WICC and the CONSORTIUM

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Exchanging knowledge during the whole year

LINKING PIN

ABOUT THE CONSORTIUM

For the development of the new ICPC-3 a Consortium is in place in which the project is undertaken. At the moment the Consortium consists of WONCA World, WONCA Europe, Radboud University Nijmegen and a number of participating countries.

The Consortium is open for new partners if they want to contribute, financially or otherwise. The benefits of taking part in the ICPC-3 Consortium is twofold: having influence on the content of ICPC-3 and a user license for the ICPC-3!

In the ICPC-3 Project a new version of the ICPC and an Interface Terminology for Primary Care is under development, based on a novel approach for classification development, i.e. based on a **content-model**.

- **This novel approach takes into account all desired uses of ICPC in International and different National Primary Care settings**.
- There will be consistency with the principle of interoperability within the Framework of International Classifications and Clinical Terminologies.
- It is also aimed to create a stable model to support continuous central development and maintenance of the ICPC and Interface Terminology.
- The ICPC-3 Project Secretariat is hosted by the Department of Primary and Community Care / Radboud University Nijmegen, the Netherlands.
- The ICPC-3 Consortium is founded specifically for the development and maintenance of ICPC-3.

THE ICPC CONTENT MODEL

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. Symptoms and complaints
   b. Interventions and Processes
   c. Diagnosis, Care and Clinical Findings
   d. Functioning - functions, activity and participation
   e. Functioning related factors – personal factors, environmental factors
3. **Temporal Properties**
   a. Duration, course, age of occurrence, stage
4. **Severity and/or – existing severity scales- ICF scale**
5. **Manifestation – Laboratory - Imaging and Clinical findings**
6. **Causality -** in disease component (congenital/hereditary infectious, neoplasm, trauma,

Maintenance attributes

A. Unique identifier

B. Subset, adaptation, and special view flag
1. Country adaptation
2. Research
3. Special indices (e.g. Public Health Indices or Resource Groupings, Case-mix)

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

D. Mapping relationships
Linkages to other systems like ICD-10 ICD-11, ICF, ICHI, SNOMED etc.
Linkages to ICPC-1, ICPC-2

E. Other rules

What will be new?

Person-Centeredness at the core of ICPC-3!

The leading principles are:

Relevant National content within ICPC-3 to suit National Primary Care needs.
The rational for additions to ICPC-3 will still be: frequency and evidence based.
Familiar will be the simplicity of the new ICPC-3, no excessive subclasses like most classifications and clinical terminologies.

The content of ICPC-3 will be 'linked' to relevant classifications, such as ICD-10, ICD-11, ICF, ICHI and clinical terminologies such as Snomed-CT.

Present progress

To achieve the new content, the first step is the review of present content of the ICPC 2.7, from an International and National perspective.

International: **this work takes place within the Consortium Core-Group and the WICC Taskforce-A. The input from Taskforce-A is through membership of the ICPC-3 Consortium Taskforce.** As a dedicated body represented within the Consortium by one of the Taskforce-members, the WICC members are reviewing all chapters of ICPC 2.7, based on a set of criteria. The result of the review is provided as proposals to and processed by the ICPC-3 Consortium Secretariat, in view of the criteria.

National: **the Country Members of the 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 are processed within the ICPC-3 Comment site.

A view on the Comment Site: next slide

- ICPC-2
  - - Process codes
  - A General and unspecified
  - B Blood, blood-forming organs, and immune mechanism
  - D Digestive
  - F Eye
  - H Ear
  - K Circulatory
  - L Musculoskeletal
  - N Neurological
  - P Psychological
  - R Respiratory
  - S Skin
  - T Endocrine, metabolic and nutritional
  - U Urinary system

		(see discussion)
B27	marc	change to: Fear of /concern about haem/immune disease other NEC (see discussion)
B28	marc	change to: Limited function/disability haem/immune systems (see discussion)
B29	marc	change to: Haem/immune symptom/complaint, other NEC *reply: New prferred term: Blood/immune system symptom/complaint, other* (see discussion)
B70	marc	ChWG suggested adding with/without known source *reply: Keep it as it is and if the etiology is known add in the label. Example B70 with a label Bartonella. Do not double code and do not change the code.* (see discussion)

About ICPC-3

In daily practice of Primary Care, Community Care and Public Health many standards are used. In Primary Care the ICPC or ICD is the starting point for registration and documentation: the “data”.

Most of the data is for use within the Primary Care setting itself, some data is used for referral, also some data comes back after consultation of a medical specialist or dismissal from a hospital.
Data that is received by others or is sent by others in most cases will require more detail or contain more detail. ***For Primary Care as such, a high level of detail is not required, even not wished for. Adequate is what is needed.*** No excessive detail, tailored to Primary Care and bridged to classifications with more detail.

The ICPC-3 content therefor will contain **linkages to several standardized classifications and clinical terminologies**. This is what is generally called a ‘telescopic’ view.

Starting with the categories or class in ICPC-3, when more detail is needed zooming-in to either ICD for diagnostic terms, ICF for functioning or ICHI for interventions.

The other way around; when detailed data is received, zooming-out to the relevant ICPC-3 categories/classes.

Including these linkages in ICPC supports the principle of continuity of data within and between health-care providers, but also supporting the use of ICPC, or ICD within a country, without losing the possibility to collect or exchange information for different purposes, such as direct patient care, research, reimbursement, aggregation or dis-aggregation, etc.

For the information exchange process, standardization is required on a different level: secure the meaning of the content by using the same (clinical) terminologies, e.g. the use of the Foundational Model of Anatomy (FMA) throughout all related classifications and Clinical Terminologies such as Snomed-CT.

In addition to the ICPC-3, an **Interface Terminology (Thesaurus)** will be developed.
This Thesaurus is a reference terminology for Primary Care that lists words grouped together according to similarity of meaning (including synonyms, or variants of terms). **The main purpose of such a reference work is to help the user "to find the correct word, or words, by which [an] idea may be most fitly and aptly expressed".** In other words it is a controlled vocabulary.

The Thesaurus can be used as an interface-terminology, as it is already used partly in the Netherlands and Belgium in the EHR for GP's/Primary Care.
The Thesaurus we intend to develop will offer all the options or views that are needed, either to start searching from ICPC, ICD-10 or ICD-11. As Snomed-CT ID's and possibly terms will be included, future implementations of SNOMED-CT can also be supported.

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