**Sample Problem List – Top-Level and Second-Level Views**

TWO LEVELS OF PROBLEM LIST VIEWS: The default opening EHR display for clinical users should be a top-level view of the complete problem list (both active and inactive problems). The fields diaplayed in the top-level view would also constitute the initial fields of the second-level view of each problem. Double clicking on any problem in the top-level view would open the second-level view of that problem. (There could also be an “Expand all” button, which would open the second-level view of every problem, which would appear consecutively.)

The fields shown in the top-level view (and thus the first three fields of the second-level view) should be the following, each accompanied by a parenthetical indicating the last edit/change date:

* Status (i.e., Active and Inactive);
* Problem title/summary (1-2 lines of display per problem);
* Problem formulation (1-2 lines of display per problem).

These three fields are also the default top-level view. That default should be customizable by each user, who should be able to choose a top-level view displaying only the Problem formulation field or the Title/summary field, as alternatives to displaying both fields together.

For all views, each user should be able to customize the sequence of problems.

Enter new problem

*Default top-level view—*

*both Title/summary and Problem Formulation fields*

|  |  |
| --- | --- |
| **Status** (last edit date) | **Title/summary** (last edit date)**Problem Formulation** (last edit date) |
|  |  |
| Active (\_\_\_\_\_\_\_\_) | Health maintenance (shingles vaccine needed) (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | Health maintenance (\_\_\_\_\_\_\_\_) |
|  |  |
| Active (\_\_\_\_\_\_\_\_) | Diabetes T2 w/ hyperglycemia[[1]](#footnote-1) (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | [Diabetes mellitus type 2](https://www.findacode.com/snomed/44054006--diabetes-mellitus-type-2.html) (\_\_\_\_\_\_\_\_) |
|  |  |
| Active (\_\_\_\_\_\_\_\_) | Wrist fracture (ER/inpatient; treated and discharged, but ongoing diabetes risk (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | [Fracture at wrist and hand level (208388003)](https://bioportal.bioontology.org/ontologies/SNOMEDCT?p=classes&conceptid=208388003) (\_\_\_\_\_\_\_\_) |
|  |  |
| Active (\_\_\_\_\_\_\_\_) | Alcoholism history, currently well-controlled (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | [Alcoholism (720002)](https://imagic.nlm.nih.gov/imagic/code/map?v=5&js=true&pabout=&pinstructions=&p=df1310fczd15138807e13&p.df1310fczd15138807e13.s=189336000&p=df1310fczd15138807e64&p.df1310fczd15138807e64.s=310495003&p=df1310fczd15138807e184&p.df1310fczd15138807e184.s=36440009&p=df1310fczd15138807e238&p.df1310fczd15138807e238.s=410070006&init-params=f%3A1%3Bdob%3A1+May+1958&pat=Female+adult+1&pat.init=Female+adult+1&q.f=1&q.dob=1+May+1958&p=df1310fcz0&p.df1310fcz0.e=Alcoholism+%287200002%29&pdone=Get+ICD+Codes&qadd=) (\_\_\_\_\_\_\_\_) |
|  |  |
| Active (\_\_\_\_\_\_\_\_) | Cirrhosis, 2dary to alcoholism, manifest by jaundice, ascites (minimal) (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | [Alcoholic cirrhosis](https://imagic.nlm.nih.gov/imagic/code/map?v=5&js=true&pabout=&pinstructions=&p=f6c7dbeazd15147735e13&p.f6c7dbeazd15147735e13.s=189336000&p=f6c7dbeazd15147735e64&p.f6c7dbeazd15147735e64.s=310495003&p=f6c7dbeazd15147735e184&p.f6c7dbeazd15147735e184.s=36440009&p=f6c7dbeazd15147735e211&p.f6c7dbeazd15147735e211.s=410070006&p=f6c7dbeazd15147735e301&p.f6c7dbeazd15147735e301.s=7200002&init-params=f%3A1%3Bdob%3A1+May+1958&pat=Female+adult+1+%28modified%29&pat.init=Female+adult+1+%28modified%29&q.f=1&q.dob=1+May+1958&p=f6c7dbeazd15147735e353&p.f6c7dbeazd15147735e353.s=420054005&p.f6c7dbeazd15147735e353.e=Alcoholic+cirrhosis+%28420054005%29&p.f6c7dbeazd15147735e353.o=cirrhosis&pdone=Get+ICD+Codes&qadd=) (\_\_\_\_\_\_\_\_) |
|  |  |
| Active (\_\_\_\_\_\_\_\_) | Malnutrition, 2dary to living circumstances (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | [Nutritional deficiency disorder](https://www.findacode.com/snomed/70241007--nutritional-deficiency-disorder.html) (\_\_\_\_\_\_\_\_) |
|  |  |
| Active (\_\_\_\_\_\_\_\_) | Living circumstances (location, transportation, social isolation) (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | [Food insecurity, housing instability etc.](https://confluence.hl7.org/display/GRAV/Social%2BRisk%2BTerminology%2BValue%2BSets) (\_\_\_\_\_\_\_\_) |
|  |  |
| Active-prelim (\_\_\_\_\_\_\_\_) | Recurrent abdominal pain (incomplete workup) (\_\_\_\_\_\_\_\_) |
| Active-prelim (\_\_\_\_\_\_\_\_)  | [This field might be left blank pending completion of the initial workup on the problem . Alternatively, the user might enter the SNOMED CT term [Abdominal pain](https://phinvads.cdc.gov/vads/ViewCodeSystemConcept.action?oid=2.16.840.1.113883.6.96&code=21522001) for the symptom without specificity, possibly to be revised when the initial workup is completed.] (\_\_\_\_\_\_\_\_) |
|  |  |
| Inactive (\_\_\_\_\_\_\_\_) | Unspecified mental health issues (which patient does not wish to address) |
| Inactive (\_\_\_\_\_\_\_\_) | [Mental disorder (74732009](https://www.findacode.com/snomed/74732009--mental-disorder.html))  |
|  |  |
| Inactive-remission (9/30/20) | Breast cancer, mastectomy in 2015, no metastases or recurrence (9/30/20) |
| Inactive-remission (9/30/20) | [Malignant tumor of breast](file:///Users/lincolnweed/Downloads/Malignant%20tumor%20of%20breast) (\_\_\_\_\_\_\_\_) |
|  |  |
| Inactive-resolved (12/15/22) | Covid-19 infection (no symptoms or positive PCR test for 6 mo’s.) (\_\_\_\_\_\_\_\_) |
| Inactive-resolved (\_\_\_\_\_\_\_\_) | [COVID-19 (840539006)](https://confluence.ihtsdotools.org/display/DOCCV19/2.3%2BClinical%2BAssessment) (\_\_\_\_\_\_\_\_) |
|  |  |
| Inactive(\_\_\_\_\_\_\_\_) | Advance directive for end-of-life care (updated 12-01-22 and still current) |
| Inactive(\_\_\_\_\_\_\_\_) | [Advance directive for end-of-life care](https://www.findacode.com/snomed/425392003--active-advance-directive.html) |
|  |  |

Enter new problem

*Alternative top-level view—Title/summary field*

|  |  |
| --- | --- |
| **Status** (last edit date) | **Title** (last edit date) |
| Active (\_\_\_\_\_\_\_\_) | Health maintenance (shingles vaccine needed) (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | Diabetes T2 w/ hyperglycemia (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | Wrist fracture (ER/inpatient; treated and discharged, but ongoing diabetes risk (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | Alcoholism history, currently well-controlled (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | Cirrhosis, 2dary to alcoholism, manifest by jaundice, ascites (minimal) (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | Malnutrition, 2dary to living circumstances (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | Living circumstances (location, social isolation) (\_\_\_\_\_\_\_\_) |
| Active-prelim (\_\_\_\_\_\_\_\_) | Recurrent abdominal pain (incomplete workup) (\_\_\_\_\_\_\_\_) |
| Inactive (\_\_\_\_\_\_\_\_) | Unspecified mental health issues (which patient does not wish to address) |
| Inactive-remission (\_\_\_\_\_\_\_\_) | Breast cancer, mastectomy in 2015, no metastases or recurrence (\_\_\_\_\_\_\_\_) |
| Inactive-resolved (\_\_\_\_\_\_\_\_) | Covid-19 infection (no symptoms or positive PCR test for 6 mo’s.) (\_\_\_\_\_\_\_\_) |
| Inactive(\_\_\_\_\_\_\_\_) | Advance directive for end-of-life care (updated 12-01-22 and still current) |

Enter new problem

*Alternative top-level view—Problem formulation field*

|  |  |
| --- | --- |
| **Status** (last edit date) | **Problem formulation** (last edit date) |
| Active (\_\_\_\_\_\_\_\_) | Health maintenance (\_\_\_\_\_\_\_\_) |
| (\_\_\_\_\_\_\_\_) | [Diabetes mellitus type 2, without complications](https://www.findacode.com/snomed/44054006--diabetes-mellitus-type-2.html) (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | Wrist fracture (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | [Alcoholism (720002)](https://imagic.nlm.nih.gov/imagic/code/map?v=5&js=true&pabout=&pinstructions=&p=df1310fczd15138807e13&p.df1310fczd15138807e13.s=189336000&p=df1310fczd15138807e64&p.df1310fczd15138807e64.s=310495003&p=df1310fczd15138807e184&p.df1310fczd15138807e184.s=36440009&p=df1310fczd15138807e238&p.df1310fczd15138807e238.s=410070006&init-params=f%3A1%3Bdob%3A1+May+1958&pat=Female+adult+1&pat.init=Female+adult+1&q.f=1&q.dob=1+May+1958&p=df1310fcz0&p.df1310fcz0.e=Alcoholism+%287200002%29&pdone=Get+ICD+Codes&qadd=) (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | [Alcoholic cirrhosis](https://imagic.nlm.nih.gov/imagic/code/map?v=5&js=true&pabout=&pinstructions=&p=f6c7dbeazd15147735e13&p.f6c7dbeazd15147735e13.s=189336000&p=f6c7dbeazd15147735e64&p.f6c7dbeazd15147735e64.s=310495003&p=f6c7dbeazd15147735e184&p.f6c7dbeazd15147735e184.s=36440009&p=f6c7dbeazd15147735e211&p.f6c7dbeazd15147735e211.s=410070006&p=f6c7dbeazd15147735e301&p.f6c7dbeazd15147735e301.s=7200002&init-params=f%3A1%3Bdob%3A1+May+1958&pat=Female+adult+1+%28modified%29&pat.init=Female+adult+1+%28modified%29&q.f=1&q.dob=1+May+1958&p=f6c7dbeazd15147735e353&p.f6c7dbeazd15147735e353.s=420054005&p.f6c7dbeazd15147735e353.e=Alcoholic+cirrhosis+%28420054005%29&p.f6c7dbeazd15147735e353.o=cirrhosis&pdone=Get+ICD+Codes&qadd=) (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | [Nutritional deficiency disorder](https://www.findacode.com/snomed/70241007--nutritional-deficiency-disorder.html) (\_\_\_\_\_\_\_\_) |
| Active (\_\_\_\_\_\_\_\_) | [Food insecurity, housing instability etc.](https://confluence.hl7.org/display/GRAV/Social%2BRisk%2BTerminology%2BValue%2BSets) (\_\_\_\_\_\_\_\_) |
| Active-prelim (\_\_\_\_\_\_\_\_) | Recurrent abdominal pain (incomplete workup) (\_\_\_\_\_\_\_\_) |
| Inactive (\_\_\_\_\_\_\_\_) | [Mental disorder (74732009](https://www.findacode.com/snomed/74732009--mental-disorder.html))  |
| Inactive-remission (\_\_\_\_\_\_\_\_) | [Malignant tumor of breast](file:///Users/lincolnweed/Downloads/Malignant%20tumor%20of%20breast) (9/30/20) |
| Inactive-resolved (\_\_\_\_\_\_\_\_) | [COVID-19 (840539006)](https://confluence.ihtsdotools.org/display/DOCCV19/2.3%2BClinical%2BAssessment) (\_\_\_\_\_\_\_\_) |
| Inactive(\_\_\_\_\_\_\_\_) | [Active advance directive](https://www.findacode.com/snomed/425392003--active-advance-directive.html)  |

“Enter new problem” button. The top-level view should be preceded by an “Enter new problem” button. This button enables 1-click access to a new problem entry screen (i.e. a screen with blank fields for the second-level view). This button should appear not just in the top-level view screen but in most or all screens viewed by clinical users. This enables the user to start a new problem at any time simply by clicking the button and entering just the problem title (the status would be Active-prelim by default, as further discussed below). In this way the burden of starting a new problem is minimized. Minimizing that burden protects against losing track of possible new problems that have been noticed but not immediately entered.

This streamlined initial problem entry has a potential downside: cluttering the problem list with preliminary, incomplete problem entries, some of which may need to be consolidated with other problems rather than maintained on the list as separate problems. This kind of clutter, however, should rapidly be cleaned up as prelim­in­ary problem entries are completed or consolidated. If that clean-up doesn’t happen, resulting in clutter, then such delay/clutter will be apparent and readily addressed. For example, whenever the problem list has three or more incomplete problem entries, the EHR system could be configured to notify the PCP, a manager, and the patient.

Last edit date. Each status and problem entry is followed by a parenthetical “last edit date,” meaning the last date the entry was changed. Ideally, this parenthetical would be a hyperlink to that last entry. This data point is usefully included in the top-level view for various reasons, particularly:

* Everyone needs to know when the status changes, e.g. when an inactive problem is re-activated due to relapse.
* Everyone needs to know when the problem is diagnosed and otherwise clarified or altered. Evolving compre­hension of the problem is communicated by changing the Problem formulation field, e.g. from a symptom such as shortness of breath (the initial title), to a pathophysiologic problem (e.g. re-titled as heart failure) to a confirmed final diagnosis (e.g., retitled as arteriosclerotic heart disease). The EHR system should automatically insert this change at the beginning of the Title/summary field, which the user might then edit. Thus a user who opens the top-level view expecting to see the symptom title will not find it. Instead he will be alerted that the shortness of breath symptom has been diagnostically refined and restated as heart failure, as of the “last edit date” for the title field.
* Everyone needs to know when the last edit date for an active problem has not changed for a long time (e.g. many weeks or many months, depending on the nature of the problem). That lack of activity raises questions such as whether the problem is being neglected or whether its status should change to inactive.

Status: Active/Inactive

* Active problems include not only the acute and chronic problems traditionally seen on problem lists but also:
	+ preliminary/incomplete problem entries;
	+ recurrent problems (which had been excluded from the problem list as temporary or self-limiting but are now entered in the problem list due to their multiple recurrences);
	+ relapsed problems (which had been on the inactive problem list but re-activated due to the relapse);
	+ mental health problems, which physicians often lack the time and training and inclination to consider;
	+ Social determinants of health (SDoH) problems, which only in recent years have been recognized as within the scope of provider responsibilities.
* Inactive problems include problems in remission[[2]](#footnote-2) and resolved problems that should remain on the problem list due to potential current or future relevance. “Inactive” does not include problems from past medical history (PMH) that were fully resolved years ago and appear to be without potential current or future relevance. An example would be a minor fracture or minor surgery, successfully treated with no complica­tions or other sequelae for several years (the period of time could be specified by provider policy or some kind of industry guideline or standards-setting).

Title: This field should be a brief entry. It’s often useful to include parenthetic­ally an acronym or other shorthand title for ease of subsequent reference. A title may be verbatim from a terminology, or free text, or a combination thereof. See the list of SNOMED concept IDs and Fully Specified Names (FSNs) at [Diabetes Mellitus Diagnoses v.02.xls](https://confluence.ihtsdotools.org/display/CP/2018-11-08%2B-%2BDPG%2Bmeeting?preview=%2F75340797%2F75341026%2FDiabetes+Mellitus+Diagnoses+v0.2.xls), 2018-Nov-02.xls. This list illustrates how a terminology system name can be brief and informative and familiar so as to be suitable as both an informal problem title and the Problem formulation field entry. In other situations free text will be needed for the title. The concept is for the title to be as useful as possible for purposes of a quick initial view of the entire problem list. In wording each problem title, the user should consider other members of the care team (including not only clinicians but the patient-fam­ily, a hospital social worker, community health workers, long-term care facilities) who are or expected to be involved in patient’s care. The top-level view will thus provide holistic context for the second level view of each problem on the list.

The title should be modifiable as the problem evolves over time. This factor, plus the judgments involved in stating the title, may result in varia­bil­ity rather than consistency for the same problem among different users and practice settings. But such variability is acceptable provided that the actual problem formula­tion is stated with care and consistency. What matters to clinical decision makers and coders and payers and researchers and other reviewers is the problem formula­tion, not the problem title.

No numbering. Note that the problems are not numbered. Numbering of problems is probably best avoided, because it is difficult to manage numbers as the problem list evolves and different portions of it are used by different clinicians in different settings. Absent numbering, problems can be referenced by their titles or title abbreviations/acronyms.

Health maintenance should be entered as an active problem on every person’s problem list. It is always active and might be the only problem for some young, healthy people.

“Active-prelim[[3]](#footnote-3)” and “Incomplete workup”: Traditionally, the contents and completeness of the initial workup for a new problem are determined by the clinical judgment of whatever doctor first considers the problem at a patient encounter. Alternatively, the initial workup could and should be determined by some form of “knowledge coupling” CDS tools specific to the problem, which is used before the clinician exercises clinical judgment during the encounter. Regardless of how the initial workup is determined, it has two core components:

* Selecting data needed for the specific problem and collecting the data (mainly via questioning the patient, followed by a physical exam and basic lab tests) and entering findings. Doctors traditionally enter only selected findings, often creating ambiguity on whether a finding was negative or was never checked. In contrast, knowledge coupling tools state questions so that findings are entered as positive, negative, or uncertain (plus allowing for supplementary free text entries).
* Problem formulation, based on analyzing the data collected in light of medical knowledge about what the patient’s combined findings mean on each problem.

When an over­burdened clinician lacks time to do a complete Problem formulation upon first seeing the patient, that clinician should immediately enter a prelim­inary problem title (e.g. an undiagnosed symptom, or abnormal test result). When more time becomes available (which may happen in stages) to resume and complete the initial workup (i.e. completing the fields in the second level view of the prob­lem), then, upon completion, the EHR system should automatically change the Status field from “Active-prelim” to “Active.” This step-by-step, deliberate approach is needed as a matter of scientific rigor, patient safety, clinical discipline, and record integrity.

A somewhat different workflow is involved when problem entry involves converting an encounter note for a temporary problem to a problem list entry, but the end result should be the same: a complete workup and fully formu­lated problem, documented in completed fields for the first and second-level problem list views.

SECOND LEVEL VIEW, PROBLEM ENTRY ELEMENTS. As stated above, the second-level view should be accessible by double clicking on each problem in the top-level view or by an “expand all” button opening the second level view of every problem. The fields in the second level view are the following, as shown 7 below.

* Status of problem (active, active-prelim, inactive etc.) When all or part of a problem list is imported electronically or manually from another EHR or paper record, each active problem entry should be labeled with the status “prelim” qualifier until the current responsible clinician reviews the entry and either verifies or revises it. The problem Status should be followed
* Date/link most recent change in status, with 1-click link to SOAP note or other entry where change was made or explained. That entry should in turn link to the next preceding change in status. In this way a history of all status changes for the problem is readily accessible in reverse chronological order.
* Title of problem, which may or may not be the same as the problem statement as formulated with the initial workup (see discussion on p. 1 above). Clinicians may wish to title a problem using language more concise or informative or understandable than the actual problem statement for purposes of a quick scan of the entire top level view. For example, “DMT2, well-controlled” might be a more useful title than “Diabetes Mellitus Type 2.”
* Problem Formulation, i.e. problem as formulated once initial workup data is fully or mostly collected and analyzed (that analysis should include both CDS and the judgments of clinical and patient). The initial workup might result in consolidating several preliminary problems (e.g. symptoms and/or abnormal test results) into a single problem (e.g. a confirmed diagnosis if a clear basis for it is stated).
	+ The problem formulation should generally follow verbatim the language from a terminology but the system should also permit the clinician to use free text or else the coded language supplemented with explanatory free text. The underly­ing alpha­numeric code should be embedded/hyperlinked in the problem statement but need not be shown in the second level view. Where a coding terminology is used, the preference, in this order, is: (a) SNOMED-CT, which is clinically oriented; (b) ICD-10 and CPT codes, which are commonly used for reim­burse­ment claims; and (c) a specialized terminology if applicable, e.g. [The HL7 Gravity Project](https://confluence.hl7.org/display/GRAV/The%2BGravity%2BProject) for SDoH problems. Users should be able to enter more than one name/code per problem state­ment. See CMS [ICD-10-CM Official Guidelines for Coding and Reporting](https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf), p. 20 (“Assign as many codes as necessary to fully explain each health­care encounter”). Similarly, the POHR principle is to assign as many codes as necessary to fully formulate the problem
	+ Of paramount importance is formulating the problem in verifiable terms that avoid uncer­tainty. This means rigorously distinguishing between what is actually known about the problem and what is believed or hypothesized by the clinician (whose views should be reflected in the assessment and/or plan portions of SOAP notes, NOT in the problem formulation). Making this distinction is essential to a problem-oriented system of care — a system that protects against cognitive biases and heuristics, a system that is patient-centric rather than provider-centric.
	+ Coding guidelines follow this fundamental principle: “Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “ruleout,” “compat­ible with,” “consistent with,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encoun­ter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.” [ICD-10-CM Official Guidelines for Coding and Reporting](https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf), Updated 1/01/2021 (p. 119). The foregoing language appears in Section IV.H (Diagnostic Coding and Reporting Guidelines for Outpatient Services, Uncertain diagnosis).[[4]](#footnote-4) Compare Section III.C (p. 117), Reporting Additional Diagnoses, Uncertain Diagnosis, which provides: “Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical signifi­cance.” This coding rule applies to inpatient diagnoses other than the “principal diagnosis,” the latter being defined as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care” (p. 112). This coding rule should not govern the POHR or clinical decisions on the abnormal findings, because it creates risk of overlooking abnormal findings or failing to follow up on them (a risk in both inpatient and outpatient care).
* Definitional elements of problem
	+ Basis, i.e. evidence justifying the problem formulation. For example, for a diabetes problem, the Basis might be HgA1c persistently above 6.5, together with generally accepted guidance defining DMT2 in those terms. The Basis should link to appropriate record entries, which would generally be flowsheets in the case of the HgA1c level.
	+ Disability, i.e. the impairment resulting from the problem. This element is patient-specific. For example, an orthopedic problem might be occupationally disabling for a manual worker, might be merely an inconvenience for an office worker, or might interfere with daily activities for a retired patient.
	+ Goal, a specific aim or measure of what is to be achieved in taking action to solve the problem. Patient input is especially important here.
	+ Stability, i.e. whether the problem is getting worse, remaining stable, or getting better. If the patient’s view differs from the clinician’s view, that discrepancy should be included in this element, because such a discrepancy may be a red flag, a clue that something may be going wrong.

Definitional problem elements show the nature of the problem. Therefore, they should be readily accessible by displaying them in the second-level problem list view. Each of these elements is subject to change. Users typically need only the most recent version of those elements. Only that version needs to appear in the second level view. But the second level view should include a link to the prior version, which similarly should include a link to its prior version.

* Links to the medication list, i.e. current medications ordered or otherwise being taken for this problem. Links to medication information for meds not necessarily being taken for this problem but that are otherwise relevant to it [SHOULD? MAY?] also be included, e.g. meds interacting with this problem or identified as relevant to it by a CDS tool.
* Link to allergies/intolerances list
* Links to any current flowsheets being used to follow this problem, and links to other flowsheets that the clinician or patient may wish to view in tandem with flowsheets on this problem.
* Link to the most recent progress notes for this problem; each note should link to preceding note.
* Specialty (or body system): This should be included to facilitate different problem list views and priorities for each users, as provided in certain CCs.
* Onset date and Date first added to problem list The onset date element should be flexible, permitting imprecise entries in the form of, for example, “before 1990,” or “about one week after a fall at the end of last month.” Such entries could later be restated as date ranges, which would be part of record review and clean-up. The date of onset is useful to show temporal sequence of problem’s origin in relation to other problems. The Date first added to problem list might be the date of patient’s first encounter when the provider opened a record for the patient, or an earlier or later date. This element should allow for entries of a month or a year where the precise date is not readily accessible. Recording the date the problem is first added to the problem list facilitates finding the most relevant entries and lessens the need to search the entire record. See the Condition.onset and Condition.recordedDate elements of the FHIR Condition resource, at [https://build.fhir.org/condition-definitions.html#Condition.clinicalStatus](https://build.fhir.org/condition-definitions.html#Condition.clinicalStatus,which). The former is defined as “Estimated or actual date or date-time the condition began, in the opinion of the clinician.” The latter is defined as: “The recordedDate represents when this particular Condition record was created in the system, which is often a system-generated date.”
* Source of the problem, e.g. imported from another EHR system per CC#103.

SAMPLE PROBLEM LIST – SECOND LEVEL VIEW

|  |  |
| --- | --- |
| *Status – Date/Link most recent change*Active | *Title*Health Maintenance (shingles vaccine needed) |
| Problem formulationHealth Maintenance, general *[this is a free text entry]* | Comments on problem formulation {free text)*[Closest SNOMED-CT term is* [*History and physical examination, annual for health maintenance, code 78318003*](https://www.findacode.com/snomed/78318003--history-and-physical-examination-annual-for-health-maintenance.html)*. See also SNOMED-CT term “At risk of disease (313424005)” and ICD-10 term, “Other specified personal risk factors, not elsewhere classified (Z91.89)”]*  |
| PCP OverviewHealth maintenance measures generally OK but still need to assess possible indi­vi­dualized risk factors not addressed by current problem list  | Nursing/other clinicians OverviewPatient seems engaged in keeping up with health main­ten­ance  | Specialist(s) OverviewEndo: Need to revisit and rein­force patient education on potential diabetes complica­tions to watch for |
| Patient Overview*[This field could automatically import most recent message from patient portal or Open Notes, which should show problem list and invite problem-specific patient inputs.]* | BasisCurrent health maintenance plan completed except for shingles vaccine | Stability N/A |
| DisabilityN/A | GoalDo periodic screening and pre­ven­tion for potential issues not addressed by current problem list  |  |
| Medication list (link)*[Link to med list, which should show list as last reconciled and date thereof, with warning that subsequent med changes may not be reflected.]* | Pending orders, procedures list (link)*[Link(s) to list(s) of pending orders, procedures, consultant reports etc.]* | Allergies/intolerances (link)*[Link to list as last updated]* |
| Progress notes, most recent (link)*[Link to most recent encounter note, which should link to prior notes, on this problem]* | Current flowsheets (link)*[Link to page w/ all flowsheets]* | Specialty category(ies)General int. med.SDoH |
| Onset date / Date added to current problem listN/A | N/A | Information sourcesPrior PCP |
|  |  |  |
| *Status – Date/Link most recent change*Active | *Title*Diabetes T2 with hyperglycemia |
| Problem Formulation[Diabetes mellitus type 2](https://www.findacode.com/snomed/44054006--diabetes-mellitus-type-2.html)  | Comments on problem formulation {free text)The foregoing SNOMED term doesn’t fit, if hyperglycemia is a complication (for which ICD-10 code is E11.65). ICD-10 code for DMT2 w/out complications is E11.9. |
| Patient OverviewI feel like I’m getting worse. Need help with diet and exercise | BasisHgA1c > 6.5 persistently; most recent is 7.3 | Stability Stable |
| DisabilityNone currently | GoalGet and keep A1c below 6.5; avoid diabetes complications |  |
| Medication list (link)As last reconciled | Medication list – orders, notes etc. (link)List as last updated | Current flowsheets (link)Link to page w/ all flowsheets |
| Specialty category(ies)EndocrinologyGeneral int. med. | Allergies/intolerances (link)List as last updated | Click for detailsRelated problems |
| Progress note, most recent (link) |  | Information source(s)Prior PCP |
| Onset date2015 est. | Date added to current problem list Jan. 2016 |  |

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| *Status – Date/Link most recent change*Active | *Title*Wrist fracture (ER/inpatient admission, treated, discharged) |
| Problem Formulation[Fracture at wrist and/or hand level](https://bioportal.bioontology.org/ontologies/SNOMEDCT?p=classes&conceptid=208388003#details)  | Comments on problem formulation {free text)ICD-10 term is “[Unspecified fracture of unspeci­fied wrist and hand, initial encounter for closed fracture](https://www.icd10data.com/ICD10CM/Codes/S00-T88/S60-S69/S62/S62.9-/S62.90XA).” |
| PCP Overview | Nursing/other clinicians OverviewPatient discharged after wrist put in a cast, but discharge plan­­ning failed to consider effect on diabetes problem (difficulty in self-administering insulin due to wrist cast). Follow-up needed. | Specialist(s) Overview |
| Patient OverviewWrist cast prevents me from doing my insulin. | BasisRadiology confirmed fracture[Link to radiology report inserted by \_\_\_\_\_\_?] | StabilityWrist is stable, but diabetes problem is worsening |
| DisabilityPotential inability to continue to self-administer insulin due to wrist cast limiting dexterity  | GoalHealing of fracture; find fix for taking insulin  |  |
| Medication list (link)*[Link to med list, which should show list as last reconciled and date thereof, with warning that subsequent med changes may not be reflected.]* | Pending orders, procedures list (link)*[Link(s) to list(s) of pending orders, procedures, consultant reports etc.]* | Allergies/intolerances (link)*[Link to list as last updated]* |
| Progress notes, most recent (link)*[Link to most recent encounter note, which should link to prior notes, on this problem]* | Current flowsheets (link)*[Link to page w/ all flowsheets]* | Specialty category(ies)Orthopedics |
| Onset date / Date added to current problem listN/A | N/A | Information sourcesPrior PCP |
|  |  |  |
| *Status – Date/Link most recent change*Active | *Title*Alcoholism history, currently well-controlled |
| Problem Formulation[Alcoholism (720002)](https://imagic.nlm.nih.gov/imagic/code/map?v=5&js=true&pabout=&pinstructions=&p=df1310fczd15138807e13&p.df1310fczd15138807e13.s=189336000&p=df1310fczd15138807e64&p.df1310fczd15138807e64.s=310495003&p=df1310fczd15138807e184&p.df1310fczd15138807e184.s=36440009&p=df1310fczd15138807e238&p.df1310fczd15138807e238.s=410070006&init-params=f%3A1%3Bdob%3A1+May+1958&pat=Female+adult+1&pat.init=Female+adult+1&q.f=1&q.dob=1+May+1958&p=df1310fcz0&p.df1310fcz0.e=Alcoholism+%287200002%29&pdone=Get+ICD+Codes&qadd=)  | Comments on problem formulation {free text)Patient abstinent for 1 year; attends AA meetings regularly. [ICD-10 term is alcohol dependence, uncomplicated (F10-20)](https://imagic.nlm.nih.gov/imagic/code/map?v=5&js=true&pabout=&pinstructions=&p=df1310fczd15138807e13&p.df1310fczd15138807e13.s=189336000&p=df1310fczd15138807e64&p.df1310fczd15138807e64.s=310495003&p=df1310fczd15138807e184&p.df1310fczd15138807e184.s=36440009&p=df1310fczd15138807e238&p.df1310fczd15138807e238.s=410070006&init-params=f%3A1%3Bdob%3A1+May+1958&pat=Female+adult+1&pat.init=Female+adult+1&q.f=1&q.dob=1+May+1958&p=df1310fcz0&p.df1310fcz0.e=Alcoholism+%287200002%29&pdone=Get+ICD+Codes&qadd=) |
| PCP Overview | Nursing/other clinicians OverviewPatient appears to have benefited greatly from AA | Specialist(s) Overview |
| Patient Overview | BasisPatient self-reporting and blood alcohol testing | StabilityStable at least, maybe getting better |
| DisabilityNone currently  | GoalHealing of fracture; find fix for taking insulin  |  |
| Medication list (link)*[Link to med list, which should show list as last reconciled and date thereof, with warning that subsequent med changes may not be reflected.]* | Pending orders, procedures list (link)*[Link(s) to list(s) of pending orders, procedures, consultant reports etc.]* | Allergies/intolerances (link)*[Link to list as last updated]* |
| Progress notes, most recent (link)*[Link to most recent encounter note, which should link to prior notes, on this problem]* | Current flowsheets (link)*[Link to page w/ all flowsheets]* | Specialty category(ies)Internal medicinePsych/mental health |
| Onset date / Date added to current problem list |  | Information sourcesPrior PCP |
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| *Status – Date/Link most recent change*Active | *Title*Cirrhosis, 2dary to alcoholism, manifest by jaundice, ascites (minimal) |
| Problem Formulation[Alcoholic cirrhosis](https://imagic.nlm.nih.gov/imagic/code/map?v=5&js=true&pabout=&pinstructions=&p=f6c7dbeazd15147735e13&p.f6c7dbeazd15147735e13.s=189336000&p=f6c7dbeazd15147735e64&p.f6c7dbeazd15147735e64.s=310495003&p=f6c7dbeazd15147735e184&p.f6c7dbeazd15147735e184.s=36440009&p=f6c7dbeazd15147735e211&p.f6c7dbeazd15147735e211.s=410070006&p=f6c7dbeazd15147735e301&p.f6c7dbeazd15147735e301.s=7200002&init-params=f%3A1%3Bdob%3A1+May+1958&pat=Female+adult+1+%28modified%29&pat.init=Female+adult+1+%28modified%29&q.f=1&q.dob=1+May+1958&p=f6c7dbeazd15147735e353&p.f6c7dbeazd15147735e353.s=420054005&p.f6c7dbeazd15147735e353.e=Alcoholic+cirrhosis+%28420054005%29&p.f6c7dbeazd15147735e353.o=cirrhosis&pdone=Get+ICD+Codes&qadd=) | Comments on problem formulation {free text)SNOMED-CT problem mapped to ICD-10 “Alcoholic cirrhosis of liver without ascites” |
| PCP OverviewProblem under control; active monitoring required | Nursing/other clinicians Overview | Specialist(s) Overview |
| Patient Overview | BasisHistory of alcohol abuse + liver biopsy | Stability |
| Disability | GoalAvoid worsening of condition[[5]](#footnote-5) by maintaining alcohol abstin­ence and improving nutrition |  |
| Medication list (link)*[Link to med list, which should show list as last reconciled and date thereof, with warning that subsequent med changes may not be reflected.]* | Pending orders, procedures list (link)*[Link(s) to list(s) of pending orders, procedures, consultant reports etc.]* | Allergies/intolerances (link)*[Link to list as last updated]* |
| Progress notes, most recent (link)*[Link to most recent encounter note, which should link to prior notes, on this problem]* | Current flowsheets (link)*[Link to page w/ all flowsheets]* | Specialty category(ies)Internal medicine |
| Onset date / Date added to current problem listN/A | N/A | Information sourcesPrior PCP |
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| *Status – Date/Link most recent change*Active | *Title*Malnutrition, 2dary to living circumstances |
| Problem Formulation[Nutritional deficiency disorder](https://www.findacode.com/snomed/70241007--nutritional-deficiency-disorder.html) (SNOMED # 70241007) | Comments on problem formulation {free text)Nutritional deficiency disorder includes both: “[Chronic disease-related malnutrition](https://www.findacode.com/snomed/441971000124107--chronic-disease-related-malnutrition.html)” (SNOMED # 441971000124107, mapped to ICD E46 “Unspecified protein-calorie malnutrition”); and “[Nutrition impaired due to limited access to healthful foods](https://imagic.nlm.nih.gov/imagic/code/map?v=5&js=true&pabout=&pinstructions=&p=54caeb43zd15246629e13&p.54caeb43zd15246629e13.s=189336000&p=54caeb43zd15246629e64&p.54caeb43zd15246629e64.s=310495003&p=54caeb43zd15246629e184&p.54caeb43zd15246629e184.s=36440009&p=54caeb43zd15246629e211&p.54caeb43zd15246629e211.s=410070006&p=54caeb43zd15246629e301&p.54caeb43zd15246629e301.s=7200002&p=54caeb43zd15246629e353&p.54caeb43zd15246629e353.s=420054005&p=54caeb43zd15246629e388&p.54caeb43zd15246629e388.s=441971000124107&init-params=f%3A1%3Bdob%3A1+May+1958&pat=Female+adult+1+%28modified%29&pat.init=Female+adult+1+%28modified%29&q.f=1&q.dob=1+May+1958&p=54caeb43zd15246629e490&p.54caeb43zd15246629e490.s=445281000124101&p.54caeb43zd15246629e490.e=Nutrition+impaired+due+to+limited+access+fo+healthful+foods&p.54caeb43zd15246629e490.o=lack+of+acces+to+good+nutrition+sources&pdone=Get+ICD+Codes&qadd=)” (SNOMED #445281000124101, mapped to ICD E63.9 “Nutritional deficiency unspecified”). Both may contribute to this patient’s problem. See [WHO malnutrition fact sheet](https://www.who.int/news-room/fact-sheets/detail/malnutrition) on various forms of malnutrition. |
| PCP OverviewHigh priority to address. Change in living circumstances may be essential. | Nursing/other clinicians OverviewPatient understands importance of problem but not what to do about it | Specialist(s) Overview |
| Patient Overview | BasisSelf-reporting, blood test results | StabilityGetting worse |
| DisabilityLimited energy and mood issues | GoalFind and use accessible and affordable sources of better nutrition |  |
| Medication list (link)*[Link to med list, which should show list as last reconciled and date thereof, with warning that subsequent med changes may not be reflected.]* | Pending orders, procedures list (link)*[Link(s) to list(s) of pending orders, procedures, consultant reports etc.]* | Allergies/intolerances (link)*[Link to list as last updated]* |
| Progress notes, most recent (link)*[Link to most recent note, which should link to prior notes, on this problem]* | Current flowsheets (link)*[Link to page w/ all flowsheets]* | Specialty category(ies)Int. Med., SDoH  |
| Onset date / Date added to current problem listN/A | N/A | Information sourcesPatient |
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| *Status – Date/Link most recent change*Active | *Title*Living circumstances (location, social isolation) |
| Problem Formulation[Food insecurity, housing instability etc.](https://confluence.hl7.org/display/GRAV/Social%2BRisk%2BTerminology%2BValue%2BSets)  | Comments on problem formulation {free text)Need to revisit Problem Formulation in light of SDoH Gravity Project Confluence page on [Gravity Terminology Value Sets](https://confluence.hl7.org/display/GRAV/Social%2BRisk%2BTerminology%2BValue%2BSets) - scroll down to domains on Food Insecurity, Housing Instability, Inadequate Housing, Transportation, and Social Connection – see the links to diagnoses (SNOMED CT, ICD-10) |
| PCP OverviewHigh priority to address | Nursing/other clinicians OverviewPatient not aware of options for finding and affording better housing | Specialist(s) Overview |
| Patient Overview | BasisSelf-reporting | StabilityGetting worse |
| DisabilityLimited ability to address other problems if problem persists | GoalFind location to move to and financial assistance |  |
| Medication list (link)*[Link to med list, which should show list as last reconciled and date thereof, with warning that subsequent med changes may not be reflected.]* | Pending orders, procedures list (link)*[Link(s) to list(s) of pending orders, procedures, consultant reports etc.]* | Allergies/intolerances (link)*[Link to list as last updated]* |
| Progress notes, most recent (link)*[Link to most recent encounter note, which should link to prior notes, on this problem]* | Current flowsheets (link)*[Link to page w/ all flowsheets]* | Specialty category(ies)SDoH  |
| Onset date / Date added to current problem listN/A | N/A | Information sourcesPrior PCP |
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| *Status – Date/Link most recent change*Active-prelim | *Title*Abdominal pain, non-acute (incomplete initial workup) |
| Problem Formulation[Recurrent acute abdominal pain](https://imagic.nlm.nih.gov/imagic/code/map?v=5&js=true&pabout=&pinstructions=&p=5e8a7805zd15300830e13&p.5e8a7805zd15300830e13.s=189336000&p=5e8a7805zd15300830e64&p.5e8a7805zd15300830e64.s=310495003&p=5e8a7805zd15300830e184&p.5e8a7805zd15300830e184.s=36440009&p=5e8a7805zd15300830e211&p.5e8a7805zd15300830e211.s=410070006&p=5e8a7805zd15300830e301&p.5e8a7805zd15300830e301.s=7200002&p=5e8a7805zd15300830e353&p.5e8a7805zd15300830e353.s=420054005&p=5e8a7805zd15300830e388&p.5e8a7805zd15300830e388.s=441971000124107&p=5e8a7805zd15300830e490&p.5e8a7805zd15300830e490.s=445281000124101&p=5e8a7805zd15300830e517&p.5e8a7805zd15300830e517.s=21522001&init-params=f%3A1%3Bdob%3A1+May+1958&pat=Female+adult+1+%28modified%29&pat.init=Female+adult+1+%28modified%29&q.f=1&q.dob=1+May+1958&p=5e8a7805z0&p.5e8a7805z0.e=Recurrent+acute+abdominal+pain+%28271858001%29&pdone=Get+ICD+Codes&qadd=) | Comments on problem formulation {free text)[SNOMED-CT problem mapped to ICD-10 R-10.0, Acute abdomen](https://imagic.nlm.nih.gov/imagic/code/map?v=5&js=true&pabout=&pinstructions=&p=5e8a7805zd15300830e13&p.5e8a7805zd15300830e13.s=189336000&p=5e8a7805zd15300830e64&p.5e8a7805zd15300830e64.s=310495003&p=5e8a7805zd15300830e184&p.5e8a7805zd15300830e184.s=36440009&p=5e8a7805zd15300830e211&p.5e8a7805zd15300830e211.s=410070006&p=5e8a7805zd15300830e301&p.5e8a7805zd15300830e301.s=7200002&p=5e8a7805zd15300830e353&p.5e8a7805zd15300830e353.s=420054005&p=5e8a7805zd15300830e388&p.5e8a7805zd15300830e388.s=441971000124107&p=5e8a7805zd15300830e490&p.5e8a7805zd15300830e490.s=445281000124101&p=5e8a7805zd15300830e517&p.5e8a7805zd15300830e517.s=21522001&init-params=f%3A1%3Bdob%3A1+May+1958&pat=Female+adult+1+%28modified%29&pat.init=Female+adult+1+%28modified%29&q.f=1&q.dob=1+May+1958&p=5e8a7805z0&p.5e8a7805z0.e=Recurrent+acute+abdominal+pain+%28271858001%29&pdone=Get+ICD+Codes&qadd=) |
| PCP Overview | Nursing/other clinicians Overview | Specialist(s) Overview |
| Patient Overview | BasisThree encounter diagnoses in 6 months | StabilityGetting worse |
| DisabilityTemporarily disabling from daily activities each occurrence | GoalDiagnose and obtain relief |  |
| Medication list (link)*[Link to med list, which should show list as last reconciled and date thereof, with warning that subsequent med changes may not be reflected.]* | Pending orders, procedures list (link)*[Link(s) to list(s) of pending orders, procedures, consultant reports etc.]* | Allergies/intolerances (link)*[Link to list as last updated]* |
| Progress notes, most recent (link)*[Link to most recent encounter note, which should link to prior notes, on this problem]* | Current flowsheets (link)*[Link to page w/ all flowsheets]* | Specialty category(ies) |
| Onset date / Date added to current problem listN/A | N/A | Information sourcesPrior PCP |
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| *Status – Date/Link most recent change*Inactive-resolved | *Title*Breast cancer, mastectomy in 2015; no metastases or recurrence |
| Problem Formulation[Carcinoma in situ of breast (189336000)](https://www.ncbi.nlm.nih.gov/medgen/57817) | Comments on problem formulation {free text)[SNOMED-CT problem mapped to ICD-10, D01.90, Unspecified type of carcinoma in situ of unspecified breast](https://imagic.nlm.nih.gov/imagic/code/map?v=5&js=true&pabout=&pinstructions=&p=cfd83ezd15319222e13&p.cfd83ezd15319222e13.s=189336000&p=cfd83ezd15319222e64&p.cfd83ezd15319222e64.s=310495003&p=cfd83ezd15319222e184&p.cfd83ezd15319222e184.s=36440009&p=cfd83ezd15319222e211&p.cfd83ezd15319222e211.s=410070006&p=cfd83ezd15319222e301&p.cfd83ezd15319222e301.s=7200002&p=cfd83ezd15319222e353&p.cfd83ezd15319222e353.s=420054005&p=cfd83ezd15319222e388&p.cfd83ezd15319222e388.s=441971000124107&p=cfd83ezd15319222e490&p.cfd83ezd15319222e490.s=445281000124101&p=cfd83ezd15319222e517&p.cfd83ezd15319222e517.s=21522001&p=cfd83ezd15319222e544&p.cfd83ezd15319222e544.s=271858001&p=cfd83ezd15319222e571&p.cfd83ezd15319222e571.s=426071002&init-params=f%3A1%3Bdob%3A1+May+1958&pat=Female+adult+1+%28modified%29&pat.init=Female+adult+1+%28modified%29&q.f=1&q.dob=1+May+1958&p=cfd83ezd15319222e599&p.cfd83ezd15319222e599.s=189336000&p.cfd83ezd15319222e599.e=Carcinoma+in+situ+of+breast&p.cfd83ezd15319222e599.o=Carcinoma+in+situ+of+breast&pdone=Get+ICD+Codes&qadd=)  |
| PCP Overview | Nursing/other clinicians Overview | Specialist(s) Overview |
| Patient Overview | BasisRegular exams and annual imaging | StabilityStable |
| DisabilityNone | GoalContinued monitoring |  |
| Medication list (link)*[Link to med list, which should show list as last reconciled and date thereof, with warning that subsequent med changes may not be reflected.]* | Pending orders, procedures list (link)*[Link(s) to list(s) of pending orders, procedures, consultant reports etc.]* | Allergies/intolerances (link)*[Link to list as last updated]* |
| Progress notes, most recent (link)*[Link to most recent encounter note, which should link to prior notes, on this problem]* | Current flowsheets (link)*[Link to page w/ all flowsheets]* | Specialty category(ies) |
| Onset date / Date added to current problem listN/A | N/A | Information sourcesPrior PCP |

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| *Status – Date/Link most recent change*Inactive-resolved | *Title*Advance directive for end-of-life care (updated 12-01-22 and still current) |
| Problem Formulation[Active advance directive](https://www.findacode.com/snomed/425392003--active-advance-directive.html) | Comments on problem formulation {free text)SNOMED CT code is 425392003 |
| PCP OverviewContents of advance directive appear sufficient to inform end-of-life clinical decisions  | Nursing/other clinicians Overview | Specialist(s) Overview |
| Patient Overview | Basis | StabilityStable |
| DisabilityN/A | GoalContinued monitoring |  |
| Medication list (link)*[Link to med list, which should show list as last reconciled and date thereof, with warning that subsequent med changes may not be reflected.]* | Pending orders, procedures list (link)*[Link(s) to list(s) of pending orders, procedures, consultant reports etc.]* | Allergies/intolerances (link)*[Link to list as last updated]* |
| Progress notes, most recent (link)*[Link to most recent encounter note, which should link to prior notes, on this problem]* | Current flowsheets (link)*N/A* | Specialty category(ies) |
| Onset date / Date added to current problem listN/A | N/A | Information sources |

1. The hyperlink in the Problem formulation field shows the SNOMED CT name and code, along with numerous more specific subcategories of diabetes, because SNOMED is the default terminology for the Problem formulation field. For comparison, this Title/summary field states the ICD-10 equivalent, which the user might feel better summarizes the patient’s condition than does the SNOMED term. See Dugan J, Shugan J, International Classification of Diseases, 10th Revision, Coding for Diabetes, *Clin Diabetes*. 2017 Oct; 35(4): 232–238. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5669129/>. This article explains: “the most common [ICD-10] code used for type 2 diabetes is E11.65 (type 2 diabetes with hyperglycemia), which reflects suboptimal control.” Table 3 in the article lists numerous complications (in addition to hyperglycemia) with their ICD-10 codes. [↑](#footnote-ref-1)
2. Arguably the term “remission” should not be used. See the Condition.abatement element of the Condition resource at <https://build.fhir.org/condition-definitions.html#Condition.clinicalStatus>. This element is defined as follows: “The date or estimated date that the condition resolved or went into remission. This is called "abatement" because of the many overloaded connotations associated with "remission" or "resolution" - Some conditions, such as chronic conditions, are never really resolved, but they can abate.” [↑](#footnote-ref-2)
3. The “prelim” qualifier is not a problem status but rather a clinical workflow or task status. As to problem status, see the Condition.clinicalStatus element of the FHIR Condition resource, at <https://build.fhir.org/condition-definitions.html#Condition.clinicalStatus> and <https://build.fhir.org/valueset-condition-clinical.html>, which states the following Condition Clinical Status Codes: active | recurrence | relapse | inactive | remission | resolved | unknown. As to clinical workflow, see generally the FHIR Workflow Overview at <https://build.fhir.org/workflow.html>. This clinical workflow status should not be confused with the artifact assessment workflow status at <https://build.fhir.org/valueset-artifactassessment-workflow-status.html>, which defines a value set with ten workflow codes, one of which is “waiting for input.” Should that code be treated as applicable to the “Active-prelim” status? [↑](#footnote-ref-3)
4. See also this guidance from the American Academy of Professional Coders (AAPC): “coders should be careful of using uncertain words in their documentation when coding diagnoses. These terms include “suspected,” “questionable,” “likely,” “possible,” “presumed,” and “consistent with.” They are subjective and do not qualify as a diagnosis. [↑](#footnote-ref-4)
5. Rather than “avoid worsening,” should the goal instead be to “improve” the cirrhosis? Is improvement realistic for cirrhosis? Did the patient weigh in on the goal? [↑](#footnote-ref-5)