Exchanged mails : Making personalized medicine in primary care more visible, pre meeting 2012

Making personalized medicine in primary care more visible, pre meeting

Attachments: msg-17154-13.html (3k)

ICFPC4.xlsx (16k)

ICFFP2.docx (17k)

Dear friends,

I want to invite you for the pre-meeting of the Update group and as part of the Update group meeting the process group meeting. I know that not all of you are able to come the Saturday and Sunday before the meeting starts but it is in my opinion important to have this meeting with some members to prepare the discussions in the complete WICC. We need a lot people who want to think about the subjects in the attachments. Although some items are not specific for the Update group alone we did start the discussion about the ICF, personal factors already on Malta a year ago and we have worked there a lot in a small group with people who prepared them before coming to the meeting. And this is what I want to propose. Let us brainstorm the two days before the WICC meeting starts. The outcome could be a proposal to link some items of the ICF and some personal factors to the ICPC. But it is of course also possible to propose something complete different. Marten will chair the discussion about the process rubrics in an 3 hour meeting at Sunday afternoon.

Is it possible to let me know if you are able to come to the pre-meeting and if you are able to start the discussion already before we meet each other in Italy. Did I forget someone from the Update group??

Best regards,

Kees

I have a comment/question : Notwithstanding the importance of the personal factors and how to code them with ICPC and link with ICF (you mean International classification of functional health problems?) don't you also think risk factors can be another point of discussion that would allow the group to take the way for the ICPC-3?

Regards

Nicola Buono

About risk factor,; we have had a lot of discussion about this issue and Sebastian Juncosa has gathered a lot of it.
My point of view is that risk factors are typically a doctor problem, not a patient one. A risk factor is a particular knowledge about a patient which is able to modify the decision taken by the doctor about his /her own decision about a a patient or about treatment or educational message.
All those situations could be internal or external to the patient but are rarely transformed by the action of the doctor.
So Risk factor could be a list of characteristics, behaviors, diseases, etc acting as metainformation susceptible to modify doctor's decisions. The are extremely variable and not susceptible to be listed as such. There are also extremely dependent from the sociological, economical and anthropological context and susceptible of moral interpretation.
not access to drugs (medicine) is a risk factor
having access to drugs is a risk factor
take the pill is a risk factor

not to the take the pill is a risk factor
have sex is a risk factor
not having sex is a risk factor
life is a risk factor
the main issue is that the risk is determined by the doctor not by the patient

such health problems deserve maybe a flag in the electronic medical record nd has to be taken in account to define a strategy but are highly dependent of the context and the subjective appreciation of the provider.
A classification of risk factor is worthless.
friendly
marc

I read carefully your report. I strongly agree that it is a useful work. I just have a small consideration for now (I think it is related to questions before the excel). How to manage risk factor or NERI when some rubric can be both, a RFE/ diagnosis and a NERI (for example, tabacco)? I think this is one issue not solved and it is a need for a good purpose. Am I wrong?

I am trying to manage to be there on saturday but I am not sure yet

Kind regards
Gustavo Gusso

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attached (see below) a short answer to Kees' questions. I don't see a problem. We have different places to store information in the EHR already now. Why should this be a bigger problem with risk-factors. They might be stored "in the background" in a list for risk-factors and if they become a RFE then they are again recorded there.
May main concern is not to overload the record and the documentation-work of the GP. Even if in many aspects people are very similar, they can be very different at the same time. Information for personalized medicine is by nature idiosyncratic and thus frequently very specific. Coding conflates things making this information very useful for research, but not for practice. We should not ask the GPs to do too much documentation that is not useful for their own purposes and tasks.
Herzliche Grüsse

Thomas

Questions

1: Do you support the idea of linking a list with personal/environmental factors, body functions and activities and participation to the ICPC? Do you have comments, additions etc. on this part of the proposal? If we reach agreement about this (the method how to link is in this moment not so important) then.

Answer Thomas: Yes in principle I support such a list. However, I wonder whether this will be workable in practice. Where does this information go in the EHR? Even if the list is only a list and not part of the classification it will have one property of classification: it conflates different things to one common term. A lot of NERI will be very specific. On the other hand we would always want to keep the list short. Research will mostly want to conflate; practice will want to be specific. In some places, as for example the preference of the patient not to take an antibiotic there might suffice a little trick in the EHR: the possibility to explicitly not prescribe. This would make clear that it was not forgotten, but decided not to prescribe it. Decisions should normally be taken together by patient and doctor.

2: Anyone who wants to participate chooses a number of chapters of the ICPC. Per chapter (looking at the symptoms and diseases and with a real encounter in your mind) you brainstorm about the personal (and if you want also the environmental, also important but we did not work it out) factors, activities/participation and functioning important for managing the episode in (symptoms/complaints/diseases/problems) that chapter. You can use the lists in the attachment and add new factors/concepts. An example: if a patient comes to you with cough you want to know some information about smoking (personal factor), work (environmental factor), family, etc. As I pointed out before all that information can be collected in the proposed list (sometimes already known to you) and can be linked to a process in component 2 diagnostic and preventive procedures, for example the rubric -30 renamed as contextual information and functioning in health evaluation. Of course we will need to code that list but that is now not the main issue. By using the 30 rubric in the encounter you indicate that you use information from the proposed list and it is possible to click on the list to make it more specific which information you exactly use. Also we need to develop qualifiers (sometimes they exist already) for many items/concepts in the list.

Please let me know your opinion and if you are able to do some work before the meeting and if you can attend the pre-meeting.

Answer Thomas: Yes I will attend the pre-meeting. However, I doubt whether I will have much time in advance to think much about adding to the content of the list. My be I succeed to think at least about one chapter and by doing so get a feeling of what might still be missing.

Herzliche Grüsse

Thomas