Reflections on the ICPC, other classifications, data elements and the Z chapter.
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From: "Kees van Boven" <cvboven@hetnet.nl>

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

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as you know and could see in my answer to Ferdinando I am well in line with your thoughts. There is and should be more than one axis in the ICPC and more than one place in the EHR to store and code information.
Thank you und herzliche Grüsse

Thomas

Perfect summary. BUT I think most questions are about "taste". This is difficult to deal even with good data

Kind regards,
Gustavo Gusso

Hi
The biaxial structure is coming from the pre Internet age, with the beginning of the database (ICPC has been developed in DBase)
Now with the power of the central units, the Internet network and the ontologies we can free ourselves of these two dimensions . Elena Cardillo, (**https://dkm.fbk.eu/index.php/Elena_Cardillo**) who ,is applying to be an observer is from the new generation of Information technology officers and will introduce us to this new fields.
We have to conserve the biaxial fundamental structure for non informatic use but we can develop as NERI as we need .
The problem we are facing now is quiet the same as in terminologies like SNOMED or UMLS
For instance Obesity, altough with the same ICPC code, could be a problem for the patient , a fact, a risk and we will have to tag it with appropriate semantic identification or which is the same, to put it in the relevant place in the EMR

Marc J

Dear Kees

you really entered the core of what's ICPC and it's use!

Indeed the RFE is the core of what we are doing, and not the diagnosis.
The episode OF CARE: the patient decides upon the point if he/she wants care for that or that problem, so that's an aspect of the RFE: this makes the RFE as the most important and patient centered aspect. (it contains also the patient's target and preferences!)
The diagnosis is an instrument of the doctor to define and assess the approach, in combination/dialog with the patient.

You know I agree very much with what you write about the non episode related information NERI, one of my favorite topics the last years.
Also I agree with the position of other classifications: I discussed this point with a specialist in engineering and informatics, and we tried do develop a visualization of a multidimensional model for what the HER contains, and integrated in this way all of the wanted classifications.
A computer system can perfectly follow all the possible links in this multidimensional framework and network in all possible directions, and help you perfect in determining what are the wrong and good links you make (a kind of extremely specialized decision support system).
But it's so complex to construct it with a group of un-specialised GP's in this matter, that it would take many many years to develop (especially when you think about the discussions that this would generate….!!) So we stopped the attempt to present this model.

For that reason my proposal (and not only mine) was to use the biaxial structure of ICPC as basic model, with all kind of 'openers' to other classifications whenever needed at the appropriate place and time, This model is more realistic than the previous one.
Defining and describing this model (ICPC as the backbone and all the waned limbs) would be already a very big step forward into ICPC3 with respecting the basic principles of ICPC2.

You know very well how much I love the aspect of components 2-6 and my believe that this is the most underestimated powerful aspect of ICPC!
Don't lose it, improve it !!
Conclusion: you have my full support for your reflections.
Thanks for it

Marc Verbeke

-i fully agree with Kees about the RFE and about "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"
-in fact we need to improve the RFE "side" of ICPC
-the emphasis should be not in "patient-care", but in "person-care" (see attached paper), taking into account with respect patients' expectations and patients' goals and patient's experience of the process of care

-of course, Kees' comment highlight the problem of "episode of care" 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

-episode of care is an artificial and toxic concept, very useful for specialist, who offer "episodic care"
-in this case, Z chapter, for example, Z19, loss or death of a child, the parentes denied having any problem with it, but their life changes totally, and the care of their illness also (for example, diabetes and heart failure), but you are not "allowed" to code this health problem (Z19) as a health problem because the concept of episode of care
-but Kees makes a suggestion even to any health problem that the patient denied, 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 example, your patient has a fracture of radius, but he thinks and insists is only "a little trauma", and because this you cannot record it (or perhaps, as "risk factor"); what about a lung cancer the patient insists is just "only cough", and so on
-the assessment of the problem is "our kimgdom"
-of course, we do not need "a diagnosis" as it; the tiranny of diagnosis is destroying General Practice (with the help of "too much prevention", "episode of care", "EHR for all" and "health team work", the **Five Horsemen of the Apocalypse**, the five myths without scientific base)
-un abrazo
-juan

Re: ICPC-3 reflections and the Z chapter
Dear Juan,
Thanks for your comments. You underlined the part “Juan does not accept the episode of care as structuring principle of documentation”. In my opinion this has nothing to do with patient or person centered. Optimal structuring information needs sometimes also information/knowledge of what happened in the family 20 years ago. For example speaking with patients, taking care, at the end of life because of lung cancer includes sometimes information that his/her child died 30 years ago.
How to build a classification?
First: The concept, the philosophy (big words!) behind: what is belonging to family practice (what do patients/people/persons expect from their FP) , who are the actors in FP domain?
Ppatient/person/family/nurses/”insurance companies” /government” etc. Which processes can you describe based on what happens in the domain of FP, and from this what is the information model to describe those processes.
Juan, I see your position in WICC as someone who is mainly speaking from a ideological background and who will stand on the brakes in structuring the consultation using classifications as the ICPC. That is ok for me but not everything what is artificial is bad or toxic (episode of care). And to end with a wink: long live the King (in the Netherlands and England the Queen).

Best regards,

Kees

Hi Juan

The first intent of ICPC is not to classify patients but to propose a tool to analyse the activity of the doctors facing patient's problems, either expressed or hidden ones.
Identification of the reason(s) for encounter, either expressed by the patient or provoked by the doctor or by a third party is essential to understand doctor's answers, decisions and influence on the process of care. We are not analyzing the patient but the activity of the doctor. As time frame is essential to the exercise of GP/FM, the introduction of time in the analyse of the process introduces naturally the concept of episode of care, means the period of time in which the doctor is accompanying the patient for one or multiple problems.
To use the term "episode" is only the introduction of time in the general descriptive and analytic process and has nothing to do with 'episodic care'
I don't understand why the analyse of one or multiple sequences of process during the time could be toxic for patient care.

About the other subject you are mentioning with distrust
By the way, health care team is central to my own practice since 34 years. I am presently in a multigenerational (I am the old one), multidisciplinary (only primary care actors) and multicultural group and this is really a must for the actors of which the patients are the vast majority.
I am clearly reluctant to EMR for all, but is maybe only because the tool I have is so bad that it is disturbing my relationships with the patients.
And finally I consider that I don't do enough prevention not because I am not willing to do it but because all but very few clinical preventive activities are scientifically sounded and that the risk to harm the patient is very high. Nevertheless prevention, like learning breast feeding, quitting tobacco, explaining the effect of Cocaine or access to potable water has to be central to Primary Care
Marc

-no doubt, Marc, we agree about these questions (the objetive of ICPC use, too much prevention, EMR for all, ...)

-except "episode of care" because the fragmentation of care that implies, toxic for patients' health and for General Practice
-as you know, personal experiences do not support science; i have had also excellent experiences with teams, but this is "personal", that's all
-un abrazo
-juan

-excellent, Kees
-i fully agree with you, except about to long live the King (not as person, but as King); not at least for the Spanish King, and in general about the idea of having a King/Queen
-we need ICPC for better understanding of our patients, colleagues and ourselves, to improve our practice, and to research and teaching
-in any case, thanks for being so patient with me
-un abrazo
-juan

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Best regards,

Kees

Thank you Kees, for sending us your reflections on the core elements
of ICP in the context of other classifications, data elements and the
Z chapter!
I agree very much on the importance of the RFE concept, which among other
important reasons you mentioned, does not force us to make a definitive and final
diagnosis at the end of a consultation under all circumstances. So also for me it
is very important that ICPC accepts symptom diagnosis and problem diagnosis
(based on frequency statistics) reflecting honestly the reality of our daily work

with our patients.
Concerning NERI you suggest to keep this information (e.g. risk factors, ICF etc.)
out of the ICPC but to register and (probably) structure it in the electronic health record
and to link it to ICPC within the episode of care. This would mean to keep to the
core concept of ICPC, but giving more flexibility by using a lot of relevant
information from other sources, an idea which seems attractive to me.
Concerning the discussion on the Z chapter your suggestion to register
our own personal view and estimate of various social aspects of our patients only in the
EHR, not giving an ICPC code to it (if the patient does not agree on
the existence of such a problem) gives the opportunity to consider
possible relevant social influences in our patients` lives without violating the ICPC principle
of patient`s expression of concern about the existence of a social problem for her/ him.
In your conclusion you ask if we want to maintain the biaxial structure of ICPC.
In my opinion this ordering principle allows to register, structure and reflect
the most important aspects of our daily work as GPs from a very practical and
pragmatic point of view, so we should not give it up.

With best wishes
Gustav Kamenski

Dear all:

I agree with Gustav. This has been a good discussion, and I think there are a couple of points that are important to our next stage of work.

First, the episode of care concept is very valuable. It provides a great frame of reference for the activity of GPs in everyday practice, and it allows us to structure much of our data in a way that makes it valuable in understanding primary care. But as we have seen in the discussion, there are important aspects of primary health care that are not a natural fit into an episode of care. That is OK. It does not mean that the episode of care is a bad concept, or that the things that do not fit are unimportant. It does not mean that those who look at primary care through a different lens are wrong. We need to understand that for some people and in some use cases, episodes will not be the core.

Second, one standard approach to recording primary care data will not fit all needs. If our mission is to provide tools for GPs worldwide, we need to expand our focus to include more than the narrow GP office viewpoint. Because primary care needs are changing, and they are diverse. So, as for the Z chapter discussion – it is very clear that in my setting, we need to be able to identify social problems whether or not they are an episode of care that we provide directly. If we attempt to follow a biopsychosocial model of care, we will need tools that can capture the domains. Of course we have to be careful to not impose our moral judgements, or over-medicalize human suffering. But we are trained to observe closely and identify problems, and we come against this threshold issue with many medical and mental health problems. So social problems should be captured. In many cases they will not be episodes of care but will be clinical modifiers, and in the NERI category.

As we think about future work, I believe that ICPC-3 will remain at its core very much as it is now. The 'new' work will allow us to move beyond the constraints of the narrow episode of care definition, and create tools that can capture the other important concepts we've discussed over the past few years. Whether we call the new work 'ICPC', or 'ICPC-extenders', or 'George' , is not so important.

I see that Marc has noted this as an issue to be discussed again at the WICC meeting, and I'd be happy to put this on the agenda.

mike

Last mail June 12, 2012