WHO-FIC Network Activities Annual Meeting

The annual meeting of the World Health Organization Network for the Family of International Classifications (WHO-FIC) was held in Tunis, Tunisia from 29 October to 4 November 2006.

The meeting was attended by 112 international participants from 10 WHO Collaborating Centres and representatives from Ministries of Health or National Statistical Bureaus from 16 countries. Representing Australia were Penny Allbon and Catherine Sykes from the Australian Institute of Health and Welfare (AIHW), Ros Madden from the Australian Commission on Safety and Quality in Health Care and Richard Madden, Kerry Innes, Sue Walker, Julie Rust and Young Tjoa from the NCCH.

The work of the WHO-FIC Network is conducted through various committees and working groups. The final meeting report, reports from each committee and working group and all the papers for the meeting may be found at: *www.who.int/classifications/network/meeting2006/en/index.html.*

The following topic areas provide an overview and highlights of some of this work.

Information Paradox

The theme of the Tunis meeting was the Information Paradox: health information is generally weakest in countries with the greatest burden of disease. Several African representatives spoke eloquently about their health needs and the scant information available to measure the need. Advocacy is hard without good data!

The Health Metrics Network (HMN), funded by the Gates Foundation, is tackling this problem and their representative spoke about the potential for alternative measures, such as verbal autopsies, to provide usable data at limited cost. Network members were keen to assist in providing classification tools to assist this work. Dr Penny Allbon, the Australian Centre head took a particular interest in developing links between the WHO-FIC Network and the HMN.

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An Asia-Pacific Network was established at the meeting, with financial support from Japan. NCCH had sponsored the attendance of Jemesa Tudravu from Fiji as part of the launch of this Network. The Network will aim to assist in implementation of health classifications throughout the region.

Electronic Tools Committee (ETC)

The highlight of the ETC meeting was the adoption of Classification Markup Language (ClaML) as the standard for exchange of WHO-FIC classifications.

It was agreed to produce a simplified version of ClaML ("ClaML light") for countries to provide WHO with details of codes included in national modifications.

Moreover, the German Institute of Medical Documentation and Information (DIMDI) and WHO are developing a tool to manage ClaML and publication for WHO-FIC Classifications. The tool and its source codes will be freely available to WHO-FIC members. The prototype of the tool was demonstrated in the meeting. The Maintenance and Publication Tool will be distributed in beta version in 2007.

Terminology Reference Group (TRG)

The first meeting of the WHO-FIC Terminology Reference Group (TRG) was also held at the October 2006 WHO-FIC meeting in Tunisia. The establishment of this group is evidence of the importance placed on the relationship between the classifications of WHO-FIC and the emerging clinical terminology initiatives. The TRG's main objectives will be to:

1. promote awareness of the need to ensure and verify congruence between concepts in clinical terminologies and the categories available within the WHO-FIC products such as ICD and ICF, and

2. to collaborate with the research community, health care providers, software developers and health authorities through a broadly-based health terminology network.

The main efforts of this group in relation to how classifications and clinical terminologies complement each other will be in the area of mapping between these two modes of clinical language translation and to guide the evolution of WHO-FIC products (eg ICD-11) so that they take account of the content and formalisms used to construct and maintain clinical terminologies. The TRG will be chaired by Dr Martti Virtanen (Sweden) and Dr Marcelline Harris (USA) and will continue to expand its membership to recruit people from different regions. Kerry Innes, Associate Director NCCH, is a member of the TRG. The next meeting of the TRG will be held at the WHO-FIC meeting in Italy in October 2007.

Mortality Reference Group (MRG)

The Mortality Reference Group (MRG) held its traditional pre-meeting meeting on 26 and 27 October, in addition to the scheduled gathering during the WHO-FIC Network meeting week. The MRG confirmed Lars Age Johansson

(Sweden) and Donna Hoyert (USA) as co-chairs for the group for a further 12 month period and Donna also provides the Secretariat. The MRG is responsible for considering coding queries and recommendations for changes to the ICD-10 from the perspective of people who use the classification for mortality (causes of death) coding. ICD has its origins in coding for this purpose.

Issues for discussion by the MRG come from a variety of sources, but principally through the mortality forum, an e-mail discussion group, hosted by the Nordic Centre. Anyone can submit a mortality coding question to this forum (e-mail: *mortforum@nordclass.uu.se*) and receive responses from international coding colleagues. Over 100 coders from 50 countries are registered with the forum.

A database of queries that have been submitted and the ensuing discussions is available at *www.pubcare. uu.se/nordwho/verksam/mortforum/mortindex.htm* Issues that cannot be resolved or that generate controversy are referred for more formal consideration by the MRG.

Discussions at the 2006 meeting were wide-ranging, encompassing issues such as:

- the relevant external cause code for victims of tsunami
- how to select the underlying cause if a death is due to a succession of accidents
- rewriting of the instructions for the coding of deaths due to neoplasms
- consideration of new guidelines for the coding of direct and indirect maternal deaths
- testing of the decision tables which are part of the automated coding software Mortality Medical Data System (MMDS) and which assist with the correct interpretation of sequences reported on the death certificate and selection of the underlying cause of death
- assistance with the development of an exam for the WHO-FIC education committee
- development of a core curriculum for teaching certifiers of deaths about completing the WHO medical certificate of cause of death
- future use of the WHO perinatal death certificate
- coding of deaths due to suicide and self-inflicted injury
- deaths due to traditional medicine procedures.

Morbidity Reference Group (MbRG)

The Morbidity Reference Group (MbRG) convened for a full day meeting on 28 October, in addition to the scheduled session on 30 October during the WHO-FIC Network meeting. The main purpose of the MbRG is to develop clear and consistent guidelines on the use of ICD for morbidity coding.

Although the MbRG was only formally established during this meeting, a considerable number of complex issues pertaining to morbidity coding were discussed. As a result of this and later work during a 3 day meeting in Vancouver in March 2007, 10 recommendations for change have been submitted for consideration by the Update and Revision Committee (URC) for 2007.

These recommendations cover a wide range of topics, including:

- procedural complications
- acute myocardial infarction
- leukaemia and lymphoma
- definition of main condition
- definition of primary malignant neoplasm
- dagger and asterisk sequencing
- change of terminology and coding for septicaemia/sepsis/septic shock
- chronic kidney disease.

During the meeting, Richard Madden (Australia) and Olafr Steinum (Sweden) were confirmed as co-chairs and Julie Rust (Australia) as secretariat, for the group for a further 12 month period.

Update and Revision Committee (URC)

The Update and Revision Committee (URC) considered a number of proposals for the updating of ICD-10. Of these, 60 were accepted, 13 withdrawn or not supported, 11 held over for consideration in 2007, 7 were errata for the second edition of ICD-10, one was referred to MbRG and 4 were referred to the revision (ICD-11).

This was the first year that a web-based work platform, known as the ICD Revision Platform and hosted by WHO, was used to generate and manage recommendations for change. There were a few teething problems; however, overall, it has considerably streamlined what is a huge task of international commenting, editing and revising work proposals for ICD-10.

Education Committee

The Education Committee continued its work with the International Federation of Health Records Organizations relating to the development of a standard way of assessing the competence of ICD coders. In the previous 12 months following an advertisement process, ICD training materials had been submitted for assessment against the core curricula developed for morbidity and mortality coding, and educators had been provided with feedback relating to the comprehensiveness of their materials when compared with the required knowledge clusters.

Practicing underlying cause of death, coders are now being invited to complete a self assessment and to sit for an exam to test their knowledge and skills. The exam process is currently being trialled in Korea and Canada. In Tunis, the Education Committee discussed the future of this program for assessment of morbidity coders and multiple cause mortality coders and the process for the certification of new coders who complete a recognised training program taught by recognised educators. The intention of this program of work is to improve the quality of morbidity and mortality coding, particularly in countries where the clinical coding role is not well supported.

l-r Ginette Therriault, Lori Moskal, Gunnar Henriksson, Alison Lyons, Kerry Innes, Julie Rust, Olafr Steinum and Rosemary Roberts

Family Development

Two items are worthy of note. There was a lengthy discussion on interventions. The existing condensed classification based on ACHI (referred to as ICHI in the beta version trial) will be renamed the Condensed Classification of Interventions. It will remain available through the NCCH website for any user who seeks it.

It was agreed that some steps should be taken towards an International Classification of Interventions. This should be broad in scope so as to be usable across countries and health care settings. During 2007, a common structure or backbone for such a classification will be developed.

There is interest from China, Korea and Japan to develop an International Classification of Traditional Medicine. Rosemary Roberts had been engaged by WHO in Manila to facilitate this work. There was an interesting presentation and discussion in Tunis and the proposers were encouraged to continue their work and report further in 2007.

The next meeting of the WHO-FIC will be held in Trieste, Italy from October 28–3 November 2007.

Launch of ICD Revision Process

The revision process was launched at a press conference in Tokyo in April 2007. Immediately afterwards, the Revision Steering Group met for the first time. It is chaired by Professor Chris Chute of the Mayo Clinic. Chris is well known in Australia and was the lead speaker at the NCCH Conference in Sydney in 2001. NCCH Director Richard Madden is a member of the Group in his role as WHO-FIC Family Development Committee Chair.

The work on specific topics will be led by a number of Topic Advisory Groups. Professor James Harrison, Head of the AIHW National Injury Surveillance Unit, is chairing the Group on Injury and External Causes.

The revision process will be addressed by Dr Robert Jakob from WHO during the NCCH Conference in Brisbane in July 2007.

The 10-AM Commandments

Assignment of Body Surface Area (BSA) code for subsequent burns admissions

What is the appropriate BSA code to assign when a patient is readmitted for grafting, debridement or dressings of the most severe burn site, when the initial admission was for multiple burns, coded separately and with a total BSA code assigned? Should the BSA relate to the original admission or to the subsequent admission only?

The BSA should reflect the area being treated at the subsequent admission.

ACS 1911 *Burns* will be reviewed for a future edition to reflect this advice.

Chemotherapy procedure code extensions

When should procedure code extension -00 *Antineoplastic agent* be assigned?

In ACHI Fourth Edition block [1920] *Administration of Pharmacotherapy* was created. The procedure codes in this block are based on route of administration of pharmacological agents and the extension codes classify broad drug categories. Excludes notes are listed for the following code extensions when used in the treatment of neoplasm and/or neoplasm related conditions:

-02 *Anti-infective agent*

-03 *Steroid*

-04 *Gamma globulin*

In these instances coders are directed to assign the extension of -00 *Antineoplastic agent*.

For example, if a patient is admitted for same day administration of an anti-infective agent, steroid or gamma globulin for the treatment of a neoplasm or neoplasm related condition, extension code -00 *Antineoplastic agent* should be assigned.

Extension -00 *Antineoplastic agent* should not be assigned for conditions that are not neoplasm or neoplasm related conditions, e.g. rheumatoid arthritis, multiple sclerosis. If a 'chemotherapy' agent is administered for conditions such as these and the agent is not classifiable to any other specified extension listed in [1920] or [1921], extension code -09 *Other and unspecified pharmacological agent* should be assigned.

Dental Cleaning

Does the code for dental cleaning 97111-00 [453] *Removal of plaque or stain* need to be assigned for each individual tooth cleaned?

The NCCH advises that 97111-00 [453] *Removal of plaque or stain* should only be assigned once. The code title for 97111-00 [453] *Removal of plaque or stain* will be reviewed for a future edition of ACHI.

Diabetic Foot Ulcer

When a patient meets the criteria for diabetes with foot ulcer, as outlined in ACS 0401 *Diabetes mellitus and impaired glucose regulation, Diabetic Foot* and they have an ulcer (as opposed to an infection) does the code for ulcer L97 *Ulcer of lower limb, not elsewhere classified* need to be assigned in addition to E1-.73 *Diabetes mellitus with foot ulcer due to multiple causes*?

The addition of L97 *Ulcer of lower limb, not elsewhere classified* does NOT need to be assigned in addition to E1-.73 *Diabetes mellitus with foot ulcer due to multiple causes* as the detail pertaining to the ulcer is already captured in the code title.

However, if the ulcer is classified to a different code, such as I70.23 *Atherosclerosis of arteries of extremities with ulceration* or L89.2 *Decubitus [Pressure] Ulcer, Stage III* or L89.3 *Decubitus [Presuure] Ulcer, Stage IV*, which provides greater specificity, these codes should be assigned in addition to E1-.73 *Diabetes mellitus with foot ulcer due to multiple causes* to fully describe the clinical diagnosis. ACS 0401 *Diabetes mellitus and impaired glucose regulation* states:

In addition to the impaired glucose regulation and diabetes code(s) from E09–E14, assign codes from other chapters when necessary, to fully describe the clinical diagnosis. These additional codes should be sequenced **after** the E09–E14 code(s).

Dysdiadochokinesia

Dysdiadochokinesia is the clinical term for an inability to perform rapidly alternating movements. It is a feature of cerebellar ataxia and is the result of lesions to the posterior lobe of the cerebellum. Dysdiadochokinesia is usually caused by multiple sclerosis in adults and cerebellar tumours in children.

If this condition meets the criteria outlined in either ACS 0001 *Principal Diagnosis* or ACS 0002 *Additional Diagnoses,* assign R27.8 *Other and unspecified lack of coordination*. Symptoms may be coded as per point f) of ACS 1802 *Signs and Symptoms* which states:

Although symptoms are generally not coded when a more definitive diagnosis exists, there are cases where symptoms should be coded….

> *f) certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right.*

The NCCH will consider indexing this condition for a future edition of ICD-10-AM.

Entropion/Ectropion Repair

Is there a default code for entropion/ectropion repair, unspecified?

There is no default code in the ACHI Alphabetic Index for repair of entropion or ectropion and clinical advice confirms that it is not appropriate to have one.

Procedure codes for repair of ectropion or entropion are listed in block [239] and include:

- cauterisation
- tightening or shortening of inferior retractors
- suture technique
- wedge resection.

Coders should be guided by the documentation in the operation report as to the type of repair and clarify with the clinician if in doubt.

External Cause of Injury Code for capsicum spray administered by Police

What is the correct external cause code assignment for capsicum spray administered by Police?

Oleoresin capsicum (OC) is an extract of pepper plants of the genus Capsicum. It is the principal active ingredient in capsicum spray and one of its other uses is as a pharmacological agent in anaesthetic and analgesic creams. An aerosol is used to disperse the liquid form of the OC extract into gas.

The correct code to assign, therefore, is Y35.2 *Legal intervention involving gas* (with an appropriate place of occurrence code.)

Nasogastric Intubation/Feeding

Nasogastric intubation refers to the process of placing a soft plastic nasogastric (NG) tube through a patient's nostril, past the pharynx and down the oesophagus into the stomach.

The most common purpose for inserting a nasogastric tube is to deliver tube feeding to a patient when they are unable to eat. This is also known as enteral infusion or gastric gavage. Patients who may need a NG tube for feeding include: premature babies, patients in a coma, patients who have had neck or facial surgery, patients on mechanical ventilation, or severe anorexic patients for stabilisation of body weight. For continuous feeding, a gravity based system is employed, with the solution placed higher than the patient's stomach.

Another purpose for inserting a nasogastric tube is to remove substances from the stomach, also known as nasogastric aspiration or suction. NG tubes are used to empty the stomach when poisoning or drug overdose has occurred or to remove air that accumulates in the

stomach. It is also used to remove stomach contents after major trauma or surgery to prevent aspiration of the stomach contents. Placing a NG tube helps prevent nausea and vomiting by removing stomach contents and preventing distention of the stomach when a patient has a bleeding ulcer, bowel obstruction or gastrointestinal diseases.

If the tube is to be used for continuous drainage, it is usually attached to a collector bag placed below the level of the stomach so that gravity empties the stomach contents. It can also be attached to a suction system, although this is more often restricted to emergency situations, as the constant suction can easily damage the stomach lining.

Assign 96202-07 [1920] *Enteral administration of pharmacological agent, nutritional substance,* for nasogastric feeding in neonates, following specific guidelines in ACS 1615 *Specific interventions for the sick neonate, enteral infusion*.

However, ACS 0042 *Procedures normally not coded* advises that nasogastric intubation should not be coded. Specific advice to not code nasogastric aspiration or feeding, other than in neonates, will be included in a future edition of the ACS.

Female Pelvic Adhesions

Why are female pelvic adhesions classified to N73.6 *Female pelvic peritoneal adhesions* under the major category N73 *Other female pelvic inflammatory diseases*?

Pelvic adhesions are classified to category N73.6 *Female pelvic peritoneal adhesions* under the major category N73 *Other female pelvic inflammatory diseases* by the World Health Organization (WHO). Typically chronic pelvic inflammatory disease results in scarring or

'adhesions', where the healing tissues become attached to neighbouring structures within the pelvis. Please note, however, that there is an exclusion note at N73.6 for *postprocedural pelvic peritoneal adhesions (N99.4)*.

Timeframe for Meniscal/Ligament Tears of Knee

Could the NCCH please consider the institution of a timeframe for meniscal/ligament tears of knee, which defines "old" and "current"?

The NCCH has researched this issue, including how injury timeframes are dealt with in other classifications. Unfortunately it is impossible to be definitive in this regard. Each case should be reviewed on its merits and coders should ultimately be guided by documentation and seek clarification from the clinician.

To publish timeframes for old and current is extremely difficult due to differences in treatment protocols for these injuries. Some patients with meniscal tears are treated conservatively while others are treated with surgical repair. Some may initially be treated conservatively but then require surgical repair at a later date.

Coders should be guided by the definitions in ACS 1906 *Current and Old Injuries*. If it still cannot be determined whether the injury is acute or not, then follow ACS 1319 M*eniscus/Ligament Tear of Knee, NOS* and assume the injury is old.

Tobacco Dependence

Where a patient is documented as a 'smoker trying to quit' or where the use of 'Nicorette' (or similar nicotine replacement product) is documented, is it appropriate to allocate the code for tobacco dependence?

The code for tobacco dependence should **not** be used for patients documented as 'trying to quit' or where the use of 'Nicorette' (or similar nicotine replacement product) is documented. ACS 0503 *Drug, Alcohol and Tobacco Use Disorders* is currently under review for a future edition of ACS.

Treatment using CellSpray®

What procedure codes should be assigned for the treatment of burns, injuries or skin defects using CellSpray®?

CellSpray® is produced from epidermal cells harvested from a thin split skin biopsy taken from a patient who requires skin grafting. The cells are stimulated to multiply, formulated as a suspension and applied to the patient via an aerosol delivery system. The spray-on system can be used in areas of the body where traditional grafting is normally difficult. It provides rapid epidermal cover, promotes healing and optimises scar quality. As the suspension is based on the body's own cells, the risks of rejection are minimised.

In addition to treating burns, CellSpray® is used in the treatment of tissue injuries and other large skin defects.

When CellSpray® is used to treat burns, assign a code from block [1643] *Split skin graft to burn of specific sites* or block [1644] *Split skin graft to burn of other sites* as appropriate.

When CellSpray® is used to treat other injuries or conditions, assign a code from block [1645] *Other split skin graft, small* or block [1646] *Other split skin graft, extensive* as appropriate.

Bibliography

Parliament of Australia, Parliamentary Library, Capsicum Spray – The Record to Date. Accessed 23 April 2007 http://www.aph.gov.au/Library/pubs/m/2001-02/02m19.htm

Clinical Cell Culture, C3, CellSpray. Accessed 20 April 2007 http://www.clinicalcellculture.com/one/02_02_cellspray.asp

Enotes.com, Nursing, Nasogastric Intubation and Feeding. Accessed 23 April 2007 http://health.enotes.com/nursing-encyclopedia/nasogastric-intubation-feeding

How Stuff Works, It's good to know, Virginia Tech. Accessed 23 April 2007 http://science.howstuffworks.com/question340.htm

National Horizon Scanning Centre, New and Emerging Technology Briefing, CellSpray for skin burns, July 2002, The University of Birmingham. Accessed 23 April 2007 http://www.pcpoh.bham.ac.uk/publichealth/horizon/PDF_files/2002reports/CellSpray.pdf

The Precise Neurological Exam, Coordination, Gait and Romberg Test, New York University School of Medicine. Accessed 23 April 2007 http://edinfo.med.nyu.edu/courseware/neurosurgery/coordination.html

Wikipedia, Dysdiadochokinesia. Accessed 23 April 2007 http://en.wikipedia.org/wiki/Dysdiadochokinesia

Wikipedia, Nasogastric intubation. Accessed 23 April 2007 http://en.wikipedia.org/wiki/Nasogastric intubation

New ICD-10-AM/ACHI/ACS

Online Public Submission Process

Over the last six months, the NCCH has been actively reviewing the public submission process. As a result, the NCCH is in the final stages of development of an online public submission platform. It is our intention to incorporate the online submission of proposals for ICD-10-AM/ACHI/ACS Seventh Edition from early 2008. Coding Standards Advisory Committee (CSAC) members and the Victorian Coding Committee (VICC) will be involved in the pilot of the platform in the latter half of 2007.

Previously, the public submission time frame was limited to a three month period during a two year cycle. However, from early 2008, the NCCH will be accepting public submissions for changes to ICD-10-AM/ACHI/ACS all year round for Seventh Edition. This will enable the States to work on submission documents as classification issues are identified and then submit them online, via the NCCH website.

The NCCH is excited by the introduction of the online public submission system, particularly as the open period will allow the preparation of submissions by the States to now occur as classification issues arise.

The NCCH is hopeful that the combination of the all year round, online public submission process will make a real difference to both the States and the update process the NCCH undertakes. In addition, the NCCH is undertaking a review of the entire classification update process with a view of making improvements for Seventh Edition.

NCCH will keep readers informed of progress over the coming months via *Coding Matters* and the NCCH website, so stay tuned!

Clinical update

Parkinson's disease

Parkinson's disease is a degenerative neurological condition that affects movement. It is the second most common degenerative neurological condition after Alzheimer's disease. Although the disease symptoms have long been known, it wasn't until 1817 that Scottish physician James Parkinson published a description of the condition in *An Essay on the Shaking Palsy*.

In Australia, Parkinson's disease affects over 300,000 people. It affects men and women equally and is more common in people over the age of 50, though it can occur in younger people. About one in 10 of those diagnosed are under 40 years of age. High profile celebrities affected by the disease, including Michael J. Fox, Muhammad Ali and the late Pope John Paul II have recently raised awareness of the disease.

Symptoms

The main symptoms of Parkinson's disease are abnormalities of movement, such as tremor and muscular rigidity. The symptoms are the result of the progressive degeneration of nerve cells in the middle area of the brain.

The specialised areas responsible for coordinating body movements are the basal ganglia, the substantia nigra and the cerebellum. They connect with each other and other areas of the brain via nerve pathways using a neurotransmitter (messenger chemical) called dopamine. Dopamine is produced in the substantia nigra. These nerve pathways help to make the body's muscular movements smooth and regular. In Parkinson's disease, the substantia nigra becomes severely depleted of dopamine and the pathways become disrupted.

Parkinson's disease is characterised by four major features:

- Tremor is an involuntary rhythmic shaking in an extremity (like a hand, arm or leg), or in the face. A Parkinson's tremor is worst at rest and gets better when the extremity is moved; it often disappears during sleep. In the hand, the thumb may move back and forth against the other fingers – Parkinson called this motion 'pill rolling'.

- Bradykinesia is the term for slowness of movement. People with bradykinesia appear to freeze. They have trouble initiating movements and they are slow in changing position. Their voice also sounds monotonous, and they have a fixed, staring, unblinking mask-like expression. They stoop, and have a shuffling gait when they walk.

- Muscles, especially in the arms, shoulders and neck, become stiff, rigid, and resistant to being passively moved. They may move in a series of ratchet-like steps that is known as 'cogwheel rigidity'.
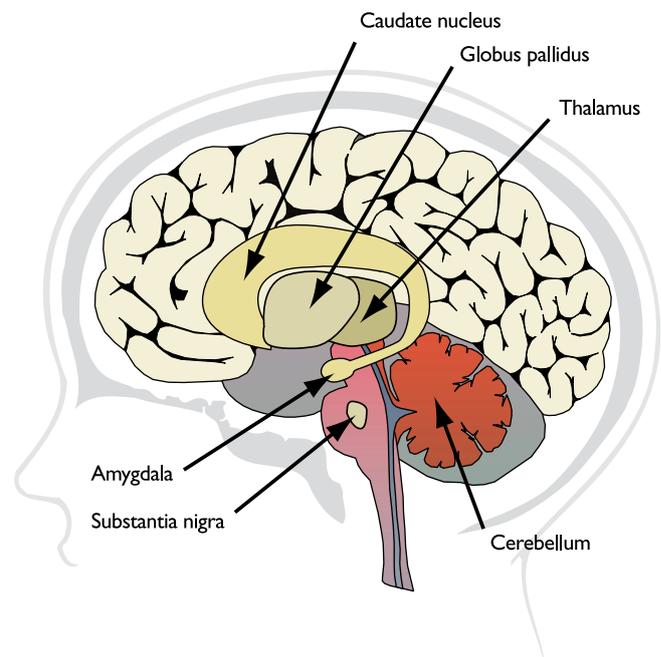
Structures in the brain related to Parkinson's disease. Basal ganglia are responsible for normal movement and walking; the substantia nigra produces the neurotransmitter dopamine, and the globus pallidus affects movement, balance and walking. The thalamus is a relay station for brain impulses and the cerebellum affects muscle coordination.

- Impaired balance or postural instability that may lead to falls.

The symptoms of Parkinson's disease tend to get worse over time – very slowly in some people, quite quickly in others. Not surprisingly, depression is common especially in the advanced stages and about one person in three with Parkinson's disease will experience dementia. The condition progresses until the person is unable to look after him or herself.

It is not known exactly what causes Parkinson's disease. Among the suspected causes are external toxins or chemicals, head trauma and possibly genetic factors. Parkinson's disease is more common in those who have a relative with the disease, so in some people at least, there is a genetic susceptibility.

Some brain diseases, like stroke, Lewy body disease, brain tumour and meningitis, damage the same brain pathways that are affected in Parkinson's disease. This can produce a very similar sort of condition – called 'parkinsonism' to distinguish it from the disease proper. Some prescribed medications can also cause parkinsonism as a side effect.

Treatment

There is presently no cure for Parkinson's disease, but as the disease progresses, it is usually treated with drugs. Several different drugs are available. They all work in much the same way – by boosting the depleted levels of dopamine in the basal ganglia.

The best known drug is Levodopa, also called L-dopa. When it was introduced in the 1960s, it was a revolution in the treatment of Parkinson's disease. It crosses easily from the bloodstream into the brain tissue, where it is broken down to become dopamine. The symptoms of tremor and rigidity disappeared overnight.

Unfortunately, the effect of the drug wears off in patients after three to five years. Dosage must then be progressively increased to get the same therapeutic effect. Side effects, mostly abnormal involuntary muscle movements called dyskinesias also become increasingly severe and may even be worse than the disease itself. Clinicians may hold off giving L-dopa treatment in the early stages of Parkinson's disease, reserving it for when symptoms become more serious. A combination of drugs and dosages may be required as the disease progresses.

In severe cases, surgery is also an option. Surgical techniques involve drilling a hole into the area where the basal ganglia are located and either introducing a brain-stimulating electrode, or destroying brain tissue with high-frequency radio waves.

Physiotherapy can improve coordination, balance and movement. Occupational therapy can enhance independence in daily living and speech therapy can help speech and swallowing.

Although, Parkinson's disease is not a fatal disease by itself, life expectancy is generally lower than that of those without the disease. The progression of the symptoms can take over twenty years or more. Appropriate treatment can provide some degree of relief from the symptoms.

Research is underway in a number of countries to determine the causes of Parkinson's disease and interventions that can delay, prevent or reverse the disease.

Bibliography

Kumar, P and Clark, M (2002), Clinical Medicine, Fifth Ed, W.B. Saunders, Sydney

http://www.abc.net.au/health/library/ff_parkinsons.htm

http://www.betterhealth.vic.gov.au/BHCV2/bhcarticles.nsf/pages/Parkinson's_disease_explained?OpenDocument

http://www.parkinsons.org.au/aboutparkinson.php

http://www.ninds.nih.gov/disorders/deep_brain_stimulation/deep_brain_stimulation.htm

http://www.ninds.nih.gov/disorders/parkinsons_disease/parkinsons_disease.htm

http://familydoctor.org/187.xml

http://en.wikipedia.org/wiki/Parkinson's_disease

ICD-10-AM/ACHI/ACS

Fifth Edition Coding Workshops
for 2007

ICD-10-AM/ACHI/ACS Fifth Edition
Coding Workshops
2007

The NCCH will be presenting the first of the continuing education coding workshops at the NCCH Conference in July 2007. As always, places are limited for the pre-conference workshop. Therefore, the NCCH will also run a series of national workshops for those coders who are unable to attend the NCCH pre-conference workshop.

This year's workshops will be presented by two of the NCCH's experienced coding education staff and will feature case scenarios and clinical records that will be distributed to participants for completion prior to attending the event. At each workshop there will be opportunity to discuss the answers with general coding tips and pointers being provided.

Register now!

The main focus of this year's continuing education workshops will be coding cases related to **diabetes,** based on feedback received from state and territory coding authorities. Other topics will include:

- chronic kidney disease
- trauma
- plastics
- obstetrics.

The NCCH will travel to all parts of the country to deliver the national continuing education workshops. The dates and locations are listed in the adjacent textbox and are subject to change but the NCCH will endeavour to keep to this timeline if possible.

Registration for national workshops will be $195 (including GST). All participants will receive a 100+ page workbook with 12 case scenarios and 6 clinical records, to be completed prior to attending. An answer book will be provided on the day (useful for referencing when back at work) plus lunch, with tea and coffee being available throughout the day.

These workshops will be delivered by two of the NCCH's experienced coding education staff with extensive knowledge of the development of the ICD-10-AM classification. Workshop participants will have the opportunity to discuss coding related issues with the experienced NCCH staff during the workshop and breaks.

Participants will need to bring their own copies of ICD-10-AM/ACHI/ACS Fifth Edition in hard copy or the eBook on laptop to the workshops.

Please complete the ICD-10-AM/ACHI/ACS Fifth Edition coding workshop registration form and send to:

National Centre for Classification in Health
PO Box 170
LIDCOMBE NSW 1825
or fax 02 9351 9722

The form can also be completed and sent online from
http://www.ncch.com.au

The proposed workshop dates and locations* are:

NEW SOUTH WALES
29 August	Bankstown
30 August	North Ryde
11 September	Newcastle
13 September	Coffs Harbour
13 September	Albury
25 September	Dubbo
27 September	Tamworth

NORTHERN TERRITORY
4 September	Darwin

QUEENSLAND
4 September	Rockhampton
5 September	Brisbane
6 September	Brisbane
6 September	Cairns

TASMANIA
11 September	Launceston

SOUTH AUSTRALIA
18 September	Adelaide
19 September	Adelaide

WESTERN AUSTRALIA
18 September	Perth
19 September	Perth

AUSTRALIAN CAPTITAL TERRITORY
21 September	Canberra

VICTORIA
1 October	Melbourne
2 October	Melbourne
3 October	Melbourne
4 October	Bendigo

*subject to change

Registration form

ICD-10-AM/ACHI/ACS Fifth Edition Coding workshops 2007

This registration form can be used as a Tax Invoice. Please keep a copy. The University of Sydney ABN 15 211 513 464. To avoid disappointment register as soon as possible to secure a place.

Registration Details

Please print clearly. Business hours contact details only please. One registration per form only. Please copy the form for multiple registrations.

Name

Position/Title

Department

Hospital/Organisation

Address

State   Postcode

Telephone   Mobile phone

Fax   e-mail

❑   Purchase order

Please check this box if a purchase order number is required for payment of invoices within your organization. Failure to check this box will result in an invoice raised by NCCH without a matching purchase order. If your order is duplicated due to YOU failing to inform NCCH of purchase order number requirements, YOU will be charged TWICE for this transaction. An administration fee may also be charged for any duplicated transactions.

Cost **$195.00** (including GST)

Workshops will be filled on a first come basis. Cancellations received with more than 10 working days notice before a workshop will be refunded, less an administration fee of $50. No refunds are available for cancellations received within 10 working days of a workshop.

Workshop Location

First preference   Date

Second preference   Date

Books or eBook?

You are required to bring your own copy of ICD-10-AM/ACHI/ACS Fifth Edition.
For seating and power allocation planning purposes, please indicate if you will be using
❑ ICD-10-AM/ACHI/ACS Fifth Edition book set **OR** ❑ ICD-10-AM/ACHI/ACS Fifth Edition eBook

Catering

Please list any special dietary needs:

Payment

Cheques and money orders are payable to: The University of Sydney – NCCH

Credit Card   ❑ VISA ❑ Mastercard   Amount $ _____

Card number ▢▢▢▢ ▢▢▢▢ ▢▢▢▢ ▢▢▢▢   Expiry date ▢▢/▢▢

Cardholder's name   Signature

Direct Debit

Payment can be made directly into the NCCH bank account by direct electronics funds transfer (EFT)

Bank Details for EFT are:

Bank: National Australia Bank
Account name: The University of Sydney NCCH Account
BSB: 082 369
Account Number: 54 372 4531

Please e-mail **fhsNCCHadmin@usyd.edu.au** to confirm that you have paid by direct EFT

Post or fax your registration to:

National Centre for Classification in Health
The University of Sydney
PO Box 170
LIDCOMBE NSW 1825 Australia
Fax: 02 9351 9**722**
Faxed on (date) ___ / ___ / ___

For further information from NCCH
phone **02 9351 9461**
or e-mail **fhsNCCHadmin@usyd.edu.au**

NCCH Profile:

Who's who in NCCH Classification Support and Development?

Classification Support and Development (CSD) division is the engine room of the NCCH. CSD is primarily responsible for development and maintenance of the content of the health classifications ICD-10-AM and ACHI and the Australian Coding Standards. CSD is located in the NCCH Sydney office at the University of Sydney.

The major activities undertaken by CSD include:

- the production of biennial editions of ICD-10-AM, ACHI and ACS
- researching and writing responses to coding queries
- the development of subsets from the ICD-10-AM/ ACHI classifications
- managing public submissions for changes to the classifications
- incorporating changes made to ICD-10 by WHO into ICD-10-AM
- writing articles for the NCCH newsletter *Coding Matters.*

CSD also provides education for clinical coders and health classification users throughout Australia and internationally. Workshops are conducted to introduce clinical coders to new editions of ICD-10-AM/ACHI/ACS prior to their implementation.

The staff of CSD bring a broad range of skill, knowledge and experience to NCCH. Their backgrounds include health information management, medical record administration, medicine and nursing. This article will introduce some of the new staff and reacquaint you with our old stagers* by briefly detailing their qualifications, experience and current projects.

* *The Macquarie dictionary describes an old stager as "a person of experience in some profession, way of life, etc.; an old hand".*

Karyn Chen

BAppSc (Health Information Management), Registered nurse
Project Officer

Karyn trained as a nurse in the mid-1980s and then worked for a number of years in the banking and education industries and as a medical receptionist. After completing her HIM degree, Karyn began working full time at NCCH in 2002.

Since joining NCCH, Karyn has coordinated the queries database and public submissions. She has written a number of articles for *Coding Matters* (including 10-AM Commandments). She has also completed many

l-r Kerry Innes, Megan Cumerlato, Julie Rust, Marla Tun and Vera Dimitropoulos

addenda proposals for ICD-10-AM/ACHI/ACS Fourth, Fifth and Sixth Editions; acted as minutes secretary for Coding Standards and Advisory Committee (CSAC); presented new edition and post implementation education workshops; updated the mapping ICD-10 to ICD-10-AM; and maintained the NCCH task database. Karyn also works casually as a coder at a public hospital and private hospital in Sydney.

Marg Cook

Certificate of Medical Record Librarianship
Project Officer

Marg has worked part-time at the NCCH since March 2006 on addenda proposals for ICD10-AM/ACHI/ACS Sixth Edition, in particular, the new definition of chronic kidney disease and its incorporation into classification practice. Marg also assists with education presentations for updates to the classification and participates in query meetings.

Marg's many years of work experience include coding and managerial positions in teaching hospitals, on-site tutor for student practical placements at several teaching hospitals and more recently as a HIM consultant in private hospitals and day surgeries. Currently she is continuing her private sector involvement with a special interest in rehabilitation.

Megan Cumerlato

BAppSc (Health Information Management)
Education Coordinator

Megan coordinates the education functions of the NCCH. She presents ICD-10-AM/ACHI/ACS educational material at workshops and seminars in Australia and internationally. Megan is currently finalising changes to ICD-10-AM/ACHI/ACS Sixth Edition, in particular changes relating to the classification of external cause of injuries. She is also preparing material for the workshops for the NCCH conference and later in the year.

Megan continues to code at a major teaching hospital on a regular basis to keep abreast of classification issues in the hospital setting. She is a casual lecturer for the University of Sydney, Faculty of Health Sciences in the Discipline of Health Information Management. Megan also lectures in the offshore program in Singapore for the Bachelor of Health Sciences program.

Vera Dimitropoulos

BAppSc (Medical Record Administration)
Classification Support Manager

Vera commenced in her role as Classification Support Manager in February 2007. She is responsible for the management of ICD-10-AM/ACHI/ACS content development. She has also been working on classification development for congenital anomalies in conjunction with the National Perinatal Statistics Unit (NPSU). Vera will also assist in the development and delivery of coding workshops and seminars for the NCCH.

Until recently, Vera worked with the Health Information Management Association of Australia (HIMAA) as Distance Education Lecturer for the Advanced Coding Course. At HIMAA, she was involved in the development of the national clinical coder certification exam and national coder competencies. She also developed and delivered HIMAA coding workshops both interstate and overseas. Prior to HIMAA, Vera was a lecturer in Clinical Classification and Health Information Systems at the University of Sydney. Her research has mainly been in clinical classification and the coder workforce.

Anne Elsworthy

Associate Dip (Medical Record Administration)
Project Officer

Anne previously worked as a Medical Record Manager and Patient and Information Services Manager in the NSW public health system. Anne commenced work at the NCCH in April 2006, although she has worked previously at the NCCH on two occasions, on the initial development of ACHI in 1995 and on the ICD-10-AM/ACHI/ACS Chronicle in 2004.

Anne coordinates responses to coding queries and other general queries about coding and classification. She also prepares material for 10-AM Commandments published
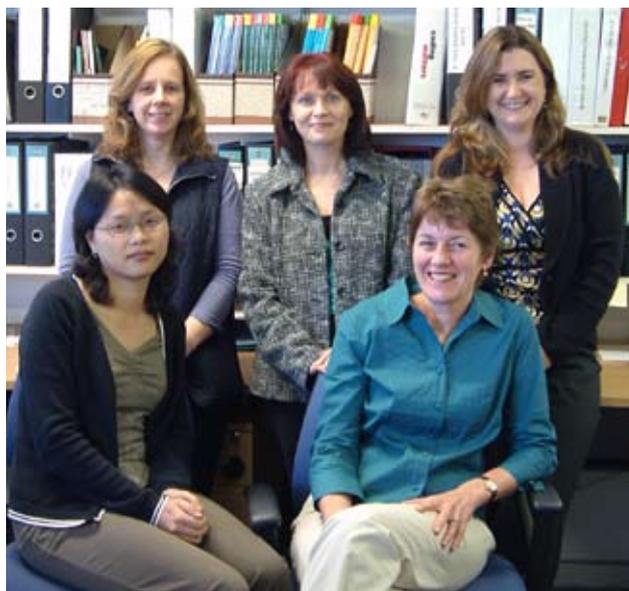
l-r Yan Guo, Bronwyn Graham, Karyn Chen, Marg Cook and Anne Elsworthy

in *Coding Matters* and assists in delivery of educational material. Anne also codes on a part-time basis at a major teaching hospital.

Anne is currently working on queries, queries and more queries!

Yan Guo

BMed, M (Health Information Management)
Project Officer

Yan has worked as a clinical coder in a number of teaching hospitals in Australia and New Zealand including Auckland and Royal North Shore Hospital over the last 5 years. More recently she was data manager in the NHMRC Clinical Trials Centre. Before immigrating to Australia, Yan was a physician in China specialising in the field of internal medicine.

Currently, Yan is working on ICD-10-AM/ACHI/ACS Sixth Edition and Chronicle, finalising addenda proposals, particularly in the area related to obstetrics and endoscopic procedures.

Kerry Innes

Associate Dip (Medical Record Administration)
Associate Director

Kerry has worked for NCCH since its establishment in 1994 and was instrumental in its creation. Previously, Kerry managed clinical record departments in various hospitals in Sydney and Perth as well as training clinical coders for NSW Health. Improving the classification of adverse events in health care is one of her key interests.

Current projects include emergency department termset development; review of the Australian Classification of Health Interventions (ACHI); development of the mental health intervention codes for ACHI Sixth Edition; advisor

to a project looking at coding illnesses in detention centres; advising a project to improve the impairment categories for the Australian Rehabilitation Outcomes Centre data collection; and involvement in the WHO development of ICD-11.

Julie Rust

BAppSc (Health Information Management)
Project Officer

Prior to joining the NCCH, Julie held senior positions in the public hospital system and worked as a consultant to private hospitals and day surgery centres.

Julie is a member of the WHO-FIC Update and Revision Committee and Secretary of the Morbidity Reference Group. This work involves providing recommendations for changes in the update of ICD-10 and revision programs for the development of ICD-11. She also works with the Australian Council on Healthcare Standards in the development of clinical indicators, specifically their relationship with ICD-10-AM and ACHI codes and the Australian Coding Standards.

Other work at NCCH includes assisting with the delivery of educational material at national workshops, participation in the coding query process, preparation of specific areas in the development of ICD-10-AM and assisting with general enquiries about coding and classification. She is currently preparing a submission of proposals to the Update and Revision Committee (WHO-FIC) for changes to ICD-10 and recommendations for ICD-11.

Lwin Marla Tun

BMed, BSurgery, M (Health Information Management)
Project Officer

Marla is responsible for updating ICD-10-AM/ACHI Sixth Edition changes in ICD-10-AM/ACHI database and production of the Electronic Code Lists and Mapping tables and writing addenda proposals for ICD-10-AM/ACHI/ACS Sixth Edition.

Marla has worked in various Sydney hospitals as a clinical coder since 1997. Her roles have included Deputy Coding and Casemix Manager at Westmead Hospital and acting Clinical Information Analyst at the Performance Monitoring and Reporting Unit, Sydney West Area Health Service prior to NCCH. Marla's research thesis for her masters degree 'Catastrophic patient clinical complexity level DRGs in same day admissions' was based on a re-coding study conducted at Westmead Hospital.

Marla is currently working on the ICD-10-AM/ACHI database enhancement project and addenda proposals on MBS updates. Marla also continues coding at Westmead Private Hospital to 'keep in touch' with the real world of coding.

CSD's latest recruits

Bronwyn Graham

GradDip (Health Information Management), Registered Nurse
Classification Support Officer

Bronwyn has worked as a Registered Nurse within a number of teaching hospitals in NSW. Since completing her HIM qualification she has worked as a Clinical Coder, Assistant Coding Manager and Coding Manager with the NSW Public Health System. Bronwyn also continues to code on a regular basis in a major teaching hospital to keep up-to-date with classification issues in the hospital setting.

Belinda Saad

BAppSc (Health Information Management), Cert IV (Assessment and Workplace Training)
Classification Support Officer

Belinda has worked in various roles in a number of teaching hospitals throughout Sydney. She worked for HIMAA as a trainer for both the Introductory and Intermediate Coding Courses conducted via distance education. She has also conducted training in relation to ICD-10-AM, ACHI and ACS in Australia and overseas including New Zealand, Fiji, Tonga, Romania and Japan.

Belinda and Bronwyn are the NCCH's newest recruits and will prepare content for the health classifications and assist the Classification Support Manager.

Bi-regional Workshop

on Injury Surveillance

In December 2006, Debbie Scott (NCCH Brisbane's new Research Fellow, joining Kirsten McKenzie on the research team) attended the WHO Western Pacific/South East Asia workshop on Injury Surveillance held in Chiang Mai, Thailand. Debbie accompanied James Harrison from the National Injury Surveillance Unit, one of the major contributors to the ICD-10-AM external causes chapter. The objective of the workshop was to facilitate national capacity in developing injury surveillance in member countries. Representatives from 19 countries attended and shared their knowledge, expertise and experiences in injury surveillance with each other.

There were presentations from nine countries describing the surveillance systems used and the role injury plays in national morbidity and mortality. In every country represented at the workshop, injury was a leading cause of morbidity and mortality, particularly in developing nations and in childhood populations. Data sources ranged from emergency department collections, hospital separations data and deaths data through to community surveys. Some countries had national collection systems that collected data on all injuries in all age groups, others had those that focussed specifically on an injury type (motor vehicle crashes) or specific age group (like children).

The challenges encountered seemed to be across the board, regardless of borders or cultures. These included commitment from policy makers, allocation of scarce resources (human and monetary) and an understanding of the importance of the data collection from those tasked to work on the collections. All countries presented a poster presentation of their surveillance systems. Cambodia was voted to have made the best presentation (though in defence of the Australian contingent, James Harrison's suitcase containing all the presentation material managed to go astray and was not located until the night before we flew home again!).

Discussions on day 2 centred on how to overcome problems in establishing and maintaining injury surveillance systems. Examples of papers included Margie Peden, Coordinator Unintentional Injury Prevention for WHO, discussing a global overview of the concept, design and establishment of Injury Surveillance, and Chamaiparn Santikarn talking about the use of ICD-10 as the coding system for injury surveillance. The day finished in small group discussions, with individual countries speaking to experts about their specific needs and problems.

One of the highlights of the workshop was a tour of Lampang hospital, where Thailand has its leading injury surveillance system up and running. Participants were able to tour the hospital and see how the injury surveillance system was working throughout the hospital.

Presentations on this day covered practical applications of injury surveillance data and the policy and system changes that are possible by using this data. Debbie presented a paper discussing the use of injury surveillance data in Australia, as an evidence base for public awareness campaigns and changes in policy and legislation.

Injury surveillance data provide a description of the magnitude of the problem and the populations most at risk. Examples of these initiatives include pool fencing, safety campaigns for toddler driveway run-overs, introduction of a design standard for bunk beds and the scheduling of dishwasher powders (and restriction of the availability of highly alkaline products for domestic use) and review of the performance standard for child resistant closures. The paper described the utility of injury surveillance data and the process whereby use of this data and the establishment of partnerships was able to make sustainable changes that will reduce injuries to Australian children. A wonderful traditional dinner complete with Thai dancers and floating paper lanterns capped the day off beautifully.

Workshop attendees outside Lampang hospital

On the last day, the participating countries discussed the impact of injury on their childhood populations and strategies for use of the injury surveillance data to attempt to reduce these injuries. Final thoughts to conclude the workshop were that injury surveillance works as a tool for prevention and control of injury. However, it requires appropriate data collection, standardised coding, analysis and dissemination. Injury surveillance is useful as a tool to inform policy development and raise public awareness. Finally, participants agreed that the workshop had been a success as it had allowed those involved in this valuable area of public health research to benefit from the experience and knowledge of others trying to achieve the same outcomes.

NCCH Profile:

Who's who in NCCH Brisbane?

The Brisbane office of the NCCH started from humble beginnings with a part-time director and a Health Information Manager in 1992. At that time, the Centre was known as the National Reference Centre for Classification in Health and was funded by the Australian Institute of Health and Welfare (AIHW) as a collaborating unit.

Since that time, the Centre has grown in fits and starts. In 1997, the Brisbane and Sydney offices united as the National Centre for Classification in Health through an agreement between the host universities, The University of Sydney and the Queensland University of Technology (QUT). AIHW and the Australian Bureau of Statistics (ABS) now fund the Brisbane office, as does the Department of Health and Ageing (DoHA) under a subcontract agreement with NCCH in Sydney. Other funds are obtained through contract and consultancy work.

The Centre has seven staff and also has a PhD student working on an Australian Postgraduate Award Industry (APAI) scholarship. Brisbane staff have qualifications in health information management, psychology, medicine, health informatics, public health, business and nursing. Two of our staff are currently enrolled in postgraduate studies. The office is located at the Kelvin Grove campus within QUT's School of Public Health. The Centre also has a secondment agreement with the Queensland Trauma Registry.

NCCH Brisbane today has three main avenues of work. These are:

- classification and coding, in particular provision of support for coders who use the WHO version of the ICD-10. This work includes development and conduct of training courses (mainly in developing countries) and providing expert advice to organisations such as the ABS and AIHW, and other researchers who are using ICD-coded data;
- research, specifically relating to the utility and quality of coded data;
- terminologies, related to the use of SNOMED-CT for health data collections.

Margaret Campbell

BBus (Health Information Management), Registered Nurse, PostGradBSc (Nursing)
Project Officer – Clinical Terminologies

Margaret has an extensive nursing background working in acute medical and surgical units, theatre, orthopaedic and rehabilitation units, and community and remote nursing services. Prior to joining NCCH in 2002, Margaret held roles in Health Information Management as a Medical Records Supervisor/Clinical Coder and has worked as a Coding Auditor/Consultant.

Since joining NCCH, Margaret has worked on secondment to the ABS where she developed the ICD-10/MMDS Chronicle, drafted the Mortality National Minimum Data Set, developed and ran quality coding audits and medical terminology training. In her role as Senior Classification Officer at NCCH Brisbane, Margaret participated in the 'Clinical Termer' research and development project and ICD-10 Mortality Coding Workshops.

Currently Margaret is working on a number of Clinical Terminology research and development projects for the Department of Health and Ageing, Australian Patient Safety Council and others.

Linping (Lyn) Chen

BMed, M (Public Health)
Research Assistant

Lyn provides support in preparing for research projects; this includes literature searches, reviews, retrieval of relevant articles from library and electronic databases, data analysis, writing reports and publications.

Lyn's background is in medicine and public health. Previously, Lyn provided research support at QUT and University of Queensland. This included collecting survey data, setting up databases and spreadsheet management, multivariate statistical data analysis and writing articles for publication and grant proposals.

Madonna Kemp

M (Health Informatics), BSc (Health Information Management), GradDip (Health Administration and Information Systems Management)
Project Officer – Clinical Terminologies

Madonna's work experience for Mount Isa Health Services District in Queensland included the roles of clinical coder and acting manager of information services, coordinator of palliative care services and assistant to the Director of Emergency. She has also managed a medical practice.

During her time with NCCH, she has been involved in various projects including data value development for National E-Health Transition Authority (NEHTA); data elements for Allergies and Alerts; and work with the Australian Patient Safety Foundation in the development of a data model for the International Patient Safety Event Classification. She is currently a member of the SNOMED International Mapping Working Group.

Madonna's role in the NCCH encompasses clinical terminology research and development, mapping heuristics and tools development, Emergency Department taxonomy and data model development.

l-r Margaret Campbell, Madonna Kemp, Kirsten McKenzie, Sue Walker, Garry Waller, Lyn Chen, Debbie Scott and Emma Enraght-Moony

Kirsten McKenzie

PhD, BSocSc (Hons) (Psych)
Research Fellow

Kirsten's responsibilities include research project management, writing grant proposals and postgraduate student supervision.

Kirsten is conducting research on health information systems particularly focusing on health classifications and terminologies pertaining to injury information. Kirsten has previously worked on research into injury data systems, trauma data linkage and injury classifications and terminologies for the past three years.

Kirsten's current projects include an Australian Research Council (ARC) funded grant – 'Developing and enhancing the quality of injury-related hospital morbidity data'; collaborating with the Department of Child Safety, Queensland Health and Abused Child Trust to examine the quality and concordance of child abuse information in emergency department and hospital records; and with Queensland Trauma Registry examining survival outcomes of trauma patients and concordance of trauma registry records and death certificates.

Emma Enraght-Moony

PostGrad BSc (Hons) (Psych), BSc (Psych)
PhD Candidate

Emma is conducting research relating to the quality of clinical documentation and coding of external causes of injury. Funding for her position is through a three-year scholarship awarded by the ARC's Linkage Grant funding scheme. The culmination of the research is the submission of a Doctoral Thesis.

Emma has research experience in prehospital/emergency medical services field, and worked as a Research Officer for Queensland Ambulance Service.

Emma's thesis research forms a component of the ARC Linkage Grant project 'Developing and enhancing the quality of injury-related hospital morbidity data', being conducted by Dr Kirsten McKenzie. Her study is specifically investigating the quality of ambulance documentation regarding external cause of injury information, and quantifying the contribution of this information source to the clinical coding process of the in-hospital patient data collection.

Debbie Scott

Certificate of Nursing (original registration in Alberta, Canada), M (Public Health), professional doctoral candidate
Research Fellow

Debbie was formerly an emergency and paediatric nurse at the Alberta Children's Hospital in Canada and a research assistant at the Mater Children's Hospital in Brisbane. Research projects with the Mater included investigating childhood acute lymphocytic leukaemia in Queensland children; a national case-control study on Ewing's Sarcoma; and investigating injury outcomes and validating the Functional Capacity Index.

Debbie has also worked as a data coder and research assistant at Queensland Trauma Registry; as a project manager for a longitudinal study investigating links between childhood injury and socio-economic status; and as manager of the Queensland Injury Surveillance Unit (QISU).

Debbie's focus is project management and writing research grant proposals. Her projects include improving the documentation and surveillance of child abuse in Queensland; development of a trauma plan for Queensland; formation of a bi-national trauma registry for Australia and New Zealand; and investigating the feasibility of changing the coding system at Queensland Injury Surveillance Unit (QISU) from National Data Standards for Injury Surveillance (NDS-IS) to International Classification of External Causes of Injury (ICECI).

Sue Walker

MHlthSc, GradDip (Public Health), BAppSc (MRA), current candidate for Doctor of Health Science
Associate Director

Sue is responsible for the management of staff and functions of NCCH Brisbane office including financial management, contract management, classification expertise (in particular relating to mortality coding) and coder education.

Sue has worked at NCCH since 1994. Her previous experience includes stints at St Margaret's Hospital in Sydney and Holy Spirit Hospital in Brisbane; data manager at the Queensland Cancer Registry; and policy officer for Queensland Health Epidemiology and Health Information Branch (now part of Data Services Unit).

Currently, Sue is conducting edit checks for the ABS's mortality processing system. Sue will also conduct the ICD-10 training course for international students in Brisbane in June-July and Federated States of Micronesia in July-August. She is planning for supervision of two WHO Fellows from Mongolia on a four week placement and participating in Brisbane research activities (external causes, child abuse, trauma tracking, suicide coding and mortality data).

Sue is current co-Chair of WHO Family of International Classifications and International Federation of Health Records Organizations Joint Collaboration for training and certification of coders; member of QUT School of Public Health Executive Committee; mentor for final year HIM students; and has just finished seeking contributions as guest editor for an upcoming HIM Journal edition relating to mortality data.

Garry Waller

BBus (HIM)
Senior Classification Officer

Garry is responsible for the development and delivery of education on ICD-10 mortality and morbidity coding, secretariat of Australasian Mortality Data Interest Group (AMDIG) and other project work.

Prior to working at NCCH, Garry has worked in an amazing variety of roles he claims were all interesting. He also has extensive experience as a clinical coder and Health Information Manager in various locations around Australia.

Garry's current projects include Phase 3 of an ARC Project – 'Identifying the quality of cause of injury information using routinely collected hospital morbidity data'; medical record review of 'External Cause of Injury' ICD-10-AM Third Edition codes in Queensland, New South Wales, Victorian and South Australian hospital medical records relevant to specific admissions for treatment of injury; and upgrading ICD-10 Education Materials.

Coding Matters Index

Volume 13 Numbers 1 to 4, June 2006 – March 2007

Visit the NCCH website for a complete index of all issues – www3.fhs.usyd.edu.au/ncchwww/site/7.6.htm#ind

10th NCCH Conference
25–27 July 2007, Brisbane, Queensland

The **NCCH** is pleased to invite you to the **NCCH** conference in Brisbane, Queensland, 25–27 July 2007.
Visit the **NCCH** website for more information as it becomes available: www.fhs.usyd.edu.au/ncch/

Conference program

The conference will cover areas such as:

- Clinical Terminologies
- ICD and WHO
- Improving coded data
- What's new in coding
- Classification and patient safety
- Coding at the coalface
- Clinical updates

Optional workshop

Places in the conference workshop are now full.

Registration

Register online: **www.fhs.usyd.edu.au/ncch**

Registration forms and conference program will be mailed to all *Coding Matters* subscribers and available on the NCCH website.

Social program

The social program will provide an opportunity to meet and mix with colleagues from throughout Australia and overseas. We're looking forward to seeing you there!

Further information

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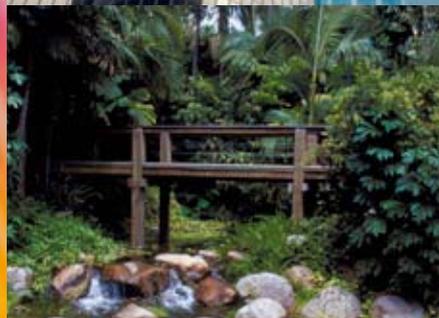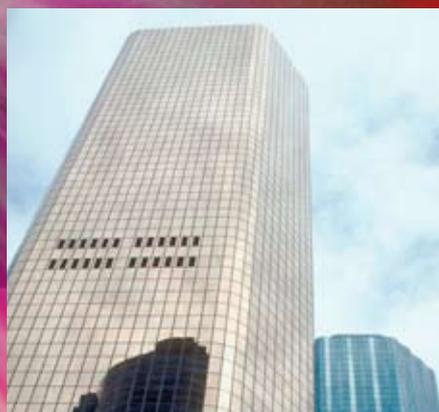
NCCH prize for clinical coding

The NCCH prize for clinical coding is awarded annually to outstanding graduate students who have completed health information management and clinical coding courses.

Recipients of the 2006 NCCH prize for clinical coding are:

Willy Chan – The University of Sydney

Meryl Harris – La Trobe University

Nicole Parkes – Open Training and Education Network – Distance Education

Natalie Rhook – Health Information Management Association of Australia Ltd

Gemma Van Fleet – Queensland University of Technology

Sharon Wiseman – Curtin University

Joint Queensland Trauma Registry (QTR)/NCCH award – **Judith Brennan** from Townsville Hospital

The NCCH congratulates the award winners and wishes them success in their careers.

l-r Mary Lou Flemming, Gemma Van Fleet and Sue Walker

Natalie Rhook

Willy Chan

Sharon Wiseman

Tea time

The recent Biggest Morning Tea sponsored by The Cancer Council prompted some research into the humble cup of tea (www.biggestmorningtea.com.au/). Apparently tea, black or green, is brimming with heart-healthy benefits.

Compounds in green and black teas have a healthful impact on several markers of heart disease risk, but debate continues as to which kind of tea is healthiest. Recent research suggests it may be a dead heat. In a study, green and black tea appeared equally protective against fatty arterial plaque buildup.

Black, oolong, and green teas are made from leaves of the *Camellia sinensis* plant. The difference between green and black tea is the level of oxidation the tea leaves experience during processing. The longer tea leaves experience oxidation, the darker they become. Research suggests oxidation levels probably have little influence over the amount of heart-healthy flavonoids different teas contain, although there may be some variation. A recent animal study suggests both green and black tea may produce similar improvements in blood vessel health. According to the researchers, the average 68kg person would have to drink 2–3 cups of green or black tea daily to get heart-health benefits similar to those achieved in the animal study.

With or without milk

Milk can do your body good, but maybe not when it's in your tea.

Women in a study who drank black tea had improved cardiovascular function – but that protection vanished if they drank it with milk. Temper the taste of your black tea with lemon instead. Or sip it as the Chinese traditionally do: straight up. Why does milk blunt tea's effects?

Researchers are not sure why milk may blunt tea's heart-healthy effects, but milk proteins called caseins are possible culprits. Tea is bursting with health-boosting polyphenols, but proteins have been shown to counteract them. In one study, when researchers added a small amount (10 percent) of milk to black tea, it reduced the tea's concentration of catechins – polyphenols credited with giving tea its antioxidant punch as well as fighting heart disease and boosting weight loss. The study results may help explain, in part, why tea's heart benefits appear to be missing in the United Kingdom, where milk is usually added to the brew.

It's not a done deal, however. Other studies have concluded that milk has no effect on tea's antioxidant powers. But the conflicting study results may simply be due to the way the scientists measured the good stuff in tea.

In this study, researchers measured the effects of tea – with and without milk – on blood vessels in the cardiovascular system. Straight black tea helped blood vessels relax and widen, allowing blood to flow more freely. Tea with milk did not produce the same effect.

Stressed?

Have a cup of tea. A further study on the effects of tea found some interesting results. A group of men were tested with two beverage choices, the men who drank a beverage that was rigged to mimic black tea's constituents recovered more quickly from stress than the group sipping a beverage missing the black tea ingredients. The credit may go to black tea's healthful polyphenols, flavonoids, and amino acids. Whatever the reason, it's a good pick-me-up when the pressure's on.

It's not just the higher caffeine content that makes black tea such a good stress fighter; both beverages tested had the same amount of caffeine.

And although all the men had a similar response to stress – their blood pressures and heart rates increased – the drinkers of black tea recovered more quickly. Within an hour of the stressful event, biological measures of stress, such as assessments of platelet activation and levels of the stress hormone cortisol, were lower in the men who drank the real stuff compared to those who drank the faux tea. The drinkers of black tea even felt more relaxed during the 50-minute stress-recovery time.

The benefits of drinking tea, in moderation, appear to be numerous with few disadvantages. Just think, the next tea break you take may be more beneficial than you imagine. See George Orwell's rules for brewing the perfect cup of tea at: http://www.netcharles.com/orwell/essays/nicecupoftea.htm

www.realage.com

CONFERENCES 2007

Jun 28-29	Clinical Pathways: sharing the lessons learnt	Melbourne, VIC	www.changechampions.com.au
July 18-20	7th National Allied Health Conference	Hobart, TAS	www.cdesign.com.au/nahc2007/
July 25-27	10th NCCH Conference	Brisbane, QLD	www.fhs.usyd.edu.au/ncch/
Aug 1-2	5th Annual Biotechnology Summit	Sydney, NSW	www.acevents.com.au/bio2007/
Aug 1-3	ACHSE National Congress	Melbourne, VIC	www.achse.org.au
Aug 6-8	5th Australasian Conference on Safety and Quality in Health Care	Brisbane, QLD	www.sapmea.asn.au/sqhc2007/
Aug 16-17	WCPI 2007: First World Congress on Pathology Informatics	Brisbane, QLD	www.wcpi07.org/
Aug 17-19	8th International Mental Health Conference	Gold Coast, QLD	www.gcimh.com.au/conference/
Aug 20-24	Medinfo 2007 - 12th World Congress on Health (Medical) Informatics	Brisbane, QLD	www.medinfo2007.org
Aug 28-30	Third International Conference on Information Technology in Health Care: Sociotechnical Approaches	Sydney, NSW	www.ithc2007.org
Sept 23-26	38th Public Health Association of Australia Annual Conference	Alice Springs, NT	www.phaa.net.au/
Sept 30-Oct 3	24th Conference of The International Society for Quality in Health Care	Boston, USA	www.isqua.org
Oct 4-7	50th Annual Scientific Convention	Sydney, NSW	www.racgp.org.au/asc2007
Oct 6-11	AHIMA Annual Convention and Exhibit	Philadelphia, USA	www.ahima.org/meetings/
Oct 8-10	HIMAA National Conference	Auckland, NZ	www.himaa.org.au
Oct 22-25	The World of Health IT 2007	Vienna, Austria	http://cfp.worldofhealthit.org/
Oct 25-26	WHO Conference on Children Health, Disability and ICF-CY	Venice, Italy	www.who.int/classifications/network/conferenceICFCY/en/index.html
Oct 28-Nov 3	2007 Annual meeting of the WHO Network of Collaborating Centres for the Family of International Classifications	Trieste, Italy	www.who.int/classifications/network/meeting2007/en/
Nov 7-11	23rd PCS/I International Working Conference	Venice, Italy	www.pcsi2007.org/
Nov 10-14	AMIA 2007 Annual Symposium	Chicago, USA	www.amia.org/meetings
Nov 21-23	Australian Association of Gerontology 40th National Conference Beyond 2007, Ageing: Evolution and Revolution	Adelaide, SA	www.aagconference.com
Dec 2-5	5th Health Services & Policy Research Conference 2007	Auckland, NZ	www.healthservicesconference.com.au
Dec 6	Australia's Welfare Conference 2007	Canberra, ACT	www.aihw.gov.au
May 20-23 2008	HIMSS AsiaPac08	Honk Kong	www.himssasiapac.org

Conference information is also published at the NCCH website http://www3.fhs.usyd.edu.au/ncch/2.4.htm

CHIK SERVICES
AUSTRALIA'S HEALTH ICT INFORMATION HUB

Informed | Independent | Not-for-Profit

CHIK Services Pty Ltd (CHIK) www.chik.com.au is a privately owned not-for-profit company established to provide global communication and specialist research services bridging the Health, Information and Communication Technology (ICT) sectors.

Uniquely positioned as an informed, independent hub within the Health ICT sector, CHIK leverages its established skills, industry knowledge, resources and infrastructure to foster and promote the capability of Australian-based companies within Australia and overseas.

Much of CHIK's strength lies in its independence, its knowledge and its extensive relationships and broad network of contacts that span the public and private sector within Australia and abroad.

In delivering services, CHIK regularly communicates with over 12,000 companies, institutions and individuals within Australia and overseas. Included within this group are representatives from Australian and State/Territory Government agencies covering Health, ICT and Industry Development, public and private hospitals, community and aged care providers, leading industry suppliers and associations, many SMEs, plus academics and researchers.

Soon after its establishment, CHIK convened an Advisory Panel to consider strategic and philosophical "big picture" issues relevant to the delivery of health services and to identify practical methods by which the health ICT industry can assist in achieving key healthcare delivery goals. Members attend in their own right, not as representatives of their respective organisations, and play no part in commercial or managerial aspects of CHIK Services.

CHIK has recently attained Endorsed Government Supplier status and is included on the Government Communication Unit's register of consultants.

Health ICT services and projects undertaken by CHIK include:

✚ **Publishing Health ICT News - a fortnightly electronic newsletter**

✚ **Publishing the Health-e-Directory - an online and in print listing of Australian eHealth product and service providers (www.health-e-directory.com.au)**

✚ **Carrying out Commissioned and Independent Research**

✚ **Hosting the Annual Health-e-Nation Conference (www.health-e-nation.com.au)**

✚ **Coordinating delegations to international Health ICT conferences**

✚ **Co-hosting annual HIMSS AsiaPac conferences & exhibitions (20-23 May 2008, Hong Kong - www.himssasiapac.org)**

CHIK is an Australian company with increasing international activities. Further information about all of CHIK's activities is available ✚ **www.chik.com.au**

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CHIK Services

A Window on the World of Health ICT