

## HEALTH SERVICES QUALITY IMPROVEMENT IMPLEMENTATION GUIDE

### EXERCISE NINETEEN

SUBJECT: PROBLEM SUMMARY LIST EXERCISE

PURPOSE: The purpose of this implementation guide is to assist clinics in complying with current Medical Manual guidelines for use of the Problem Summary List (NAVMED 6150/20). Problem Summary Lists are required for all health records.

BACKGROUND: The health record is the official repository for all information regarding eligible beneficiaries' health status. As such, it becomes the focus for managing comprehensive health care delivery. The Coast Guard uses the Problem Oriented Medical Record (POMR) as a structure which allows patient health problems to be the focus of documentation in the medical record. The POMR systematically identifies health problems and their progress through four processes:

1. Acquisition of a data base of relevant patient information
2. Identification of problems discovered during data base acquisition and on subsequent visits
3. Development of a plan to address identified problems
4. Recording progress made in resolving problems

These processes are documented in the health record on the SF 600 and Problem Summary List on an ongoing basis.

The Coast Guard health care system is very similar to a health maintenance organization or large Family Practice group. Patient records are used over the course of time by multiple providers. Because much of the active duty care is provided by non-Coast Guard providers, the Medical Officer must ensure that the health record of a departing member is updated prior to departure. Problem Summary Lists can be valuable tools for organizing important information in a predictable place and format, thus saving time otherwise spent looking back through multiple SF 600's, lab slips, etc., for information.

DISCUSSION: The Problem Summary List is not a list of every diagnosis or office visit. It is a time saving and efficient method of noting significant information. The information on the outpatient Problem Summary List generally falls into three broad categories: preventive medicine and readiness; chronic illness and injury; and acute recurrent illnesses.

1. Preventive Medicine and Readiness Items: These include drug sensitivities and other allergies that impact on fitness for duty and clinical treatment (e.g., cause anaphylactic reactions). These problems should be recorded in the first three lines at the top of the form and are not numbered. The top three lines should also contain pertinent preventive medicine information for quick reference such as normal or deficient G6PD, sickle cell trait (positive or negative), or other conditions affecting readiness. The first line should be used to record specific allergies, or if no drug allergies are known, the acronym "NKDA". The specific nature of the allergy should be listed (e.g., Betadine allergy - rash). Test results can be abbreviated "G-6PD wnl, SC + or -, ACh level wnl", etc.
2. Chronic Illnesses and Injuries: These include illnesses which would impact on individuals' future health care. Chronic illness is defined as illness for which medication is needed for greater than three weeks, which resolves with residual abnormalities, or has a potential to recur. Examples include: pneumonia which has resolved with residual radiologic abnormality or physiologic abnormality (such as a bronchiectatic segment or persistent sputum production); pericarditis with a persistent change in electrocardiogram; cardiac abnormality requiring SBE prophylaxis; iron deficiency anemia; or psychiatric problems. Attempted suicide must be recorded on the Problem Summary List. Chronic injuries are those which have the potential to cause instability of a joint, long term weakness of a muscle group, or chronic pain. Included in this class would be a grade II or III sprain resulting in an unstable ankle mortise, an anterior cruciate ligament injury, or a rotator cuff injury.

3. Acute Recurrent Illnesses: These should be entered as appropriate. For example, recurrent otitis media in children should be documented, because inclusion may help determine a course of therapy. Other diagnoses to consider for inclusion are urinary tract infections, sexually transmitted diseases, and the like.

Exhaustive, time-consuming retrospective review of records is not recommended to improve Problem Summary List Documentation. However, the Clinic Automated Management System (CLAMS) has screens available which will facilitate the process of creating an updated Problem Summary List retrospectively. The Supplemental Update Screen, Supplemental Data Record Screen and Patient Visit Recall Screen all have information that may be included on the Problem Summary List.

A Medical or Dental Officer does not need to diagnose a condition personally in order to record it on the Problem Summary List. All significant allergies, diagnoses or procedures should be entered on the Problem Summary List as they are discovered, whether by direct observation, diagnosis, or patient history. Examples include patient reported surgeries or hospitalizations (other than routine obstetric care). An ideal time to update the problem list is during a physical exam.

The Problem Summary List should be the first document on the top of the right side of the health record. It should remain as the top document and not be covered with other forms.

ACTION: Each clinic will ensure that a Problem Summary List, NAVMED 6150/20, is available in each health record in the prescribed location. Information must be entered as elicited (i.e., when G-6PD or sickle trait test results return). Medical Officers will update the Problem Summary List as patients are seen in the clinic. At units without a medical officer, the senior HS or administrator must keep the problem lists up to date. Enclosure (1) provides an example of a properly completed problem summary list which may be used for reference. Health records will be reviewed for compliance during MLC Site Surveys.