Reflections on the ICPC, other classifications, data elements and the Z chapter.

What should we keep in mind when we are talking about the ICPC-3?

I feel (so it is subjective) that we do not give enough priority to the basic concepts of the ICPC. This is probably the result from not using the RFE as start of an episode of care. The RFE is almost not used by most of our members and maybe also not used because most of the WICC members do not see the importance of registering the RFE. The same applies to the processes. For me this is strange because 37% of our episode diagnoses have the same code as the RFE. But of course there are more reasons why the RFE is important!
The main difference with the ICD and also with other classifications is that the ICPC is biaxial. Every chapter, representing a body system and problem areas is divided into 7 components. And every component can be used for the RFE. So if you only want to use the ICPC in the diagnostic mode you only need component 1 and7, in fact you are working on 1 axe. And it seems to me some members of WICC go for this. By choosing for this you lose the basic idea, the concept behind the ICPC: the concept idea is that the ICPC characterizes the domain of Family Practice and typifies the way the FP works. And this means not only coding the diagnosis/problem. Maybe we as members of WICC do not differ in the way we deal with our patients but I am sure we differ in registering the RFE and using all the components for classifying the encounter. The ICPC is RFE (patient centered) driven classification, and the full spectrum of problems (including organic, psychological and social) managed by the FP are recorded in the form of episodes of care.
A big difference between the ICPC and the ICD at **diagnostic** level is that we in primary care accept symptom diagnosis and problem diagnosis and that our rubrics more or less are based on frequency of problems/diseases/symptoms in primary care. It is impossible that there are problems/diseases/symptoms in the ICPC who cannot be mapped to the ICD. Looking at the new ICD 11 (at chapter level) there is almost nothing changed in comparison with the ICD 10. The content model (ICD11) is not a paper model, it is for HER use.

NERI and other classifications

And of course there are data elements that are in a strict sense not a part of the ICPC and not coded with the ICPC but who are still important. But by using a link it is possible to bring that information in for describing the episode of care. And some of us are doing this already for many years. The ICPC uses or can use coded information from other classifications (ATC, ICF, ICHI, Risk Factor classification etc.). And also personal factors/NERI information/patient preferences can be linked to the episode of care at the moment that information is important for that episode. That is exactly the same way we now use the ATC. The ATC becomes “important” in the episode/encounter at the moment you want to prescribe a drug for a specific problem/disease. So extending the code system is always possible but why? Maybe only when you do not want to use other classifications for more granular information?

Data elements in our HER

We store a lot of information in our HER but for example for describing the management of the episode otitis media we just need a small part of all hat information. For information at population level (how many of your patients have measured the blood pressure last year etc.) you need intelligent software, for incidence and prevalence of diseases/problems the episode of care often is sufficient but not always. The episode of care for coxarthrosis can stop after for example surgery, but

when you want to count how many patients you have in your practice that have had surgery for coxarthrosis you cannot use the episode of care, so some old episodes of care can stay on a separate list.

The discussion around the Z chapter

First I want to give again the definition of an episode of care: The episode of care is defined as a health problem or disease from its first presentation to a health care provider until the completion of the last encounter for that same health problem or disease (WICC 2005, p 11). An episode of care can consist of one or many contacts concerning that same health problem. The title of the episode of care (the diagnostic label) may be modified over time from a symptom diagnosis to a disease diagnosis. Every contact, which mostly has the form of a consultation, can be described by three major elements: the reason for encounter (RFE), the diagnostic or therapeutic process, and the resulting health problem or disease label at the end of the consultation. These three elements can be coded with the ICPC-2. Even though the episode of care may have (temporarily) come to an end, the episode of disease and the episode of illness may continue. Depending on many variables (the disease, the patient, the FP, the health care system), later on, the episode of care can be 'revived' (even after years).

Not all the information you have fit in the episode of care, sometimes because the patient do not want to talk with you about a problem, he or she does not want care from you as GP although you could think that it is important. If you want you can store that information in a separate field in you're HER or if you decide that that information should be a part of the encounter and of an episode of care you can start an episode with -64. Obesity as example: some patients do not want to talk with you about this, the same applies for drinking alcohol and maybe many other kind of information/problems/diseases. So from the patient's view they do not want to receive care from you. And of course you can try to make episodes of care but we know as experienced GP if someone does not want care do not try to give it. Still you can store that information in your HER, for example in a Risk Factor field.

So for me it is clear that Juan who do not accept the episode of care as an important structuring principle of documentation has problem with the basic concept that for coding a social problem **in the episode of care** require the patient's expression of concern about etc.

So it has nothing to do with being competent as a GP to diagnose etc.

Conclusion

The main question for me is do we want to maintain the biaxial structure of the ICPC?

And if we choose to maintain the biaxial structure and the episode of care model we can go further to investigate which data elements from other classifications which are important in primary care can be linked to the episode of care (most of them to the processes and maybe some as a new component). In the HER we store all the information necessary for a good practice and we use the concept of the episode of care to structure the information necessary at the moment the patient visits you. Changing a code structure is always possible but you must have an idea and data to support those changes. Till now when we discussed the ICPC-3, we have especially been focused on the use of the ICPC in the diagnostic mode at the 70-99 rubrics, the least specific part reasoning from primary care!

Kees