# Diagnosis -Related Dates for USCDI with Example

**Onset Date**

* Date patient reports symptoms began or known date of event leading to establishment of the diagnosis (e.g. knee pain began when patient fell off her bicycle during the race on 8/28/20)
* May be an approximation, i.e., field must support fuzzy dates.

**Diagnosis Date**

* Will be the date when a physician or other healthcare professional first established the diagnosis. May be diagnosis by pathologist or radiologist, or other specialist, or the provider who ordered the test or obtained a pathologic specimen.
  + If required, need to accept “Unknown”

If required, need to have an additional date field “Reported Date of Diagnosis”

* Should be a precise date at least to the day. However:
  + Caveat: What about when new to system patient says “I was diagnosed with diabetes when I was 10”)
  + Therefore, must have, “non clinician” Reported Diagnosis Date”? (patient/ family member/ etc.)
  + Need to call out the issue that the diagnosis date is indelible,
  + Sometimes diagnosis is within an encounter only (Encounter Diagnosis)
* This is distinct from and may be different than the date that a diagnosis was entered onto the patient’s problem list or otherwise entered into an HIT system (AKA **Recorded Date**), which would typically also be captured in the audit trail of the electronic system and may optionally be displayed to end users.
* This date field should be available for optional documentation associated with each diagnosis on a patient’s problem list and/or medical diagnosis history.
* Note: As diagnoses may evolve over time (e.g., shortness of breath > pulmonary edema > heart failure > heart failure due to left ventricular systolic dysfunction), each diagnosis should have a distinct Date of Diagnosis as it was identified/established by a healthcare professional.

**Resolution Date**

* Date the diagnosed problem was completely resolved. This may be documented contemporaneously, e.g., in the case of a curative surgery, or after the fact based on patient reporting.
  + Asserted concerns:
    - Few clinicians currently document resolutions
    - Currently not captured in EHRs – but would be valuable to have
    - If it becomes a “MUST” this will be burdensome to clinicians at this time
* May be an approximation. (Clinicians might capture data of resolution whenever the patient has their next visit – maybe a year later).
* This date field should be available for optional documentation associated with each diagnosis on a patient’s problem list and/or medical diagnosis history.
* Note: This is distinct from the date that a diagnosis was deleted from the patient’s problem/diagnosis list in and EHR or other HIT system, which would typically also be captured in the audit trail of the electronic system and may be displayed to end users.

In all cases the dates associated with a diagnosis should persist with the original entry (be indelible). E.g., if a new PCP is using data received from an outside organization to create or reconcile a patient chart, the original dates associate with the definitions above should persist.

Example:

**Onset Date**: Patient with a long smoking history reports a worsening cough over the last 6 months and unintentional weight loss (Dx: Cough, Weight Loss). Date is an approximation, today minus 6 months.

**Diagnosis Date**: *Diagnosis Date = Recorded Date*: CXR reveals a lung mass. Lung biopsy reveals lung cancer. Date is date of Bx result being interpreted by pathologist and physician entering the diagnosis in a pathology information system or the EHR.

**Diagnosis Date**: *Diagnosis Date Does NOT = Recorded Date*: New to health system patient provides verbal medical history. Electronic record not available or not made available. Record is opened in new system July-2016-10. Patient states Lung Cancer Diagnosis was July 2010. Diagnosis Added to record in new system by physician – but the physician did not make the initial diagnosis.

**Diagnosis Date**: *Diagnosis Date Does NOT = Recorded Date*: New to health system patient provides verbal medical history. Electronic record not available or not made available. Record is opened in new system July-2016-10. Patient states diabetes was when he was 10. Diagnosis Added to record in new system by physician – but the physician did not make the initial diagnosis.

**Resolution Date:** The patient underwent a lobectomy with clear cancer margins and negative lymph nodes and standard chemotherapy for the lung cancer. The patient has been disease free for over 5 years and the oncologist has determined that further monitoring is not warranted. Date is when the oncologist determined that further monitoring is not warranted and the patient is considered cured of the disease.

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