Resolving Problem List Problems: HIM's Role in Maintaining an Effective EHR Problem List

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Prior to the widespread implementation of electronic health records (EHRs), problem lists were usually maintained by physicians through a simple documentation tool in the paper record, such as a "front sheet" or by copying a diagnosis list to a specified area within the paper chart and placing it behind an appropriately labeled tab for easy retrieval.

While the concept of having a problem list is not new in an EHR, maintaining it consistently in an electronic environment requires diligence on the part of every clinician who is treating a patient, and maintenance of the list at each inpatient or outpatient visit. This includes not only first-hand observations of the patient, but information obtained from other practitioners who are caring for the patient when transferring care.

Problem list functionality within an EHR can be an excellent and important tool to help clinical staff maintain an up-to-date problem list for every patient. However, getting physicians to accept the work it takes to properly keep up the problem list can be challenging. For example, physicians may be reluctant to document a problem for which they are not personally providing treatment.

However health information management (HIM) professionals, with their unique understanding of documentation content and data analysis skills, can assist physicians by enacting policies and procedures that will limit variation in the completion of the problem list and ease the frustration that can accompany poor problem list management.

Problem List No Longer Optional

Because of the need to standardize documentation for clinical quality initiatives, problem lists are no longer an optional tool used to assist in a quick review of a patient's current medical problems. Problem lists are now a core measure for stage 1 of the "meaningful use" EHR Incentive Program.[1] In order to meet the meaningful use core measure for problem lists, 80 percent of the patients seen by the eligible professional, or admitted as an inpatient to the emergency department of an eligible hospital, must have at least one entry on the problem list or a notation that there are no known problems for the patient. This information must be recorded as structured data. As the meaningful use program advances to stage 2 and beyond, the problem list will only continue to grow in importance for meaningful use and clinical care.

An accurate problem list aids in patient safety and also ensures that patients receive consistently high quality care. It's essential for physicians to obtain an at-a-glance view of the patient's ongoing medical issues because it ensures that appropriate care can be given at every clinical visit.

The AHIMA Thought Leadership paper "Problem Lists in Health Records: Ownership, Standardization, and Accountability" describes the multiple roles for problem lists in the 21st century, including the following:[2]

- Serves as a key focus for building and maintaining patient engagement
- Functions across the continuum of care to serve as a means of communication between patients and among care providers
- Triggers interactive decision support to aid the patient's personal healthcare decisions
- Links to clinical research studies to allow for interaction between a patient and researchers to identify potential research participants; provides other subjective data
- Connects the patient to social networks whose members share a common problem
- Enhances decision support activities in conjunction with other tools
- Readily accessible to give everyone involved with care access to the same information (subject to patient consent)

- Leverages emerging informatics tools including multi-dimensional displays and hyperlinks to related sections of a health record

HIM Must Lead Problem List Policymaking

In the past each treating physician had more flexibility in determining the easiest way to approach problem list documentation and maintenance. However, in today's competitive environment, providers are increasingly held accountable for cost-effective, high-quality care. This makes it essential that a problem list be standardized to ensure that clinical decisions can be made during the patient's visit, but also during transitions of care from one provider setting to the next.

Many healthcare organizations have struggled to develop policies regarding the use and maintenance of problem lists. As a result, "ownership" can be difficult to achieve, and accountability for accuracy may be difficult to establish. Family physicians may be reluctant to update the problem list with conditions that are being treated by a specialist, or a specialist may feel uncomfortable updating the list when they have a limited view of the patient's overall healthcare status.

In developing a policy, HIM professionals should analyze the functionality within the organization's EHR system. Once the choice of tools and an understanding of capabilities have been established, ownership of the problem list should be determined and documented. A co-sponsoring physician should be enlisted to assist in the development of the policy, provide clinician support for physician adherence to the policy, and assist with monitoring the process for potential problems. The physician sponsor can also assist HIM leadership in developing ongoing education on appropriate problem list maintenance.

Once the policy has been enacted, HIM professionals can assist in ensuring that the problem list is properly maintained and updated. Frequent reviews when coding or doing documentation analysis can help identify issues with problem list adoption and assist the organization in addressing any outstanding needs or barriers.

An effective policy should address key components of problem list management, including the following:

1. Ensure that the physician reviews and updates the problem list at every clinic or emergency room visit, as well as frequently reviewing the list and making appropriate changes throughout the duration of any inpatient stay.
2. Detail the appropriate content of the problem list, including diagnoses and symptoms that warrant current or later testing or a return visit; or any findings that could be clinically relevant at a future visit.
3. Refinement of diagnoses should occur as problems become more specific. For example "chronic cough" could be updated to "chronic obstructive pulmonary disease" once a diagnosis is made.
4. Delegate the responsibility of updating the problem list to the physician who first obtains the information from the patient, with future updates noted by each physician who makes a new diagnosis. Any known active problems missing from the problem list should always be added as soon as the omission is noted, even if the diagnosis was made by a different physician.
5. Instruct physicians to remove any problems that are inactive, duplicative, or were entered in error.
6. Clearly identify who can add, change, or resolve problems on the problem list.
7. Provide guidance or instructions as to how to resolve or address disagreements between providers in the same healthcare organization or setting.

Education Needed on List Exclusions

Physicians should also be instructed on exclusions from the problem list, such as self-limiting problems—including problems that will resolve on their own, such as a cold or an insect bite—past medical history that is not being actively managed at the present time, such as a healed fracture that occurred in the past but no longer requires active treatment, and any past problem list entries that are no longer being actively addressed.

Also, problems being treated surgically should be removed from the problem list once the surgery has occurred and the post-operative care has been completed. However, surgical interventions with long-term treatment implications should remain on the problem list permanently, such as the presence of an implant or organ transplant.

While ultimate responsibility for problem list maintenance should be delegated to physicians or clinical caregivers, health information professionals play a significant role in ensuring that problem lists are created, updated, and reviewed frequently to assist the healthcare organization in not only meeting the requirements for meaningful use, but also in providing the best quality of patient care and highest possible measure of patient safety.

Notes

[1] Centers for Medicare and Medicaid Services. "Eligible Professional Meaningful Use Core Measures: Measure 3 of 14." April 2013. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/3_Maintain_Problem_ListEP.pdf.

[2] AHIMA. "Problem Lists in Health Records: Ownership, Standardization, and Accountability." AHIMA Thought Leadership Series. December 2012.

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