REPORT FROM THE PROCESS GROUP

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Discussion on ICPC-2

We discussed if our time should be spent improving the process rubrics on ICPC-2 (namely, replying to comments received since the process rubrics were approved in 2014) or move to work on process for ICPC-3. There are important comments that should be decided upon, but there are also some problems with the way process classification is structured in ICPC-2 that could not be solved. We should admit that we can only reach solutions that can be accepted by a majority, it will be very difficult to reach consensus.

We decided to solve the issues raised with ICPC-2 first.

- -65: move the text in consider section to note.
- -66: move referral to -67 and -68 from consider to exclusion

Discussion on ICPC-3.

We looked at IC-Process-PC and what could be used for ICPC-3.

- Debate on whether we should classify things like tests, medicines and referrals very specifically or make broader categories and then map to more specific classifications (like ATC for medicines).
- Should we keep the link between process and chapter? There are many problems that arise when trying to assign processes to chapters.
- Broader debate – what is the relevance of classifying processes, what information do we seek to obtain? Most process rubrics should be easily classified automatically by electronic medical records without the need for physician intervention. This would mean process classification needs to be made simple. At the same time, some people might need more detail in the classification.
- Should we have a stepwise structure with large categories being subdivided (more divisions than just chapter and components). We need to develop a data model for process. There are different data models around the world that should be considered.

We sought to list activities to classify (sections):

1. Reasons for encounter and clarification of reasons for encounter (-48, -60, -61, -63, -64, -65, -69)

2. Diagnostic and screening
    - Physical examination (-30, -31, IC-Process-PC 46)
    - Tests
        - Labs (→ LOINC?) (-32 → -38)
        - Functional test (-39)
        - Endoscopy (-40)
        - Imaging (-41)
        - Electric tracing (-42)
        - Others (-43)

          [to be decided where to put IC-Process-PC 43, 44 – split them into functional and other?]
3. Treatment
    - Education / counseling (-45, -58)
    - Medication (→ ATC, other category for non-ATC) (-44, -50. -55)
    - Surgery (minor / major) (-51, -52, -53, -54, -56, -59)
    - Rehabilitation (-57)
4. Administrative
    - Certifications (-62)
5. Collaboration
    - Consulting with other health care providers (-46, -47) [include multi-professional meetings]
    - Referrals (-66, -67, -68)
6. Other

Attributes of processes (optional, inspired by JK's archetype)

- Attributes of GP and practice
- Specimen collection / performing the test / ordering / consultation [/ referral – deleted because it would cause confusion with the activity of referral]
- Screening or diagnostic purpose, preventive or treatment
- Medication route of administration: oral, subcutaneous, topical, intramuscular, intravenous, rectal, other)
- Medication duration: (acute, intermittent, continuous, chronic)
- Immediate / subsequent to the visit
- On site / elsewhere

Other attributes (not linked to processes):

- Location (office, hospital, emergency department, patient home, …)
- No need to classify length of consultation?
- Type of visit (face to face, telephone, videoconferencing, email, third party, surrogate, failed, …)
- Scheduled / non-scheduled
- Urgent / non-urgent