Problem List Guidance in the EHR

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Problem lists facilitate continuity of patient care by providing a comprehensive and accessible list of patient problems in one place. Problem lists used within health records are a list of illnesses, injuries, and other factors that affect the health of an individual patient, usually identifying the time of occurrence or identification and resolution.[1] They are an important communication vehicle used throughout the entire healthcare continuum.

Today the healthcare industry is transitioning from free-text expression of problems to encoded problem lists to facilitate information retrieval and meet requirements of the federal meaningful use program, which pays incentives for the implementation of electronic health records (EHRs).

Capture and storage of information in standard encoding systems support data sharing, provide a more practical and accurate way to conduct data analysis, and support the ability to retrieve information about both common and unique problems. Well-designed problem lists provide a clear picture of patient issues requiring consideration or intervention and frequently serve as a table of contents for more comprehensive health record details. In addition, problem lists offer a data source for research studies, quality measures, and other secondary data-reporting requirements.

Some healthcare providers have not yet used a designated record section for problem recording and must explore how to structure, manage, and identify content to include in a problem list. Administration and maintenance of problem lists can present challenges, and most organizations struggle to define content, responsibilities, and accountability for maintaining an accurate, updated problem list.

Organizations must develop clear policies and guidance regarding the structure and use of problem lists in order to ensure reliability and integrity of the process.† The process for maintaining problem lists must be designed to integrate with a clinician's workflow to be successful. If the functionality for adding and removing active problems is difficult or awkward to accomplish, the list can become overwhelming and unreliable as a current data source.

This practice brief reviews applicable standards for problem list content, examines the role of the problem list in the EHR, and provides guidance on managing problem lists.

Current National Standards

Adopting existing national standards is critical to achieving complete, consistent, and quality data, as well as working toward the future of healthcare data exchange. Currently, there is no single standard for the structure or content of problem lists. However, there are existing standards that address problem list content, with some variation between them.

Therefore, healthcare organizations must ensure their policies and procedures for problem lists designate standards that best apply to their operational needs and future health information exchange uses with other providers while meeting the needs of the patient.[‡]

Some standards to consider when developing problem list policies and guidance are outlined below.

The Joint Commission

Organizations surveyed under the Joint Commission's Hospital Accreditation Standard (RC.02.01.07) are required to initiate a summary list for patients by the third visit. While a summary list is not the same as a problem list, many view the two lists as identical.

The summary list can include any significant medical diagnoses and conditions, any significant operative and invasive procedures, any adverse and allergic drug reaction, and any current medications, over-the-counter medications, and herbal

preparations. These additional content elements potentially require additional provider consideration or intervention.

The standard requires providers update a patient's summary list whenever there is a change in diagnosis, medications, or allergies to medications and whenever a procedure is performed. It also requires the list be readily available to practitioners so they can access the information quickly to provide care, treatment, and services.

ASTM International

Section 7.9, segment 5, of ASTM International's Standard Practice for Content and Structure of the Electronic Health Record (E1384-07) notes that problem lists should contain

> all past and existing diagnosis, pathophysiological states, potentially significant abnormal physical signs and laboratory findings, disabilities, and unusual conditions. Other factors such as social problems, psychiatric problems, risk factors, allergies, reactions to drugs or foods, behavioral problems, or other health alerts may be included.[2]

The standard also notes that the problem list should be amended as more precise definitions of problems become available. Controlled vocabulary for problem lists may be contained in a problem list directory master table.

Of note in this standard is the reference to past diagnoses and social care factors. Some problem lists limit entries to those factors requiring current action or consideration.

Health Level Seven International

Designated by the International Organization for Standardization as a standard, Health Level Seven International's Electronic Health Record System Functional Model (EHR-S FM) provides additional guidance for EHR content. The model states, "A problem list may include, but is not limited to chronic conditions, diagnoses, or symptoms, functional limitations, visit or stay-specific conditions, diagnoses, or symptoms."[3]

The model recognizes that problem lists are dynamic and must be managed over time and may in fact be maintained over the life of an individual. For this reason the record system should support documentation of historical information and track the changing character of problems and their priority.

The model outlines the following functional requirements related to problem lists:

1. The system SHALL capture, display, and report all active problems associated with the patient.
2. The system SHALL capture, display, and report a history of all problems associated with a patient.
3. The system SHALL provide the ability to capture the onset date of problem.
4. The system SHALL provide the ability to capture the source, date, and time of all updates to the problem list.
5. The system SHALL provide the ability to deactivate a problem.
6. The system SHOULD provide the ability to manually order/sort the problem list.
7. The system SHOULD provide the ability to capture the chronicity (chronic, acute/self-limiting, etc.) of a problem.
8. The system MAY provide the ability to re-activate a previously deactivated problem.
9. The system MAY provide the ability to associate encounters, orders, medications, notes with one or more problems.

The source for problem list updates or resolutions-that is, the authentication and identification for all health record entries-must be recorded. In order to maintain data integrity and fulfill legal requirements all pertinent dates must be captured and stored, including date and/or time noted or diagnosed, dates and/or time of any changes in problem specification or prioritization, and the date/time of resolution. Automated time stamps may be used where appropriate.

Accreditation Association for Ambulatory Health Care

The Accreditation Association for Ambulatory Health Care's standard is used by outpatient facilities providing ambulatory health services. The standard indicates if a patient has had multiple visits/admissions or if the clinical record is complex and

lengthy, a summary of past and current diagnoses or problems, including past procedures, is documented in the patient's record to facilitate the continuity of care.[4]

The standard requires that the presence or absence of allergies and untoward reactions to drugs and materials be recorded in a prominent and consistent location in all clinical records. This information must be verified at each patient encounter and updated whenever new allergies or sensitivities are identified.

Healthcare Information Technology Standards Panel

The Healthcare Information Technology Standards Panel convened stakeholder meetings between 2005 and 2010 to advance interoperability and EHR adoption. An informative set of harmonized work products formed a solid foundation for future standards development, such as adopting SNOMED CT as the standard vocabulary for documenting patient problems with links to ICD-9-CM to support data sharing and interoperability.[5]

Since that time the HIPAA transactions and code sets have been updated to require the use of ICD-10-CM/PCS by October 1, 2013.

Alignment with meaningful use requirements provides for use of ICD or SNOMED CT for problem list encoding with migration to SNOMED CT completed by 2015. There are distinct differences in the use of a classification (e.g., ICD) and a reference terminology (SNOMED CT) that must be taken into account. Both provide the ability for information retrieval and consistency of record entries facilitated by a controlled vocabulary. The National Library of Medicine has developed a designated subset of SNOMED CT specifically for use in problem lists.

Meaningful Use Program

The American Recovery and Reinvestment Act of 2009 established the meaningful use incentive program, which encourages nationwide adoption of EHRs that improve patient care. The program requires the problem list contain all past and existing diagnoses, pathophysiological states, potentially significant abnormal physical signs and laboratory findings, disabilities, and unusual conditions.[6]

Reporting requirements for the problem list for the stage 1 meaningful use requirements state the provider must "maintain an up to date problem list of current and active diagnoses based on ICD-9-CM or SNOMED-CT for 80% of patients, and 80% of all patients have to have at least one coded problem as opposed to their entire problem list coded." The provider is required to place all patients on a common dictionary through coding.

In addition, the stage 1 meaningful use final rule includes the following requirements for an EHR system and its use:

- Capable of electronically exchanging key clinical information (e.g., problem list, medication list, allergies, and diagnostic test results) among care providers and patient-authorized entities.
- Provides patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request.
- Provides patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies).
- Provides clinical summaries, including problems, to patients for each office visit.
- Generates lists of patients by specific conditions for quality improvement, reduction of disparities, research, and outreach. The user will be able to electronically select, sort, retrieve, and generate lists of patients according to, at a minimum, the data elements included in the problem list, medication list, demographics, and laboratory test results.
- Sends reminders to patients per patient preference for preventive or follow-up care based on data elements included in the problem list.[7]

The objectives clearly emphasize the importance of using a problem list within EHRs to facilitate communication, enhance documentation, and serve as input for the patient's engagement in the care planning and use within personal health records.

Interoperability

Problem list interoperability facilitates patient engagement, health information exchange, and other secondary data use. Achieving interoperability requires the use of terminology and messaging standards such as those maintained by HL7 and ASTM International.

Clinical document architecture (CDA) is a document mark-up standard used to express many different document types. CDA supports the implementation of ASTM International's Standard Specification for the Continuity of Care Record (E2369-05).

The resulting standard, developed collaboratively by ASTM International and HL7, is the Continuity of Care Document (CCD), a standard format for the exchange of basic patient information.[8] These emerging structured document standards were developed by ASTM International and HL7 in a standard format for the exchange of basic patient information.

Standards based on database architecture such as CDA-rather than proprietary, closed systems with custom database architectures-serve interoperability best. Standards enable interoperability as all the technical functionality can be used by all systems, not just one. If one system's functionality is based upon a proprietary or "closed" architecture, then only that system is working on that functionality.

The CCD specifies SNOMED CT as the terminology standard for use in defining problems and vital signs. The CCD standard interface transaction format is the method envisioned to migrate data between EHR applications and eventually to personal health records accessible by the patient or their designated caregiver.

EHR products in use today vary in their ability to export and import according to the CCD transaction format, so it is important for HIM professionals to monitor and inform their organizations about the use of this emerging standard for interoperability.

Workflow

Incorporating a problem list in EHRs offers a powerful tool for clinical decision making and quality improvement initiatives because it provides a concise view of patient conditions and creates a source for data mining. Without proper structure and oversight it is also a potential source of clinical and administrative error if the data lack integrity or the encoding results in inaccurate representation.

Problem lists are dynamic tools to be co-managed by multiple care providers who frequently collaborate to manage complex clinical issues. The structured lists provide a "working" list of conditions subject to refinement during an episode of care. They require flexibility in recording and careful monitoring for currency.

Since care providers generally have different opinions on what should and should not be included on the problem list, organizations must develop and implement clear policies regarding problem list content as well as governance for failure to comply with organizational directives. Major challenges associated with managing problem lists include policy development, policy compliance, and difficulty maintaining an accurate, current, comprehensive, and reliable problem list.

The issues with problem lists are as much related to process, policy, and enforcement as they are to software system design and development.

Policy Development

A problem list must be maintained in order to ensure the integrity of the list. In problem lists, current problems should be documented, and the resolved problems should be easily identified.

HIM professionals are uniquely skilled candidates for spearheading policy development since the resulting documentation from the problem list drives other entries in the patient's record. However, it is also critical to include a clinical champion to cosponsor the policy. All clinical stakeholders should be involved in the policy development process, along with representatives from information systems, medical staff, nursing service, quality management and clinical departments, and all other personnel contributing or affected by problem list data management.

To most effectively use and manage problem list data, organizations must create policies that address the following:

Determine the purpose and scope of the problem list in the healthcare enterprise or setting. Examples of purpose inlcude:

- Facilitating continuity of care between patient visits
- Providing a comprehensive list of patient problems for use in patient care and secondary data reporting
- Serving as a communication vehicle during transitions of care and between care providers

Typical "out of scope" activities for problem lists include:

- Using problem lists as a source for billing data or revenue management
- Forcing problem lists to substitute for a final diagnosis list for discharge summaries

Identify who has ultimate responsibility for maintaining the problem list and include this accountability in the approved policy document. For example, the treating provider is responsible for reconciling the problem list at the beginning and end of each episode of care. For primary care, the primary care provider is ultimately responsible. When specialty care is provided, the specialist is responsible for updating the problem list to the appropriate level of specificity. For inpatient care, the attending physician is responsible for problem list maintenance. For organizations utilizing a multidisciplinary problem list, sections may be used for separate disciplines. Examples include nursing, physical or speech therapy, social workers, psychologists, and other allied health professionals authorized to provide problem list entries.

Identify who is authorized to add, update, and resolve problems. For example, all independent licensed providers should review and update the problem list at the end of each encounter.

Establish timeliness requirements for making problem list entries and outline consequences for noncompliance.

Designate the types of entries to be included in the problem list and any encoding systems used for representation. Determine the items to enter in problem lists. For example, ASTM International's Standard Practice for Content and Structure of the Electronic Health Record requires pathophysiological states, potentially significant abnormal physical signs and laboratory findings, disabilities, and unusual conditions be included in the problem list. It also notes that providers may include social and psychiatric problems, risk factors, allergies, and health alerts. Organizations should describe the purpose of each item to include on a problem list.

Provide a detailed workflow for developing the list, updating it, and resolving problems, including the method of problem list documentation entry into the health record.

Define procedures and accountability for maintaining and updating the problem list clinical vocabulary or problem list term subsets used by the EHR system.

Identify what role the patient plays in problem list development and maintenance.

Identify what (if any) barriers exist to ensuring problem list integrity of the health record.

Describe the process for auditing problem lists for accuracy and completeness.

Appendix A in the online version of this practice brief provides a sample policy and procedure template.

Problem List Entry and Encoding

There are differing opinions about who should be authorized to add entries to the problem list. Separate lists for physicians, nurses, or other care providers (e.g., social workers, therapists, pharmacists) may be a help or a hindrance depending on the specific organization and its use of the problem list. More people adding entries contribute to more complex maintenance.

In addition to determining who may make entries to the problem list, organization must consider the method of entry they will use. Some systems allow free text entries, while others use an interface terminology. Interface terminology includes term or phrase look-ups, known as pick lists, to populate the list. The terms are usually linked or mapped to standardized code sets (e.g., ICD or SNOMED CT) to enable re-use of the data captured for reporting or other secondary use.

Pick lists are efficient in situations where the number and complexity of conditions are limited. Direct selection of codes by clinicians requires knowledge of coding guidelines and conventions to be accurate.

A facility may also use internal customized taxonomy to encode the problem list. This taxonomy should be mapped to ICD- 9-CM, ICD-10-CM, or SNOMED CT.

Provider organizations may also opt to use natural language processing applications to parse free-form text and extract discrete data to populate problem list entries for confirmation. The use of natural language processing saves time by presenting a list of potential entries that have already been linked to SNOMED CT codes.

This approach can improve the accuracy and consistency of the problem list, make updating easier, and increase compliance in the creation and updating of the problem list by clinicians.

It is also possible for clinicians to manually update and assign codes by accessing the code through pick lists or search engines, but there are data integrity challenges inherent in this approach. It should be noted there is ongoing debate on this approach from practitioners and administrators. Many are reluctant to have computers making behind-the-scenes decisions (mapping links to the code sets) and pre-filling the problem list without their note of approval and validation that the code stored accurately reflects the intended clinical facts.

The standardized terminology selected must represent complex clinical data accurately and in a computable form to efficiently retrieve and analyze the encoded data to drive automated decision support, reporting, and research functionality. SNOMED CT's hierarchically organized and interrelated predefined medical concepts support relevant query and retrieval operations useful for clinical data representation.

The National Library of Medicine has released the Clinical Observations Recording and Encoding, or CORE, a subset of SNOMED CT. CORE facilitates the use of SNOMED CT for encoding of problem list data in EHRs. This set of SNOMED CT terms and codes is freely reusable worldwide without licensing or intellectual property restrictions.[9]

SNOMED CT or ICD-9-CM Code Set Requirements

Encoding the problem list with a standard terminology has many benefits including:

- Providing a controlled vocabulary for expression of problems and conditions
- Enabling the problem list to serve as an information retrieval tool in the EHR by allowing clinicians to use different words to describe the same condition (semantic interoperability)
- Supporting the "collect once, use many times" principle, making data sharing more efficient and reducing administrative costs of reporting
- Facilitating automation of data capture and clinician workflow and documentation capture
- Capturing data at the point of care to support continuity of care

Classification systems by design aggregate data into categories, sometimes resulting in loss of clinical facts and details. ICD was designed for statistical representation, while SNOMED CT was designed for representation of clinical data at the concept level, making a case for its utility in electronic environments.

Organizations should discuss which system to use for encoding the problem list with stakeholders, keeping in mind the regulation requirements. The ICD version required by HIPAA as of October 1, 2013, is ICD-10-CM, while meaningful use requires SNOMED CT. Organizations should confirm all current and future uses of the codes and resulting data uses.

Creating Customized Problem List Subsets

An additional approach for standardizing the problem list terminology is to modify the legacy application and replace the existing problem selection list with an adopted standard or designated value set for problems. There are important considerations when modifying the legacy application for creating a problem list subset since the new standard may not be fully compatible with the old data, making it difficult to compare legacy data with the new representation.

Implementation considerations that should be addressed include:

- Whether existing problems on the patient's problem list currently represented in ICD-9-CM remain in ICD-9-CM and whether the new problems expressed using SNOMED CT achieve a phased implementation. This approach requires additional mapping if there is a need to compare the classification to the terminology for some reason.
- Whether the problem list application interfaces with other applications that must be maintained. For example, does the current system pass ICD-9-CM codes from the problem list to the billing application? Does the system provide alerts or reminders that are triggered from certain ICD-9-CM codes captured in the problem list?

Organizations must establish a process for updating and maintaining the problem list subset at designated intervals.† SNOMED CT updates are currently released in January and July of each calendar year. If the problem list subset is expressed in SNOMED CT and mapped to ICD-9-CM, then updates from ICD-9-CM are required.

The use of terminologies must be managed, so organizations frequently employ a terminology asset manager to manage the maintenance, version control, and integrity of standard code sets used in the organization. Additional responsibilities may include data mapping or managing new term requests or problem list entries for inclusion in the subset.

This role may also serve as a terminology modeler, creating local extensions to the standard or submitting requests to the designated standards development organization for new terms or codes.

Use of standardized terminology in a problem list allows providers to precisely document the clinical care given to their patients, support clinical decision making, and facilitate interoperability of health information exchange with internal and external partners.

Functionality Planning

Best practices for EHR functionality include analysis of system functions and results, including the following:

1. EHR functionality should not autopopulate problems to the problem list without clinician confirmation. An authorized provider should be required to actively promote a problem captured within the current system or from another source to the problem list.
2. EHR functionality should have efficient and reliable problem search capabilities to prevent redundant entries.
3. EHR functionality should present problems from the CORE subset of SNOMED CT or a designated problem list value set that has been fully vetted and approved by the medical staff that allows providers to select terms that are clinically relevant for documenting patient care.
4. EHR functionality should offer customized views of the problem list for each provider by request without restricting access to the full list.
5. EHR functionality should streamline the task of problem list maintenance by incorporating natural language processing where available, clinical decision support, and computerized physician order entry to prompt a provider to add, update, or resolve problems on the patient's problem list. In addition, business rules can be created based on data in the EHR that alert physicians to potentially add, modify, or resolve problems.
6. EHR functionality must allow for correcting errors on the problem list. Incorrect problems or diagnoses need to be identified as such.
7. Problem list entries should be linked to a corresponding code from a controlled structured nomenclature for consistency.
8. Problem list software should provide for audit trails so changes made with date and time stamps are available for review.

Well-designed problem lists provide important information for patient care and support meaningful use requirements and health information exchange. There are many approaches to a well-designed problem list. The key is to define clear policies and procedures that support the organization's objectives in using the information contained in a problem list.

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Appendix

An appendix is available in the online version of this practice brief in the AHIMA body of Knowledge at www.ahima.org:

- Appendix A: Sample Policy and Procedure Template

Prepared By

Beth Acker, RHIA
June Bronnert, RHIA, CCS, CCS-P
Teresa Brown, RHIT, Six Sigma Black
Jill S. Clark, MBA, RHIA
Betty Dunagan, RHIA
Tracy Elmer, RHIA
Suzanne Goodell, MBA, RHIA
Kate Green, RHIT, CCDS
Pamela Heller, RHIA, CCS-P
Casey Holmes
Margo Imel, MBA\TM, RHIT
Kathy Johnson, RHIA
Crystal Kallem, RHIA, CPHQ
Melanie Loucks, MA, RHIT
Sheetal Patel, RHIA
Debbie A. Reed, RHIT, CCS-P, CCP-P
Rita Scichilone, MHSA, RHIA, CCS, CCS-P
Anne L. Tegen, MHA, RHIA, HRM

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Kathy Arner, LPN, RHIT, CCS, CPC, MCS, CPMA
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Crystal Kallem, RHIA, CPHQ
Junius Logan, MD, RHIT
Lori Nobles, RHIA
Kathleen Peterson, MS, RHIA, CCS
Allison Viola, MBA, RHIA
Diana Warner, MS, RHIA, CHPS, FAHIMA
Lou Ann Wiedemann, MS, RHIA, FAHIMA, CPEHR

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