary embolism” as examples
  7. Mortality Coding
     Explanation on the selection of underlying causes of deaths from death certificates, with examples of what to do and what not to do in specific cases
  8. Morbidity Coding
     Difference between mortality and morbidity coding, sources of morbidity data, general principles of morbidity coding
  9. URLs of ICD-Related Websites

- Contents of the “Manual for Writing Death Certificates” (published March 2013)
  1. Meaning of Death Certificates (Post-Mortem Certificates)
  2. When to Use the Death Certificate and When to Use the Post-Mortem Certificate
  3. Instructions on Writing the Certificates
  4. Notes
     (1) Cooperation in the Vital Statistics Survey
     (2) Handling of Death Certificates (Post-Mortem Certificates)

(4) Support of ICD users

The ICD Office responds to inquiries on ICD codes found in the Standard Disease Name Master Index, which is recognized as a standard terminology in the field of health
information in Japan.

The office also answers various other queries from the public and provides related documents where necessary to promote ICD implementation.

(5) Promotion of research through Health and Labour Sciences Research Grants

The Ministry of Health, Labour and Welfare (MHLW) promotes research on the WHO Family of International Classifications through the Health and Labour Sciences Research Grants. The Director of the Japan ICD Office serves as a member of a research selection committee for the grant. The research conducted under this grant in FY 2012 was as follows:

- Development of a Japanese Kampo Classification from WHO Traditional Medicine Classification
- Research on Improving Accuracy of Death Certificates through Intervention by Health Information Management Division in Writing Death Certificates
- Empirical Research on the Validity of ICD Omics Sub Information Model (iCOs)

The outlines of the research results can be found at the following website:

http://mhlw-grants.nih.go.jp/niph/search/NISR00.do (Japanese text only)

The following research projects are planned for in FY 2013:

- Empirical Research on the Validity of ICD-11 Omics Sub Information Model (iCOs)
- Research on Feasibility of Using WHO-DAS as a Tool to Promote ICF Implementation
- Validity of Kampo Patterns Classification for ICD-11
- Discharge Summaries Contributing to the Quality of Hospital Care in Terms of Improving Accuracy of Mortality Statistics
- Research on Structured Comparison and Analysis of WHO ICD-10 (2010) and ICD-10 Proclamation

(6) Management of ICF Expert Committee

The ICD Office serves as a secretariat of the Expert Committee on Classification of Functioning, Disability and Health (ICF Expert Committee), which, similarly to the ICD Expert Committee, is established under the Statistics Committee of the MHLW’s Social Security Council. The members of the ICF Expert Committee include researchers of health care and social welfare, professional care providers, and disabled persons. The committee normally meets twice yearly to deliberate on the implementation of ICF.
The committee met in September 2012 and February 2013 in the last one year, as shown below.

- The 12th Meeting of the Expert Committee on Classification of Functioning, Disability and Health
  Date and Time: September 27 (Fri.), 2012 10:00-12:00
  Place: Ministry of Health, Labour and Welfare, Common Meeting Room No.6
  Agenda: 1. Selection of chair
          2. Implementation and use of ICF
  Reference: [http://www.mhlw.go.jp/stf/shingi/2r9852000002ksqi.html](http://www.mhlw.go.jp/stf/shingi/2r9852000002ksqi.html)
  (Japanese text only)
  Minutes: [http://www.mhlw.go.jp/stf/shingi/2r9852000002mvfc.html](http://www.mhlw.go.jp/stf/shingi/2r9852000002mvfc.html)
  (Japanese text only)

- The 13th Meeting of the Expert Committee on Classification of Functioning, Disability and Health
  Date and Time: February 20 (Fri.), 2012 14:00-16:00
  Place: Ministry of Health, Labour and Welfare, Meeting Room No.17
          2. Challenges facing ICF implementation and education
          3. Curriculum for ICF implementation and education
  Reference: [http://www.mhlw.go.jp/stf/shingi/2r9852000002vsze.html](http://www.mhlw.go.jp/stf/shingi/2r9852000002vsze.html)
  (Japanese text only)
  Minutes: [http://www.mhlw.go.jp/stf/shingi/2r9852000002xr4s.html](http://www.mhlw.go.jp/stf/shingi/2r9852000002xr4s.html)
  (Japanese text only)

(7) ICF Symposium

The ICD Office has been organizing symposia since 2010 to promote education and implementation of ICF as a common language across multiple fields, including health care and nursing care. Going a step beyond the scope of the last two symposia, this year’s 3rd ICF Symposium focused on the theme of “Challenges and Approaches to Practical Use of ICF” and particularly the use of ICF in health care settings.

Mr. Nenad Kostanjsek, Technical Officer, Classifications, Terminologies and Standards, WHO, sent a video letter in which he spoke about the concepts and possible uses of ICF. It was shown at the symposium and had a very positive reception.
The 3rd ICF Symposium

“Towards Practical Use of ICF: Challenges and Approaches”

Date and time: December 17, 2012 13:00-17:00
Place: National Museum of Emerging Science and Innovation, MIRAICAN Hall
Organizers: Ministry of Health, Labour and Welfare and Japan Society of Health Information Management

Program:
1. Opening Addresses
2. Video Letter from WHO (Nenad Kostanjsek)
3. Basics of ICF and Its Use in Health Care (Yayoi Okawa, National Center for Geriatrics and Gerontology)
4. Use of ICF towards Holistic Health Care and Expectations (Hiroshi Nonaka, President, Tokyo Medical Association)
5. Use of ICF in Nursing Care (Shinji Funada, Japan Association of Certified Care Workers)
6. ICF from the Perspective of Health Information (Yuji Takahashi, Vice President, Seirei Hamamatsu City Rehabilitation Hospital)
7. ICF in Terms of Patients’ Expectations on Health Care (Kuniko Obinata, Senior Consultant, Dentsu Public Relations Inc.)
8. Panel Discussion

(Japanese text only)

(8) Others
In February 2013, the ICD Office launched the Japanese Collaborating Centre’s website to disseminate information about the WHO Family of International Classifications and the Centre’s activities. The office is considering ways to reinforce the website’s functions for sending out information, including the use of the website for information sharing among those involved in the work of ICD revision.
2. Activities of the National Institute of Public Health

(1) Activities of the National Institute of Public Health

The National Institute of Public Health (NIPH) conducted (a) collection and dissemination of information on ICD use, (b) preliminary discussions on ICD-11 field trials, and (c) study on ICF implementation in Japan.

(a) Collection and dissemination of information on ICD use

The uses of ICD include mortality and morbidity statistical surveys, medical insurance reimbursements, and clinical, epidemiological, and medical economics research. In anticipation of an even broader use of ICD in public health, health care, and social welfare in Japan, it is essential that we promote understanding of how ICD is used and what significance it has among all parties concerned. This effort will need to include regular collection of related information to take stock of the current uses of ICD in Japan and to examine future challenges. This year, we sorted out information on the use of ICD in research on public health and health care in Japan.

The institute identified 112 research papers, published in Japanese as the original language from 2008 through 2013, that noted the use of ICD-10 in their abstracts (from searches on Japan Medical Abstracts Society (JAMAS) database) and categorized them based on how ICD-10 was used in the research. The results showed that in around 80% of cases, ICD-10 was used as a standard or benchmark to categorize or select groups in group comparison research. The remainder included use of ICD-10 as a diagnostic standard in non-quantitative case reports and as a benchmark in medical economics assessments and regional correlation studies, each with several percentage points. At the chapter level, many research cited using “Chapter V. Mental and behavioral disorders” as a diagnostic standard. A number of researches addressed or identified issues related to the clinical use of ICD-10 and to the 11th revision of ICD.

ICD serves a significant purpose in research in public health, health care, and social welfare, through which the scientific foundation and validity of ICD can be verified. We plan to expand our study on ICD use in research and beyond to promote systematized use of ICD, enhance understanding about ICD, and identify needs in Japan.

(b) Preliminary discussions on ICD-11 field trials

One of the requirements in the ICD revision process is field tests to ensure validity of ICD-11 coding. We assisted in the preliminary discussions on the field tests for a traditional medicine classification that will be included for the first time in ICD as Chapter

XXIII. Japan Society for Oriental Medicine (JSOM) has prepared a detailed report on these preliminary discussions. In terms of applying what we learned to other chapters of ICD-11, the need to simplify cases for use in field trials and having clear coding rules may be pertinent.

(c) Study on ICF implementation in Japan

We are considering ICF implementation in Japan through a study on the development of the Japanese version of WHO-DAS and its potential use and another study on the relation between ICF and other existing assessment tools in Japan. Through these two studies, we identified potential challenges in clinical application of ICF in Japan and collected and presented basic data based on a field survey for the former study and a literature review for the latter. The next section, “Implementation of ICF for periodic data collection,” by Tsutsui discusses the two studies in more detail.

(2) Implementation of ICF for periodic data collection

[Implementation of activities]

In 2001, WHO established ICF as a standard conceptual framework to capture diseases, functioning, and disorders, and its uses have expanded in a variety of fields in WHO’s member states in the past decade. The use of ICF and, in particular, its application for development of social security statistics is an international issue that also pertains to Japan as a member state of WHO.

Turning our attention to the fields of public health, health care, nursing care, and social welfare in Japan, we notice that our medical insurance system and nursing insurance system already have their own measures for assessment. As a result, a patient, for example, who is discharged from a hospital but still requires nursing care in the patient’s home, will have two sets of information: one based on a measure of assessment as an inpatient and one based on another measure as a recipient of nursing care. The existence of such multiple measures of assessment is a barrier to promoting seamless collaboration among different types of health care professionals.

Japan is developing a system of integrated care as an essential component of care for chronic disease patients who make up a large percentage of social security recipients in Japan today. Implementation of a more comprehensive measure of assessment of patients should be integral to this process.

ICF provides a meaningful conceptual tool to sort these existing measures and comprehensively capture diseases, functioning, and disabilities. However, there has been insufficient study done on the relation between ICF and the existing tools of
assessment.

Today, two research projects have been initiated, one on “development of the Japanese version of WHO-DAS and its potential use” and the other on “relation between ICF and existing assessment tools” to examine the possibility of implementing ICF in Japan. This section will discuss this year’s activities undertaken for the two research projects.

[Implementation method and status]
I. Development of the Japanese version of the WHO-DAS and its potential for use

In accordance with the WHO-DAS translation guidelines that specify linguistically faithful translations, the institute reviewed the Japanese versions of the WHO-DAS questionnaires and the manual. It also conducted a field survey using the WHO-DAS interview questionnaires and self-administered questionnaires on 41 persons (13 physically disabled, 19 mentally retarded, and 5 mentally disabled persons) from September to December 2012, to revise the Japanese versions of the manual and identify problems with the questionnaires.

II. Study on the relation between ICF and existing assessment tools

Prior to the study of the relation between ICF and the existing assessment tools, the institute reviewed research papers mainly from outside Japan to examine problems related to ICF. The results provided basic data based on which to design our study, to be conducted in 2013, on the clinical application of ICF coding.

[Results and implications]
I. WHO-DAS survey

As for the WHO-DAS field survey, we found mismatches in 12 items (33.5%) on average among all subjects for the interview and self-administered versions of WHO-DAS. The breakdown was 1.4 items (23.9%) in Domain 1 (Cognition), 1.0 items (19.1%) in Domain 2 (Mobility), 0.7 items (17.4%) in Domain 3 (Self-care), 1.7 items (33.9%) in Domain 4 (Getting along), 2.9 items (35.9%) in Domain 5 (Life activities), and 4.3 items (54.3%) in Domain 6 (Participation). (Figures in parentheses in the breakdown show percentage of mismatches within each domain.) Domain 6 (Participation) had the lowest correspondence rate, followed by Domain 5 (Life activities) and Domain 4 (Getting along). The correspondence rate was highest in Domain 3 (Self-care).

The results suggest that review of the translations in the manual and the questionnaires is needed particularly in Domain 5 (Life activities) and Domain 6 (Participation), which had the highest levels of mismatch.
Some subjects pointed out, during our interviews, that while WHO-DAS assumed respondents were living within a community, there was a need, for clinical implementation of WHO-DAS, to consider how to assess respondents living in care homes. Some said that the 5-scale choices were not well-adapted to Japanese customs and that the answers in the self-administered version tended to cluster around the mean (i.e. “Moderate”).

II. Literature review to identify issues related to clinical application of ICF

Our literature review identified some conceptual problems with ICF. The first is the difference between “Activities” and “Participation.” When the framework of ICF was first developed, it was considered that “Activities” referred to activities on the personal level and “Participation” as participation on the social level (corresponding to the difference between “Disability” and “Handicap” in ICIDH).

However, there has not been an agreement as to which domains belong to Participation and which to Activities, so that one person might see a domain as belonging to personal activities while another person might see the same domain in social participation. To break this impasse, WHO claimed that Participation and Activities could encompass anything and left it for users to decide if a domain belonged to Participation, Activities, or both. This unsatisfactory state created too many overlaps between Participation and Activities and uncertainties as to whether the observed actions, etc. belonged to Participation or Activities or both.

The second is the distinction between “Performance” and “Capacity.” “Performance” relates to what a person does in his or her current environment whether or not with the aid of assistive devices or personal assistance.

On the other hand, “Capacity” refers to a person’s ability to execute a task or action in a “standardized environment.” However, it is not clear what specifically this standardized, or uniform, environment was. There is also no information about how to reliably conduct assessment in such an environment.

WHO says that it is very important for the development of ICF that users consider different approaches and test, record, and share their experiences in the early stages of ICF implementation. However, because of the two problems mentioned above, users often do not have clear rules for assessment and are left to make difficult choices when using ICF.

To address this issue, for example, countries like Australia, which are significantly more advanced in ICF implementation, recognize that ICF could be used in the following three ways as regards collection of data on persons with disabilities (see ICF
Australian User Guide Version 0.5):

1) Using the ICF as a framework to organize thoughts and ensure that major factors of interest are not omitted from a plan;

2) Using the ICF classification as a menu to select the domains most relevant to the information one needs, in which case one will need to decide at which level to use the classification: chapter level (for instance, ‘mobility’), at block level (for instance, ‘walking and moving’), second-level category (for instance, ‘walking’) or third-level category (for instance, ‘walking short distances’);

3) Using the ICF to assist a researcher select a scale that is related to the ICF or that ensures the data collected will map to an ICF qualifier.

The implication from the practical example in Australia is that ICF can theoretically be used for different purposes depending on each use and that a right combination of the scope of its use and tasks needs to be set suited to the purpose.

[Assessment]

As for the WHO-DAS survey, the respondents pointed out that there was some difficulty in understanding some of the questions in the current questionnaires and that the questionnaires needed to take into account those living in care home settings. On the other hand, the survey was valuable in that we were able to use WHO-DAS to collect data on persons with disabilities in Japan. The implication was that we would need to revise the manual and questionnaires based on the results obtained from the survey.

As for clinical application of ICF in Japan, the implication from the practical example in Australia was that we should select a set of domains from ICF, rather than using ICF in its entirety. It would be important to test the effectiveness of such a domain set in a survey that also covers the tools already existing in Japan.

[Issues]

As for WHO-DAS, we think that while the data obtained from our survey could be used for international statistical comparison, we will need further consideration on how to use the assessment tool at the clinical level in public health, health care, and social welfare.

As for ICF, we will need to select a set of ICF domains that could be used clinically in Japan and design and conduct surveys to assess patients using the selected domain set together with the existing tools.
3. Activities of the National Cancer Center

[Implementation method and status]

Improving the accuracy of ICD implementation requires evaluation of the code assignment process. This is needed particularly to address the issues concerning logical consistency among multiple codes and integration of different codes. Moreover, process evaluation is also necessary for the rules for underlying cause of death selection in mortality statistics and for selection of the main condition in morbidity statistics.

National Cancer Center (NCC), one of the Japanese Collaborating Centre’s supporting organizations, has been leading the development of quality control logic and related tools for hospital-based cancer registries in the country. It is now considering applying its quality control expertise to different aspects of ICD implementation.

Each year, data on more than 600,000 cancer cases are compiled nationally from hospital-based cancer registries in Japan (40 sets of data per case). When the call for data is made, the designated institutions access the server of NCC and upload the data files. A set of 300 logic checks is performed during uploading until the cases are error-free by the time the uploading is complete. The quality of hospital-based cancer registry data, therefore, is very high. NCC is making further improvements to this internet-based system, comprising (1) data upload and (2) error checks (for quality control), so that the online checks can be performed any time, instead of only during uploading the cancer registry data.

With respect to preparation of morbidity statistics at medical institutions, National Cancer Center Hospital is conducting demonstration tests for disease name assignment for each admitted case and to pilot test the above-mentioned server-based quality-control system for checking coding errors. Next year, we plan to implement the system following verification tests at a number of medical institutions.

As for mortality statistics, NCC plans to consider feasibility of providing feedback on death certificates prepared by medical institutions, which will also include pilot testing of IRIS.

Healthcare institutions and the WHO-FIC Collaborating Centre (the National Cancer Center) will collaborate in and share information on the quality control of morbidity and mortality data, identifying the status of ICD use and coding issues and offering solutions to users.
[Results and implications]

The quality control system that runs on a central server has many advantages, including (1) easier implementation of improved error logics without the need for updating on the part of users, (2) analysis of frequent errors and notification of the results to users enables improvement in coding precision on a national scale, and (3) use of similar systems for preparation of mortality and morbidity statistics and related statistics contributes to cost reduction through system standardization.

[Assessment]

There is significant advantage in using the quality control system running on a central server.

[Issues]

Security-related issues remain in relation to handling of data in an online network.
4. Activities of Japan Hospital Association/Japan Society of Health Information Management

(1) Education and implementation activities related to health information management and international classifications

(a) Hosting of a scientific conference

Japan Society of Health Information Management (JHIM) held its annual scientific conference in Nagoya City in September 2012. It provided an opportunity to present the latest research and related information and exchange information about various cases encountered in medical and educational institutions. The conference included an outstanding research paper award, a session for students of health information management, and selection of outstanding presentations.

   Number of participants: 2,154
   Number of presentations: 274

(b) Lifelong education workshops for health information managers

JHIM organized lifelong education workshops for health information managers in six regions in Japan (Hokkaido, Osaka, Nagoya, Ehime, Tokyo, and Nagasaki) with total participation of 1,403.

(c) Training of health information administrators

JHIM trains health information administrators, runs seminars for them, and organizes certification exams. This year, JHIM certified 10 new health information administrators and renewed certification for additional 5. (There are a total of 55 certified health information administrators in Japan as of present). Certified health information administrator is an upper-level qualification for health information managers.

(d) JHIM revised its Code of Ethics.

(e) JHIM published the journal *Shinryo Joho Kanri* (Health Information Management) three times in the past year.

(2) Research on health information management

(a) Research on improving the accuracy of death certificates through intervention by health information managers

(b) Study on recording of health information in disasters

   The major earthquake and tsunami in 2011 in Japan prompted research on health information recording during disasters, resulting in drafting of a standard format for recording health information in emergencies.
(3) Cooperation with the WHO-FIC Network
(a) JHA/JHIM submitted five comments to Japan ICD Office, in the Ministry of Health, Labour and Welfare, for ICD-10 updates of the Update and Revision Committee (URC) in 2013.
(b) Upon signing of an agreement between WHO and the Japanese Collaborating Centre on translation of the ICD web-based training tool into Japanese, JHA/JHIM began translation of the tool.
(c) JHA/JHIM co-hosted the ICF Symposium titled, “Towards the Use of the International Classification of Functioning, Disability and Health (ICF),” with the Ministry of Health, Labour and Welfare.

(4) Cooperation with the Ministry of Health, Labour and Welfare on ICD
JHA/JHIM provided comments on the 2013 version of the “Manual for Writing Death Certificates” and “ABC of ICD” published by the Ministry of Health, Labour and Welfare.

(5) Activities to strengthen international collaboration in health information management
JHIM, as a member association of International Federation of Health Information Management Associations (IFHIMA), which is an NGO in official relations with WHO, participated in IFHIMA Congress held in May in Montreal, Canada.

JHIM submitted a bid to host the 2016 IFHIMA Congress, and Japan was selected as the host country for the 2016 Congress.

JHIM is serving its second term as a director on IFHIMA Executive Board. In that role, JHIM assisted countries in the Southeast Asia region and developing countries.
5. Activities of Japan Society for Oriental Medicine

[Implementation method and status]
Japan Society for Oriental Medicine (JSOM) held discussions by teleconferences and face-to-face meetings with the Traditional Medicine TAG on the 11th revision of ICD. As a counterparty organization in Japan, JSOM’s Terminology and Classification Committee developed a Japanese version of a traditional medicine classification.

[Results and implications]
WHO has been considering including a classification of traditional medicine as Chapter XXIII of ICD-11. Chapter XXIII consists of traditional medicine disorders and traditional medicine patterns. Japan will develop a classification of traditional medicine patterns but will not use a classification of traditional medicine disorders.

[Assessment]
The work to date has progressed well with Traditional Medicine Module 1 incorporated as Chapter XXIII in ICD-11 beta version and viewable from the ICD-11 browser.

[Issues]
Following a review process and field trials, the traditional medicine classification is expected to be finalized.

[Collaboration with WHO]
Via the Centre, Japan Society for Oriental Medicine and Institute of Kampo Medicine provided financial assistance to the ICTM project in the sum of ¥40 million (approx. $405,000) and ¥15 million (approx. $152,000), respectively.
We believe closer collaboration with WHO is needed in the face of increased and improved collaboration needed to smoothly navigate the review process and the field trials.
Part II. Activities in the WHO Family of International Classifications (WHO-FIC) Network

1. Participation in the WHO-FIC Network

(1) Council
The Head of the Collaborating Centre for the WHO-FIC in Japan attends teleconferences of the Council at the request of WHO and engages in discussions about the governance of the WHO-FIC Network. At the annual meetings of the WHO-FIC Network, the Council reviews the annual reports of committees and networks and deliberates on the strategic direction of the Network for the coming year. The Head of the Collaborating Centre for the WHO-FIC in Japan represents the Centre in voting in the election of the Council Co-Chairs.

(2) Update and Revision Committee (URC)
(a) ICD update
As for proposals for ICD-10 updates (2013) due by the end of March 2013, the Centre called on members of the ICD Expert Committee and Japan ICD WGs to submit proposals for updates, following the standard process of the past years. With no new proposals, the Centre submitted two proposals to the URC that had been carried over from the previous year.

For the next round of ICD-10 updates (2014), the Japanese Association of Medical Sciences, the country’s foremost medical science association presiding over 119 specialist medical societies in the country, has agreed to cooperate in proposing updates. Preparations are underway to introduce a process whereby the ICD Expert Committee will screen proposals from the Japanese Association of Medical Sciences and the Centre will submit proposals for updates from Japan to the URC.

The Centre intends to firm establish this process involving the Japanese Association of Medical Sciences for ICD updates.

As for the proposed updates presented by the URC in May 2013, the Centre requested feedback from members of the ICD Expert Committee and Japan ICD WGs and based on their recommendations, conducted a further in-depth review and voted on the ICD update platform by the deadline in September.

(b) ICF update
The Centre made a preliminary review of the proposed ICF updates presented by the
URC in July 2013, and requested further examination by the National Center for Child Health and Development. After receiving their feedback in late August, the Centre made a final review to develop its positions and voted on the ICF update platform by the deadline in September.

**3. Education and Implementation Committee (EIC)**

The Centre participated in 2 teleconferences of the EIC held in the past year as well as in a mid-year face-to-face meeting of the EIC in Washington D.C. in April 2013 to provide and collect information and exchange views.

The Centre made a decision to translate the ICD web-based training tool into Japanese and signed a translation agreement with WHO. Japan Hospital Association/Japan Society of Health Information Management have commenced the translation work.

The Centre conducted a survey on the state of health information management and ICD education and implementation in Southeast Asia region and provided input into the EIC.

**4. Mortality Reference Group (MRG)**

The Centre attended and joined discussions at the mid-year face-to-face meeting of the MRG in Washington D.C. in March, and presented a draft proposal on indexing for carbon monoxide poisoning. The meeting agreed to continue this work. The Centre was also asked to join the Table Group and will do so from the next annual meeting in October.

**5. Functioning and Disability Reference Group (FDRG)**

The Centre provided examples for and commented on the ICF Practical Manual. It participated in FDRG teleconferences to provide input, gather information, and exchange opinions.

At the annual meeting, the Centre took part in the final review of the ICF Practical Manual, which then went to the Education and Implementation Committee (EIC) for review and commenting.

**6. Revision Steering Group (RSG)**

Kenji Watanabe, of the Japanese Collaborating Centre, participates in the monthly teleconference of the RSG as the Co-Chair of the Traditional Medicine TAG. The Centre receives updates on the ICD-11 review process and field trial from the WHO Secretariat
for dissemination to the parties concerned in Japan.

(7) Asia-Pacific Network (APN)
[Implementation method and status]
(a) Meeting of the Co-Chairs and the host country of the Asia-Pacific Network meeting

On February 11, 2013, Dr. Hiroyoshi Endo, the incoming Co-Chair of the Asia-Pacific Network (APN), and Prof. Sukil Kim, the APN Co-Chair, met to discuss the future activities of the APN and the agenda for the 6th APN meeting.

On the following day on February 12, the Co-Chairs were joined by Dr. Wansa Paoin, Head of the Thai Collaborating Centre, the host of the 6th APN meeting, for discussion.

(b) The 6th Asia-Pacific Network meeting (face-to-face meeting)

On July 18 and 19, 2013, the 6th Asia-Pacific Network Meeting was held in Bangkok, Thailand, with the cooperation of the Collaborating Centre for the WHO-FIC in Thailand. Some 40 persons from nine countries (India, Indonesia, Korea, Thailand, Japan, Hong Kong, Malaysia, Myanmar, and Laos) participated, with Myanmar participating for the first time in an APN meeting. Vietnam, which had made plans to participate, could not attend due to travel problems.

Dr. Endo and Prof. Kim presided as Co-Chairs.

Dr. Suwat Kittidilokkul, Director, Bureau of Health Policy and Planning, Ministry of Public Health, Thailand delivered the opening remarks, followed by a video message from Dr. Bedirhan Ustun of WHO.

The Asia-Pacific Network was launched in 2006 as a regional network of the wider WHO-FIC Network with the support of Japan Hospital Association. President of Japan Hospital Association hosted a banquet on the eve of the 6th network meeting.

Commemorating Thailand’s designation as a Collaborating Centre in 2012, this year’s meeting heard presentations by the Thai Centre on the state of health information management and ICD implementation in Thailand. All participating countries gave presentations on their health information systems and discussed the future activities of the APN.

(c) Questionnaires for the WHO-FIC Implementation Database

Prior to the meeting, the Japanese Collaborating Centre distributed questionnaires to the participating countries for the WHO-FIC Implementation Database, which is being developed by the Dutch Collaborating Centre. Professor Kim presented a summary of the responses from four countries (India, Indonesia, Myanmar and Laos) at the APN meeting.

(d) List of educational resources in the Asia-Pacific region (survey)
Following up on the APN meeting’s decision to list educational resources available in the Asia-Pacific region, the Japanese Collaborating Centre prepared and distributed questionnaires to identify resources of each country.

(e) Planning of a follow-up working session

To develop an Asian version of ICD-10 shortlist, which was one of the action items agreed to at the 6th APN meeting, the Co-Chairs and Thailand, which has the ICD-10-TM for PCU, plan to have a meeting in December 2013.

(f) Development of Asia-Pacific core education module

The Japanese Collaborating Centre prepared a plan for developing an Asian core education module, which was another action item agreed to at the 6th APN meeting.

[Results and implications]

(a) The APN meeting served to take stock of the state of ICD implementation and health information management in the Asia-Pacific region.

(b) Based on discussions on the activities in the next two years, the APN drew up a strategic workplan for the second stage of its development. The strategic workplan includes the following activities:

- Development of an Asian version of ICD-10 shortlist
- Compilation of a list of educational resources in the Asia-Pacific region (survey) (including advanced educational programs)
- Development of a common education module for Asia-Pacific
- Cooperation in the work of ICD-11
- Needs assessment on DRG case mix

(c) Committees

It was decided to abolish the Health Information System Working Group. The Mortality Working Group and the Morbidity Working Group will be renamed, as follows:

1) Mortality Use Committee
2) Morbidity Use Committee

(d) The next face-to-face meeting of the APN will be in Malaysia in 2014.

[Assessment]

As this year’s APN meeting was the first face-to-face meeting in the past three years, it provided a meaningful opportunity to take stock of and be updated on the state of ICD implementation in the Asia-Pacific region.

The 6th meeting of the Asia-Pacific Network, now in its 7th year, contributed to fully establish the network among participating countries.
In comparison to the days of APN’s launch in 2006, participating countries are engaging more actively in the discussions, and much progress has been made in terms of each country’s cooperation in the network’s activities.

The meeting also succeeded in deciding tangible objectives for the network’s activities for the next two years, as APN embarks on the second stage of its development.

The meeting shed light on the remarkable progress by developing countries in ICD implementation and health information management, a testament to the role played by the APN. Myanmar, a first-time participant to an APN meeting, is also making progress. We can expect further implementation in the Asia-Pacific region.

[Issues]

An ICD shortlist and an education module will need to be developed to meet the needs of developing countries in ICD implementation. In addition, the network will need to be further expanded to other countries in the region.

[Collaboration with WHO]

Dr. Bedirhan Ustun of WHO delivered the opening remarks for the 6th APN meeting.

At a session on ICD-11, Dr. Ustun made a presentation on the current state of the revision process and discussed related issues with the participants.

Ms. Jyotsna Chikersal of the WHO Regional Office for South East Asia (SEARO) made a presentation on ICD implementation and challenges in the SEARO region.

[Collaboration with other WHO-FIC Collaborating Centres]

The Thai Collaborating Centre hosted the 6th APN meeting and provided support to enable participants from Laos, Vietnam, Myanmar, and Indonesia to attend. The Japanese Collaborating Centre and Indian Collaborating Centre attended the meeting.

(8) Others

While not directly related to the activities of the WHO-FIC Network, many network members are involved in the IRIS User Group project.

Although Japan has its own system that it developed to compile mortality statistics and has not introduced IRIS for the purpose, the Japanese Collaborating Centre is considering implementing IRIS as it has potential to efficiently incorporate and reflect ICD revision and updates on mortality statistics.

In March 2013, the Centre attended an IRIS meeting, and through the generous cooperation of the IRIS Institute, obtained information about mortality statistics
compilation in countries that had introduced IRIS. Specifically, the Centre visited Germany, France, and Italy to gather information and exchange views, and found that many of those countries were grappling with the same issues as our Centre.
2. ICD Revision: Towards ICD-11

Less than two years remain until the planned submission of ICD-11 to the World Health Assembly in 2015. However, there have been delays in the planned review process and field trials. As for the review process, the Japanese Collaborating Centre requested and received a video letter from WHO explaining the process. However, the completion of a browser for the review, to be developed by WHO, has been delayed.

(1) Internal Medicine TAG

The Japanese Collaborating Centre assists the activities of the Internal Medicine TAG, which is presided over by Professor Kentaro Sugano, of Jichi Medical University in Japan, as Chair. The Centre’s work includes monitoring the progress of the TAG’s activities and drawing up proposals.

(a) Organization of an international face-to-face meeting of the Internal Medicine TAG

The Centre organizes a face-to-face meeting attended by the Chairs of 8 WGs and Managing Editors of the IM-TAG each year. This year’s meeting was as follows:

Date and Time: February 6 and 7, 2013
Venue: United Nations University, Elizabeth Rose Conference Hall (Shibuya-ku, Tokyo)
Agenda:
- Progress report from WHO Secretariat (Dr. Ustun)
- Progress report from WGs of the Internal Medicine TAG
- Progress report from Managing Editors
- Report on future steps

(b) Organization of the meeting of the Japanese members of the Internal Medicine TAG

Japanese members specializing in internal medicine in their respective WGs and the ICD Expert Committee have formed a study group to support the activities of the members of the IM-TAG who are based in Japan.

In addition to exchange of information by e-mail and telephone, the group meets face-to-face once or twice a year.

This year’s face-to-face meetings were as follows:

- 1st domestic meeting of the Internal Medicine TAG in Japan in fiscal 2012
  Date and Time: September 10 (Mon.) 15:00-17:00
  Place: Ministry of Health, Labour and Welfare, conference room (Chiyoda-ku, Tokyo)
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Agenda: 1. Presentation by WHO (Dr. Ustun)
2. Progress report from WGs
3. Progress report from HIM-TAG

- 2nd domestic meeting of the Internal Medicine TAG in Japan in fiscal 2012
  Date and Time: January 25 (Fri.) 16:00-18:00
  Place: The Japanese Society of Internal Medicine, conference room (Bunkyo-ku, Tokyo)
  Agenda: 1. Progress report from WGs
         2. Preparation towards the international meeting of the Internal Medicine TAG

(2) Traditional Medicine TAG

The Traditional Medicine TAG (ICTM), co-chaired by Professor Kenji Watanabe (Keio University) of Japan Society for Oriental Medicine, a member of the Japanese Collaborating Centre, is developing a chapter on traditional medicine that will become a new addition to ICD-11 as Chapter XXIII.

This year’s activities related to the International Classification of Traditional Medicine (ICTM) are described below.

I. Development of Kampo medicine classification and terminology for ICD and ICTM

[Objective]
To contribute towards ICD and ICTM by constructing a Kampo medicine classification and terminology.

[Background]
WHO has a specialized department for formulating its policies on traditional medicine in its headquarters in Geneva. WHO Western Pacific Region (WPRO) also has a department for traditional medicine, which is promoting internationalization mainly of traditional medicine of Japan, China and Korea.

WHO’s involvement in developing an international classification of diseases for traditional medicine began in 2006 as a part of WPRO’s project to standardize health information used in traditional medicine, which resulted in an international standard terminology on traditional medicine in 2008.

The WHO headquarters took over the project from 2009. The year 2010 saw the official launch of the ICTM project, with international conferences on ICTM convening
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four times since 2010. On December 6, 2010, an international press conference was held simultaneously in Geneva and Tokyo to officially announce that WHO will produce ICTM and that the core part of ICTM will be incorporated into ICD-11 as Chapter XXIII.

Of all the traditional medicine systems in the world, Chapter XXIII will mainly include the system of traditional medicine practiced in Japan, China, and South Korea, which is widely used in these countries as well as in Europe, the United States, and the rest of the world and often integrated into national health care systems. The Japanese Collaborating Centre cooperates in the activities of the ICTM project.

[Implementation method and status]

As a national classification of traditional medicine had not existed in Japan, Kampo medicine experts have been drawing up a Kampo medicine classification under the helm of the Terminology and Classification Committee of the Japan Society for Oriental Medicine (JSOM), a member of the WHO-FIC Collaborating Centre in Japan. As regards terminology, the Terminology and Classification Committee’s existing glossary was translated into English.

In both China and South Korea, there are two types of classifications for traditional medicine (namely, one for disease names and one for patterns). As for Kampo medicine classification, we decided to classify patterns only, as there was a substantial risk that Kampo disease name classification would cause confusion with Western medicine terminology. We expect to use double coding, consisting of a pattern and a Western medicine disease term, in Japan.

In Japan, we also have “formula patterns,” which are used for prescription-based diagnosis. We worked on the translation of these patterns and on the creation of their terminology.

[Results and implications]

Development of a Japanese Kampo classification

In Kampo medicine’s diagnostic system, classification of deficiency/excess and cold/heat is essential. Based on this classification, we created a logic where after selecting from deficiency/excess and cold/heat, an acute disease, such as an acute febrile infection, would be selected from the six stage patterns, and a chronic disease from qi, blood and fluid patterns. Coincidentally, this classification method matches the concept of post-coordination that WHO is promoting in ICD-11.

On September 13 and 14, 2012, the Traditional Medicine TAG held a meeting in Tokyo to discuss issues related to traditional medicine patterns, and succeeded in substantially reducing the number of pattern codes from 700 to 239. In this process, the
meeting agreed to reduce the number of Kampo pattern codes through post-coordination.

For example, in a case with a combination of deficiency, cold, and qi-deficiency patterns, the qi-deficiency pattern becomes the stem code, with the deficiency and cold patterns used as qualifiers of the stem code. This is in line with Japan’s proposal to significantly reduce the number of pattern codes through post-coordination.

As for inclusion of the Formula Patterns, another proposal by Japan, the participants agreed that such a classification was necessary in their countries too, but because the prescriptions that would go into the classification were country specific, the title of Formula Pattern would remain in Chapter XXIII with each respective country working on its contents.

Meanwhile, the Traditional Medicine TAG completed almost all of the sections on traditional medicine disorders at a conference held in Hong Kong from May 2 to 5, 2012. Finally, the sections on traditional medicine disorders have 10 subsections with 207 codes, and the sections on traditional medicine patterns have 10 subsections with 239 codes.

Issues of terminology

An International Classification of Traditional Medicine (ICTM) conference convened in Shanghai in March 2012 to reach conclusion on the issue of terminology. The greatest challenge faced at this conference was the question of how to translate some of the traditional medicine disorders (“disorders” are used in traditional medicine to distinguish from “diseases” in Western medicine) like nue, or okori, in Japanese. Nue generally refers to malaria, but since its diagnosis does not require evidence of malaria parasites, the term, strictly speaking, is not limited to malaria. Therefore, an agreement was reached to translate nue as malaria-like disorder.

The conference had fewer problems with the terminology of traditional medicine patterns, as many of the concepts were unique to traditional medicine and disparate from Western medicine. Discussions focused on aligning terminologies with the existing WHO International Standard Terminologies on Traditional Medicine in the Western Pacific Region (IST) developed by the WHO Regional Office for the Western Pacific. The countries participating in the development of IST had been limited to Japan, China, Korea, and Pacific countries. It was decided to expand the range of countries participating in developing the ICTM terminology of the WHO headquarters and to have full discussion on the controversial terms. The conference also agreed to focus on the semantics of traditional medicine terms, rather than use traditional descriptions often
The Collaborating Centre for the WHO-FIC in Japan contained in IST, so that Western medicine practitioners would be able to understand the meaning of the terms.

Leading up to the face-to-face meeting where final decisions were made on terminology, managing editors and members of the Project Advisory Group (PAG) held numerous teleconferences to build consensus and solve most of the issues. The last remaining issue was the question of the terminology of the Six Stage Patterns, which consist of Taiyang disease, Yangming disease, Shaoyang disease, Taiyin disease, Shaoyin disease, and Jueyin disease, in pinyin, or Greater Yang disease, Yang Brightness disease, Lesser Yang disease, Greater Yin disease, Lesser Yin disease, and Reverting Yin disease, in IST. Discussions within the ICTM Terminology Working Group (WG) and at the ICTM conference adopted the terms Early Yang stage, Middle Yang stage, Late Yang stage, and so on, in accordance with Shang Han Lun, or the Treatise on Cold Damage Disorders. However, as there are still disagreements, final fine-tuning of terminology is needed.

[Assessment]

ICD is a basic classification for international health statistics, including mortality and morbidity statistics, with a history of use of more than 110 years since 1900, but its scope has until now been limited to Western medicine. However, with the widespread practice of traditional medicine around the world in recent years, the plan now is to incorporate traditional medicine in the next revised version of ICD. Towards that objective, the Collaborating Centre for the WHO-FIC in Japan has been collaborating with the Traditional Medicine TAG in the work of developing a traditional medicine classification. As a result, the ICD-11 beta version, now available to the public online, includes a traditional medicine classification (Traditional Medicine Module 1) as Chapter XXIII of ICD-11.

[Issues]

The planned review and field trial of ICTM should provide a clear profile of ICTM as a classification ensuring international comparability of data.

[Collaboration with WHO]

(a) Contributions to the ICTM Project

In 2012, Japan Society for Oriental Medicine contributed ¥20 million (approx. $200,500) to the ICTM Project. In 2013, Japan Society for Oriental Medicine and the Institute of Kampo Medicine contributed ¥20 million and ¥15 million (approx. $152,000),
respectively, to the project.

(b) Reporting to and exchanging information at the WHO-FIC Network Meeting

(c) Participated in the annual WHO-FIC Network Meeting in Brasilia, Brazil, from October 13 to 19, 2012, to ascertain the progress of the entire ICD revision process and to report on the progress of the Traditional Medicine TAG. Poster presentation by the Traditional Medicine TAG was awarded the Poster Award.

(d) Exchange of information at the Revision Steering Group (RSG) teleconferences

Professor Kenji Watanabe, of the Japanese Collaborating Centre, participates in the monthly teleconference of the RSG as the Co-Chair of the Traditional Medicine TAG, and reports on the progress of the traditional medicine classification within the ICD revision process.

[Collaboration with other WHO-FIC Collaborating Centres]

Participation in and exchange of information at WHO ICTM conferences

In March 2012, members of the Terminology WG and PAG held a conference in Shanghai. In May 2012, ICTM conference convened in Hong Kong. In September 2012, a conference on traditional medicine patterns was held in Tokyo. In June 2013, a Stakeholder Meeting was organized at the WHO headquarters in Geneva.

II. Traditional medicine information models for ICD revision and ICTM development

[Background]

Revision from the ICD-10 to ICD-11 involves three major changes: 1) An electronic version will be made available; 2) Terminology will be introduced; and 3) Information model will allow the use of the ontology engine. The inclusion of the information model, above all, is a significant change.

Stanford University led the development of the information model for Chapters I to XXII of ICD-11 using Protégé, ahead of the development of the ICTM information model. While the ICTM Project fell behind revision work in other chapters, the development of the ICTM information model also used the Protégé. The ICTM information model is different from the model in other chapters in that it provides for definitions in Japanese, Chinese, and Korean and phonetic transcriptions. It nonetheless allows viewing of the traditional medicine classification on the same ICD-11 beta browser on the web.

The development of the Kampo pattern classification must also be based on this information model.
[Implementation method and status]

Development of a terminology and an information model for Japanese Kampo classification

As in the development of the Kampo pattern classification, the Terminology and Classification Committee of the Japan Society for Oriental Medicine (JSOM), a member of the Japanese Collaborating Centre, led the development of a terminology and an information model for the Japanese Kampo pattern classification and their input into the iCAT.

Input into the iCAT

The Managing Editors played the main role in inputting the above information model into the iCAT.

[Results and implications]

Development of a terminology and an information model for Japanese Kampo classification

Based on JSOM’s existing glossary, we created definitions and an information model for the Kampo pattern classification and completed their input into the iCAT.

[Assessment]

The Kampo pattern classification was originally created in a post-coordinated fashion. As of August 2013, it is included in Chapter XXIII of the ICD-11 beta version using post-coordination together with our original definitions.

[Issues]

The responsibility for data input into the iCAT has now transferred from the managing editors to the WHO headquarters. The WHO headquarters is expected to make changes on the iCAT in communication with the reviewers.

[Collaboration with WHO]

See above.

[Collaboration with other WHO-FIC Collaborating Centres]

Japan, China, and Korea, together with the managing editors and members of the ICTM Project Advisory Group (PAG) communicated through teleconferences and by other means to make adjustments to the traditional medicine information model.
(3) Mortality TAG (M-TAG)

As a member of the M-TAG’s stability analysis group, the Japanese Collaborating Centre participated in a number of teleconferences and cooperated in the analysis. The Centre also cooperated in the work of the ICD-11 translation tool that WHO developed and is in the process of drawing up a Japanese-English correspondence list.

(4) Review process

After WHO set out a direction for the review process at the last WHO-FIC Network meeting in Brasilia, the Japanese Collaborating Centre has been making preparations for conducting the review.

(a) Recommendation of reviewers

With the cooperation of the Japanese Association of Medical Sciences, the Centre selected 42 experts in internal medicine and other specialties and recommended them to WHO as reviewers in June. The Centre is monitoring progress in the nomination of the reviewers in communication with the WHO Secretariat and the reviewers.

(b) Distribution of WHO video letter

Considering the need to brief the reviewers on the review process prior to the start of the process, the Centre made a request to WHO for a video letter containing specific aspects of the review process. After receiving the video letter in mid-July, the Centre distributed it to all reviewers in Japan to prepare for rapid and effective implementation of the review process.

(c) Preparation for a meeting of reviewers to report on the progress

The Centre is planning a meeting of reviewers from Japan in December 2013 when the first stage of the review is expected to come to a close. The participants will report the progress and results of their reviews.

The Centre is considering inviting all reviewers and TAG members from Japan to this meeting for the specific purpose of promoting information sharing and exchange among them.