A Problem Isn't a Problem Until It's Defined: Improving the Documentation of a Problem List in an Electronic Medical Record

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TEAM

- A. Peter Catinella MD, Management Team
- Roland Ruegner PA-C, Team Leader/Facilitator
- Marti Trunell PA-C, Member
- Ingrid Crose, Member
- Sylva Lowenmark MA, Member
- Teddie Gornichec MA, Member
- Shelly Bird MA, Member
- Marlene Falleroni MA, Member

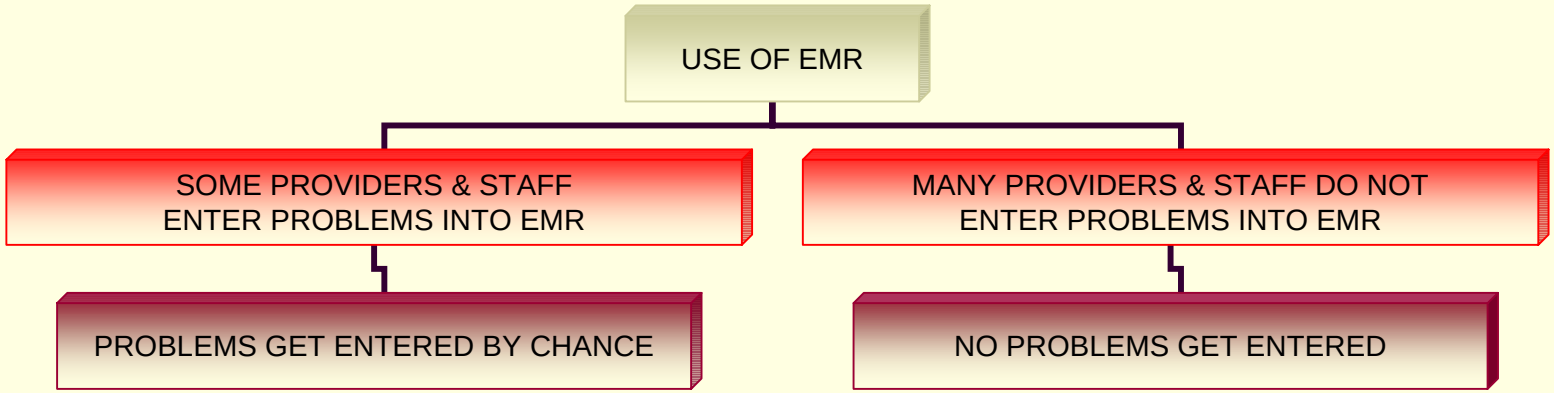
Project Goals

- By the end of this project, this team will:
  - Improve the documentation of patients' medical problems into the EMR Problem List
  - Update the Problem List on a daily basis
  - Use Problem List to develop population-based data reporting and studies
  - Achieve 0% of records w/o Problem List by Dec. 1st 2004,(100% with Problem List)

Description of Project

- Rationale
  - Problem List found in less than 12% of patients on an audit using a convenience sample
  - No current uniform or defined process for entry of problems
  - Problem List keys medical providers to clinical picture of patient
- Need
  - Develop a simple defined process to enter in problems in a consistent manner on a daily basis

Previous Process



NO PROCESS!

Technology

- University of Utah Electronic Medical Record (EMR)
  - Training done on entering in problems to EMR
  - Involves Multiple screens and clicks
  - Uses a data dictionary for diagnostic terms
    - SNOWMED or ICD9 Codes

Why No Problem List Is A Problem

- Having a problem list is a medical standard
- Increases time in room
- Increases accuracy & speed of diagnosis and treatment
- Decreases risk of mistakes & adverse events

Questions that need to be Answered

- What is an Active Problem?
- What is an Inactive Problem?
- What is a Resolved Problem?
- Is there a better way to to track problem list?
- What if the patient doesn’t have a problem?

Prioritized List of Change Ideas

- Provider writes problem on encounter, Medical Assistant enters problems at end of day/ next AM.
- Provider enters problem during patient visit.

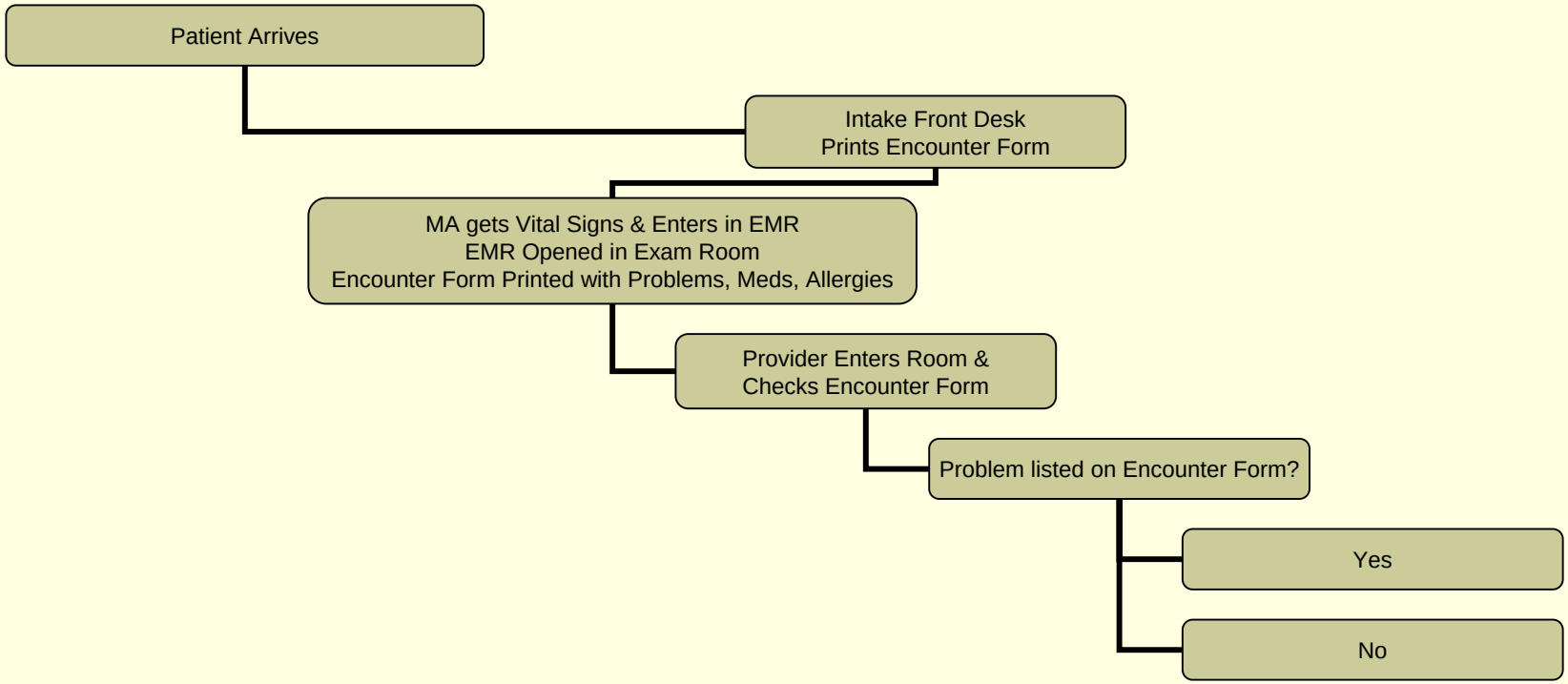
1st option was chosen

- The time the other option takes away from the actual patient-provider contact.
- 2nd option breaks the flow of patient visit to much.

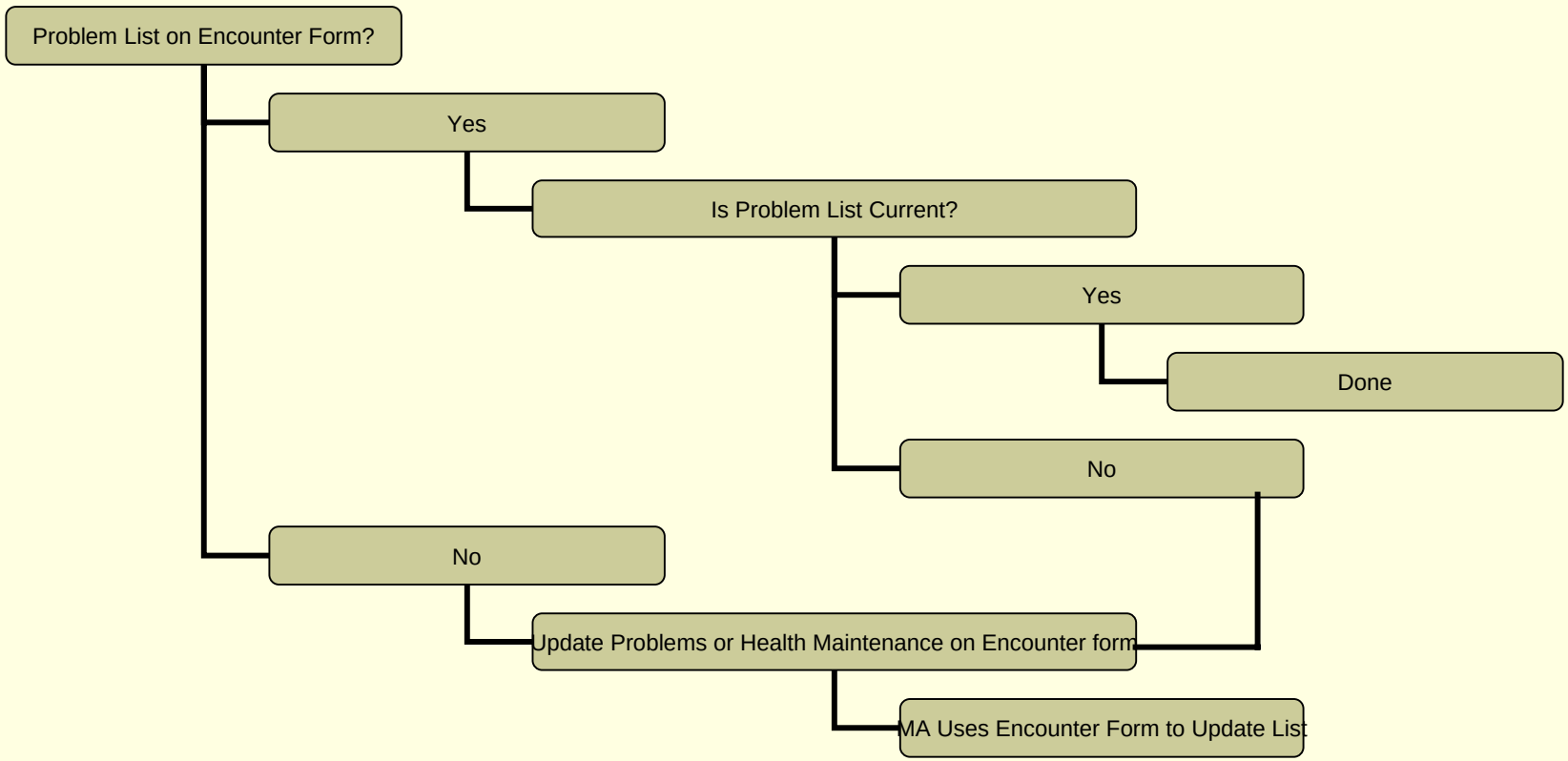
FLOW CHART

HOW WE WILL ENTER PROBLEMS ON PROBLEM LISTS

NEW PROCESS


Patient Arrives
Intake Front Desk
Prints Encounter Form
MA gets Vital Signs & Enters in EMR
EMR Opened in Exam Room
Encounter Form Printed with Problems, Meds, Allergies
Provider Enters Room &
Checks Encounter Form
Problem listed on Encounter Form?
Yes
No

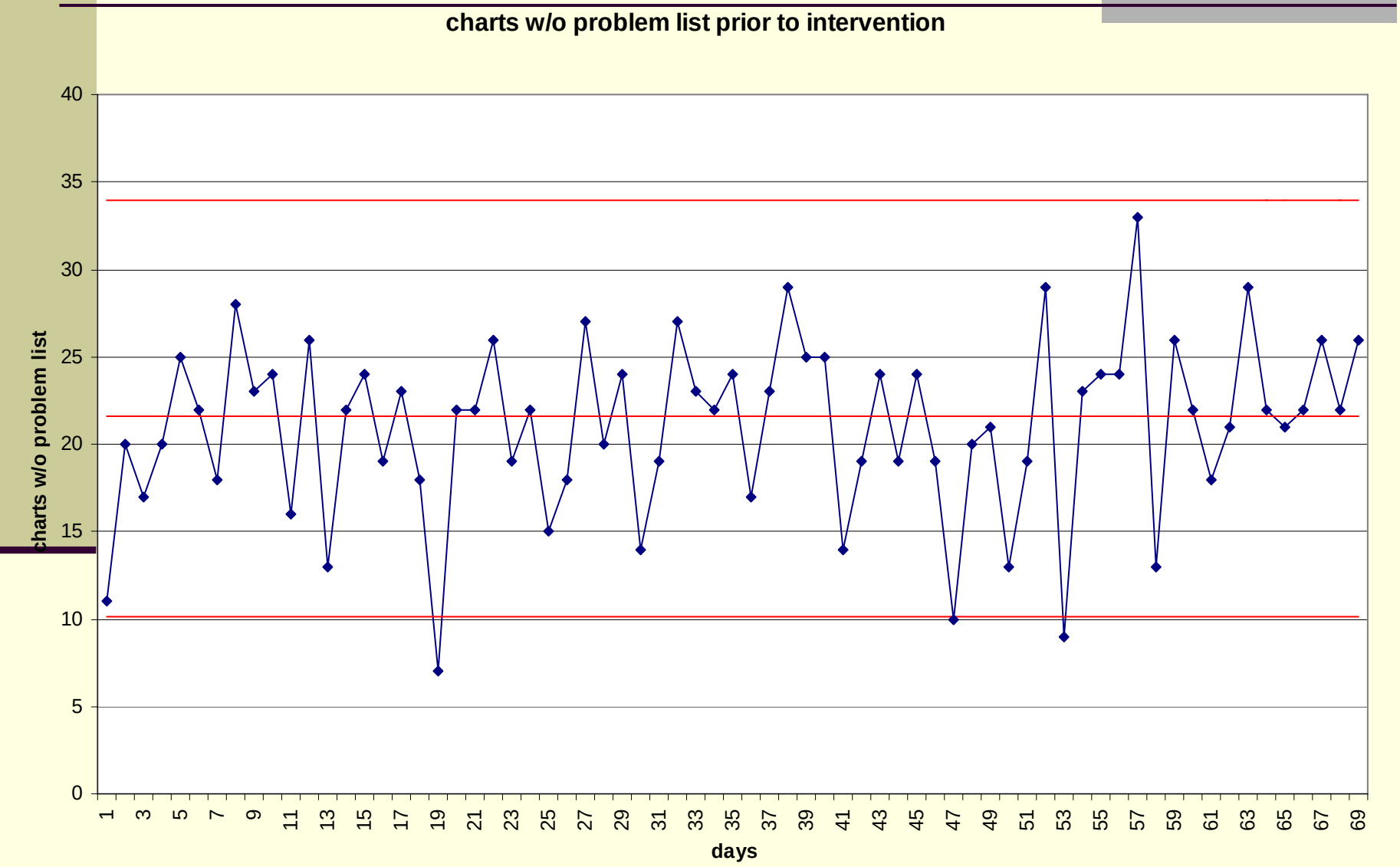
NEW PROCESS


Problem List on Encounter Form?
Yes
Is Problem List Current?
Yes
Done
No
No
Update Problems or Health Maintenance on Encounter form
MA Uses Encounter Form to Update List

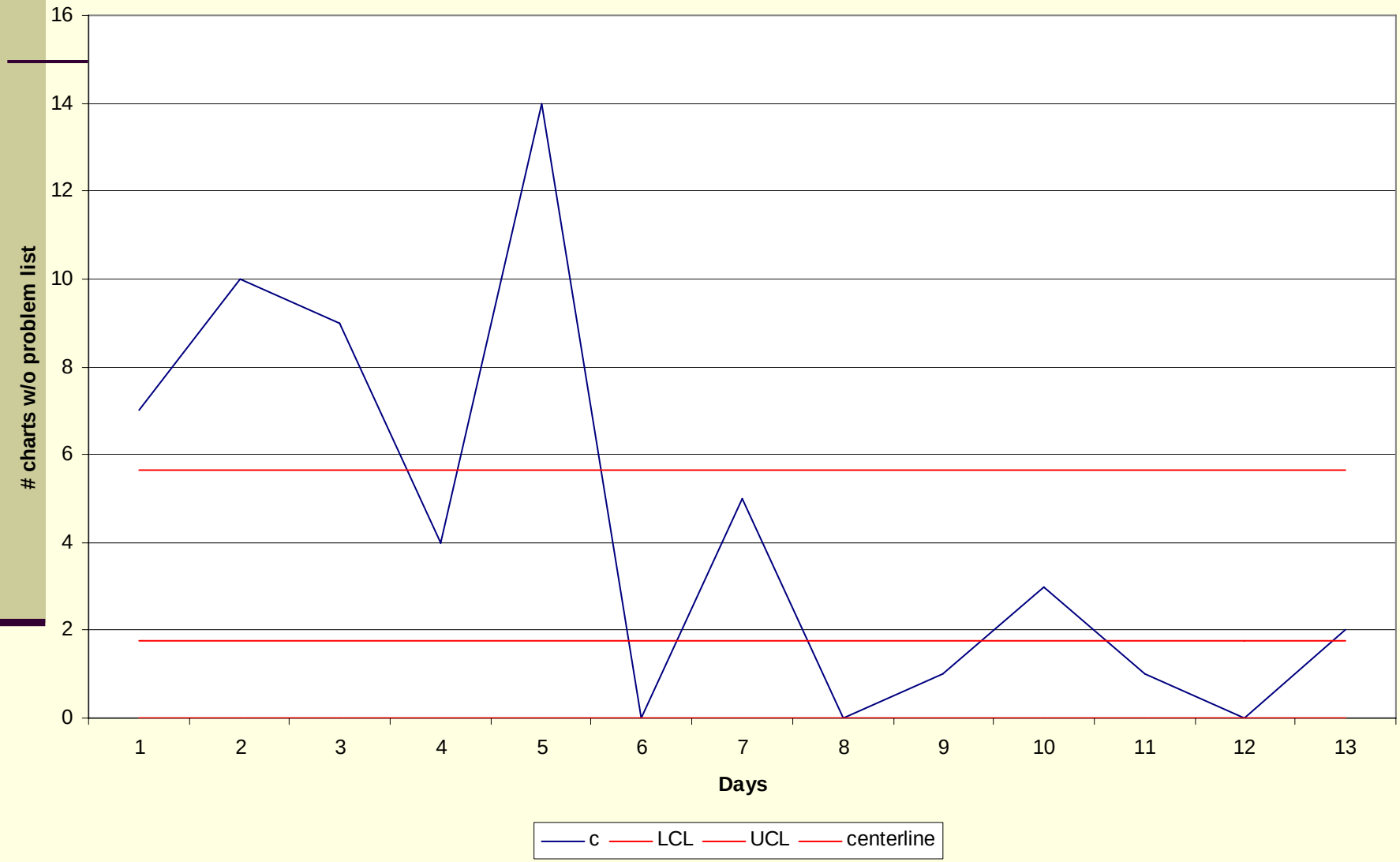
Team/Resources

- All resources are available in the Clinic
  - people as listed in the TEAM
  - computers and software in place

Initial Data



Problem List Post Intervention



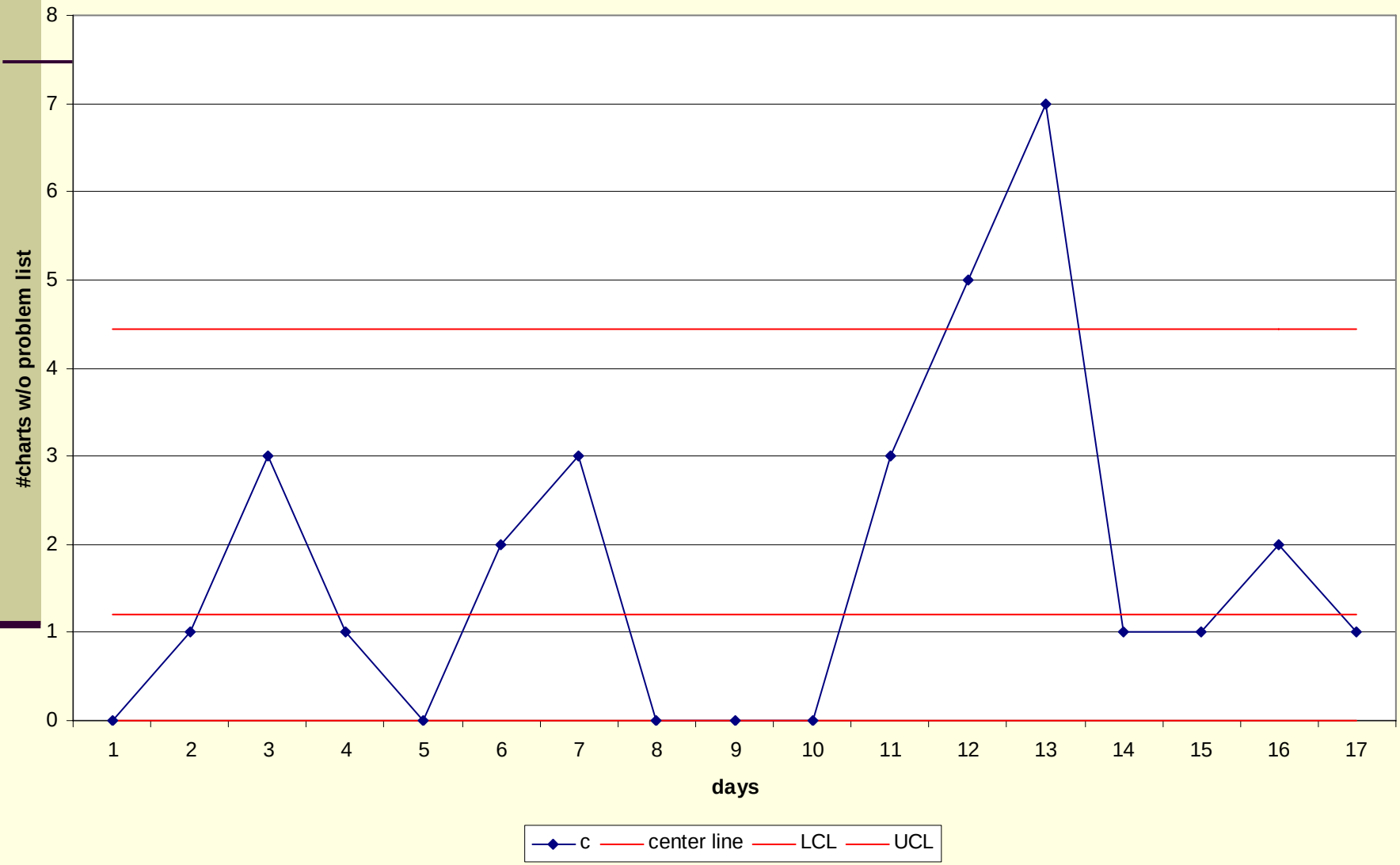
Team meeting

- Problems
- not listed in Snomed
- can’t read providers’ writing
- pt doesn’t have a problem
- adds considerable time to MA work (measured initially at about 2 hrs/day)

solutions

- Consult provider, find equivalent solves 1st two.
- Snomed has listing for NO PROBLEM.
- Increased time for MA decreased with practice, also appears to be a good trade off for the benefit.

2nd intervention



Schedule

- Goal = 0/day
- currently at about 1/day
- Dec 1st 2004 in when we want to reach goal

FOR MORE INFO...

Holding the Gain

- Monitor 5 random days/month
- Add audit for accuracy to the monitoring (compare what is on problem list to what is on paper encounter form)