

World Organization of Family Doctors International Classification Committee



ICPC-3

Where have we come from?
&
Where are we going?



Wonca International Classification Committee

Wonca

World family doctors. Caring for people.

1972	WONCA inaugural meeting,	working party established Convenor Robert Westbury, Canada)	‘develop an agreed classification of disease in general practice... to be clearly related to the ICD....’.	Ch: Robert Westbury
1975	ICHPPC	International Classification of health Problems in primary Care	Retained ICD-8 structure, Endorsed by WHO	Ch: Robert Westbury
1979	ICHPPC-2		Upgrade to align with ICD-9; endorsed by WHO	Ch: Robert Westbury
1983	ICHPPC-2 DEFINED	Contained the International Glossary of Primary Care	With inclusion and exclusion criteria; endorsed by WHO	Ch: Jack Froom (US)
1979	RFE-C work began	Reasons for encounter Classification	WHO working group – included many WICC members	Leads: Maurice Woods & Henk Lamberts
1983	RFE-C Trial		18 countries involved	Led by Henk Lamberts
1986	IC-Process- PC	International Classification of Process in Primary Care		Ch: Jack Froom
Late 80s to late 90s		Also worked on Functional Status Measures (Published by the Research Committee of Wonca), and on Severity of Illness measurement, in association with Duke University		



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1987	ICPC	International Classification of Primary Care	<p>Broke from ICD format</p> <ul style="list-style-type: none">• Component 1: Drew on the NAMCS Reason for visit classification; the RFE-C Components 2&3: broadly corresponds with ICD (procedures); and with IC-Process-PC;• Chapters P and Z drew on WHO sponsored Triaxial Classification Group work• Component 7: based on ICD-9, most the same as in ICHPPC -2 Defined	Chair: Maurice Wood (US)
1995	Glossary	Wonca International glossary for general/family practice		Ed: Niels Bentzen
1998	ICPC-2		Now with inclusion and exclusion criteria for each rubric. Reprinted 1999, 2002	Chair & Lead Charles Bridges-Webb
2003	Dictionary	Wonca Dictionary of General/Family practice		Ch & Ed: Niels Bentzen
2005	ICPC-2-R		Revisions made based on updates to ICPC-2 E, the electronic version of ICPC-2 + additional changes	Henk Lamberts & Inge Okkes



WICC activities since 1998 release of ICPC-2?

✦ **ICPC-2 update Group has:**

✦ completed regular updates which include

- corrections to rubric inclusions and exclusion and cross references;
- corrections to maps to ICD 10.
- Updates to map to ICD-10 in response to WHO changes in ICD10.

✦ **Kept good list of issues that can't be solved with ICPC-2, must be fixed in ICPC-3**

✦ **2003-4:** Produced 2 pager with colour designation of correct Components in English, French and Spanish + template. More languages added over years (all available Kith).

✦ Established arrangement with **KITH** to hold electronic versions of ICPC.

✦ Established **version control** for ICPC-2 versions held on Kith

✦ **Had very interesting discussions about:**

- ✦ how we should deal with patient risk factors
- ✦ difficulties with current Process codes and proposals to limit to a single set in core ICPC-3 with links to other systems perhaps.
- ✦ quaternary prevention, coding rules, NERI or PERI
- ✦ What changes are needed for ICPC-3?



ICPC-3 structure: Brasov--2008

Need for ICPC-3 was recognised: reasons included—

- ✦ to correct errors in ICPC-2 (that cannot be corrected in updates)
- ✦ Correct allocation of rubrics to true component (like 2 pager)
- ✦ Merge chapters X and Y (simple xl file showing relationship between X & Y presented (HB))
- ✦ Accommodate new rubrics for which no space available (e.g. chronic kidney disease)
- ✦ Incorporate data elements not now included in ICPC
- ✦ Resolve current data retrieval problems. **This is about research**

Michel De Jonghe proposed 2A2N but option discussed was
1 alpha + 3 numeric (1A3N)

O'Halloran and Britt asked to prepare white paper and distribute.
(note, the white paper later circulated proposed 2A1N structure)



Florianopolis--2009

- ✦ Eric Falcoe and Marianne Rosendal presented whitepaper proposing uptake of De Jonghe 2A2N structure (further developed second alpha meaning)
- ✦ Britt, O'Halloran & Miller withdrew 2A1N proposal –felt 2A2N far better.
- ✦ Clear consensus for Falkoe/Rosendal/DeJonghe proposal with second alpha to designate TYPE (infection, trauma etc)
- ✦ **Unanimous vote** to adopt this structure for ICPC-3
- ✦ **Aim:** to finalise by November 2013
- ✦ **ICPC-2 Update group** closed as it was thought updates would not be needed any more
- ✦ **Reported** Wonca--IHTSDO agreement to work together on forming a GP/FM Ref-Set of SNOMED CT, mapped to ICPC-2. Work to be done by University of Sydney (IHTSDO funded). Proposed work program was **endorsed** by WICC



Ghent--2010

- ✦ ICPC-2 Update group re-established as it was recognised that some people would want to continue to use ICPC-2 and maps to ICD-10 would need to be updated with changes in ICD 10.
- ✦ Draft application of agreed structure (2A2N) applied to proposed Chapter G—resulted in some changes to second alpha code – changes were agreed.
- ✦ HB proposed changes in second alpha, which were agreed to after discussion (e.g. not to use O, as earlier proposed) and presented Chapter G with revised structure
- ✦ Decision of 2A2N reviewed, in response to JK Soler proposal for ANNA structure.
- ✦ **Agreed by acclamation** that WICC 'move ahead with development of 2A2N structure for ICPC-3'.
- ✦ Discussion of work needing to be done for development of ICPC-3
- ✦ White paper on **Data Model** (Mennerat) distributed +presented.
- ✦ Risk-factor working group proposed a classification for this area – NERI group formed.
- ✦ M Klinkman reported WHO work on chapter P which will assist in development of Chapter 3 for ICPC-3.



Barcelona--2011

- ✦ Presentation of the XY chapter (Chapter G) – full draft (H Britt)....
- ✦ Draft version of revised process component, with inclusion and exclusion criteria, presented for discussion.
- ✦ Discussion on ICPC coding rules (T. Kuehlein), group formed to develop white paper
- ✦ Risk –factors v's diagnoses discussion – more work needed
- ✦ Prevention and screening classes in ICPC-2e (T. Kuehlein)
- ✦ Updates on work with ACG, WHO, IHTSDO (SNOMED)
- ✦ MK agreed to prepare ICPC-3 Blueprint and circulate
- ✦ Action plan for 2011-12 very specific in minutes of the meeting (*circulate*)

AND

- ✦ **managed to do nothing further about ICPC-3 move to 2A2N structure except to agree we need a blueprint of what ICPC-3 should 'look like' (broader view than core code structure).**



ICPC-3 core: work since 2011 Barcelona

- ✿ I applied changes to numerics within the second alpha according to agreed changes in Barceleno and (as agreed) removed some second alpha groups e.g limited function.
- ✿ Gojo and Daniel have reviewed Chapter G draft and made comments (not yet incorporated)
- ✿ Daniel also had a go at reviewing another chapter
- ✿ Michel has applied the 2A2N structure and reviewed some aspects of rubrics
- ✿ Shabir has been considering ICPC-2 coverage for South Africa.



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NEXT

Brief presentations

 Shabir

 Daniel

 Michel

The 2A2N structure

- ✿ proposes no change to the original principals of:
 - ✦ Chapter – component structure
 - ✦ aetiology before location
 - ✦ episode of care/POMR (Weed) model
- ✿ 1st alpha = chapter
- ✿ 2nd alpha = component or subcomponent



Second alpha in 2A2N structure

Component 1 Symptoms & complaints	Component 7 Diagnoses/disease
S – S ymptoms/complaints	G – infections (G erms)
S80... Fear of....	N – N eoplasms N01.... Malignant... N50... Benign...: N90....Uncertain
S90... Concern about...	T – T rauma/injury
S98...Limited function....	A – congenital A nomalies
S99 -Other symptom/complaint NOS/NEC	D – other D iseases



Next

Proposal for discussion on a way
forward

Steps needed to review a chapter



Things which may help us

- ✚ **ICPC-2 Update Group** provide list of issues identified over the years that you 'can't fix' in update
- ✚ **Terje provide** KITH defined rules for rubric label format, incl, excl formats; caps, colons, semi-colons etc.
- ✚ **Michel provide** his XL files



More things to help us

✦ **Julie provide**

- ✦ Use frequency of ICPC-2 rubrics from international data
- ✦ Draft SNOMED to ICPC-2 map
- ✦ Use frequency (international) of SNOMED terms mapped to each ICPC-2 rubric
- ✦ Access database of 'problem areas' identified over years

✦ **Others provide**

- ✦ Any additional ICPC-2 usage data not already in international set
- ✦ Any lists of 'problem areas' identified over years



Next steps – in XL

- ✦ *Leave column 1 blank for ICPC-3 code entered later*
- ✦ In column 2: create list of ICPC-2 codes in your chapter,
- ✦ In column 3: enter inclusion criteria for each rubric
- ✦ In column 4: enter exclusion criteria for each rubric
- ✦ In column 5: enter international data frequencies

SOURCE for incl. excl criteria: ICPC-2 V 4.2 Kith



- ✪ *Consider:* Are there any rubrics in YOUR chapter that should be in another chapter?
 - ✪ Move them to a section on bottom of the sheet with comment and suggest where it should be moved TO.
- ✪ *Consider:* are there rubrics in OTHER chapters that should be moved into YOUR chapter?
(e.g. sleep apnoea needs to be moved from P chapter)
- ✪ Add each into its correct component and record its ICPC-2 code in **GREEN** to show it has moved in.
- ✪ Enter its ICPC-2 inclusions, exclusion, frequency



- ✦ Sort the rubrics into correct component (as per 2 pager)
- ✦ Sort like-with-like within component (e.g. all infections together)
- ✦ Consider logic within sub-component (e.g. position within sub-component according to clinical logic). Move around as needed
- ✦ Look at subgroups: is there a place for everything? If not - add Other..... **NEC/NOS**
e.g. Other malignant neoplasms = **-N09**;
Other Benign = **-N59**; Other uncertain = **-N98**;
Other neoplasm NOS/NEC = **-N99**
- ✦ **In column 1 enter the ICPC-3 code**



- ➊ Add all the numbers in column 5 to get the total.
- ➋ Enter in Column 6 the Per cent of total in current version of Chapter (Components 1 and 7 only)
- ➌ You now have a working draft chapter for detailed review



Review the update group reports and any other 'issues' reports submitted by members.

- ❖ Update group has identified issues in ICPC-2 over the years which need work. Changes would be required that are too big for an update.
- ❖ Consider the list provided by Update group and members 'list of 'issues'. Try to solve the problems.
- ❖ Add description of the solution in the "Comments box" or raise for broader discussion the possible solutions.
- ❖ **Colour any suggested changes in blue.**



Consider international data

- ⊕ Look at the rubrics with VERY low or NO frequency of use.
- ⊕ Should these be retained?
- ⊕ Reason for retention could include:
 - ⊞ This is a standard rubric across all chapters (e.g. fear of)
 - ⊞ Though low frequency it is a public health issue of importance. You need to be able to identify an increase or sudden surge in its use.
 - ⊞ Add your thoughts in the 'Comments box' whenever needed.



Consider international data (2)

- ❖ Look at the rubrics with VERY high usage. Is the rubric a single concept of high frequency? **If so** retain as is.
- ❖ **If not** and it includes multiple concepts:
 - ❖ Look at SNOMED terms frequency data in that rubric.
 - ❖ Does one of the multiple concepts in the rubric have very high usage compared with others? Consider: should it have its own rubric? Discuss in group and decide.
 - ❖ **If yes:**
Create, place in correct position, give code, label, define inclusions and exclusion criteria. In column 2 (ICPC-2 code, enter the code this WAS part of before you made a new rubric.
 - ❖ **Enter ALL these data in brown.**



Cross chapter implications

- ✚ Some changes you wish to make may have implications for other chapters.
- ✚ Keep a list of these in another spreadsheet with details of which chapter(s) the change affects.



Cross chapter issues

- ✚ There are some issues which arise across multiple chapters.
- ✚ How these are dealt with will require broader discussion in WICC as a whole. E.g. we deal with cysts inconsistently; Peri-anal, perennial, vulval itches etc need a standard approach etc. Where does 'skin stop'?



Process codes

- ❖ While in some countries you cannot use a process code as a problems label, in other countries the GPs do it whether they should or should not.
- ❖ Discussions last year: core process group in Chapter A or a chapter of its own. Others still want chapter specific process codes.



Process codes (continued)

- ✦ In chapter G I found there were some Problem labels frequently used by GPs that were processes directly related to the chapter.
- ✦ I kept a list of these so we can consider how to manage these process problem labels. They include Pap smear, and Sexual health screening. (XL file)
- ✦ Should we consider including a specific process section in each chapter for which it is needed?



Risk factors-NERI/PERI

- ❖ Same issue as processes: e.g. what of 'risk behaviour – STI' ?
- ❖ While it is a person related factor, it is directly associated with the genital chapter.
- ❖ Should such chapter specific NERI/PERIs be included in the chapter?



Proposal to move forward

- ✚ Discussion now.
- ✚ Decisions (including software choice)
- ✚ HB prepare a White paper describing the process for revision of a chapter to get it to Alpha stage for wider review.
- ✚ Distribute white paper for discussion
- ✚ Finalise white paper.



Questions and discussion

- ❖ Should chapter specific NERI/PERIs be included in the chapter in the Core?
- ❖ Should we consider including a specific process section in each chapter needed in the Core?
- ❖ Can we get agreement to move forward?
- ❖ Can we establish chapter groups?
- ❖ Can we establish realistic timelines for stages of work?
- ❖ What software should we use for this work?