

Appendix D: Best Practice Considerations for Problem Lists

Issue/Barrier	Best Practice Considerations
Time and effort	There are a variety of approaches available to ensure efficient use of the electronic problem list. Physician acceptance of the process is important. Detailed policies and procedures aid in the use of the problem list and minimize time and effort. Consistent training and education is also key.
Training/education	Training for an EHR system implementation often is limited to the use of the product rather than use of the inquiry fields, which are critical for creating problem list entries. Training must include how to perform optimal searches for problem entries suitable for sharing with others and secondary data use. Physicians tend to have questions directly related to coding guidelines. Trainers should be well versed in these guidelines.
ICD-9-CM–based searching	Although ICD-9-CM may work well for charge capture in an electronic environment, a classification system where clinical conditions are classified into categories is not the best solution for documentation on the problem list.
Consistency in choosing the correct or most specific problem	Policies and procedures for clinical staff using the problem list are needed to ensure that the most specific diagnosis or problem statement is chosen. Linking to a classification system or other terminology is optimized when the expression of the condition or problem is as specific as the circumstances allow.
Primary care, specialty, and emergency providers have varying needs for conditions on the problem list	Policies and guidelines for problem list use in organizations with more than one medical specialty are helpful. Accountability for maintaining a complete problem list should be assigned to the primary care physician. This is sometimes referred to as the “medical home” for patients using healthcare services from more than one provider. It is plausible that a sharable problem list system would provide a mechanism for specialty physicians to recommend additions to the complete problem list to the primary care provider for a comprehensive health profile in one place. Removal of problems from the list would occur at the discretion of the primary care physician in consultation with the patient or authorized caregiver.
Billing needs may utilize the problem list for diagnostic	Due to challenges with specifying the entries on the problem list, best practice is to use the problem list for reference of the diagnostic statements and clinical conditions rather than the single source of

information use for claims submission	documentation for encoding required for healthcare payment or reimbursement.
Physician acceptance of structured coding is resisted	SNOMED CT and ICD-9-CM coding schemes can be cross-referenced with frequently used entries lifted to the front of the table, resulting in faster lookups
Varying clinical settings use varied diagnoses and workflow	Multiple lookup schemes or subsets of problem list entry choices should be developed consistent with the clinical workflow best suited for patient care needs and optimal data capture.
Lookup speed is critical to user acceptance	Clinician involvement in developing cross references, problem look-up process, and search optimization increases more relevant returns on entries and better results for specificity in expression of problems.
Incomplete entries or “free text entries” for unlisted problems are not coded	Organizations should provide personnel resources committed to the review of uncoded or inaccurate/incomplete entries. This position (often someone with HIM training) should be empowered to add choices or encode the free text entry using the appropriate coding schema to build a dynamic system that easily adapts as needed. An approval process for adding new entries should be established to ensure data quality and control.
Review of unlisted codes is frequent or ongoing	Plan for an ongoing review of problem list entries not linked to controlled vocabulary. Resource distribution within HIM in an EHR environment may result in changes from filing to code review and quality improvement activities related to problem list maintenance.
Multiple entries risk data integrity concerns	Order-receiving departments such as laboratory and pharmacy may update the problem list directly, either through direct edit or automated input. This best practice allows for data capture at the source of physician order to capture the condition requiring the test or therapy provided.
Interactivity with computerized physician order entry systems is limited by application integration issues	Technical review of CPOE systems with problem lists can limit risk of interactivity issues. Best practice is for careful consideration of exchange of data between the systems and what the process is for data validation and use.

<p>Clinicians resist changes in work flow</p>	<p>System benefits of a well-designed and managed problem list outweighs the costs. Coded entries support research and information retrieval; improved patient safety limits liability; automating entries from laboratory and pharmacy improve regulatory compliance; patient satisfaction ratings improve with information sharing across providers with a useful list of problems suitable for inclusion in personal health records and continuing care</p>
<p>No universally adopted standard exists for problem lists content, use, or linkage to a clinical terminology or other clinical code set</p>	<p>Best practice requires that the work unit or task force responsible for problem list technical framework and use defines standards that will be used across the enterprise with an eye towards national or international standard that enable data sharing.</p>
<p>No defined cross mapping guidelines exists</p>	<p>Cross mapping of problems to clinical data standards has been done by individual institutions but to date has not been adopted by IT developers. Best practice is to review any recognized guidelines appropriate to the organization's workflow and data needs. Include companies that provide interface terminologies that translate problem text phrases into clinical data standards for secondary use including billing, patient-friendly terms, and other specialized needs.</p>
<p>There is poor industry implementation of SNOMED CT guidelines</p>	<p>Organizations who have adopted SNOMED CT as a standard terminology should advocate for guideline development that would enable reliable health information exchange. Adoption of a reference terminology is a useful step toward interoperability but if everyone uses the system differently the benefit may not be realized.</p>
<p>V code diagnosis</p>	<p>V code diagnoses rarely are necessary in the active problem list for lack of a better code. Pregnancy (v22.2) is an example of this exception for the duration of the pregnancy. Organizations need to provide guidelines for their users of these rules and exceptions.</p>
<p>Multiple accurate diagnosis describing the same condition</p>	<p>The problem list should be examined and corrected for accuracy at every patient encounter. In the process of clinical evaluation of the problem list, those repetitive diagnoses that describe the same condition should be identified. The more accurate diagnosis should be retained and the less accurate diagnosis removed.</p>

Symptom type diagnosis	Problems that are primarily symptoms should rarely be promoted to the active problem list. Occasionally, a symptom should be included as an active problem while a disease-specific diagnosis is being determined. In this case, multiple encounters will be required in order to arrive at the diagnosis. Pelvic pain is an example of such a problem. In the case of these subacute symptom problems, treating providers should be careful to resolve the symptom from the active problem list when treatment is concluded or when a more accurate diagnosis is identified.
Acute condition diagnosis	An alternative is to set a date at which time such a condition will drop off the active problem list automatically. Subacute problems that will require several encounters before resolution are appropriate to include. Upon resolution, the provider will need to determine if the problem should be completely resolved to an inactive list or transferred to the past medical history section of the problem list.

<p>Implementation from paper to electronic problem list</p>	<p>Make a decision and form a plan of action of how to proceed. Options to consider are:</p> <ol style="list-style-type: none">1. While still in paper record, updating and correcting the paper problem list will ensure that it is entered correctly into the electronic problem list.2. Prepopulation of data into the electronic problem list can take place during the training period.3. Prepopulation can be done at time of service while using the paper problem list to enter the electronic problem list.4. Whose responsibility is it to ensure that the correct data elements are added and to move, correct, and amend discrepancies?5. How can we best use the computable problems as a decision support tool?
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