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Wonca
World family doctors Caring for people
EUROPE

ICPC-3 consortium

Why changing the ICPC-2?

- Use case is primary care, general practice and first contact care

- ICPC is used by general practitioners
- ICPC is used in emergency care/para-medics
- ICPC is used by nurses in Brazil
- ICPC is used by practice assistants and nurses in the Netherlands
- ICPC is used national insurance companies

Basic principles for developing a primary care classification

How do we use the information from primary care to improve individual patient and population health?

How do we develop ICPC-3 to address the challenges the care for people with comorbidities?

How do we truly adopt patient-centeredness into the ICPC-3?

The leading principles for the selection of the classes are

- The rational for additions to ICPC-3 will still be: frequency and evidence based.
- Relevant Regional Extensions on content within ICPC-3 to suit National Primary Care needs.
- Covering every kind of contact in Primary and Community Care for all disciplines involved.
- Familiar will be the simplicity of the new ICPC-3, no excessive and theoretical subclasses or terms like most classifications and clinical terminologies.
- Residual classes only for ‘other’ specified.
- The content of ICPC-3 will be 'linked' to relevant classifications, such as ICD-10, ICD-11, ICF, ICHI, *DSM-V (?),* clinical terminologies such as Snomed-CT, but also to previous versions of ICPC-1 , ICPC2.7 and to the SDG's (United Nations' Sustainable Development Goals) where possible and relevant.

Why changing the code structure?

- Lack of coding space
- Regional needs for specific codes
- More emphasis on prevention
- More emphasis on functioning

In the new ICPC-3, see Browser

+- 710 classes in the core ICPC

242 Symptom/complaint/abnormal finding classes, 365 Disease classes, 103 classes in new chapter Z and chapter V functioning

Top Extensions, regional classes
Africa 31, South America 22, Europe 401

Extension classes (scale value, temporality, gender etc) 23 classes

How did we develop the ICPC-3, the steps

Review the present content of the ICPC-2.7 from an International and National perspective WICC as **think tank** providing information, ideas and advice.

International by the Consortium Core group and the WICC Taskforce A group (WICC).
Input form Taskforce A is through membership of the ICPC-3 Consortium Taskforce.

National: First the Country members of the Consortiun Taskforce are reviewing the ICPC-2.7 on content that is of relevance, and is not present or cannot be registered as a separate entity for the Countries own needs.

All results of the reviews in the ICPC-2 comment site and structured within the ICPC-3 Content model in the Classification Manager (ClaM)

Severity of illness and functional status

Information about severity of illness and functional status assessment of the patient may be recorded in association with use of ICPC, and means of classifying these are therefore included in this book. The Duke/WONCA Severity of Illness Checklist (DUSOI/WONCA) can be related to ICPC rubrics and may be applied to individual health problems, as well as being summed to indicate the severity of the patient's combined health problems (Chapter 7). The COOP/WONCA functional status assessment charts apply to the patient independent of his/her health problems, and are explained in Chapter 8.

THE ICPC-3 CONTENT MODEL - September 2019 -

Any Rubric/Category in ICPC is represented by:

Descriptive characteristics

1. **TITLE of Entity: Name of rubric**
   a. Textual description, concise an detailed
   b. Short title - Inclusion – Exclusion - Index terms/synonyms – Coding hint - Note
2. **Type of Entity**
   a. Organ System
      - Symptoms, complaints and abnormal findings
      - Diagnosis and Health Problems
   b. Interventions (patient related) and Processes (administrative)
   c. Factors influencing health status (Z-chapter)
      - Environment
      - Reasons for contact (non-illness related)
   d. Functioning
      - Functions, Activity and Participation
   e. Functioning related factors
      - Personal factors, Environmental factors)
3. **Extensions**
   a. Duration, course, age of occurrence,
   b. Severity and/or – existing severity scales- ICF scale, stages

Maintenance attributes

A. Unique identifier

B. Attributes (subset, adaptation, and special view flag)
1. Categories – in disease component (congenital, infectious, neoplasm, injury, life-style, risk factor, other, unknown)
2. Categories – in environment component – context and contactReason)
3. Country adaptation
4. Research
5. Special indices (e.g. Primary Health Care Indicators, Public Health Care Indicators, Emergency and First aid or Resource Groupings, Case-mix)

C. Hierarchical relationships
Parents and children in the ICPC structure:
Chapter
Component
Class

D. Reference relationships
References to classes as in ICPC-1, ICPC-2, ICD-10, ICD-11, ICF, ICHI, SDG's, and terms as in Snomed-CT etc.

E. Other rules

ICPC-3 consortium

Use case classes for epidemiology

The classes at international level, the core ICPC, can be used for international comparison

The regional extension wit regional codes at the level of the inclusions are meant for regional comparison

Description

A characterization (information about) of the class needed to understand the scope of the class.

Inclusion

All the diseases/problems/findings/processes that are important for PC but do not reach the International frequency cut off. We advise to have the clinical important subclasses at national level in the inclusions. The goal is to inform the GP what is in the class.

Exclusion

Exclusions are classes, which serve the purpose of guiding the user to the correct class in the classification. E.g. in case someone expects that '**hyperventilation'** is a kind of '**shortness of breath'** and is classified in **RS02 Shortness of breath/dyspnoea**, will find **hyperventilation** as an **exclusion term** with a **reference code** in **RS02**, referring to **RS04 Breathing problem, other specified**.

Coding hint

A suggestion to consider another class

Index terms

Index Terms are listed primarily as a **guide to the content of the category**, in addition to, or to illustrate the complete definition. The Index Terms list is selected from the preferred term, the inclusion terms and the terms from ICD-10, ICD-11, ICF, ICHI, and Snomed-CT. The lists of inclusion terms are by no means exhaustive. There we will have the synonyms, laymen terms.

References to former ICPC (1 and 2v7) and ICD10-11, ICF, ICHI

The references in ICPC-3 to the ICD-11 are based on the ICPC-2 –ICD-10 conversion (but not always the same)

The selection of ICF references are twofold:
the first reference is to the Functioning part of the ICPC-3, containing a set of 52 ICF items from the validated Primary Care Functioning Scale (PCFS)

the second reference is to the ICF itself. As part of the effort to harmonize terminology within the ICPC-3, the exact terms from ICF are used where the reference is selected

ICHI References (waiting for the process group)

SNOMED CT References

The selection for Snomed–CT references is based on:
The existing cross references from SNOMED to ICPC-2 developed and agreed in a collaboration between Snomed International and WONCA International Classification Committee.

The frequency of the used search terms/concepts of the Dutch thesaurus with linkages between ICPC-2 and ICD-10.

Frequency of the search terms/concepts of the Belgium thesaurus with linkages between ICPC-2 and ICD-10.

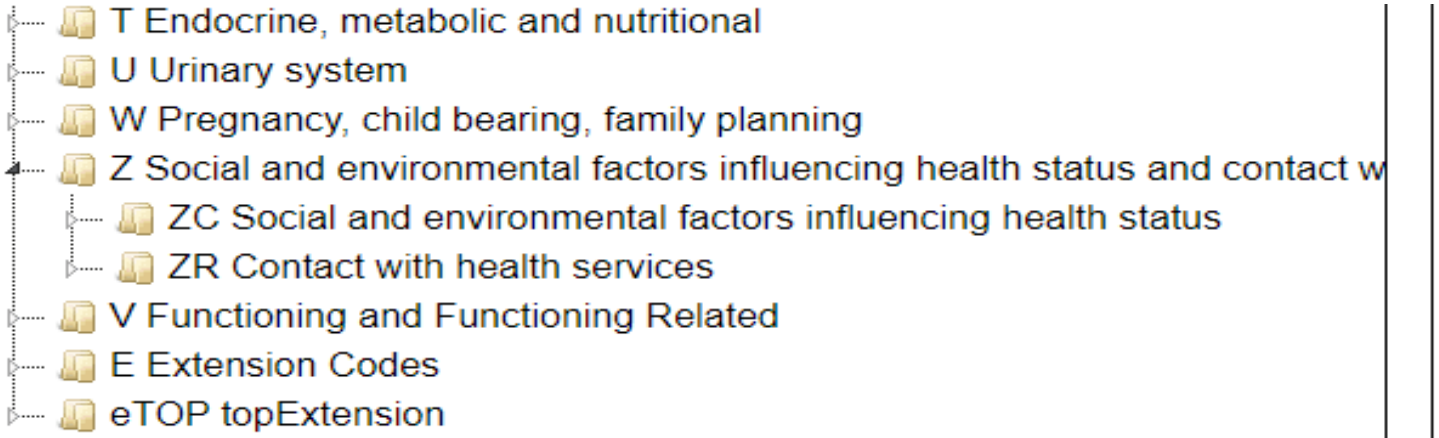
The ‘exactness’ of terms is represented in the order of the references to Snomed-CT.

Prevention and risk factors related to a RFE or episode of care in Chapter Z (1)

Although prevention has been part of the process codes, there are only two codes that can be used as an episode of care:
‘ – A98 Prevention’, and ‘A97 No disease’,

Which means that one of the building blocks of Primary Care cannot be recorded in more detail than that. Only combining the A98 and A97 with ICD-10 Z-codes, (by using the ICPC-ICD Thesaurus) on reasons for contact with the health care system, shows the array of reasons for encounter that take place in Primary Care practices and the large role prevention plays in PC.

Prevention and risk factors related to a RFE or episode of care in Chapter Z (2)



Description ZR Contact with health services

In some cases a patient has a contact the provider cannot interpret as a complaint or diagnosis within the other chapters of ICPC-3.

This contact is related to the complete life circle such as first contact, prevention, screening and case finding, certification, family planning and final stage of life contact

Prevention and risk factors related to a RFE or episode of care in Chapter Z (3)

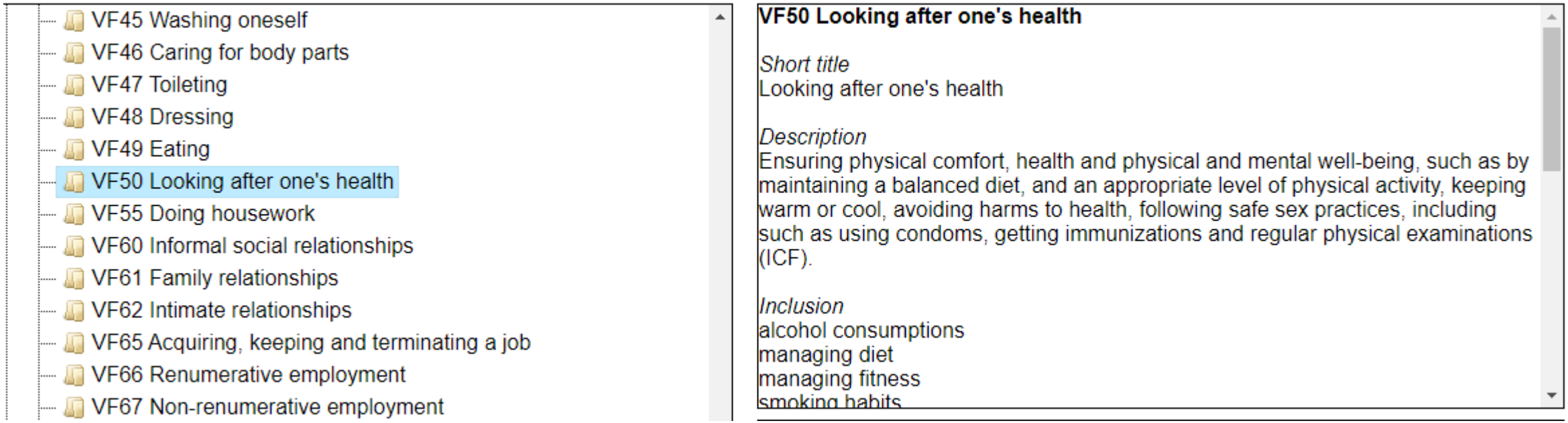
The classes in this part of the chapter previously classified in
A97, no disease,
A98 health maintenance/preventive medicine,
A21 Risk factor for malignancy (personal, family),
A23 Risk factor NOS (personal, family),
A20 Euthanasia request/definition,
Family planning: W10, W11, W12, W14, W13.

All those classes do not relate to complaint or diagnosis and that is why we propose to have them in this chapter

Risk factors

Label classes as a risk factor using the extension chapter of the new ICPC-3, the class causality.

To register risk factors without having it registered as an episode or RFE, the functioning class VF50 looking after one's health can be used with which alcohol consumptions, managing diet, managing fitness, smoking habits, mental well-being can be registered.

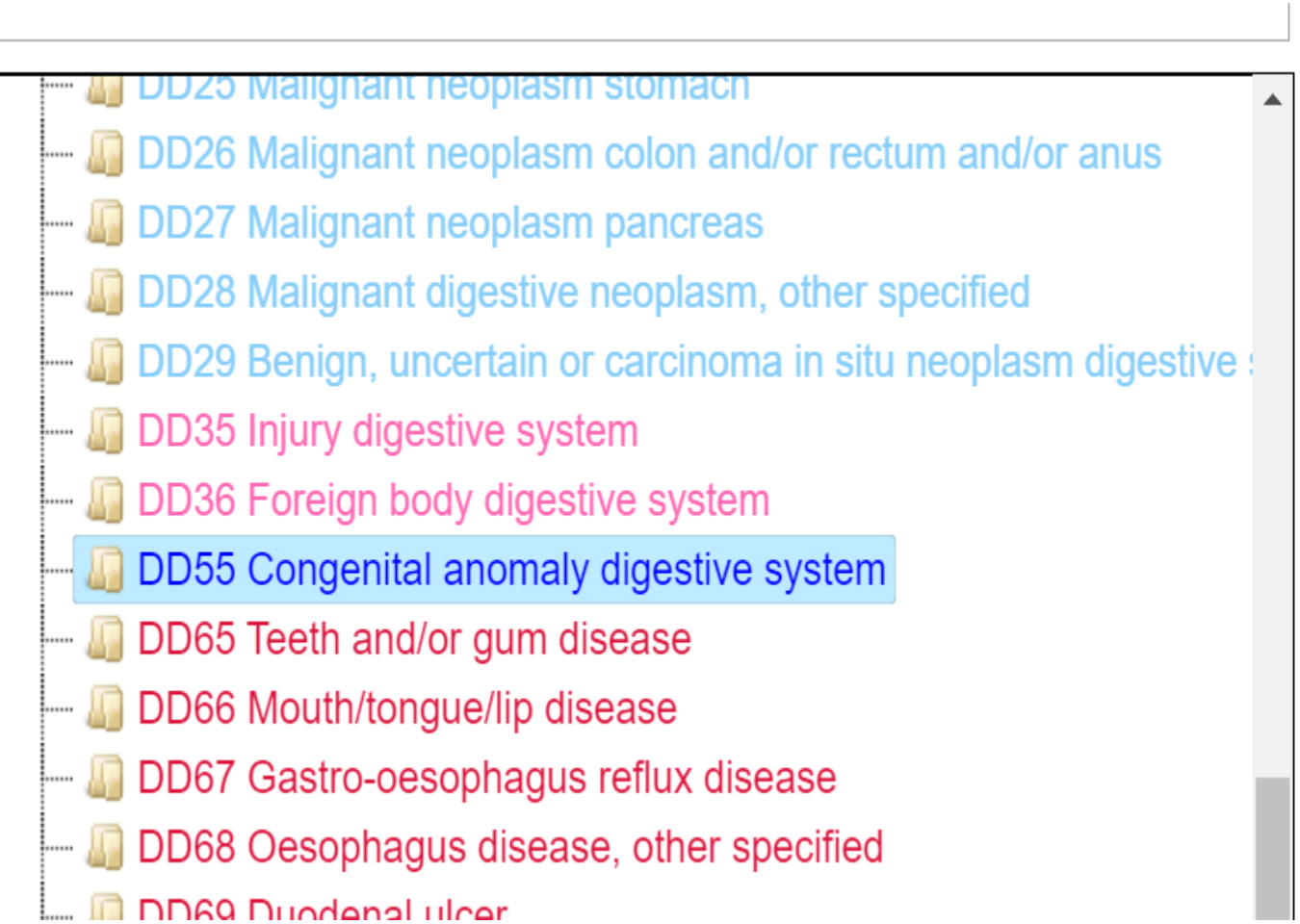


Coding Instruction or CodingHint

In case a patient indicates to experience a problem in managing one's lifestyle related to specified habits, code the problem to ZR75 Problems related to lifestyle, or PS12, PS13, PS14, PS15, TD66, TD67

Double coding

Congenital and hereditary

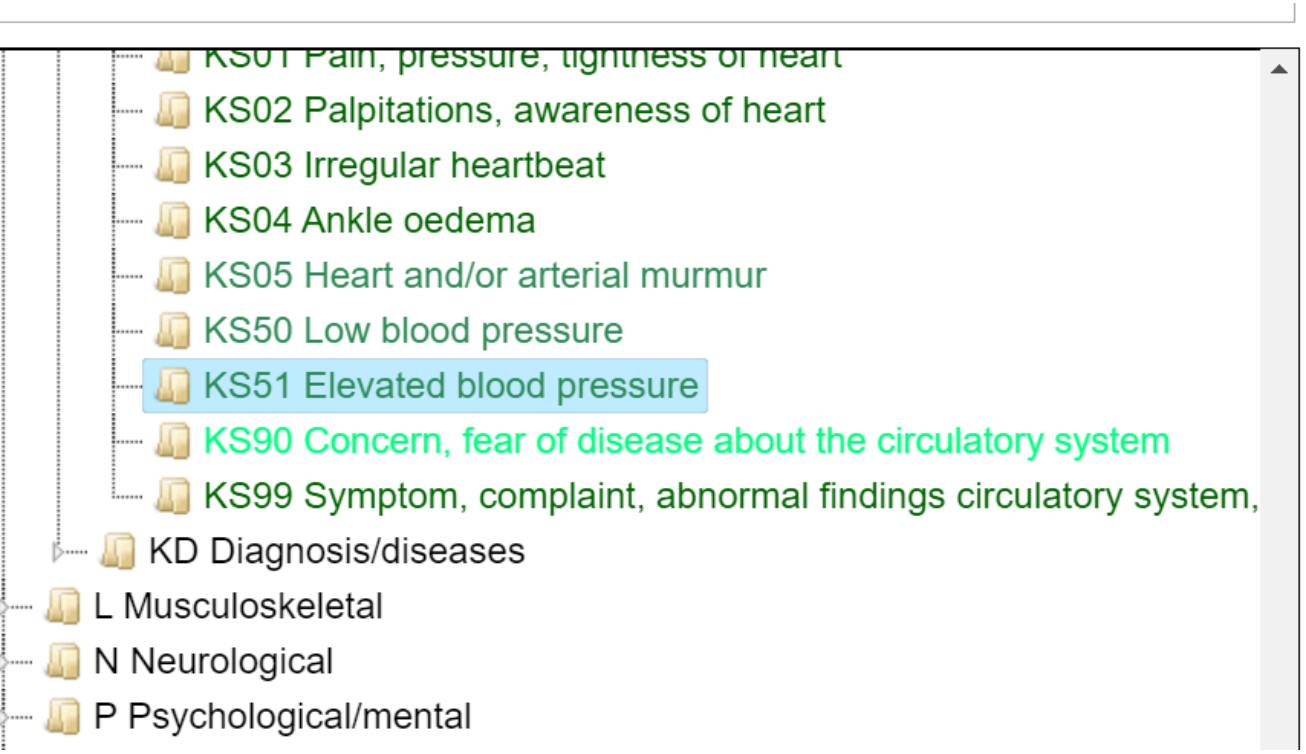


DD55 Congenital anomaly digestive system

Short title
Congenital anomaly digestive system

Inclusion
biliary anomaly
cleft lip/gum/palate DD55.00
congenital pyloric stenosis DD55.01
gastro-oesophageal reflux disease (without oesofagitis) DD55.02
Hirschprung's disease
Meckel's diverticulum DD55.03
megacolon
oesophageal atresia
tongue-tie DD55.04

Abnormal (clinical) finding



Settings Manual Logout

KS51 Elevated blood pressure

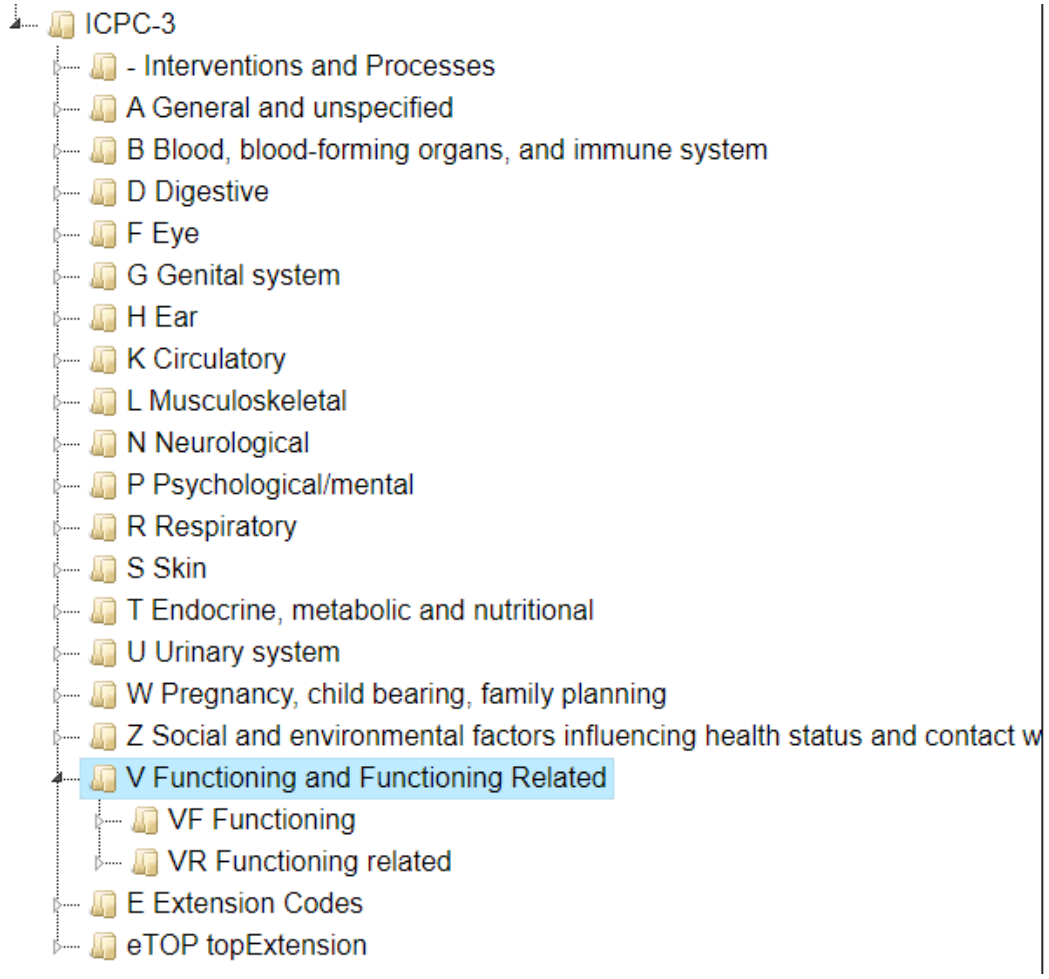
Short title
Elevated blood pressure

Inclusion
labile hypertension
transient hypertension
white coat hypertension n

Exclusion
hypertension, uncomplicated KD73 ; hypertension,complicated KD74

IndexTerms
labile hypertension
transient

Functioning and Functioning Related



V Functioning and Functioning Related

Description
This chapter allows a description of the functioning and functioning related aspects of all (first) persons contacting the Health Care system in Primary- and Community Care settings. The Functioning and Functioning Related items are a selected subset of items from the WHO-International Classification of Functioning, Disability and Health, which provide an overview of a person in a person-in-context approach.
Where indicated a specific set of items is available in the form of a self-administered tool for the assessment of functioning. As a tool it is called the Primary Care Functioning Scale (PCFS).
The PCFS has demonstrated a high content and construct validity for use in Primary Care settings.
The intended population for the PCFS is the agegroup 50+ for which it has been tested, but it might also be informative for persons in the agegroup below 50 with problems in functioning within the area of the set of items

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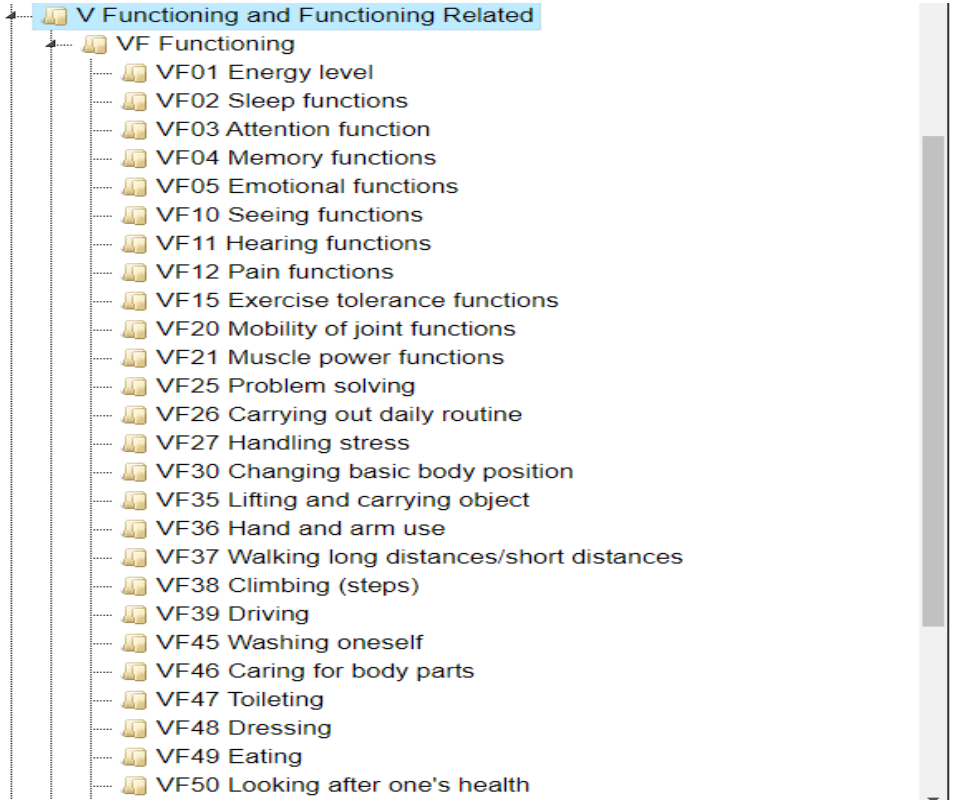
Functioning

Description

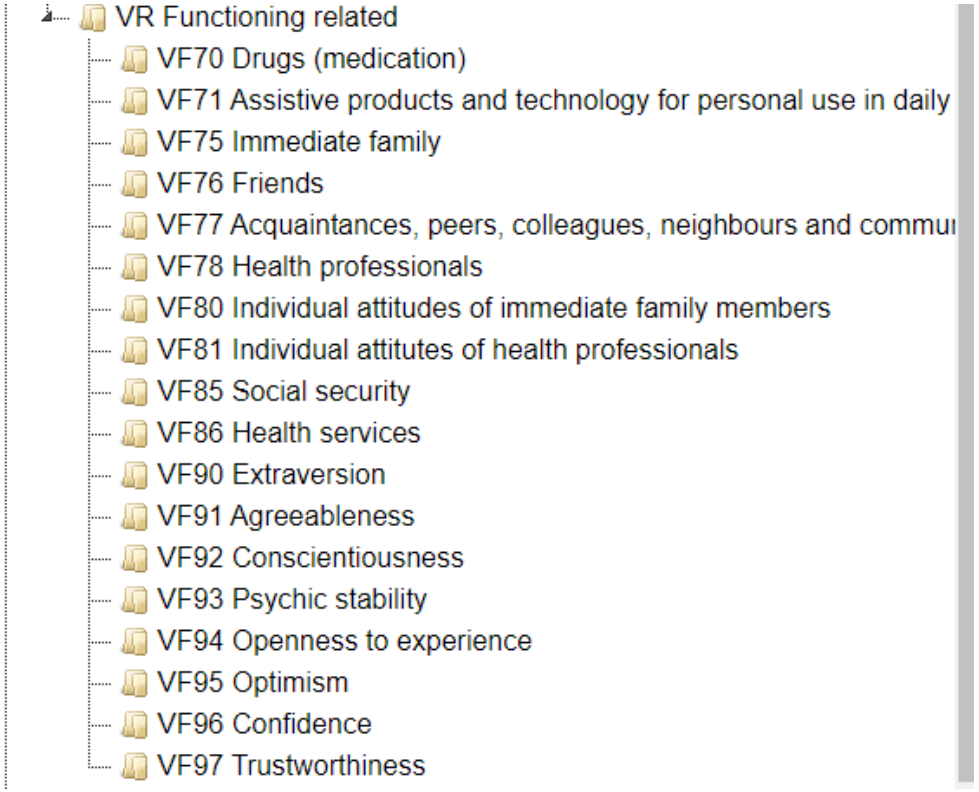
Functioning related factors describe the context in which Functioning takes place. They are made up by the environmental factors the person lives in (the things outside the person) and the personal characteristics in which one person differs from another person.



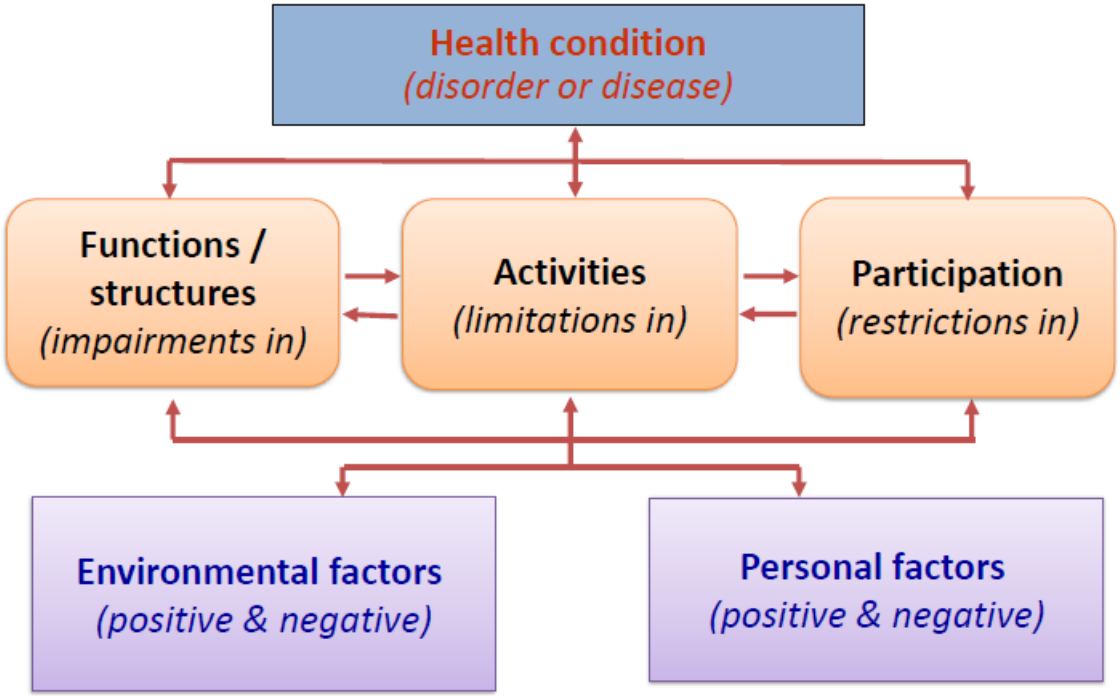
Functioning related

Description

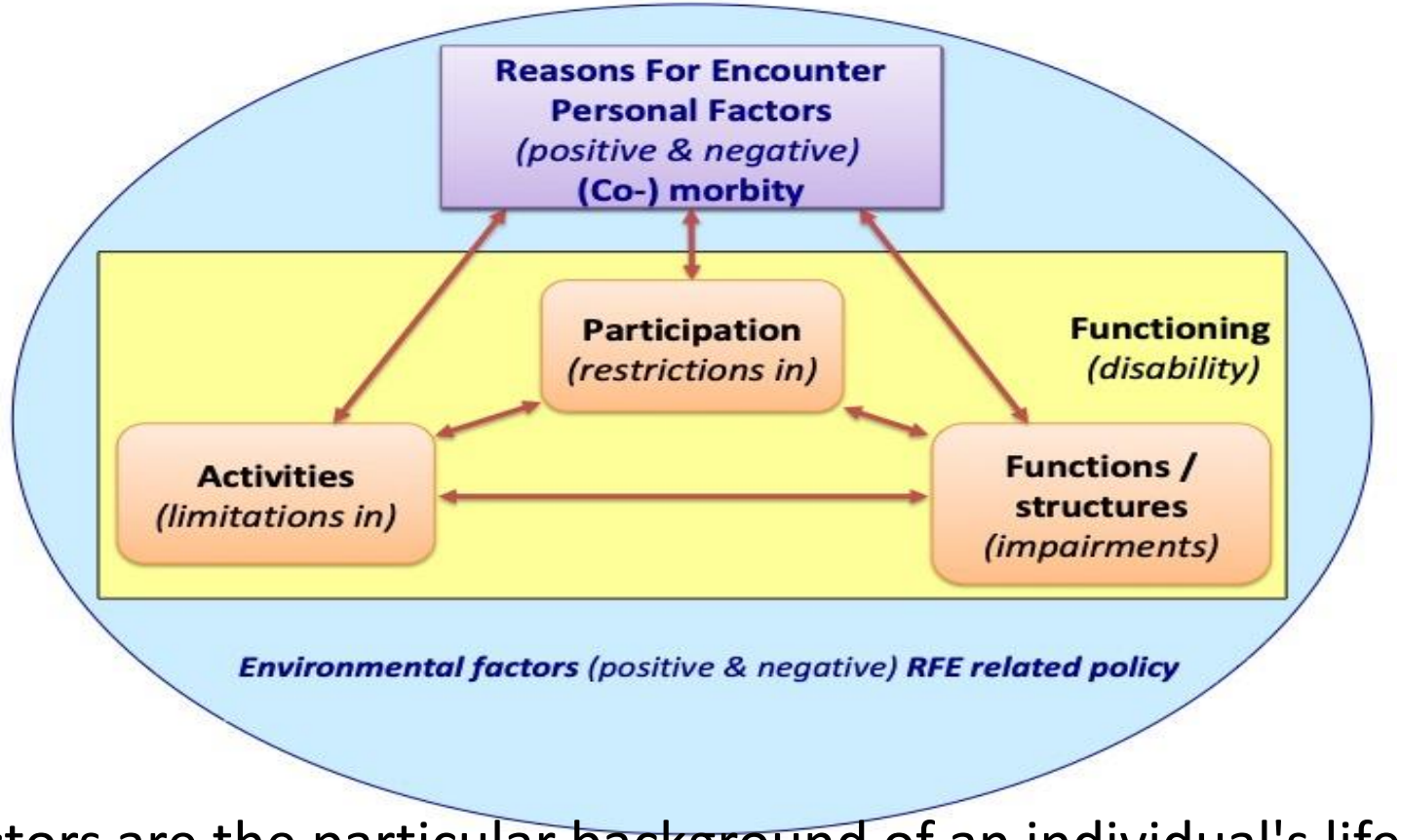
Functioning related factors describe the context in which Functioning takes place. They are made up by the environmental factors the person lives in (the things outside the person) and the personal characteristics in which one person differs from another person.



ICF Scheme


Health condition
(disorder or disease)
Functions / structures
(impairments in)
Activities
(limitations in)
Participation
(restrictions in)
Environmental factors
(positive & negative)
Personal factors
(positive & negative)

Using Functioning, Environmental and Personal factors in Primary Care (under construction!)



Personal factors are the particular background of an individual's life and living, and comprise features of the individual that are not part of a health condition or health states. These factors may include gender, race, age, other health conditions, fitness, lifestyle, habits,

Syndrome, Disease, Disorder, Symptom, Sign

How do we deal with this in the ICPC?

Used literature: WONCA dictionary (WD)/ MESH (M) and Merriam Webster (MW) Epidemiology dictionary (ED)

Question: are the syndromes in the right component?

Disease

DISEASE (WONCA dictionary)

A biological dysfunction on basis of well-known pathological or pathophysiological processes or with a well-known etiology. Disease is a concept of reality and can therefore exist without a physician's jugdement.

MESH
A definite pathologic process with a characteristic set of signs and symptoms. It may affect the whole body or any of its parts, and its etiology, pathology, and prognosis may be known or unknown.

1. Literally, dis-ease, the opposite of ease, when something is wrong with a bodily function. A disorder that can be assigned to a diagnostic category.

2. Disease, illness, and sickness are better regarded as not synonymous:

a. Disease is the biological dimension of nonhealth, an essentially physiological dysfunction

b. Illess is a subjective or psychological state of the person who feels aware of not being well; the experience of a person with a disease; a social construct fashioned out of transactions between healers and patients in the context of their common culture

c. Sickness is a state of social dysfunction of a person with a disease; the role that the individual assumes when ill; a result of being defined by others as “unhealthy.”

In the real world, lay concepts of illness and medical concepts of disease interact and shape each other. Neither disease nor illness is infinitely malleable: both are constrained by biology and by culture .

Disorder

WD: Disturbance of the normal health status. It is used in an attempt to generalize rather than use the more specific term disease.

MW: An abnormal physical or mental condition

ED: A disturbance of an organ or body system from normal balance or healthy function

Syndrome (1)

(ED) A complex of signs and symptoms that tend to occur together, often characterizing a disease.

(M) A characteristic symptom complex

(MW)
1: a group of signs and symptoms that occur together and characterize a particular abnormality or condition

2: a set of concurrent things (such as emotions or actions) that usually form an identifiable pattern

Syndrome (2)

(WD) **SYNDROME a symptom complex in which a combination of symptoms and signs occurs more frequently than would be expected on the basis of chance alone. The term is used in three different ways:**

1. The symptomatic presentation of a health problem or group of health problems e.g. the hyperthyroid syndrome. This use of the term is prevalent in general practice as many health problems are met in an early phase, or cannot or need not be diagnosed by additional diagnostic procedures.

Syndrome (3)

2. As synonymous jargon on basis of a historical vocabulary. Example: Down's syndrome which is in fact a well-known disease (trisomy-21).

3. As synonym for the concept behind the term nosological diagnosis. A prerequisite for considering a set of symptoms and signs as a SYNDROME is its clinical utility for understanding, diagnosis, prognosis, or treatment.

Small group discussion

Question: do all syndromes have to be classified in component 7?
If so why, if not why not?

Or do we want some (which) in component 1 and most in component 7.
Why?

Use the browser to find the S(s)yndromes in the ICPC-3

ZC Social and environmental factors influencing health status

Environmental Factors make up the physical, social and attitudinal environment in which people live and conduct their lives.

Social can be understood in different ways, depending on the perspective that needs to be understood as a reason for contact.

That is why the persons own direct problems with an illness or phase of life, and problems in relationships as a reason for contact are classified within this component as well.

- ZC Social and environmental factors influencing health status
  - ZC01 Own illness problem
  - ZC02 Phase of life problem
  - ZC05 Partner relationship problem
  - ZC06 Child relationship problem
  - ZC07 Parent/family member relationship problem
  - ZC08 Health care provider relationship problem
  - ZC09 Relationship problem others
  - ZC10 Loss/death of partner problem
  - ZC11 Loss/death of child problem
  - ZC12 Loss/death of parent/family member problem
  - ZC13 Finances associated problems
  - ZC15 Education problem
  - ZC16 Work problem
  - ZC17 Unemployment problem
  - ZC20 Food/water problem
  - ZC25 Illness of partner problem
  - ZC26 Illness of child problem
  - ZC27 Illness of parents/family problem
  - ZC30 Partners behaviour problem
  - ZC31 Child behaviour problem
  - ZC32 Parent/family behaviour problem
  - ZC35 Violence problem
  - ZC36 Housing problem
  - ZC37 Legal problem
  - ZC38 Social welfare problem
  - ZC39 Health care system problem
  - ZC99 Social and environmental problem, other specified

Short title
Violence problem

Description
Victim of physical abuse/violence, rape, sexual attack.

Inclusion
maltreatment/sexual abuse child ZC35.00
maltreatment/sexual abuse by partner ZC35.01
problems related to assault/rape ZC35.02
victim of physical abuse
victim of rape
victim of sexual attack

Exclusion

Add Comment | Show All Comments

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- G Genital system
  - GS Symptoms, complaints and abnormal clinical findings
    - GS01 Pain penis
    - GS02 Pain testis/scrotum
    - GS03 Pain genital, other specified
    - GS04 Pain breast
    - GS05 Menstrual pain
    - GS06 Intermenstrual pain
    - GS07 Menstruation absent/scanty
    - GS08 Menstruation excessive
    - GS09 Menstruation irregular/frequent
    - GS10 Intermenstrual bleeding
    - GS11 Premenstrual symptom/complaint
    - GS12 Postponement of menstruation
    - GS13 Menopausal symptom/complaint
    - GS14 Postmenopausal bleeding
    - GS15 Postcoital bleeding
    - GS16 Vaginal discharge
    - GS17 Vaginal symptom/complaint/abormal clinical finding, other s
    - GS18 Vulval symptom/complaint
    - GS19 Pelvis symptom/complaint
    - GS20 Penis symptom/complaint
    - GS21 Scrotum/testis symptom/complaint
    - GS22 Prostate symptom/complaint

Ad

- GD Diagnosis/diseases
  - GD01 Syphilis
  - GD02 Gonorrhoea
  - GD03 Genital herpes
  - GD04 Genital trichomoniasis
  - GD05 Genital human papilloma virus infection
  - GD06 Genital Chlamydia infection
  - GD07 Sexual transmitted disease, other specified
  - GD08 Genital candidiasis/balanitis
  - GD09 Pelvic inflammatory disease
  - GD10 Prostatitis/seminal vesiculitis
  - GD11 Orchitis/epididymitis
  - GD12 Vaginitis/vulvitis
  - GD25 Malignant neoplasm cervix
  - GD26 Malignant neoplasm prostate
  - GD27 Malignant neoplasm breast
  - GD28 Malignant neoplasm genital, other specified
  - GD29 Fibromyoma uterus/cervix
  - GD30 Benign neoplasm breast
  - GD31 Benign neoplasm genital
  - GD32 Genital neoplasm in situ/uncertain

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Neoplasm in the ICPC-3

Malignant (MN): the neoplasm invades surrounding tissue or disseminates from its point of origin and begins to grow at another site;

In situ (IN): the neoplasm is malignant but still fully confined to the tissue in which it originated;

Benign (BN): the neoplasm grows in the place of origin without the potential for spread;

Uncertain (UN): it is undetermined or unknown whether the neoplasm is benign or malignant.


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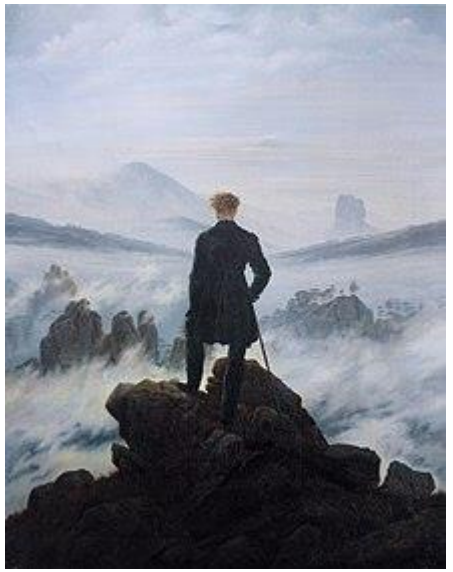

Wer ein Warum hat, dem ist kein Wie zu schwer. (Nietzsche)

He Who has a Why, no How is too heavy.


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WICC a Chronic Episode of Care or WOW?