

## FAQ - Referral

# How to indicate a problem/diagnosis has been resolved when the date of resolution is unknown?

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## Background

The Service Referral SCS includes a "Date of Resolution/Remission" field which is defined in the DCM as "the date or estimated date that the problem/diagnosis resolved or went into remission."

In the CDA implementation guide, this is mapped to an observation with code "103.15510" in the code system "1.2.36.1.2001.1001.101", with an observation value that is a date time, as shown below:

In practice, many existing clinical systems do not record the date of resolution/remission, but only a flag that indicates that the problem has been resolved.

## Clinical safety note

It is important to note that the meaning of the "resolved" flag is ambiguous: it may mean that the problem has been resolved, or only that it is in remission, or not currently an active concern. The nature of the resolution depends on the type of condition. For example, most problems/diagnoses such as gastric ulcer, duodenal ulcer, angina pectoris, etc. are episodic in nature and have long term or lifelong implications for continuing management of the patient.

Implementers should be aware of this ambiguity, since there are obvious clinical safety issues. For instance, if the problem list is presented to the treating clinician in a clinical dashboard as two separate lists – a "past medical history" list and a "current medical history" list – the clinician may not realise the ambiguities

involved. In addition, a decision support engine might ignore problems or diagnoses marked with obvious clinical safety implications.

This FAQ does not resolve such ambiguities; it only describes how to represent the flag for the problem diagnosis being resolved.

## Representation

The representation of the problem resolved flag is similar to that for "Date of Resolution/Remission", as shown below:

This fragment goes in the CDA document in exactly the same space as the first fragment on the previous page.

The CDA path (from the CDA Implementation guide) is:

ClinicalDocument/component/structuredBody/component

[med hist]/section/entry[prob]/observation/

#### Note that:

- The entryRelationship is attached to the observation that represents the problem or diagnosis.
- The active status flag takes the place of the date of resolution/remission; a date observation (code 103.15510) and a status observation (code 103.15517) are not to be provided together.
- The meaning of the status flag and the date are tied together.
  - If there is a date of resolution, the "active status" is implied to be false.
  - If neither a date nor a flag are provided, the "active status" is unknown, and it must be understood that the problem may not be resolved or be in remission.

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