CROSS CHAPTER ISSUES ICPC3

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ISSUES

ICPC foundation layer

ICPC structural integrity

ICPC principles and rules

Codes moving across chapters

-26, -27, -28, functioning

ZP and personal information

Joining X and Y, and the role of W

Archetypes and rubric tags

Renumbering

Prevention

Clinical findings

ICPC FOUNDATION LAYER

Nijmegen Consortium Information note on “The general principles for the content of ICPC-3”

- “For the revision of the ICPC the content is based on ICPC 2.7”
- Content model

THE ICPC-3 CONTENT MODEL - February 2019 -

Any Rubric/Category in ICPC is represented by:

Descriptive characteristics

1. **TITLE of Entity: Name of rubric**
   a. Textual description, concise and detailed
   b. Short title – Inclusion – Exclusion – Index terms/synonyms – Coding hint – Note
2. **Type of Entity**
   a. Organ System
      - Symptoms, complaints and abnormal clinical findings
      - Diagnosis and Health Problems
   b. Interventions (patient related) and Processes (administrative)
   c. Problems influencing health status (Z-chapter)
   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. Causality – Inherited disease component (congenital, hereditary, infectious, neoplasm, injury, life-style, risk factor, other, unknown)
2. Country adaptation
3. Research
4. 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

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

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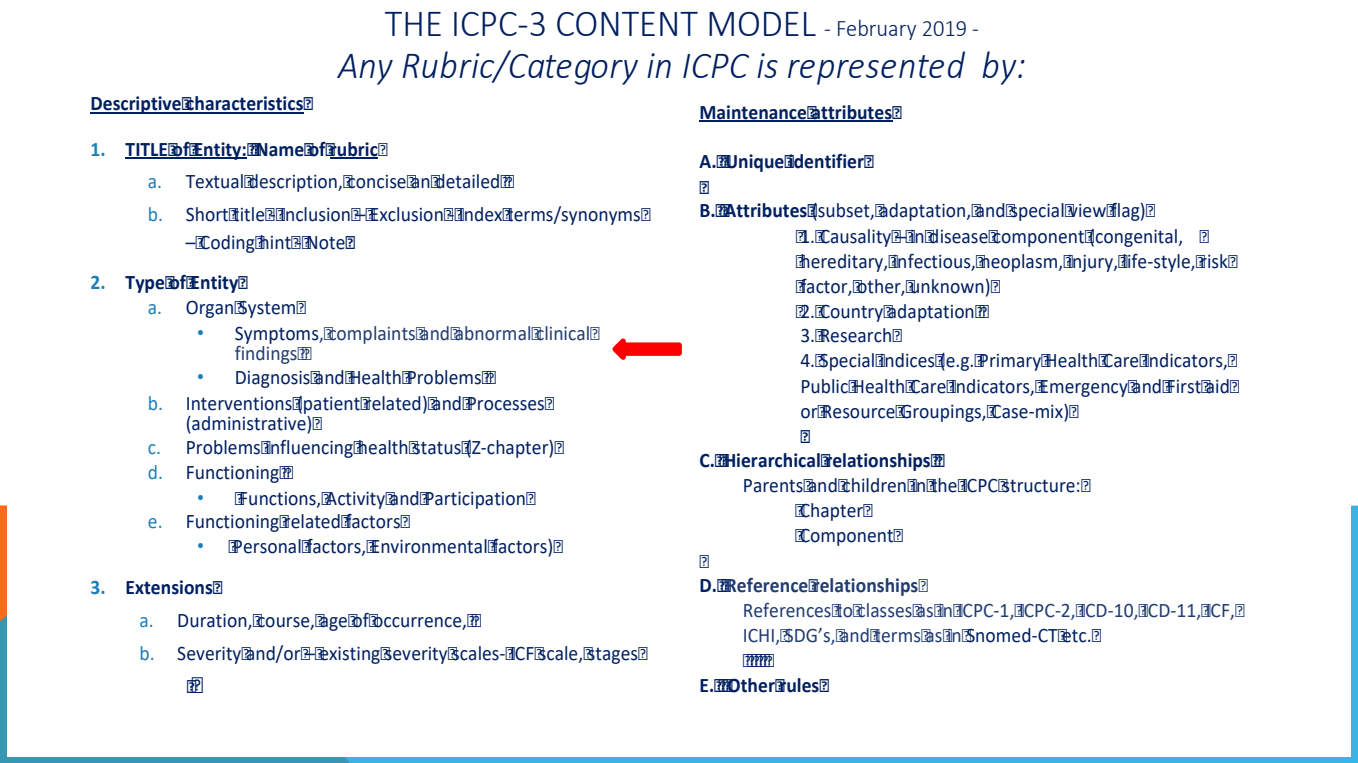

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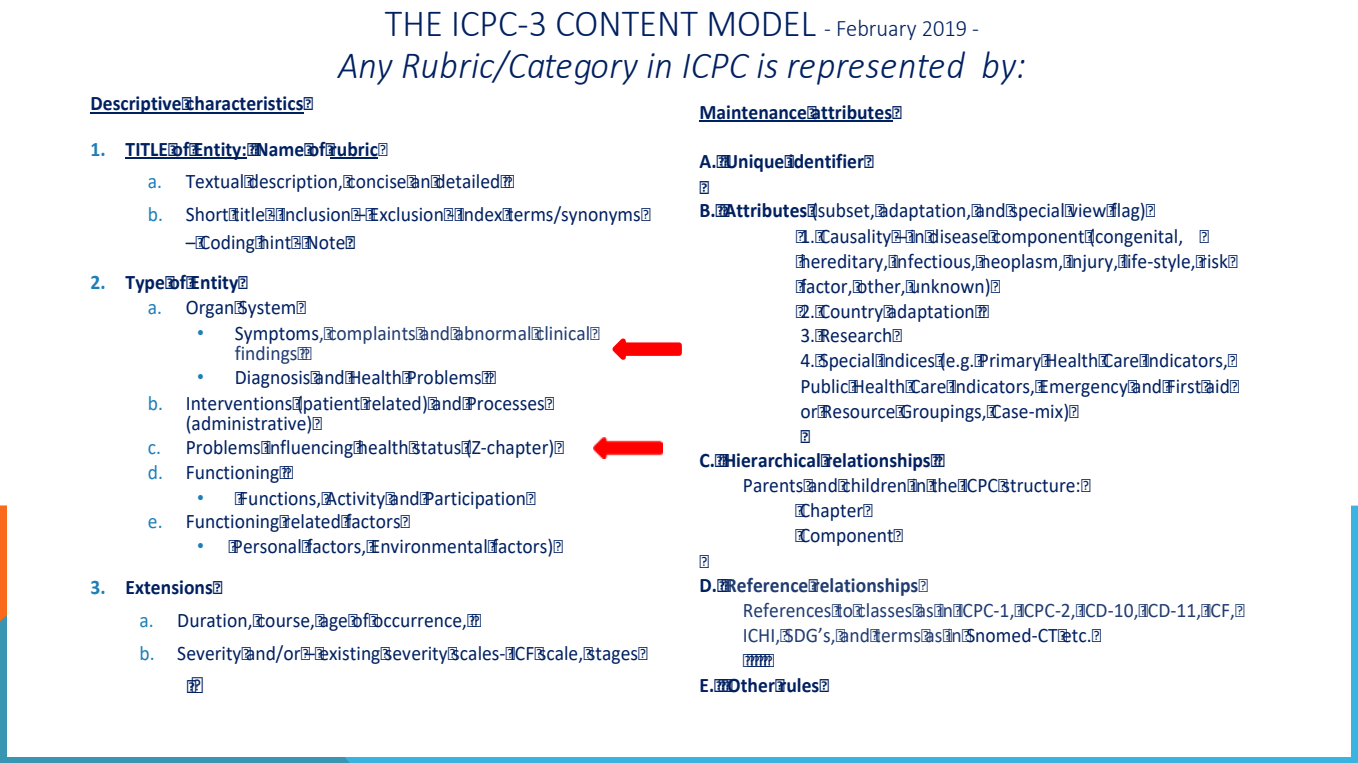

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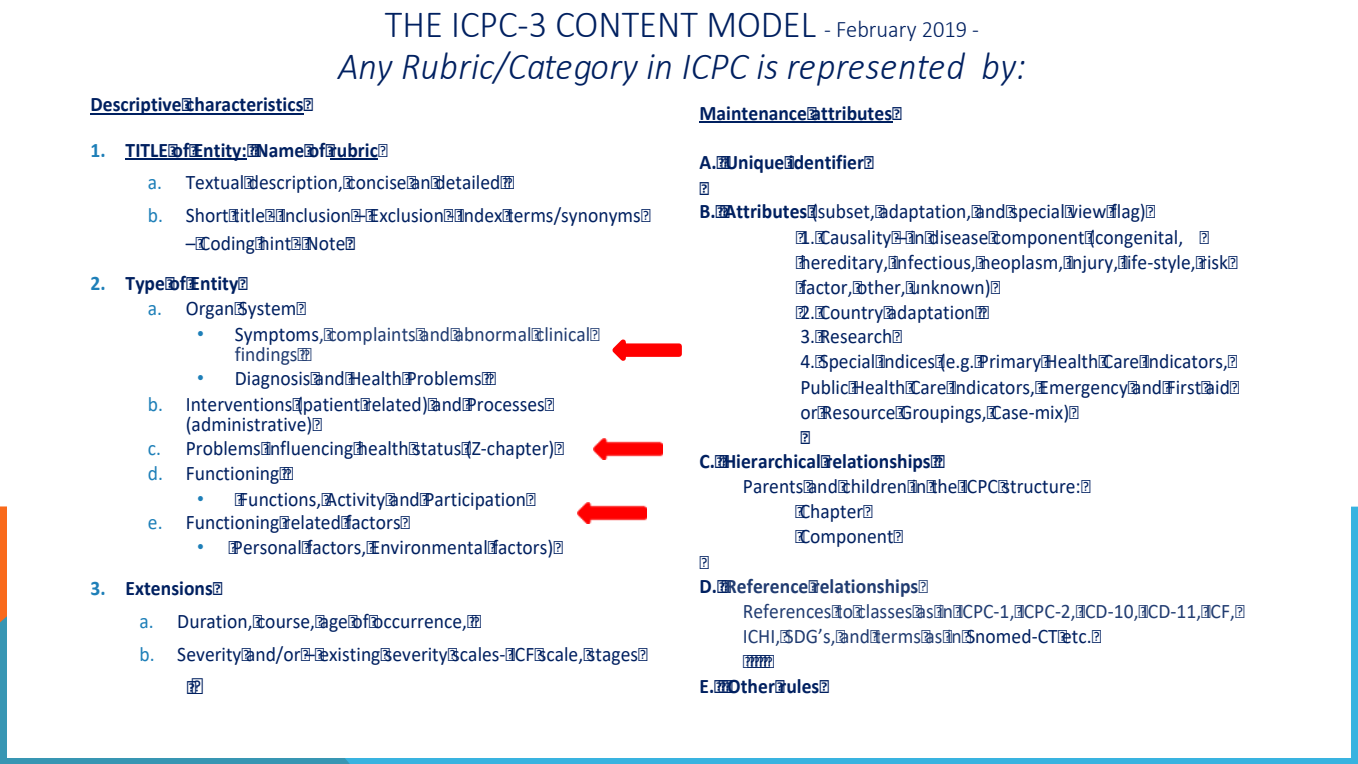

ICPC STRUCTURAL INTEGRITY

ICPC is a classification, with mutually exclusive classes and residual classes

The foundation layer is based on ICPC-2 (v2.7)

It is empirical, and additions and deletions must be frequency and evidence based

Chapters reflect body systems or areas of health care

Components 1 and7 are used for labelling health problems

Components 2 to 6 are used for labelling interventions

Components 1 to 7 are all used to label reasons for encounter (including requests for interventions)

New additions in Chapter “Functioning” and Chapter ZP need to follow these rules

Move of component 1 in Z to component 7 must be justified

ICPC PRINCIPLES AND RULES

Importance of empiricism:

- ICPC was originally based on large studies that collected data from general practice in a consistent way.

Mutually exclusive concepts.

Classification principles. Everything has a place, and a place for everything (avoid ambiguity, residual classes, etc.)

The granularity is appropriate and based on empirical data.

- Prevalence (0.5 per 1000 py).
- Frequency and error of measurement.

Importance of the Episode of Care

Prevalence as an RFE and as a problem label

Renumeration of classes / mnemonic codes

Decision to merge rubrics should not be taken lightly

- Different diagnostic relations of RfE (K01-K02 examples).
- Consider the agreement/disagreement among WICC members
- if in doubt, do not change just for changes' sake; consider to discuss and think about proposals.

ICPC and ICD relationships, all linked to SNOMED CT.

Considering ICD and especially changes from ICD-10 to ICD-11 when considering moving a concept to another class or chapter

CODES MOVING ACROSS CHAPTERS

WICC Chapter groups and/or TGA have recommended or suggested 8 changes from one chapter to another

The actual changes made in the ICPC-3 files need be tagged and reviewed for consistency

Unless the change/s is made visible *per se* or documented it may be difficult to appreciate and review

-26, -27, -28, FUNCTIONING

-26 – "fear of cancer…" and "-27 fear of other…" are consistent across chapters, and there have not been many calls for major change. However, it is a cross-chapter issue, and should be reviewed by TGA

-28 – limited functioning/disability was frequently used in some chapters, much less so in others

- RfE: A28 – 0.6/1000py; B28 – 0; D28 – 0.1; F28 – 0.3; H28 – 0.1; K28 – 0.1; L28 – 4.9; N28 – 0.6; P28 – 0.1; R28 – 0.2; S28 – 0; T28 – 0; U28 – 0.2; W28 – 0.1; X28 – 0; Y28 – 0; Z28 – 0.1
- RfE + Problems: A28 – 0.5/1000py; B28 – 0.2; D28 – 0.4; F28 – 1.5; H28 – 0.5; K28 – 0.8; L28 – 0.4; N28 – 0.5; P28 – 0.2; R28 – 0.1; S28 – 0; T28 – 0; U28 – 1.2; W28 – 0.1; X28 – 0.4; Y28 – 0.2; Z28 – 1.9

Removing all such -28 codes in each chapter is not justified by frequency data

Creating a new chapter must follow all the ICPC rules, including having 7 components, being appropriate for RfE and Problem labelling, based on empiricism, and consonant with the rule of mutual exclusivity and domain completeness

ZP AND PERSONAL INFORMATION

The chapter group work on Chapter Z was completed and reviewed by the TGA, and did not contain the ZP proposals

The ZP proposals require robust discussion by the TGA and review by WICC

Creating a new chapter must follow all the ICPC rules, including having 7 components, being appropriate for RfE and Problem labelling, based on empiricism, and consonant with the rule of mutual exclusivity and domain completeness

JOINING X AND Y, AND THE ROLE OF W

Many codes in G (the great majority) will still be sex-linked, such as “prostate cancer,” “penis pain,” “vulval pruritus” and “ovarian cyst.” As such, the join does not resolve the sex issue. Rubrics will not be unisex. W is also quite similar

There is a major issue with having divided male or female symptoms but unisex disease labels, since the analysis of diagnostic associations will require division of the disease into male and female patients (since the diagnostic association may be quite different in the two sexes)

The analysis of the diagnostic association between breast lump, female and breast cancer, female will be impossible in ICPC-3 unless the data has a separate tag for male and female patients.

Once you lump you cannot split.

Proposal to be considered: only join those codes in Chapter X and Y which are genuinely unisex…. such as “syphilis,” “gonorrhoea,” and “herpes?” These could be moved to Chapter A, for example

ARCHETYPES AND RUBRIC TAGS

The use of an archetype model allows the solution of many issues such as:

- Grouping of risk factors
- Grouping of neoplasms
- Grouping of infections
- Other groupings, similar to the colour codes
- Rubrics which should be used only in males, or females, or in defined age groups
- Diagnoses which are usually only incident once (i.e. life-long)
- Alternative views for the AANN code, to allow shorthand codes similar to ICPC-2 codes (e.g. R05S – R05 – cough)
- Embedded links to thesaurii or mappings to other classifications
- TGA could work on this proposal

RENUMBERING

The actual renumbering should take care to

- Possibly avoid renumbering familiar codes
- Avoid the impression of much space unutilised (e.g. B- chapter with 200 spaces but only 24-25 codes in 1 and 7 together)
- Cater for process codes
- Not change for re-ordering purposes only, since this de-values people familiar with prior codes

PREVENTION

A proposal to add specificity with suggestions for adding specificity by coding interventions (possibly included in the notes or comments of A98) should be prepared by the TGA

Coding the appropriate RfE and intervention adds much specificity to the A98 class, which is very large

CLINICAL FINDINGS

ICPC does not cater for coding clinical findings *per se*, but codes clinical signs expressed as a reason for encounter or used to describe a problem

Component 1 rubrics with clinical finding labels (e.g. "fever") are usually expressed as an RfE, but may be also be used to label a problem or diagnosis

Component 7 rubrics with clinical finding labels (e.g. "high blood pressure") are used to label a problem, but also as an RfE

There is no complete classification of clinical findings in ICPC, and to give this impression is wrong

A move of a rubric with a clinical finding label (such as K85 – high blood pressure – "elevated blood pressure not meeting criteria for K86 and K87; transient/labile hypertension") to component 1 means that such is now a symptom/sign label and not a problem/disease label. It does not define it as a clinical finding

High blood pressure (defined by one high blood pressure reading) is as much a clinical finding as type II diabetes is a clinical finding (defined by two abnormally high blood test results). Diabetes is not a clinical finding (abnormally high blood sugar result) as much as K85 is not a clinical finding (abnormally high blood pressure, white coat hypertension). They are both problems defined by a clinical finding/sign/test result, and should be treated consistently

The decision to move K85 to Component 1 should be considered in this context, and one must justify why high blood sugar and diabetes might be treated differently

If we insist in stating that ICPC 3 will now include clinical signs, we need to develop a classification of clinical signs empirically, define states of all such signs (present/absent, high/normal/low, unknown/not measured, residual class/NEC, etc.) prevalent in primary care, and include it in ICPC-3

TGA needs to discuss this issue and feedback

TASK GROUP ROLES

Access to foundation layer

Review cross chapter changes

Assess changes for adherence to rules and principles

Review changes to -28 and functioning

Review changes to chapter G and W

Review changes to Z and ZP

Suggest rules for tags and rubric labels and attributes

Make proposals about renumbering

Make proposals about prevention

Discuss the issue of clinical findings