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Problem List

The purpose of the problem list is to present in one place, a current, concise picture of all of the patient's problems and significant health factors. This is done so that the UWS Care Team composed of the supervising clinician and treating interns has an overview of the patient's health care needs. With the advent of electronic health records (EHR), the problem list is also shared by practitioners from other clinics and disciplines who are in the same system (i.e. Epic).

The problem list is used in a number of ways: 1) It is used by interns and APs to better follow the patient's case, making sure that the patient as a whole is considered and not just the chief complaint; 2) it serves as a convenient overview for anyone else treating the patient who might not be familiar with the case; 3) it provides a data base from which epidemiology data can be drawn.

> *Clinical tip*: During the complete history and physical exam the intern should note those items that should go on the problem list. This can be done on a piece of paper or marked as a temporary reminder on the intake form.

When assuming the care of a patient from another intern, you will use the previous problem list (which may have been generated by various providers throughout the EPIC system) and management plans and update them as necessary based upon your own assessment and the patient's prior response to care. Consult with your clinical supervisor to determine what further examination, if any, you might be required to perform when assuming care.

Key Clinic Charting Requirements:

1. The problem list, like the previous SOAP notes, should *routinely* be reviewed prior to each patient visit.

2. New problems are not to be added or existing problems modified or resolved without the approval of the supervising clinician.

What is a "Problem"?

In this context a "problem" is any significant concern, complaint, or finding that may affect the patient's health (present or future), treatment, or prognosis (expected outcome). The list will always include the problem that brought the patient in (chief complaint) and any other current health problems that the patient is aware of. But it also may include conditions or findings incidentally derived from the history, physical exam, x-rays, lab work or further questioning. There are potentially 6 types of problems that are included on the problem list.

1. Problems to be treated for which a diagnosis has been determined.

Any problems that have been diagnosed with the intention to treat are entered on the problem list in diagnostic language with ICD codes.[1]

In order to treat, it is required that the patient have a working diagnosis (either a specific anatomical diagnosis such as *cervical sprain* or a more general symptom-based diagnosis such as *cervicalgia* reflecting that at least an initial assessment has been performed).

At UWS Clinics we use a 4 part analysis when teaching clinical thinking as it relates to musculoskeletal conditions. In a paper charting format these parts can be combined into a single item on the problem list:

> *"Acute, traumatic, moderate lumbar sprain (847.2) with deep referred pain to the right posterior thigh, associated with lumbar joint dysfunction (739.3) complicated by a lower cross syndrome (ICD)."*

CHARTING IN EPIC

In an EHR format the charting strategy is very different. Whereas the 4 part format for musculoskeletal skeletal cases still informs the case analysis, decision-making, and discussions with the clinical supervisor, it is simplified for the purposes of the electronic record.

Check with your clinician to see which parts of the 4 part diagnosis they wish to capture at the level of the problem list and the way they wish to annotate it.

In the EHR system, each component that carries an ICD code is charted as a *separate problem* (as opposed to multiple parts of the same problem).

Using the code search button, an ICD code is chosen. For the example above, the diagnosis would be broken into multiple problems and some components may be left out entirely:

- *847.2 "Lumbar sprain"*
- *"Deep referred pain to the right posterior thigh" (may added as a comment under lumbar sprain in the display window or left off the problem list entirely and remain only as a part of the SOAP)*
- *739.3 "Lumbar joint dysfunction" (may added as a separate problem or left off the problem list entirely and remain only as a part of the SOAP)*
- *728.9 "Lower cross syndrome" (3 options: enter as a separate problem, enter simply as an annotation under lumbar sprain in the display window, dropped from the problem list entirely and entered only in the SOAP notes.)*

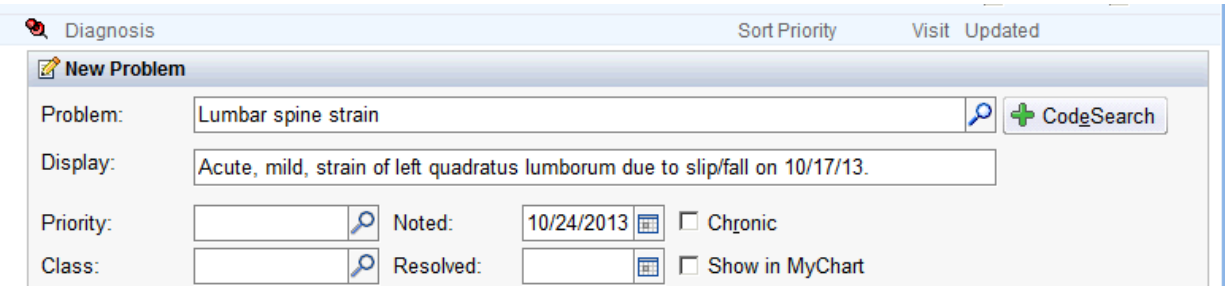
USING THE DISPLAY WINDOW

The display window can be used several ways. The exact wording of the diagnosis can be modified. For example, since there is no specific code for facet syndrome, the ICD code for "cervicalgia" could be re-worded in the display window to read "cervical facet syndrome."

[1] ICD codes are billing codes that correspond to the patient's health problem.

One can include modifiers that describe severity (e.g., mild, moderate, severe), duration (e.g., acute, chronic), cause (e.g., traumatic, postural) and pain referral (e.g., "*deep referred pain to the right posterior thigh"), or* painless contributors *(e.g., "upper cross syndrome").* The display window allows for a brief narrative description of the problem. This is very useful for gaining a quick insight into the patient's problems.

Example



Clinic Requirement: Any additions or alteration in the display window must have pre-approval from the supervising clinician.

USING THE OVERVIEW WINDOW

The overview window can be used to capture a variety of information. The main use for the Overview Window in the UWS clinic system is to record the elements of the management plan for that particular problem.

Management Plans

Every problem must have a management plan, but how that management plan is charted depends on the nature of the problem. There are three common situations: 1) a management plan for a problem that is being treated in a UWS clinic, 2) a plan which significantly overlaps with a plan already charted for a related problem, and 3) a plan for a problem that is only to be monitored or noted.

1) A plan for problems under care at UWS

A complete management plan must include the following elements:

- *Re-eval due* ***
- *Goals of treatment will be* ***
- *Outcome markers used to assess progress will be* ***
- *Treatment in this clinic for above diagnosis(es) will include* ***
- *The patient will be treated* *** *times per* *** *for* ***
- *Prognosis* ***
- *Date of MP****

Epic *TIP*: Type in the smart phrase *UWSMP* to bring up the management plan template.

2) *A plan which significantly overlaps with a plan already charted for a related problem.*

When one problem is essentially secondary to another problem on the problem list (the primary diagnosis), the interventions and management of the two problems may significantly overlap. In those circumstances instead of repeating the entire plan again using the management plan template, simply refer to the management plan already entered under the primary diagnosis. For example, a myofascial pain diagnosis may be linked to a lumbar joint dysfunction diagnosis elsewhere on the problem list. The entry in the overview section for the myofascial pain syndrome could then be "See management under lumbar joint dysfunction." In some cases one problem could be linked to multiple problems. For example: Myalgia could be linked to *lumbar joint dysfunction, sprain of deltoid (ligament) ankle and calcifying tendinitis of shoulder.*

3) *A plan for a problem that is only to be monitored or noted.*

Some problems on the problem list do not necessitate using the management plan template. Examples include problems awaiting further assessment (e.g., undiagnosed, untreated knee pain to be more fully assessed at a later time), a problem treated elsewhere and not co-managed in our clinic (e.g., hemochromocytosis), health risks that simply require vigilance (family history of breast cancer), or examination findings that only require monitoring (e.g., an enlarged lymph node). In these cases rather than using the management template, simply make a brief management notation. For example, "to be assessed," "monitor," "managed by James Smith, ND."

Changing a management plan

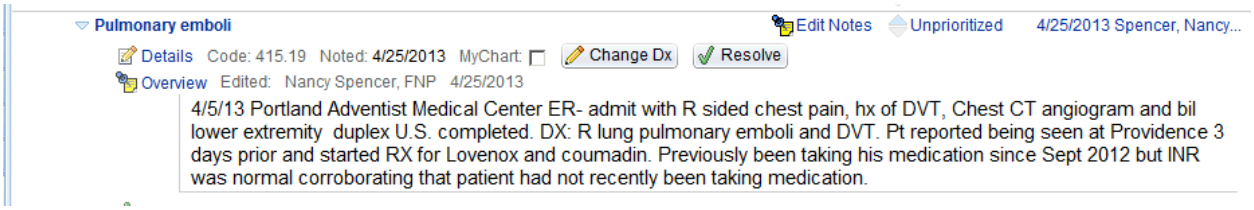
Practitioners should be aware that when management plans are changed (for example, during a re-evaluation) the original plan is overwritten and disappears from that overview window. However, any previous management plan can be accessed by going to *chart review*. **Note: it is critical that you do not overwrite management plans from other practitioners from other care facilities!**

> *Epic TIP*: To access older management plans using *chart review*, see Appendix 1.

Management plans and notes from other providers

In the EPIC system, you will be able to see display and overview notes from other practitioners. Below is an example of an entry by a medical practitioner offering useful information that you might want to know about your patient. Some providers use the overview window to add succinct summary of the problem.

Example from another provder : Pulmonary embolism.



It is important never to modify and or change in any way the notes from another provider! If, however, you are co-managing a particular problem, your management plan can be added to the problem's overview window.

2. Problems still being evaluated which do not yet have a diagnosis, but are captured with an ICD code for a symptom.

Sometimes the patient presents to the doctor with several complaints and there is not time to evaluate all of them. Or the patient may bring up a new complaint at a regular treatment visit when there is not time to perform a complete history and examination. The doctor places those problems that will be evaluated later on the problem list. This is done so that s/he remembers to schedule a time for a relevant history and examination. It also serves as a reminder of these issues when treating other problems. Since no diagnosis has been made these problems are written as a complaint--either a symptom (e.g., pain, numbness, dizziness) or an exam finding (e.g., a rash, isolated blood pressure elevation, sensory loss). ICD codes that correspond to a patient's symptoms (e.g., knee pain) are chosen rather than a code related to a specific diagnosis (meniscus tear). This problem must be annotated "to be assessed" in the display window.

If the doctor is in the middle of evaluating a problem but does not intend to treat until the diagnosis is clarified, then it is written as a complaint along with the further assessment steps being taken. For example, *"Generalized abdominal pain of unknown origin."* See questions #3-5 in the "Frequently Asked Questions" section for examples of how to write provisional or "rule out" diagnoses if you think it is appropriate to offer a trial of treatment even though your evaluation (including ancillary studies) may be incomplete.

3. Problems that are being monitored.

Sometimes the patient and/or the doctor notes a problem but thinks it may be temporary and wants to first monitor to see if it persists before scheduling an evaluation or treatment. These problems are written on the problem list as a complaint--either a symptom or an exam finding. The problem list acts as a prompt so that the doctor remembers to monitor them.

Minor problems that are expected to quickly self-resolve without treatment are not always listed, but should be noted in the plan (P) section of a SOAP note. Check with your supervising clinician on a case-to-case basis to see if they should also be added to the problem list.

4. Problems being managed elsewhere that you are not treating.

Significant problems that the patient has, even if they are already being managed by other providers, must also be recorded. If the provider they are seeing is in the EPIC system, it should already be on the problem list. Otherwise, add it. These problems may impact the prognosis for conditions you are treating, may contraindicate some treatments that you might otherwise use, and/or impact the patient's overall health. This reminds the doctor to consider these issues when treating the patient.

If the practitioner acquires prior medical records, the problem can be written in diagnostic language (e.g., 564.1 irritable bowel syndrome). If based solely on the patient's report, it can be recorded as a symptom (e.g., 564.9 unspecified functional disorder of the intestines) or as a v code (V12.7 personal history of disease of the digestive system). The display or overview windows can be used to add any other useful comments (e.g., "patient reports being treating

by ND for inflammatory bowel disease"). The type of practitioner should be identified (e.g., PCP-MD, neurologist, ND, acupuncturist, LMT, PA, athletic trainer). Consult with your supervising clinician. S/he may want you to include additional information such as the provider's name or contact information.

> *Clinical tip*: Sometimes you will be treating conditions that are managed elsewhere. When possible, it is good practice to contact and coordinate your care with the other providers who are managing the same problem. Be sure to get permission from your supervising clinician before making contact. Chart any communication with another provider regarding the patient.

5. Patient issues that may affect management but are not likely to change.

Items that are not going to change but that may impact the patient's health or treatment, or mislead the doctor on physical examination, are noted. These are usually items from the patient's past health history or findings discovered while working up an unrelated complaint.

Note: For example, a permanent spinal anomaly (e.g., block vertebra) or acquired condition (scoliosis) should be added as a separate problem if, in the judgment of the provider, the anomaly may *directly impact current or future treatment*. In addition, it can be linked to another problem currently under care. For example, a congenital block vertebra would be entered as its own problem and could also appear in the display window under a cervical sprain diagnosis. Be aware, however, that if the block vertebra is recorded *only* in the display window of the cervical sprain, it will disappear when the sprain is resolved.

> **Clinic Requirement**: Issues that not only affect management but may result in significant contraindications should be noted as an alert in the Care Coordination Note which allows it to be viewed in the Snapshot section of the patient record.

6. Identified risk factors for the patient's health

Problems can include risk factors from family history (e.g., mother and sister with breast cancer) or lifestyle behaviors that are known to increase the chances of future morbidity or mortality and *are judged to be significant enough* to be added to the problem list. Some, like obesity or smoking, may impact the prognosis of problems being treated. These and others also remind the doctor to recommend appropriate lifestyle changes or screening tests[2] as indicated. They may also serve as a reminder to the doctor that if certain symptoms develop they should be taken more seriously than for a patient without this risk factor.

Only risk factors that are significant for your patient are listed (see "Frequently Asked Questions" section, question 7-10).

[2] Screening tests are used to identify a risk for a future condition in an otherwise healthy individual (e.g., screening for high blood pressure which may be a risk for heart disease) or to detect a subclinical condition in a patient without apparent symptoms (e.g., a mammogram to detect early asymptomatic breast cancer). In contrast, diagnostic tests are performed to diagnose a condition that currently is causing symptoms.

Charting minor problems

Sometimes a patient has additional minor problems which require making a decision about whether or not to add them to the problem list. They roughly fall into one of three categories.

1) **Minor, self-limiting problems that should be noted but likely require no treatment or followup**. A cold, for example, may warrant a note as a SOAP entry but rarely would qualify to be elevated to the problem list.
2) **A minor problem, but one that the practitioner wants to check in on and monitor if only for a brief time.** Two options exist and the choice will depend on the supervising clinician. The problem can be captured just in the SOAP (noting in the P the need to check with the patient on the next visit) or it may be elevated to the problem list if there is potential for it to be or become more serious or chronic.
3) **A minor problem that the practitioner chooses to work up more extensively and to treat**. In this scenario, the problem must be added to the problem list.

Using the problem list

In EHR every problem is assigned an ICD code. In paper charting only those problems with services being billed require ICD codes. In nearly all circumstances the chief complaint should be elevated to the highest level of diagnosis based on the level of diagnostic certainty. (e.g., knee pain becomes meniscus tear).

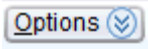
Paper charting tip. Each problem should be dated based on the *first day* it presented to the clinic (not the date you recorded it on the problem list or the date when the patient first experienced the symptoms). When doing a re-evaluation, do not change the original date of the problem. The problem date NEVER CHANGES. In EHR this is not a problem.

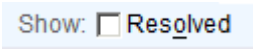
Clinical tip: Remember that Medicare patients or other 3rd party payers may have specific requirements regarding how the diagnosis is written or which ICD codes are used. Check with your clinical supervisor if your patient has Medicare coverage or is in another special billing group.

Changing the problem list

A problem list is flexible and must be continuously revised and updated to reflect changes in the patient's status. The diagnosis of a certain problem may change at any time, it may resolve, and new problems may continuously be added. It is important that the chart accurately reflect that a problem has resolved so that it is not continuously carried forward as an open problem. Do not, however, resolve a problem without the direction of your clinical supervisor and only after an appropriate assessment has been made (which usually requires data from both the S and O components of a SOAP). Likewise, problems must be updated when they change (e.g., a traumatic sprain strain may have resolved but a myofascial pain syndrome may now be present as a residual effect that still requires care).

In EPIC existing diagnoses can readily be edited by using the "Change" and "Resolve" buttons after selecting a diagnosis from the Problem List. The "change dx" and "resolve" buttons are found under "details." Problems that have been resolved in the past can still be accessed.

Epic TIP: To access a list of resolved problems, start on the *problem list* screen, then click on *options* 

, check the *resolved* box 

and scroll to the bottom.

Frequently Asked Questions

1. **Can a symptom or exam finding be added to the problem list?** Yes**.** After an initial assessment of a patient**,** it may not be possible to elevate a particular symptom or exam finding to a higher diagnostic level. Findings such as a "cervical mass," or "LUQ tenderness," or "diffuse right calf pain" might defy analysis at the moment. Further investigation or simply an extended period of observation may be necessary. The problem can be left at a SOAP note level or can also be added to the problem list. To enter on to the EPIC problem list, the finding must first be located on the menu of diagnostic codes. Diagnostic codes are not necessary to record the problem in the SOAP notes.

   In paper charting, you can add positive findings or subjective complaints to a problem without codes and in your own words. In paper charting, you can also cluster them, if appropriate (for example, "abdominal tenderness," "bloating," and "nausea" would all be listed as the same problem since they are likely to be interrelated).

2. **Is it acceptable to modify your provisional diagnosis with "rule out…"?** Yes. For example, "Traumatic lumbosacral sprain/strain with deep referred pain to right posterior thigh, R/O herniated intervertebral disc." R/O denotes that this competing diagnosis is still a possibility and has yet to be ruled out. Ruling it out may require additional tests and procedures or simply monitoring response to treatment. The R/O designation is rarely needed. Beginning interns may be tempted to inappropriately use this phrase to cover highly unlikely competing diagnoses. Be sure to check with your clinical supervisor before adding an R/O. In EHR, you can add this comment in the display window.

3. **What if I am really unsure about the working diagnosis**? Ask your clinical supervisor and s/he will decide. If there is significant uncertainty, the working diagnosis may be labeled as "suspected" or "probable." Generally, avoid labeling it as "possible." For example, your diagnosis could be "probable medial meniscus tear of the right knee, awaiting MRI confirmation." These additional comments can be entered in the display window. Having a diagnosis allows you to treat the patient. If later the MRI instead reveals only an inflamed plica, you can update the diagnosis and continue with care.

4. **In some cases, a diagnosis cannot be made without an x-ray. How can I write a diagnosis before the x-ray is even ordered?** You are writing a provisional diagnosis. It represents what you suspect is wrong with the patient based on physical examination and history. Further, it helps to direct your x-ray study. If it turns out that the x-ray does not support your diagnosis, you can reconsider. For example in an acute ankle injury that merited an x-ray, one could write "Right ankle sprain R/O fracture" or "Suspected right ankle fracture."

5. **What are some examples of "significant health problems" that should be charted in the problem list?** Here are a few: medical problems that affect the overall health of the patient like hypertension, overweight/obesity, SLE, AIDS, diabetes, etc. Significant health risk factors for future health problems like smoking, unhealthy drug or alcohol behaviors, a personal history of cancer, a significant family history of breast cancer or ankylosing spondylitis; incidental lab or x-ray findings which need to be monitored, further investigated or treated, like isolated elevated ALP, liver enzyme abnormalities, iron

deficiency anemia, a lung shadow, etc.; psychosocial issues, if pertinent, like feeling of paranoia, pain behaviors, inappropriate affect, clinically diagnosed depression. In Epic, any of these health problem entries must be linked to an ICD code.

DO NOT write problems in diagnostic language if they have not been sufficiently evaluated. A patient whose blood pressure is elevated at one visit would be listed as "ICD 796.2 elevated blood pressure" until a sufficient number of readings are obtained to meet diagnostic criteria for hypertension (see CSPE pathway on Hypertension).

6. **How do I know if a health risk factor is "significant?"** It is important not to clutter the problem list with a lot of minor health risks. There generally needs to be some valid evidence that a particular factor is truly a health risk and one significant enough to impact the patient and the practitioner's management of the patient. To a certain degree this is a judgment call, so before including questionable health risks check some reliable databases for evidence and then consult with your clinical supervisor. On the other hand, a good health promotion problem list will include important health risks so that the practitioner can help the patient make good lifestyle and nutritional choices. The CSPE care pathways on Overweight, Hypertension, and Dyslipidemia contain some good information.

7. **What about family history risk factors?** Genetic risks are usually not strong factors unless it is in a first degree relative. In addition, genetic risks that are also impacted by lifestyle are usually not significant unless manifested at an early age or represented in multiple family members (either first or second degree).

8. **How do I know if I'm putting too much or not enough on my problem list?** Consult with your clinical supervisor.

9. **What if I am treating a low back problem and on a particular day the patient also says s/he "slept wrong" and his/her neck is stiff. Is this enough of a problem to be on the problem list?** These situations come up often. They can be tricky. If a minor problem arises in the course of the office visit that is not treated and is so minor that it is not assessed other than a few screening questions, make a note in the P section of the SOAP to check it on the next office visit. If it proves to be a problem that requires treatment, further evaluation, or continued monitoring, it should be added to the problem list. Notify your clinical supervisor immediately. S/he will decide whether a problem is actually this minor.

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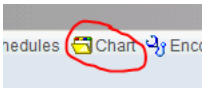
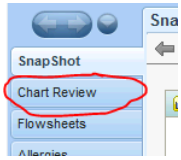
Appendix I: Accessing Prior Management Plans

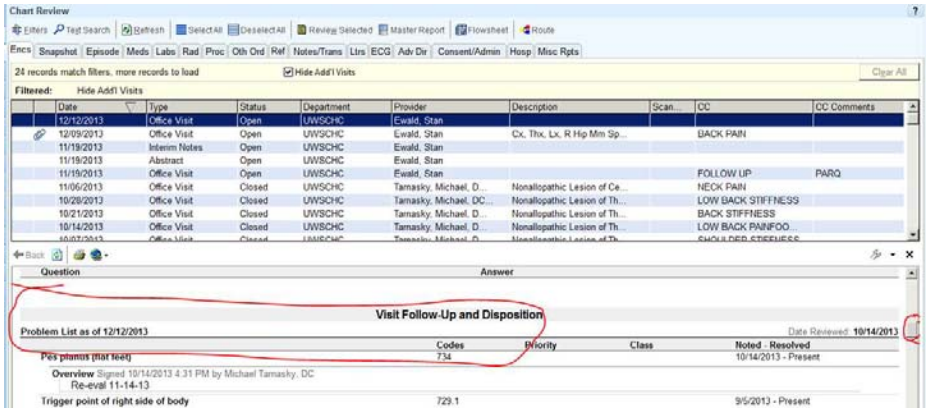
To access prior management plans, perform the steps below.

1. Go to *chart review* 

2. Find the **patient** in question by name. 

3. You will be in "SnapShot;" now click on "**Chart Review**." 

4. Click on the **most recent visit** prior to the new plan to highlight that visit. In the report window below, scroll down to the **problem list section**.



5. Find the **specific diagnosis** that the plan is attached to and the plan will come into view. If the plan has a "**Previous Version**" link, you can click on that to find previous versions of that problem overview note.