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

Roland Ruegner PA-C
ARUP Employee Health Clinic
500 Cipeta Way
Salt Lake City, Utah 84108
801-583-2787 x 2400
ruegner@aruplab.com
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

USE OF EMR

SOME PROVIDERS & STAFF ENTER PROBLEMS INTO EMR

PROBLEMS GET ENTERED BY CHANCE

MANY PROVIDERS & STAFF DO NOT ENTER PROBLEMS INTO EMR

NO PROBLEMS GET ENTERED

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 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 too much.
FLOW CHART

HOW WE WILL ENTER PROBLEMS ON
PROBLEM LISTS
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
    - Update Problems or Health Maintenance on Encounter form

No
- 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

charts w/o problem list prior to intervention
Problem List Post Intervention

# charts w/o problem list

Days

LCL

UCL

centerline
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

#charts w/o problem list

LCL
UCL
Schedule

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