

## **Appendix A: Definitions of Problem Lists from Authoritative Sources**

### **Dr. Weed's Problem-Oriented Medical Record**

Dr. Weed is considered a pioneer for innovation in HIM for advancing a problem-oriented medical record approach. In his approach, each medical record should have a complete list of all the patient's problems, including both clearly established diagnoses and all other unexplained findings that are not yet clear manifestations of a specific diagnosis, such as abnormal physical findings or symptoms. When the data warrant, these findings can be crystallized into a specific diagnosis. The problem list is not static in its composition, but is a dynamic table of contents of the patient's chart, which can be updated at any time.

Inherent in the problem-oriented approach to data organization is the necessity for completeness in the formulation of the problem list and careful analysis and follow-through on each problem as revealed in the titled progress notes, requiring that the proper data be collected and that the conclusions drawn from this data are logical and relevant.

Weed, Lawrence L. "Medical Records That Guide and Teach." *New England Journal of Medicine* 278, no 11 (1968): 593–600.

### **ASTM Internationals's Standard Practice for Content and Structure of the Electronic Health Record (EHR) (E1384-02a)**

#### **7. The Overall Structure of the Electronic Health Record**

##### 7.9 Segment 5, Problem List:

7.9.1 This includes specified clinical problems, a diagnosis summary and stressor exposure, an ongoing list of clinically significant health status events and factors, resolved and unresolved, in a patient's life. This list should contain all past and existing diagnoses, 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. The problem list is to be amended as more precise definitions of the problems become available. Controlled vocabulary for problem lists may be contained in a problem list directory master table.

7.9.2 This segment contains a master list of all of a patient's problems or diagnoses. It may be referenced, as noted in 7.18.2 in presenting the diagnostic summary beginning each encounter/episode. All problems or diagnoses initially recorded in a specific encounter/episode will also be entered in this master list.

7.9.3 Whenever possible, identification of risk factors (health alerts) that should be known prior to implementing any health services should be included in this section. They can be considered to be instances of a special type of patient problem and include allergies, contagious conditions, and adverse reaction to specified treatments.

The full standard is available for purchase including the E2369-05 standard with Continuity of Care attributes and data object descriptions at <http://www.astm.org>.

### **The Joint Commission's Standard IM.6.40**

For patients receiving continuing ambulatory care services, the medical record contains a summary list(s) of significant diagnoses, procedures, drug allergies, and medications.

### **Elements of Performance for IM.6.40**

1. The summary list(s) is initiated for the patient by the third visit and maintained thereafter.
2. The summary list(s) contains the following information:
  - Known significant medical diagnoses and conditions
  - Known significant operative and invasive procedures
  - Known adverse and allergic drug reactions
  - Known long-term medications, including current medications, over-the-counter drugs, and herbal preparations
3. The summary list(s) is quickly and easily available for practitioners to access needed information.

Available online at <http://www.jointcommission.org/>.

### **Federal Health Architecture, Consolidated Health Informatics Problem List**

Diagnosis/problem list is broadly defined as a series of brief statements that catalog a patient's medical, nursing, dental, social, preventative, and psychiatric events and issues that are relevant to that patient's health care (e.g. signs, symptoms, and defined conditions).

Available online at <http://www.hhs.gov/healthit/chiinitiative.html>.

### **Health Level Seven Electronic Health Record System Functional Model, Release 1, Chapter 3: Direct Care Functions, February 2007**

#### **Function DC.1.4.3 (Manage Problem List)**

Description: 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.

Problem lists are managed over time, whether over the course of a visit or stay or the life of a patient, allowing documentation of historical information and tracking the changing character of problem(s) and their priority. The source (e.g. the provider, the system ID, or the patient) of the updates should be documented. In addition all pertinent dates are stored. All pertinent dates are stored, including date noted or diagnosed, dates of any changes in problem specification or prioritization, and date of resolution. This might include time stamps, where useful and appropriate.

The entire problem history for any problem in the list is viewable.

**Health Level Seven's Personal Health Record System Functional Model**, Release 1 for public comment, Chapter 3: Personal Health Functions, August 2007

**Function PH.2.5.1 (Manage Problem Lists)**

Problems are a core feature of the medical record that provides structure and direct management. A problem may be a definitive diagnosis but may also be a symptom complex, a working hypothesis, or anything else that bothers the account holder. What is defined and included as a problem is arbitrary, although there may be institutional guidelines. The account holder, along with their medical advisor such as their PCP, may wish to establish their own guidelines regarding who can add or change problems on the primary list.

Individual providers may not agree with some of the diagnoses listed as problems and would want to maintain their own list version. The account holder may add problem definitions authored themselves or from non-traditional providers that have no correlate in allopathic medicine. Problems can be further characterized as acute, chronic, resolved, historic, and recurrent.

**Example:** Problem list items may include: chronic conditions, diagnoses, allergies, or symptoms, both past and present, as well as functional status and all pertinent dates, including date of onset, diagnosis, changes and resolution.

Available online at <http://www.hl7.org/ehr/>.