What is the International Classification of Primary Care?

- Biaxial, alphanumeric classification of primary care problems *and related actions*
  - 17 chapters [A-Z]: body systems
  - Components in each chapter:
    - *symptoms and complaints [01-29]*
    - *diagnostic / screening / preventive services [30-49]*
    - *medication / treatment / procedures [50-59]*
    - *test results [60,61]*
    - *administrative [62]*
    - *referrals, other reasons for encounter [63-69]*
    - *specific diagnoses [70-99]*
- Organized into episodes of care

ICPC

- Produced by the WONCA International Classification Committee (WONCA = World Organization of Family Physicians)
- first published 1987 by Oxford University Press; second revision was published in 1998
- 2nd revision was accepted within the World Health Organization Family of International Classifications
- 3rd Revision in Development

key features of ICPC

- Incorporates patient "voice" in Reason for encounter (RFE)
- Symptom diagnoses where appropriate
- Accommodates social problems (chapter Z)
- Episode-based - can track process of care for problem over time
- Limited granularity of basic code set – based upon prevalence of diagnosis
- NOT A TERMINOLOGY - mapped to standard terminologies, classifications

Maps and windows for ICPC

- ICPC-2-R to ICD-10
- ICPC-2-R to ICD-9-CM
- ICPC-2 to SNOMED-CT primary care reference termset (refset) created by the IHTSDO GP/FP working group
- windows from ICPC to:
  - *CPT, SF-12, WONCA/COOP charts*
  - *work on ATC-codes, ICF*


Transhis

RFE shortness of breath in **25-44 yo** N=973 episodes.

ICPC	*Final Diagnosis*	*Prevalence*	*OR (post prob)*
R78	Acute bronchitis	27.8%	20.03
R02	Shortness of breath	12.7%	
R98	hyperventilation	11.7%	24.47
R96	Asthma	10.4%	57.09
R74	URI	8.6%	1.84
R75	Sinusitis	2.9%	0.82
R96	Pneumonia	2.8%	13.16

Source: EFP / Dutch Transition Project database

RFE shortness of breath in **65-74 yo** N=788 episodes.

ICPC	*Final Diagnosis*	*Prevalence*	*OR (post prob)*
R78	Acute bronchitis	30.4%	7.25
R02	Shortness of breath	14.6%	
K77	Heart failure	10.5%	15.13
R	Emphysema/COPD	4.8%	21.14
R98	Hyperventilation	4.8%	12.92
R81	Pneumonia	4.3%	5.21
R96	Asthma	3.5%	4.0

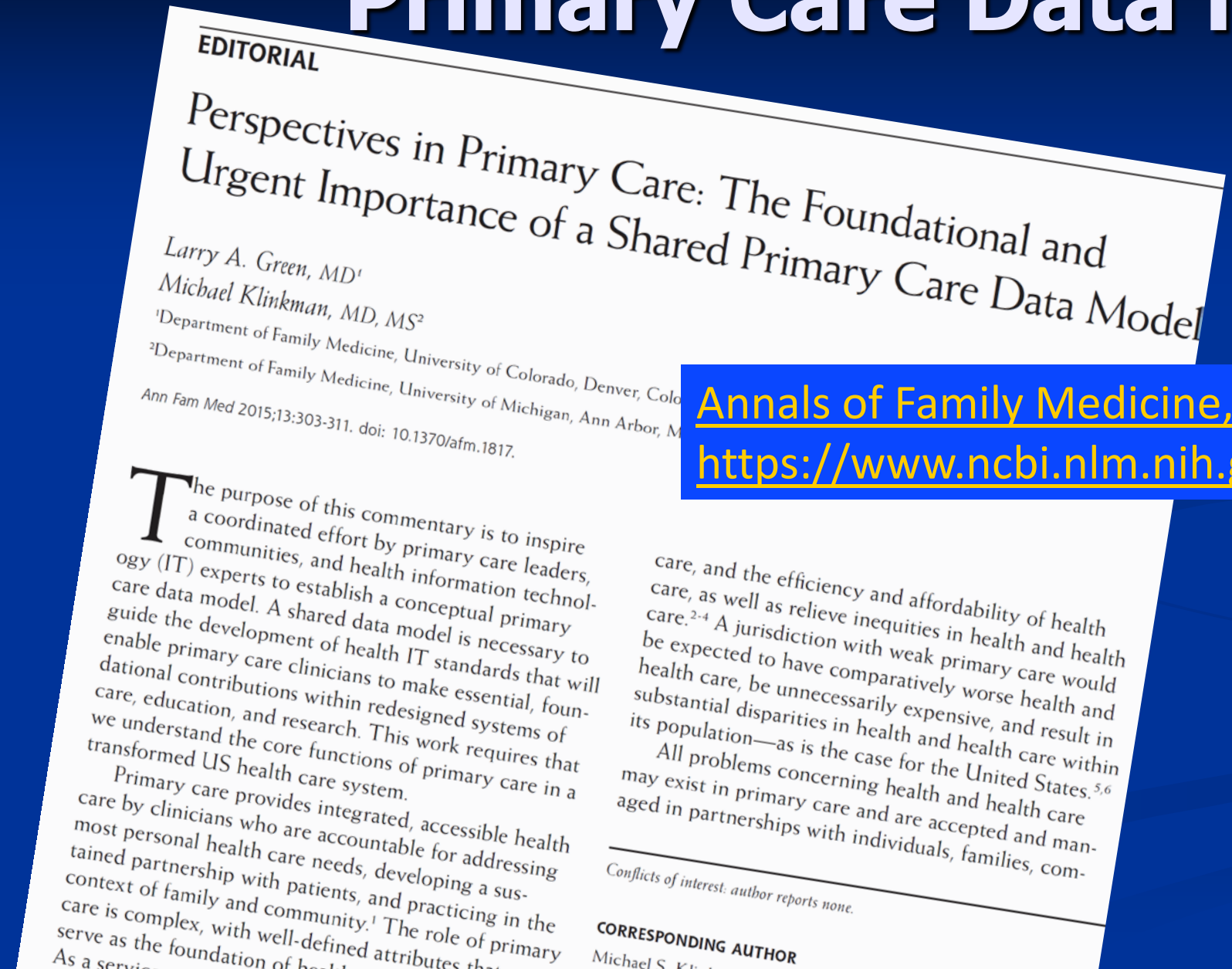
Source: EFP / Dutch Transition Project database

Comorbid conditions in men 45-64 (n=613) **and men 65-74** (n=547) **with diabetes**

Diagnosis	*% 45-64*	*% 65-74*
Hypertension	22.8%	28.8%
Hyperlipidemia	13.2%	10.8%
Ischemic heart disease	8.0%	14.1%
Low back pain	8.0%	4.6%
Sleep problems	5.2%	6.8%
Depressive disorder	3.9%	4.6%
ED/impotence	3.4%	1.8%
Heart failure	-	7.1%

Source: EFP / Dutch Transition Project database

Primary Care Data Model



EDITORIAL

Perspectives in Primary Care: The Foundational and Urgent Importance of a Shared Primary Care Data Model

Larry A. Green, MD[1]
Michael Klinkman, MD, MS[2]
[1]Department of Family Medicine, University of Colorado, Denver, Colo
[2]Department of Family Medicine, University of Michigan, Ann Arbor, M

Ann Fam Med 2015;13:303-311. doi: 10.1370/afm.1817.

The purpose of this commentary is to inspire a coordinated effort by primary care leaders, communities, and health information technology (IT) experts to establish a conceptual primary care data model. A shared data model is necessary to guide the development of health IT standards that will enable primary care clinicians to make essential, foundational contributions within redesigned systems of care, education, and research. This work requires that we understand the core functions of primary care in a transformed US health care system.

Primary care provides integrated, accessible health care by clinicians who are accountable for addressing most personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.[1] The role of primary care is complex, with well-defined attributes that serve as the foundation of health
As a servic

care, and the efficiency and affordability of health care, as well as relieve inequities in health and health care.[2-4] A jurisdiction with weak primary care would be expected to have comparatively worse health and health care, be unnecessarily expensive, and result in substantial disparities in health and health care within its population—as is the case for the United States.[5,6]

All problems concerning health and health care may exist in primary care and are accepted and managed in partnerships with individuals, families, com-

Conflicts of interest: author reports none.

CORRESPONDING AUTHOR
Michael S. Kl

Annals of Family Medicine, 2015
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4508165/