Proposed guidelines for the management of the Epic problem list

1. Actively manage the problem list with each patient encounter.
2. With each encounter, resolve problems, add them to the history, or change the diagnosis as appropriate. This can be done by right clicking on the problem and choosing from the drop down menu or using one of the buttons that allows for change or resolution.
3. Do not add duplicate diagnoses. Change or activate diagnoses from the chronic list as appropriate if you need the problem to be on a hospital or other list. For example, if you are managing hypertension in the hospital, make the problem a hospital problem from the chronic problem list rather than typing hypertension in again as a new hospital problem. If you notice duplicate problems, delete the duplicates. Note that acute exacerbation of systolic heart failure and exacerbation of chronic obstructive pulmonary disease are not duplicates of chronic heart failure or of chronic obstructive pulmonary disease. It would be appropriate to add acute exacerbation of a chronic problem separately in cases where the patient is admitted or treated for this problem. Depending on the clinical situation and circumstance, you might resolve the acute exacerbation when it has been appropriately managed. Whether to and when to resolve a problem is up to the treating physicians clinical judgment.
4. Combine diagnoses that are really the same problem but with varying degrees of specificity. Keep the most accurate and specific diagnosis present. If you see, cancer, breast cancer, and carcinoma in situ of the breast all representing the presence of a single breast cancer, then delete cancer and breast cancer; keep carcinoma in situ of the breast. If you are updating a cancer diagnosis with a more specific diagnosis (such as carcinoma in situ of the breast), use the “change diagnosis” button to update the problem rather than adding a more specific but duplicate problem to the list.
5. Do not include daily information that does not have significant meaning going well into the future in the overview associated with a problem. For example, do not state that a patient feels better or had an episode of vomiting unless you think that this is an important event, finding, or notation that should be available for others to see months or years from now. If you want to update progress from day to day in the hospital, place the updates in the progress note rather than in the overview.
6. For data that you do want to place in the overview for notation by others into the future, include the date with the year in the overview. Do not use terms like today, tomorrow, last week, prior to admission, a specific month with no year documented etc…
7. When discharging a patient from your care environment, be sure to clean up the problem list and overview so that it is left in a form that is “timeless” for the patient and will help that patient get better care across the continuum of systems and environments.
8. Only remove information placed in the overview by others if it is clearly incorrect or it clearly violates the guidelines outlined above.
9. The Care Coordination Note that can be created and edited from the Problem List screen should only be used to create or edit a Person Centered Care Plan for the patient.