1. General Information

Seq. #: 1500 **Name:** Medical Record Number (MRN)

Coding Instructions: Indicate the patient's medical record number as assigned by the medical practice.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Patient_MRN
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 1510 **Name:** Encounter Date

Coding Instructions: Indicate the date of the patient encounter or visit to the physician office.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	EncounterDate
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 1530 **Name:** Location ID

Coding Instructions: Indicate the Location Identification number assigned for the office location by the ACC-NCDR.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LocationID
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

1. General Information

Seq. #: 1540 **Name:** Provider Last Name

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Physician_LastName
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 1541 **Name:** Provider First Name

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Physician_FirstName
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 1542 **Name:** Provider Middle Name

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Physician_MidName
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

1. General Information

Seq. #: 1550 **Name:** Provider NPI

Coding Instructions: Indicate the evaluating provider's National Provider Identifier (NPI).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Physician_NPI
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (10)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 1555 **Name:** Encounter TIN

Coding Instructions: Indicate the practice Tax Identification Number (TIN) to which the Encounter should be billed. If the practice has changed TINs or the provider bills to multiple TINs, be certain that the TIN recorded for the encounter reflects the appropriate billing TIN at the time of the encounter.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	EncounterTIN
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Integer (9)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 1560 **Name:** Patient New to the Practice

Coding Instructions: Indicate if this encounter is the first time the patient was treated by the practice.

Note(s):

If the patient was treated at the same practice but a different location, then code 'No'.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	PatNew
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

1. General Information

Seq. #: 1565 **Name:** Primary Reason for Encounter

Coding Instructions: This element has been retired effective v1.4

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Atrial Fibrillation related	
2	Coronary Artery Disease related	
3	Diabetes related	
4	Heart Failure related	
5	Hypertension related	
6	Other Cardiac related reason	
7	Non-Cardiac related reason	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Encounter_Reason
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2000 **Name:** Patient Last Name

Coding Instructions: Indicate the patient's last name. Hyphenated names should be recorded with a hyphen.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LastName
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2010 **Name:** Patient First Name

Coding Instructions: Indicate the patient's first name.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	FirstName
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2020 **Name:** Patient Middle Name

Coding Instructions: Indicate the patient's middle name(s).

Note(s):

If the patient has multiple middle names, enter each middle name separated by a single space.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	MidName
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2030 **Name:** SSN

Coding Instructions: Indicate the patient's United States Social Security Number (SSN).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SSN
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (9)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2040 **Name:** Patient ID

Coding Instructions: Indicate the number created and automatically inserted by the software that uniquely identifies this patient.

Note(s):

Once assigned to a patient at the participating facility, this number should never be changed or reassigned to a different patient.
If the patient returns to the same medical practice or for follow-up, they must receive this same unique patient identifier.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PatientID
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Integer (9)
Default Value:	NULL
Usual Range:	
Valid Range:	1-999999999
DataSource:	Automatic

Seq. #: 2050 **Name:** Date of Birth

Coding Instructions: Indicate the patient's date of birth.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DOB
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2060 **Name:** Sex

Coding Instructions: Indicate the patient's sex at birth.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Male	
2	Female	

Supporting Definitions: (none)

Technical Specifications

ShortName: Sex
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes (DCR,PINN)
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
DataSource: User

Seq. #: 2065 **Name:** Patient Deceased

Coding Instructions: Indicate if the patient died, regardless of etiology.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName: Death_Ind
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes (DCR,PINN)
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
DataSource: User

Seq. #: 2067 **Name:** Death Date

Coding Instructions: Indicate the patient's date of death.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName: Death_Date
Parent Seq #: 2065
Parent Name: Patient Deceased
Parent Value: Yes
Missing Data: Report
Harvested: Yes (DCR,PINN)
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range:
DataSource: User

A. Patient Demographics

Seq. #: 2068 **Name:** Primary Cause of Death

Coding Instructions: Indicate the patient's PRIMARY cause of death, i.e. the first significant abnormal event which ultimately led to death.

Target Value: The last value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Cardiac	
2	Neurologic	
3	Renal	
4	Vascular	
5	Infection	
6	Valvular	
7	Pulmonary	
8	Unknown	
9	Other	

Supporting Definitions: (none)

Technical Specifications

ShortName:	DeathCause
Parent Seq #:	2065
Parent Name:	Patient Deceased
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2070 **Name:** Race - White

Coding Instructions: Indicate if the patient is White as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **White (Race):**

Having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceWhite
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2071 **Name:** Race - Black/African American

Coding Instructions: Indicate if the patient is Black or African American as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Black/African American (Race):**

Having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceBlack
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2072 **Name:** Race - Asian

Coding Instructions: Indicate if the patient is Asian as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Asian (Race):**

Having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceAsian
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2073 **Name:** Race - American Indian/Alaskan Native

Coding Instructions: Indicate if the patient is American Indian or Alaskan Native as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **American Indian or Alaskan Native (Race):**

Having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceAmIndian
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2074 **Name:** Race - Native Hawaiian/Pacific Islander

Coding Instructions: Indicate if the patient is Native Hawaiian or Pacific Islander as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Native Hawaiian or Pacific Islander (Race):**

Having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceNatHaw
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2076 **Name:** Hispanic or Latino Ethnicity

Coding Instructions: Indicate if the patient is of Hispanic or Latino ethnicity as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Hispanic or Latino Ethnicity:**

A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	HispOrig
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2080 **Name:** Race - Asian Indian

Coding Instructions: Indicate if the patient is Asian Indian as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Race - Asian Indian:**

Having origins in any of the original peoples of India.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity.

Technical Specifications

ShortName:	RaceAsianIndian
Parent Seq #:	2072
Parent Name:	Race - Asian
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2081 **Name:** Race - Chinese

Coding Instructions: Indicate if the patient is Chinese as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Race - Chinese:**

Having origins in any of the original peoples of China.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceChinese
Parent Seq #:	2072
Parent Name:	Race - Asian
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2082 **Name:** Race - Filipino

Coding Instructions: Indicate if the patient is Filipino as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Asian - Filipino:**

Having origins in any of the original peoples of the Philippines.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceFilipino
Parent Seq #:	2072
Parent Name:	Race - Asian
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2083 **Name:** Race - Japanese

Coding Instructions: Indicate if the patient is Japanese as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Asian - Japanese:**

Having origins in any of the original peoples of Japan.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceJapanese
Parent Seq #:	2072
Parent Name:	Race - Asian
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2084 **Name:** Race - Korean

Coding Instructions: Indicate if the patient is Koreans as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Asian - Korean:**

Having origins in any of the original peoples of Korea.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceKorean
Parent Seq #:	2072
Parent Name:	Race - Asian
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2085 **Name:** Race - Vietnamese

Coding Instructions: Indicate if the patient is Vietnamese as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Asian - Vietnamese:**

Having origins in any of the original peoples of Viet Nam.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceVietnamese
Parent Seq #:	2072
Parent Name:	Race - Asian
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2086 **Name:** Race - Other Asian

Coding Instructions: Indicate if the patient is of other Asian ethnicity as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Asian - Other Asian:**

Having origins in any of the original peoples elsewhere in Asia.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceAsianOther
Parent Seq #:	2072
Parent Name:	Race - Asian
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2090 **Name:** Race - Native Hawaiian

Coding Instructions: Indicate if the patient is Native Hawaiian as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Native Hawaiian/Pacific Islander - Native Hawaiian:**

Having origins in any of the original peoples of the islands of Hawaii.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceNativeHawaii
Parent Seq #:	2074
Parent Name:	Race - Native Hawaiian/Pacific Islander
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2091 **Name:** Race - Guamanian or Chamorro

Coding Instructions: Indicate if the patient is Guamanian or Chamorro as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Native Hawaiian/Pacific Islander - Guamanian or Chamorro:**

Having origins in any of the original peoples of the Mariana Islands or the island of Guam.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceGuamChamorro
Parent Seq #:	2074
Parent Name:	Race - Native Hawaiian/Pacific Islander
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2092 **Name:** Race - Samoan

Coding Instructions: Indicate if the patient is Samoan as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Native Hawaiian/Pacific Islander - Samoan:**

Having origins in any of the original peoples of the island of the Samoa.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RaceSamoan
Parent Seq #:	2074
Parent Name:	Race - Native Hawaiian/Pacific Islander
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2093 **Name:** Race - Other Pacific Islander

Coding Instructions: Indicate if the patient is of other pacific island ethnicity as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Native Hawaiian/Pacific Islander - Other Pacific Island:**

Having origins in any of the original peoples of any other island in the Pacific.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	RacePacificIslandOther
Parent Seq #:	2074
Parent Name:	Race - Native Hawaiian/Pacific Islander
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2100 **Name:** Hispanic Ethnicity Type - Mexican/Mexican American/Chicano

Coding Instructions: Indicate if the patient is of Mexican/Mexican American/Chicano ethnicity as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Hispanic Ethnicity - Mexican/Mexican American/Chicano:**

Having origins in any of the original peoples of Mexico.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	HispEthnicityMexican
Parent Seq #:	2076
Parent Name:	Hispanic or Latino Ethnicity
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2101 **Name:** Hispanic Ethnicity Type - Puerto Rican

Coding Instructions: Indicate if the patient is of Puerto Rican ethnicity as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Hispanic Ethnicity - Puerto Rican:**

Having origins in any of the original peoples of Puerto Rico.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	HispEthnicityPuertoRico
Parent Seq #:	2076
Parent Name:	Hispanic or Latino Ethnicity
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2102 **Name:** Hispanic Ethnicity Type - Cuban

Coding Instructions: Indicate if the patient is of Cuban ethnicity as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Hispanic Ethnicity - Cuban:**

Having origins in any of the original peoples of Cuba.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	HispEthnicityCuban
Parent Seq #:	2076
Parent Name:	Hispanic or Latino Ethnicity
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 2103 **Name:** Hispanic Ethnicity Type - Other Hispanic/Latino/Spanish Origin

Coding Instructions: Indicate if the patient is another Hispanic, Latino, or Spanish origin as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Hispanic Ethnicity - Other Hispanic/Latino/Spanish Origin:**

Having origins in any of the originals peoples in other Hispanic, Latino or Spanish territories.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Technical Specifications

ShortName:	HispEthnicityOtherOrigin
Parent Seq #:	2076
Parent Name:	Hispanic or Latino Ethnicity
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

A. Patient Demographics

Seq. #: 2200 **Name:** Patient Zip Code

Coding Instructions: Indicate the patient's United States Postal Service zip code of their primary residence.

Note(s):

The Patient Zip Code will display in the Demographics Section of the data collection form however the coding instructions will remain in the Episode of Care Section in the data dictionary.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	ZipCode
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (10)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4000 **Name:** Coronary Artery Disease

Coding Instructions: Indicate if the patient has been diagnosed with Coronary Artery Disease (CAD).

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Coronary Artery Disease:**

A history of coronary artery disease (CAD) is evidenced by one of the following:
1. Currently receiving medical treatment for CAD
2. History of Myocardial Infarction
3. Prior CV intervention including, but not limited to, CABG and/or PCI

Source: STS

Technical Specifications

ShortName:	CAD
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4002 **Name:** Coronary Artery Disease Date

Coding Instructions: Indicate the documented date of diagnosis of coronary artery disease. If no diagnosis date is recorded, indicate the first encounter date where coronary artery disease was recorded. If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	CAD_Date
Parent Seq #:	4000
Parent Name:	Coronary Artery Disease
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4010 **Name:** Atrial Fibrillation or Flutter

Coding Instructions: Indicate if the patient has been diagnosed with atrial fibrillation or atrial flutter.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Atrial Fibrillation:**

A cardiac arrhythmia arising from the atrium with an atrial rate 300 bpm and an irregularly irregular ventricular response in the presence of conduction. AF can be further characterized as:
• First diagnosed
• Paroxysmal AF: AF that terminates spontaneously or with intervention within 7 days of onset. Episodes may recur with variable frequency.
• Persistent AF: Continuous AF that is sustained >7 days
• Long-standing Persistent AF: Continuous AF >12 months in duration.
• Permanent AF: The term “permanent AF” is used when the patient and clinician make a joint decision to stop further attempts to restore and/or maintain sinus rhythm. Acceptance of AF represents a therapeutic attitude on the part of the patient and clinician rather than an inherent pathophysiological attribute of AF. Acceptance of AF may change as symptoms, efficacy of therapeutic interventions, and patient and clinician preferences evolve.
• Nonvalvular AF: AF in the absence of rheumatic mitral stenosis, a mechanical or bioprosthetic heart valve, or mitral valve repair

Source: 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation

Technical Specifications

ShortName:	Afib
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4012 **Name:** Atrial Fibrillation or Flutter Date

Coding Instructions: Indicate the documented date of diagnosis of atrial fibrillation/flutter. If no diagnosis date is recorded, indicate the first encounter date where atrial fibrillation/flutter was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Afib_Date
Parent Seq #:	4010
Parent Name:	Atrial Fibrillation or Flutter
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4020 **Name:** Dyslipidemia

Coding Instructions: Indicate if the patient has been diagnosed with dyslipidemia.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Dyslipidemia:**

National Cholesterol Education Program criteria and includes documentation of the following:

1. Total cholesterol greater than 200 mg/dL (5.18 mmol/l); or

2. Low-density lipoprotein (LDL) greater than or equal to 130 mg/dL (3.37mmol/l); or

3. High-density lipoprotein (HDL) less than 40 mg/dL (1.04 mmol/l).

For patients with known coronary artery disease, treatment is initiated if LDL is greater than 100 mg/dL (2.59 mmol/l), and this would qualify as hypercholesterolemia.

Source: 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary Artery Disease

Technical Specifications

ShortName:	Dyslipidemia
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4022 **Name:** Dyslipidemia Date

Coding Instructions: Indicate the documented date of diagnosis of dyslipidemia. If no diagnosis date is recorded, indicate the first encounter date where dyslipidemia was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Dyslipidemia_Date
Parent Seq #:	4020
Parent Name:	Dyslipidemia
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4030 **Name:** Hypertension

Coding Instructions: Indicate if the patient has been diagnosed with hypertension.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Hypertension:**

Hypertension is defined by any one of the following:
1. History of hypertension diagnosed and treated with medication, diet and/or exercise.
2. Prior documentation of blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic for patients without diabetes or chronic kidney disease, or prior documentation of blood pressure greater than 130 mm Hg systolic and/or 80 mm Hg diastolic on at least two occasions for patients with diabetes or chronic kidney disease.
3. Currently on pharmacologic therapy for treatment of hypertension.

Source: 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary Artery Disease

Technical Specifications

ShortName:	Hypertension
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4032 **Name:** Hypertension Date

Coding Instructions: Indicate the documented date of diagnosis of hypertension. If no diagnosis date is recorded, indicate the first encounter date where hypertension was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Hypertension_Date
Parent Seq #:	4030
Parent Name:	Hypertension
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4040 **Name:** Heart Failure

Coding Instructions: Indicate if the patient has been diagnosed with heart failure (HF).

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Heart Failure:**

Physician documentation or report of any of the following symptoms of heart failure prior to this care encounter described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention, low cardiac output secondary to cardiac dysfunction; or the description of rales, jugular venous distension, or pulmonary edema. A previous hospital admission with principal diagnosis of heart failure is considered evidence of heart failure history.

Date of first onset may be helpful.

Source: ACC/AHA 2005 Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients With Chronic Heart Failure

Technical Specifications

ShortName:	HF
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4042 **Name:** Heart Failure Date

Coding Instructions: Indicate the documented date of diagnosis of heart failure. If no diagnosis date is recorded, indicate the first encounter date where heart failure was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	HF_Date
Parent Seq #:	4040
Parent Name:	Heart Failure
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4050 **Name:** Heart Failure new diagnosis (within 12 months)

Coding Instructions: Indicate if the patient has been diagnosed with heart failure (HF) within the last 12 months.

Target Value: Any occurrence between 12 months prior to current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HF_New_Dia
Parent Seq #:	4040
Parent Name:	Heart Failure
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4052 **Name:** Heart Failure Etiology

Coding Instructions: Indicate the primary etiology for the patient diagnosed with heart failure (HF).

Target Value: Any occurrence between 12 months prior to current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Ischemic	
2	Hypertensive	
3	Valvular	
4	Congenital	
5	Idiopathic/dilated	
6	Peripartum	
7	Chemotherapy-Induced	
8	Substance-related	Etiology is alcohol or stimulant based
9	Tachycardia-Mediated	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HF_Etio
Parent Seq #:	4040
Parent Name:	Heart Failure
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4060 **Name:** CAD - Stable Angina

Coding Instructions: Indicate if the patient has been diagnosed with stable angina.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **CAD - Stable Angina:**

Angina without a change in frequency or pattern for the 6 weeks before this procedure. Angina is controlled by rest and/or sublingual/oral/transcutaneous medications.

Source: 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary Artery Disease.

Technical Specifications

ShortName:	StableAngina
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4062 **Name:** CAD - Stable Angina Date

Coding Instructions: Indicate the documented date of diagnosis of stable angina. If no diagnosis date is recorded, indicate the first encounter date where stable angina was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: **CAD - Stable Angina:**

Angina without a change in frequency or pattern for the 6 week before this procedure. Angina is controlled by rest and/or sublingual/oral/transcutaneous medications.

Source: 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary Artery Disease.

Technical Specifications

ShortName:	StableAngina_Date
Parent Seq #:	4060
Parent Name:	CAD - Stable Angina
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4070 **Name:** Stable Angina new diagnosis (within 12 months)

Coding Instructions: Indicate if the patient has been diagnosed with stable angina within the past 12 months.

Target Value: Any occurrence between 12 months prior to current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	StableAngina_New_Dia
Parent Seq #:	4060
Parent Name:	CAD - Stable Angina
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4080 **Name:** CAD - Unstable Angina

Coding Instructions: Indicate if the patient has been diagnosed with unstable angina.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **CAD - Unstable Angina:**

Unstable angina requiring hospitalization is defined as:
1. Ischemic discomfort (angina or symptoms thought to be equivalent) 10 min in duration occurring
- at rest, or
- in an accelerating pattern with frequent episodes associated with progressively decreased exercise capacity
2. Prompting an unscheduled hospitalization within 24 h of the most recent symptoms. Hospitalization is defined as an admission to an inpatient unit or a visit to an emergency department that results in at least a 24 h stay (or a change in calendar date if the hospital admission or discharge times are not available)
3. At least one of the following:
a. New or worsening ST or T wave changes on resting ECG (in the absence of confounders, such as LBBB or LVH)
- Transient ST elevation (duration 20 min) New ST elevation at the J point in 2 contiguous leads with the cut-points: 0.1 mV in all leads other than leads V2-V3 where the following cut-points apply: 0.2 mV in men 40 y (0.25 mV in men 40 y) or 0.14 mV in women
- ST depression and T-wave changes New horizontal or down-sloping ST depression 0.05 mV in two contiguous leads and/or new T inversion 0.3 mV in 2 contiguous leads with prominent R wave or R/S ratio 1.
b. Definite evidence of inducible myocardial ischemia as demonstrated by:
- an early positive exercise stress test, defined as ST elevation or 2 mm ST depression prior to 5 METS, or
- stress echocardiography (reversible wall motion abnormality), or
- myocardial scintigraphy (reversible perfusion defect), or
- MRI (myocardial perfusion deficit under pharmacologic stress) and believed to be responsible for the myocardial ischemic symptoms/signs.
c. Angiographic evidence of new or worse 70% lesion and/or thrombus in an epicardial coronary artery that is believed to be responsible for the myocardial ischemic symptoms/signs.
d. Need for coronary revascularization procedure (PCI or CABG) for the presumed culprit lesion(s). This criterion would be fulfilled if revascularization was undertaken during the unscheduled hospitalization, or subsequent transfer to another institution without interceding home discharge.
4. Negative cardiac biomarkers.
Heart fail

Source: 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary Artery Disease.

Technical Specifications

ShortName:	UnStableAngina
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4082 **Name:** CAD - Unstable Angina Date

Coding Instructions: Indicate the documented date of diagnosis of unstable angina. If no diagnosis date is recorded, indicate the first encounter date where unstable angina was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	UnstableAngina_Date
Parent Seq #:	4080
Parent Name:	CAD - Unstable Angina
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4090 **Name:** Peripheral Arterial Disease

Coding Instructions: Indicate if the patient has been diagnosed with Peripheral Arterial Disease (PAD).

For PAD resulting in restriction of both blood flow and oxygen to a certain organ or part of the body, also code 'Yes' to ischemic vessel disease (IVD).

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Peripheral Arterial Disease:**

Current or previous history of peripheral arterial disease (includes subclavian, iliac, femoral, and upper- and lower-extremity vessels; excludes renal, coronary, cerebral, and mesenteric vessels and aneurysms). This can include:
- Claudication on exertion
- Amputation for arterial vascular insufficiency
- Vascular reconstruction, bypass surgery, or percutaneous revascularization in the arteries of the extremities
- Positive noninvasive test (e.g., ankle brachial index <= 0.9, ultrasound, MR or CT imaging of >50% diameter stenosis in any peripheral artery (i.e., subclavian, femoral, iliac) or angiographic imaging)

Source: ACCF/AHA 2011 Key Data Elements and Definitions of a Base Cardiovascular Vocabulary for Electronic Health Records.

Technical Specifications

ShortName:	PAD
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4092 **Name:** Peripheral Arterial Disease Date

Coding Instructions: Indicate the documented date of diagnosis of peripheral artery disease. If no diagnosis date is recorded, indicate the first encounter date where peripheral artery disease was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PAD_Date
Parent Seq #:	4090
Parent Name:	Peripheral Arterial Disease
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4100 **Name:** PAD - Acute Limb Ischemia

Coding Instructions: Indicate if the patient has been diagnosed with Acute Limb Ischemia as a result of Peripheral Arterial Disease (PAD).

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **PAD- Acute Limb Ischemia:**

Acute limb ischemia is defined by a sudden onset of pain or paresthesia of the buttock, hip, thigh, calf or foot.

Source: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease.

Technical Specifications

ShortName:	PADAcuteLimbIsch
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4102 **Name:** PAD - Acute Limb Ischemia Date

Coding Instructions: Indicate the documented date of diagnosis of Acute Limb Ischemia. If no diagnosis date is recorded, indicate the first encounter date where acute limb ischemia was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PADAcuteLimbIsch_Date
Parent Seq #:	4100
Parent Name:	PAD - Acute Limb Ischemia
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4110 **Name:** PAD - Claudication

Coding Instructions: Indicate if the patient has been diagnosed with claudication as a result of peripheral arterial disease (PAD).

Target Value: Any occurrence between birth and encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **PAD - Claudication:**

Claudication is defined by reproducible, exertional, discomfort characterized by cramping, aching, fatigue of the buttock, hip, thigh, calf or foot that resolves within ten minutes of rest.

Source: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease.

Technical Specifications

ShortName:	PADClaud
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4112 **Name:** PAD - Claudication Date

Coding Instructions: Indicate the documented date of diagnosis of claudication. If no diagnosis date is recorded, indicate the first encounter date where claudication was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PADClaud_Date
Parent Seq #:	4110
Parent Name:	PAD - Claudication
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4120 **Name:** PAD - Critical Limb Ischemia

Coding Instructions: Indicate if the patient has been diagnosed with Critical Limb Ischemia as a result of Peripheral Arterial Disease (PAD).

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **PAD - Critical Limb Ischemia:**

Critical limb ischemia includes ischemic rest pain, ulceration, or gangrene. This results in tissue loss and may or may not lead to amputation.

Source: NCDR

Technical Specifications

ShortName:	PADCritLimbIsch
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4122 **Name:** PAD - Critical Limb Ischemia Date

Coding Instructions: Indicate the documented date of diagnosis of critical limb ischemia. If no diagnosis date is recorded, indicate the first encounter date where critical limb ischemia was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PADCritLimbIsch_Date
Parent Seq #:	4120
Parent Name:	PAD - Critical Limb Ischemia
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4130 **Name:** PAD - Foot/Leg Cellulitis

Coding Instructions: Indicate if the patient has been diagnosed with foot/leg cellulitis as a result of peripheral arterial disease (PAD).

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **PAD - Foot/Leg cellulitis:**

Cellulitis is defined as a bacterial skin infection and can spread to the bloodstream.

Source: NCDR

Technical Specifications

ShortName:	PADFootCell
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4132 **Name:** PAD - Foot/Leg Cellulitis Date

Coding Instructions: Indicate the documented date of diagnosis of foot/leg cellulitis. If no diagnosis date is recorded, indicate the first encounter date where foot/leg cellulitis was recorded. If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PADFootCell_Date
Parent Seq #:	4130
Parent Name:	PAD - Foot/Leg Cellulitis
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4140 **Name:** PAD - Lower Extremity Osteomyelitis

Coding Instructions: Indicate if the patient has been diagnosed with lower extremity osteomyelitis as a result of peripheral arterial disease (PAD) with or without limb ischemia.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **PAD - Lower Extremity Osteomyelitis:**

Lower extremity osteomyelitis defined as an inflammation of bone caused by an infectious organism such as bacteria.

Source: NCDR

Technical Specifications

ShortName:	PADLowExtOst
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4142 **Name:** PAD - Lower Extremity Osteomyelitis Date

Coding Instructions: Indicate the documented date of diagnosis of lower extremity osteomyelitis. If no diagnosis date is recorded, indicate the first encounter date where lower extremity osteomyelitis was recorded.

If multiple diagnosis dates exist, indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PADLowExtOst_Date
Parent Seq #:	4140
Parent Name:	PAD - Lower Extremity Osteomyelitis
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4150 **Name:** Diabetes Mellitus (any)

Coding Instructions: Indicate if the patient has a history of diabetes mellitus regardless of the type of diabetes mellitus, the duration of disease or need for antidiabetic agents.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Diabetes Mellitus:**

The American Diabetes Association criteria (33) include documentation of the following:
1. Hemoglobin A1c 6.5%; or
2. Fasting plasma glucose 126 mg/dL (7.0 mmol/L); or
3. 2-h Plasma glucose 200 mg/dL (11.1 mmol/L) during an oral glucose tolerance test; or
4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose 200 mg/dL (11.1 mmol/L) This does not include gestational diabetes.

Source: 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary Artery Disease

Technical Specifications

ShortName:	Diabetes
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4152 **Name:** Diabetes Mellitus Date

Coding Instructions: Indicate the documented date of diagnosis of diabetes. If no diagnosis date is recorded, indicate the first encounter date where diabetes was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Diabetes_Date
Parent Seq #:	4150
Parent Name:	Diabetes Mellitus (any)
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4160 **Name:** Diabetes Mellitus Type I

Coding Instructions: Indicate if the patient has been diagnosed with Diabetes Mellitus Type I.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Diabetes Mellitus Type I :**

Type 1 diabetes is a condition characterized by high blood glucose levels caused by a total lack of insulin. Occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin.

Source: American Diabetes Association

Technical Specifications

ShortName:	DiabMellTypeI
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4162 **Name:** Diabetes Mellitus Type I Date

Coding Instructions: Indicate the earliest documented patient diagnosis date of Diabetes Mellitus Type I.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DiabMellTypeI_Date
Parent Seq #:	4160
Parent Name:	Diabetes Mellitus Type I
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4170 **Name:** Diabetes Mellitus Type II

Coding Instructions: Indicate if the patient has been diagnosed with Diabetes Mellitus Type II.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Diabetes Mellitus Type II:**

Type 2 diabetes is a condition characterized by high blood glucose levels caused by either a lack of insulin or the body's inability to use insulin efficiently.

Source: American Diabetes Association

Technical Specifications

ShortName:	DiabMellTypeII
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4172 **Name:** Diabetes Mellitus Type II Date

Coding Instructions: Indicate the earliest documented patient diagnosis date of Diabetes Mellitus Type II.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DiabMellTypeII_Date
Parent Seq #:	4170
Parent Name:	Diabetes Mellitus Type II
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4180 **Name:** Pre-diabetes

Coding Instructions: Indicate if the patient has been diagnosed with pre-diabetes.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Pre-diabetes :**

Pre-diabetes is a condition in which blood glucose levels are higher than normal but are not high enough for a diagnosis of diabetes. People with pre-diabetes are at increased risk for developing Type 2 diabetes and for heart disease and stroke. Other names for pre-diabetes are impaired glucose tolerance and impaired fasting glucose.

Source: American Diabetes Association

Technical Specifications

ShortName:	PreDiabetes
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4182 **Name:** Pre-diabetes Date

Coding Instructions: Indicate the earliest documented patient diagnosis date of pre-diabetes.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PreDiabetes_Date
Parent Seq #:	4180
Parent Name:	Pre-diabetes
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4190 **Name:** Diabetic Peripheral Neuropathy

Coding Instructions: Indicate if the patient has documented diabetic peripheral neuropathy.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Diabetic Peripheral Neuropathy:**

Peripheral neuropathy is nerve damage that affects the feet, legs, or hands. Peripheral neuropathy causes pain, numbness, or a tingling feeling.

Source: American Diabetes Association

Technical Specifications

ShortName:	DiabPheriNeuro
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4192 **Name:** Diabetic Peripheral Neuropathy Date

Coding Instructions: Indicate the documented date of diagnosis of Diabetic Peripheral Neuropathy. If no diagnosis date is recorded, indicate the first encounter date where Diabetic Peripheral Neuropathy was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DiabPheriNeuro_Date
Parent Seq #:	4190
Parent Name:	Diabetic Peripheral Neuropathy
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4200 **Name:** Diabetic Autonomic Neuropathy

Coding Instructions: Indicate if the patient has documented diabetic autonomic neuropathy.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Diabetic Autonomic Neuropathy:**

Autonomic neuropathy is a type of neuropathy affecting the lungs, heart, stomach, intestines, bladder or genitals.

Source: American Diabetes Association

Technical Specifications

ShortName:	DiabAutoNeuro
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4202 **Name:** Diabetic Autonomic Neuropathy Date

Coding Instructions: Indicate the documented date of diagnosis of Diabetic Autonomic Neuropathy. If no diagnosis date is recorded, indicate the first encounter date where Diabetic Autonomic Neuropathy was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DiabAutoNeuro_Date
Parent Seq #:	4200
Parent Name:	Diabetic Autonomic Neuropathy
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4210 **Name:** Diabetic Retinopathy

Coding Instructions: Indicate if the patient has documented diabetic retinopathy.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Diabetic Retinopathy:**

Diabetic retinopathy or retinopathy is an eye disease that is caused by damage to the small blood vessels in the retina. Loss of vision may result.

Source: American Diabetes Association

Technical Specifications

ShortName:	DiabRetinopathy
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4212 **Name:** Diabetic Retinopathy Date

Coding Instructions: Indicate the documented date of diagnosis of Diabetic Retinopathy. If no diagnosis date is recorded, indicate the first encounter date where Diabetic Retinopathy was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DiabRetino_Date
Parent Seq #:	4210
Parent Name:	Diabetic Retinopathy
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4220 **Name:** Ischemic Vascular Disease

Coding Instructions: Indicate if the patient has documented ischemic vascular disease.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Ischemic Vascular Disease:**

Ischemic vascular disease entails a clogging of the arteries that results in restriction of both blood flow and oxygen to a certain organ or part of the body. This could result in a number of problems that are dependent upon the location of the blockage.

Source:

Technical Specifications

ShortName:	IVD
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4222 **Name:** Ischemic Vascular Disease Date

Coding Instructions: Indicate the documented date of diagnosis of ischemic vascular disease. If no diagnosis date is recorded, indicate the first encounter date where ischemic vascular disease was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	IVD_Date
Parent Seq #:	4220
Parent Name:	Ischemic Vascular Disease
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4230 **Name:** Peripheral Vascular Disease

Coding Instructions: Indicate if the patient has documented peripheral vascular disease.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Peripheral Vascular Disease:**

Peripheral vascular disease (PVD) refers to diseases of blood vessels outside the heart and brain. It's often a narrowing of vessels that carry blood to the legs, arms, stomach or kidneys.
There are two types of PVD:
• Functional PVDs don't involve defects in blood vessels' structure. (The blood vessels aren't physically damaged.) These diseases often have symptoms related to "spasm" that may come and go.
• Organic PVDs are caused by structural changes in the blood vessels. Examples could include inflammation and tissue damage.

Source: American Heart Association

Technical Specifications

ShortName:	PVD
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4232 **Name:** Peripheral Vascular Disease Date

Coding Instructions: Indicate the documented date of diagnosis of peripheral vascular disease. If no diagnosis date is recorded, indicate the first encounter date where peripheral vascular disease was recorded.

If multiple diagnosis dates exist indicate the earliest value

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PVD_Date
Parent Seq #:	4230
Parent Name:	Peripheral Vascular Disease
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4240 **Name:** Chronic Kidney Disease

Coding Instructions: Indicate the first documented instance of the chronic kidney disease stage for the patient.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Chronic Kidney Disease/Renal Insufficiency:**

Chronic kidney disease is defined as either kidney damage or GFR 60 mL/min/1.73 m2 for 3 months.

Kidney damage is defined as pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests or imaging studies.

Indicate the patient's stage of disease:
* Stage 0: No known kidney disease
* Stage 1: Kidney damage with normal or high GFR 90 mL/min/1.73 m2
* Stage 2: Kidney damage with mildly decreased GFR 60 - 89 mL/min/1.73 m2
* Stage 3: Moderately decreased GFR 30 - 59 mL/min/1.73 m2
* Stage 4: Severely decreased GFR 15 - 29 mL/min/1.73 m2
* Stage 5: Kidney failure GFR 15 mL/min/1.73 m2 or on dialysis

Source: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease

Technical Specifications

ShortName:	CKD_History
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4242 **Name:** Chronic Kidney Disease Date

Coding Instructions: Indicate the first documented instance of each chronic kidney disease stage.

If multiple diagnosis dates exist indicated the earliest value for that specified chronic kidney disease stage.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	CKD_Date
Parent Seq #:	4240
Parent Name:	Chronic Kidney Disease
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4246 **Name:** Chronic Kidney Disease Stages

Coding Instructions: Indicate the stage of chronic kidney disease that the patient has. If the chronic kidney stage is unspecified then document as CKD-Unspecified.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Stage 1	Kidney damage with normal or high - GFR =>90 mL/min/1.73 m2
2	Stage 2	Kidney damage with mildly decreased - GFR 60-89 mL/min/1.73 m2
3	Stage 3	Moderately decreased - GFR 30-59 mL/min/1.73 m2
4	Stage 4	Severely decreased - GFR 15-29 mL/min/1.73 m2
5	Stage 5	Kidney failure - GFR <15 mL/min/1.73 m2 or on dialysis
6	Unspecified	Stage of Kidney Disease is not specified

Supporting Definitions: (none)

Technical Specifications

ShortName:	CKD_Stage
Parent Seq #:	4240
Parent Name:	Chronic Kidney Disease
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4250 **Name:** Chronic Liver Disease

Coding Instructions: Indicate if the patient has documented cirrhosis or chronic liver disease.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Chronic Liver Disease/Hepatic Dysfunction:**

Hepatic dysfunction is defined as dysfunction of the liver that results in hypoalbuminemia (<2 grams/dL), coagulopathy (PT > 1.5 x upper limits of normal), and hyperbilirubinemia (> 3.0 x upper limits of normal). Code as "Yes" if the patient develops 2 out of these 3 laboratory abnormalities.

Source: STS

Technical Specifications

ShortName:	CLD_History
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4252 **Name:** Chronic Liver Disease Date

Coding Instructions: Indicate the documented date of diagnosis of chronic liver disease. If no diagnosis date is recorded, indicate the first encounter date where chronic liver disease was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	CLD_Date
Parent Seq #:	4250
Parent Name:	Chronic Liver Disease
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4260 **Name:** Metabolic Syndrome

Coding Instructions: Indicate if the patient has been diagnosed with metabolic syndrome.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Metabolic Syndrome:**

Metabolic syndrome is a name for a group of risk factors that occur together and increase the risk for coronary artery disease, stroke, and type 2 diabetes.

Metabolic syndrome is present if you have three or more of the following signs:
- Blood pressure equal to or higher than 130/85 mmHg
- Fasting blood sugar (glucose) equal to or higher than 100 mg/dL
- Large waist circumference (length around the waist):
  - Men - 40 inches or more
  - Women - 35 inches or more
- Low HDL cholesterol:
  - Men - under 40 mg/dL
  - Women - under 50 mg/dL
- Triglycerides equal to or higher than 150 mg/dL

Source: U.S. National Library of Medicine's MedlinePlus

Technical Specifications

ShortName:	MetaSyndro
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4262 **Name:** Metabolic Syndrome Date

Coding Instructions: Indicate the earliest documented patient diagnosis date of Metabolic Syndrome.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	MetaSyndro_Date
Parent Seq #:	4260
Parent Name:	Metabolic Syndrome
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4263 **Name:** Systemic Embolism

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Syst_Embo
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4264 **Name:** Prior Stroke or TIA

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	PriorStrokeCVA
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4270 **Name:** Gastroparesis

Coding Instructions: Indicate if the patient has documented gastroparesis.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Gastroparesis:**

Gastroparesis is a form of neuropathy that affects the stomach. Digestion of food may be incomplete or delayed, resulting in nausea, vomiting, or bloating, making blood glucose control difficult.

Source: American Diabetes Association

Technical Specifications

ShortName:	Gastroparesis
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4272 **Name:** Gastroparesis Date

Coding Instructions: Indicate the documented date of diagnosis of gastroparesis. If no diagnosis date is recorded, indicate the first encounter date where hypertension was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Gastroparesis_Date
Parent Seq #:	4270
Parent Name:	Gastroparesis
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4280 **Name:** Erectile Dysfunction (men)

Coding Instructions: Indicate if the patient has documented erectile dysfunction.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Erectile Dysfunction (men):**

Impotence of organic origin.

Source: ICD-9-CM 607.84/ICD-10-CM 607.84

Technical Specifications

ShortName:	ErectDysfun
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4282 **Name:** Erectile Dysfunction Date

Coding Instructions: Indicate the documented date of diagnosis of erectile dysfunction. If no diagnosis date is recorded, indicate the first encounter date where hypertension was recorded.

If multiple diagnosis dates exist indicate the earliest value.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	ErectDysfun_Date
Parent Seq #:	4280
Parent Name:	Erectile Dysfunction (men)
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4290 **Name:** Depression

Coding Instructions: Indicate if the patient has documented depression.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Depression:**

Depression is characterized by depressed or sad mood, diminished interest in activities which used to be pleasurable, weight gain or loss, psychomotor agitation or retardation, fatigue, inappropriate guilt, difficulties concentrating, as well as recurrent thoughts of death

Source: CDC

Technical Specifications

ShortName:	Depression
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4292 **Name:** Depression Date

Coding Instructions: Indicate the earliest documented patient diagnosis date of Depression.

Target Value: The first value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Depression_Date
Parent Seq #:	4290
Parent Name:	Depression
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4300 **Name:** Family History of Atrial Fibrillation

Coding Instructions: Indicate if the patient has family history of a first degree relative having atrial fibrillation.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	Unknown	

Supporting Definitions: (none)

Technical Specifications

ShortName:	FamilyHxAF
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4302 **Name:** Family History of Diabetes Mellitus

Coding Instructions: Indicate if the patient has a family history of a first degree relative having diabetes mellitus.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	Unknown	

Supporting Definitions: (none)

Technical Specifications

ShortName:	FamilyHxDiab
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4304 **Name:** Family History of Heart Failure

Coding Instructions: Indicate if the patient has a family history of a first degree relative having of heart failure.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	Unknown	

Supporting Definitions: (none)

Technical Specifications

ShortName:	FamilyHxHF
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4306 **Name:** Family History of Dyslipidemia

Coding Instructions: Indicate if the patient has a family history of a first degree relative having dyslipidemia.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	Unknown	

Supporting Definitions: (none)

Technical Specifications

ShortName:	FamilyHxDL
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4308 **Name:** Family History of Hypertension

Coding Instructions: Indicate if the patient has a family history of a first degree relative having hypertension.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	Unknown	

Supporting Definitions: (none)

Technical Specifications

ShortName:	FamilyHxHTN
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 4310 **Name:** Family History of Premature Coronary Artery Disease

Coding Instructions: Indicate if the patient has a family history of a first degree relative having premature coronary artery disease.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	Unknown	

Supporting Definitions: **Family History of Premature Coronary Artery Disease:**

Family history includes any direct blood relatives (parents, siblings, children) who have had any of the following diagnosed at age less than 55 years for male relatives or less than 65 years for female relatives
1. Angina
2. Acute myocardial infarction
3. Sudden cardiac death without obvious cause
4. Coronary artery bypass graft surgery
5. Percutaneous coronary intervention

Source: NCDR, The Society of Thoracic Surgeons

Technical Specifications

ShortName:	FamilyHxCAD
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

B. Diagnoses/Conditions/CoMorbodities

Seq. #: 4312 **Name:** Family History of Hypercholesterolemia

Coding Instructions: Indicate if the patient has a family history of a first degree relative having hypercholesterolemia.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	Unknown	

Supporting Definitions: (none)

Technical Specifications

ShortName:	FamilyHxHypercholesterolemia
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

C. Event

Seq. #: 5135 **Name:** Event ID

Coding Instructions: Indicate all patient's history of cardiac events.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: **E001 - CAD - Myocardial Infarction:**

A myocardial infarction is evidenced by any of the following:

1. A rise and fall of cardiac biomarkers (preferably troponin) with at least one of the values in the abnormal range for that laboratory [typically above the 99th percentile of the upper reference limit (URL) for normal subjects] together with at least one of the following manifestations of myocardial ischemia:
a. Ischemic symptoms.
b. ECG changes indicative of new ischemia (new ST-T changes, new left bundle branch block, or loss of R- wave voltage).
c. Development of pathological Q- waves in 2 or more contiguous leads in the ECG (or equivalent findings for true posterior MI).
d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.
e. Documentation in the medical record of the diagnosis of acute myocardial infarction based on the cardiac biomarker pattern in the absence of any items enumerated in a-d due to conditions that may mask their appearance (e.g., peri-operative infarct when the patient cannot report ischemic symptoms; baseline left bundle branch block or ventricular pacing).

2. ECG changes associated with prior myocardial infarction can include the following (with or without prior symptoms):
a. Any Q-wave in leads V2-V3 >=0.02 seconds or QS complex in leads V2 and V3.
b. Q-wave >=0.03 seconds and >=0.1 mV deep or QS complex in leads I, II, aVL, aVF, or V4-V6 in any two leads of a contiguous lead grouping (I, aVL, V6; V4-V6; II, III, and aVF).
c. R-wave >=0.04 seconds in V1-V2 and R/S >=1 with a concordant positive Twave in the absence of a conduction defect.

3. Imaging evidence of a region with new loss of viable myocardium at rest in the absence of a non-ischemic cause. This can be manifest as:
a. Echocardiographic, CT, MR, ventriculographic or nuclear imaging evidence of left ventricular thinning or scarring and failure to contract appropriately (i.e., hypokinesis, akinesis, or dyskinesis).
b. Fixed (non-reversible) perfusion defects on nuclear radioisotope imaging (e.g., MIBI, thallium).

4. Medical record documentation of prior myocardial infarction.

Source: Joint ESC-ACC-AHA-WHF 2007 Task Force Consensus Document"Universal Definition of Myocardial Infarction".

E002 - PCI - Bare Metal Stent Implant:

Indicate the date the patient had a Percutaneous Coronary Intervention (PCI) that involved the implantation of a Bare Metal Stent (BMS).

Source:

E003 - PCI - Drug Eluting Stent Implant:

Indicate the date the patient had a Percutaneous Coronary Intervention (PCI) that involved the implantation of a Drug Eluting Stent (DES).

Source:

Technical Specifications

ShortName:	EventID
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (4)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E004 - PCI - Other (non-stent) Intervention:

Indicate the date the patient had a Percutaneous Coronary Intervention (PCI) that involved balloon angioplasty. This does not include the implant of a Bare Metal or Drug Eluting Stent.

Source:

E005 - Systemic Embolism:

Indicate if the patient has been diagnosed with a systemic embolism.

Source:

E006 - Minor Hemorrhage:

The patient had a documented minor hemorrhage - regardless of location.

A minor hemorrhage is either clinically overt but not major or occult (e.g., asymptomatic guaiac-positive stool). A major hemorrhage is one which leads to transfusion of at least 2 units of whole blood or erythrocytes, requires hospitalization or surgery, results in permanent disability, or involves a critical anatomic site; or any bleeding event the physician characterizes as "major".

Source:

E007 - Intracranial Hemorrhage:

Indicate if the patient had an intracranial hemorrhage.

Intracranial hemorrhage is defined as bleeding into or around the brain potentially caused by one of the following:
- Hemorrhagic conversion of a primary ischemic stroke
- Subarachnoid hemorrhage
- Intracerebral hemorrhage
- Other (including subdural and epidural hematomas)
- Unknown

Note:
1. If the patient had an intracranial hemorrhage with a loss off brain function, intracranial hemorrhage (event ID E007) and hemorrhagic stroke (event ID E016) should be specified.
2. If the patient had an intracranial hemorrhage without loss of brain function only, intracranial hemorrhage (event ID E007).

Source:

E009 - NICM Hemorrhage Location - Intra-articular (Atraumatic):

Indicate if the patient had a documented major hemorrhage within a joint.

Source:

E010 - NICM Hemorrhage Location - Intra-ocular:

Bleeding associated with abrupt deterioration of visual acuity.

Source:

E011 - NICM Hemorrhage Location - Intra-spinal:

Indicate if the patient had a documented major hemorrhage within the spinal.

Source:

E012 - NICM Hemorrhage Location - Pericardial:

Indicate if the patient had a documented major hemorrhage around the heart.

Source:

E013 - NICM Hemorrhage Location - Retroperitoneal/Abdominal:

Indicate if the patient had a documented major hemorrhage around the abdomen.

Source:

E014 - TIA:

Indicate the date the patient had a transient ischemic attack (TIA).

A transient ischemic attack (TIA) is a brief episode of loss of blood flow to part of the brain resulting in transient stroke-like symptoms. Most symptoms of a TIA disappear within an hour, although they may last for up to 24 hours and include:
- Numbness or weakness, especially on one side of the body
- Confusion or trouble speaking or understanding speech
- Trouble seeing in one or both eyes

Source:

E015 - Ischemic Stroke:

Indicate the date the patient had a documented ischemic stroke.

An ischemic stroke is a loss of neurological function caused when a blood vessel that supplies blood to the brain is blocked.

Source:

E016 - Hemorrhagic Stroke:

Indicate the date the patient had a hemorrhagic stroke.

Hemorrhagic stroke is defined as bleeding into or around the brain that results in transient or permanent neurological deficit.

Note:
1. If the patient had an intracranial hemorrhage with a loss off brain function, intracranial hemorrhage (event ID E007) and hemorrhagic stroke (event ID E016) should be specified.

2. If the patient had an intracranial hemorrhage without loss of brain function only, intracranial hemorrhage (event ID E007).

Source:

E017 - Coronary Artery Bypass Graft:

Indicate the date the patient had coronary artery bypass graft (CABG) surgery.

Source:

E018 - Cardiac Valve Surgery:

Indicate the date the patient had cardiac valve surgery.

Source:

E019 - Heart Transplantation:

Indicate the date the patient had a heart transplantation surgery.

Source:

E020 - Cardiac Therapeutic Procedure:

The patient had any procedure to treat a pathologic structural, or pathophysiological functional, disorder of the heart.

Source:

E021 - Cardioversion:

Indicate the date the patient had received an electrical or pharmacological cardioversion, whether successful or unsuccessful.

Source:

E022 - LVAD:

Indicate the date the patient had a left ventricular assist device (LVAD) placed.

An LVAD is a mechanical pump that temporarily and artificially aids the natural pumping action of the left ventricle.

Note:
1. Event must not be selected if the patient had the device previously, but the device is no longer in place.

Source:

E023 - CRT:

Indicate if the patient received a cardiac resynchronization therapy (CRT) device.

A CRT device is a biventricular pacemaker that sends electrical signals to both ventricles that resynchronizes the heart chambers and helps it pump more effectively. It may or may not have an atrial pacing wire.

Note:
1. Event must not be selected if the patient received a cardiac resynchronization therapy device and defibrillator (CRT-D).

Source:

E024 - CRT-D:

Indicate the date the patient received a cardiac resynchronization therapy device and defibrillator (CRT-D).

A CRT-D is a biventricular pacemaker that sends electrical signals to both ventricles as well as a defibrillator. It may or may not have an atrial pacing wire.

Note:
1. Event must not be selected if the patient had the device previously, but the device is no longer in place.

Source:

E025 - ICD:

Indicate the date the patient received an implantable cardioverter defibrillator (ICD).

Event must not be selected if the patient had the device previously, but the device is no longer in place.

Source:

E026 - PTCA:

Indicate if the patient received percutaneous transluminal coronary angioplasty (PTCA).

PTCA is a minimally invasive procedure to open up blocked coronary arteries, allowing blood to circulate unobstructed to the heart muscle. This angioplasty is a non-stent balloon angioplasty.

Note: If a stent is used during angiography, PTCA (event E026) must not be selected.

Source:

E027 - Permanent Pacemaker:

Indicate if the patient has a permanent pacemaker. Event must not be selected if the patient had the device previously, but the device is no longer in place.

Source:

E028 - Vascular Complication (Requiring Intervention):

Indicate if the patient had a documented vascular complication intervention.

Vascular complications can include, but are not limited to, access site occlusions, peripheral embolizations, dissections, pseudoaneurysms and/or AV fistulas. Any noted vascular complication must have had an intervention such as a fibrin injection, angioplasty, or surgical repair to qualify. Prolonged pressure does not qualify as an intervention, but ultrasonic guided compression after making a diagnosis of pseudoaneurysm does qualify.

Source:

E029- PCI (Any):

Indicate the date the patient had a Percutaneous Coronary Intervention (PCI).

Source:

E030- Stroke (Any):

Indicate the date the patient had a documented stroke.

Source:

E031- Hemorrhage (Any):

Indicate the date the patient had a hemorrhage of any kind.

Source:

E032 -Non Intracranial Major Hemorrhage (Any):

Indicate the date the patient had a documented intracranial hemorrhage - outside of the cranium.

Source:

E033 -Carotid Endarterectomy (any):

Indicate the date the patient had a documented carotid endarterectomy.

Source:

E034 - Carotid Endarterectomy (Right):

Indicate the date the patient had a documented right carotid endarterectomy.

Source:

E035 -Carotid Endarterectomy (Left):

Indicate the date the patient had a documented left endarterectomy.

Source:

E036 -Carotid Artery Stent (any):

Indicate the date the patient had a documented carotid artery stent.

Source:

E037 -Carotid Artery Stent (Right):

Indicate the date the patient had a documented right carotid artery stent.

Source:

E038- Carotid Artery Stent (Left):

Indicate the date the patient had a documented left carotid artery stent.

Source:

E039 - Gestational Diabetes Mellitus (GDM):

Gestational Diabetes Mellitus is a type of diabetes mellitus that develops only during pregnancy and usually disappears upon delivery, but increases the risk that the mother will develop diabetes later. GDM is managed with meal planning, activity, and, in some cases, insulin.

Source: American Diabetes Association

E040 - Diabetic ketoacidosis (DKA) :

Diabetic ketoacidosis (DKA) is an emergency condition in which extremely high blood glucose levels, along with a severe lack of insulin, result in the breakdown of body fat for energy and an accumulation of ketones in the blood and urine. Signs of DKA are nausea and vomiting, stomach pain, fruity breath odor and rapid breathing. Untreated DKA can lead to coma and death.

Source: American Diabetes Association

E041 - Hyperosmolar Hyperglycemic Syndrome (HHS):

Hyperosmolar hyperglycemic nonketotic syndrome is an emergency condition in which one's blood glucose level is very high and ketones are not present in the blood or urine. If HHNS is not treated, it can lead to coma or death.

Source: American Diabetes Association

E042 - Hypoglycemia (Severe):

Hypoglycemia is a condition that occurs when one's blood glucose is lower than normal, usually less than 70 mg/dL. Signs include hunger, nervousness, shakiness, perspiration, dizziness or light-headedness, sleepiness, and confusion. If left untreated, hypoglycemia may lead to unconsciousness. Hypoglycemia is treated by consuming a carbohydrate-rich food such as a glucose tablet or juice. It may also be treated with an injection of glucagon if the person is unconscious or unable to swallow. Also called an insulin reaction.

Source: American Diabetes Association

E043- Peripheral Bypass :

Indicate the date the patient had a peripheral bypass.

Note(s):

Peripheral artery bypass is surgery to reroute the blood supply around a blocked artery in one of your legs.

Source:

E044- Peripheral Intervention:

Indicate the date the patient had a peripheral intervention.
Note(s):

Peripheral catheter based intervention, balloon angioplasty, stenting, atherectomy for example.

Source:

E049 - Acute Pancreatitis:

Acute pancreatitis is a sudden attack causing inflammation of the pancreas and usually associated with severe upper abdominal pain. The pain may last several days and may be serious.

Source:

E050 - Bariatric Surgery:

Indicate if the patient has undergone bariatric surgery. Bariatric surgery can include:

- Adjustable gastric banding (AGB)
- Roux-en-Y gastric bypass (RYGB)
- Biliopancreatic diversion with a duodenal switch (BPD-DS)
- Vertical sleeve gastrectomy (VSG)

Source:

E051 - Bariatric Surgery - Adjustable Gastric Banding:

A type of bariatric surgery that involves inserting a thin, inflatable ring or gastric band to create a new, smaller stomach pouch.

Unlike conventional gastric bypass surgery, gastric band surgery is:
Minimally invasive no cutting, stapling, or re-routing of the intestinal tract.
Reversible and adjustable.

Source:

E052 - Bariatric Surgery - Biliopancreatic diversion with duodenal switch:

A type of bariatric surgery in which a large portion of the stomach is left intact, including the pyloric valve that regulates the release of contents from the stomach into the small intestine. The duodenum is divided near this valve, and the small intestine divided as well. The portion of the small intestine connected to large intestine is attached to the short duodenal segment next to the stomach. The remaining segment of the duodenum connected to the pancreas and gallbladder is attached to this limb closer to the large intestine

Source:

E053 - Bariatric Surgery - Roux-en-Y gastric bypass:

A type of bariatric surgery that reduces the size of your stomach to a small pouch – about the size of an egg. It does this by stapling off a section of it. This reduces the amount of food you can take in at meals. The surgeon then attaches this pouch directly to the small intestine, bypassing most of the rest of the stomach and the upper part of the small intestine. This reduces the amount of fat and calories you absorb from the foods you are able to eat for even more weight loss.

RYGB can be done as an open surgery, with a large cut (incision) on your abdomen to reach your stomach. Or it can be done as a laparoscopic RYGB, using a lighted tube with a tiny camera, called a laparoscope.

Source:

E054 - Bariatric Surgery - Vertical Sleeve gastrectomy:

A type of bariatric surgery that generates weight loss by restricting the amount of food (and therefore calories) that can be eaten by removing 85% or more of the stomach without bypassing the intestines or causing any gastrointestinal malabsorption.

Source:

E055 - Foot Ulcer:

Ulcers are slow healing wounds on the skin. Diabetic foot ulcers occur on the feet of people with type 1 and type 2 diabetes

Source:

E056 - Gout:

a disease in which defective metabolism of uric acid causes arthritis, especially in the smaller bones of the feet, deposition of chalkstones, and episodes of acute pain.

Source:

E057 - Hemodialysis:

Healthy kidneys clean your blood and remove extra fluid in the form of urine. They also make substances that keep your body healthy.
In hemodialysis, a dialysis machine and a special filter called an artificial kidney, or a dialyzer, are used to clean your blood. To get your blood into the dialyzer, the doctor needs to make an access, or entrance, into your blood vessels. This is done with minor surgery, usually to your arm.

Source: National Kidney Foundation

E058 - Hyperthyroidism:

Hyperthyroidism is a disorder that occurs when the thyroid gland makes more thyroid hormone than the body needs. Hyperthyroidism is sometimes called thyrotoxicosis, the technical term for too much thyroid hormone in the blood. Thyroid hormones circulate throughout the body in the bloodstream and act on virtually every tissue and cell in the body. Hyperthyroidism causes many of the body's functions to speed up.

Source: HHS

E059 - Hypothyroidism:

Hypothyroidism is a disorder that occurs when the thyroid gland does not make enough thyroid hormone to meet the body's needs. Thyroid hormone regulates metabolism the way the body uses energy and affects nearly every organ in the body. Without enough thyroid hormone, many of the body's functions slow down

Source: HHS

E063 - Nonalcoholic Fatty Liver Disease (NAFLD):

NAFLD is the build up of extra fat in liver cells that is not caused by alcohol. It is normal for the liver to contain some fat. However, if more than 5% - 10% percent of the liver's weight is fat, then this is considered NAFLD.

Source: American Liver Foundation

E064 - Sleep Apnea:

A sleep disorder characterized in 2 ways:
-Obstructive sleep apnea(OSA): The blockage of the airway, usually when the soft tissue in the back of the throat collapses during sleep.
-Central sleep apnea: Unlike OSA, the airway is not blocked, but the brain fails to signal the muscles to breathe due to instability in the respiratory control center.

Source:

E065 - Syncope:

Indicate the date the patient had documented syncope.

Syncope is defined as the transient loss of consciousness and postural tone.

Source:

E066 - Left Bundle Branch Block:

Indicate if the patient has a documented left bundle branch block.
If multiple diagnosis dates exist indicate the most recent value.
Supporting Definition:
-Left Bundle Branch is characterized by QRS duration 120 ms or longer, delayed onset of intrinsicoid deflection in 1, V5, and V6 >60 ms, broad and notched or slurred R waves in I, aVL, V5, and V6, rS or QS complexes in right precordial leads, ST-segment and T waves in opposite polarity to the major QRS deflection.

Source: ACC/AHA/HRS 2006 Key Data Elements and Definitions for Electrophysiological Studies

C. Event

E067 - Peritoneal Dialysis:

Healthy kidneys clean your blood and remove extra fluid in the form of urine. They also make substances that keep your body healthy.
A soft plastic tube (catheter) is placed in your belly by surgery. A sterile cleansing fluid is put into your belly through this catheter. After the filtering process is finished, the fluid leaves your body through the catheter.

Source: National Kidney Foundation

E068 - Solid Organ Transplant - Kidney :

Indicate if the patient had a kidney transplant surgery performed

Source:

E069 - Solid Organ Transplant - Pancreas:

Indicate if the patient had a pancreas transplant surgery performed.

Source:

E070 - Solid Organ Transplant - Heart:

Indicate if the patient had a heart transplant surgery performed

Source:

E071 - Solid Organ Transplant - Other:

Indicate the patient had a transplant surgery other than a kidney or pancreas transplant.
Note: "Other" solid organ transplant should only includes only liver, lung)

Source:

E072 - Cardiac Surgery :

Indicate if the patient had cardiac surgery as defined by CMS CPT Codes listed below:
33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92920, 92924, 92928, 92933, 92937, 92941,92943, 92980, 92981, 92982, 92984, 92995, 92996

Source: CMS Betablocker measure specifications for QPP #7

Seq. #: 5136 **Name:** Event Date

Coding Instructions: Indicate all dates, if documented, of cardiac events that occurred.

Note(s):

All occurrences on current encounter.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	EventDate
Parent Seq #:	5135
Parent Name:	Event ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 3020 **Name:** Insurance - Private Health Insurance

Coding Instructions: Indicate if the patient's insurance payor(s) included private health insurance.

Note(s):

A health maintenance organization (HMO) is considered private health insurance.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Private Health Insurance:**

Private health insurance is coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company.

Source: U.S. Census Bureau

Technical Specifications

ShortName:	InsPrivate
Parent Seq #:	3027
Parent Name:	Insurance - None
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 3022 **Name:** Insurance - Medicaid

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	InsMedicaid
Parent Seq #:	3027
Parent Name:	Insurance - None
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 3023 **Name:** Insurance - Military Health Care

Coding Instructions: Indicate if the patient's insurance payor(s) included Military Health Care.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Military Health Care:**

Military Health care - Military health care includes TRICARE/CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs (VA).

Source: U.S. Census Bureau

Technical Specifications

ShortName:	InsMilitary
Parent Seq #:	3027
Parent Name:	Insurance - None
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 3024 **Name:** Insurance - State Specific Plan (non-Medicaid)

Coding Instructions: Indicate if the patient's insurance payor(s) included State-specific Plan.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **State Specific Plan:**

State-specific plan - Some states have their own health insurance programs for low-income uninsured individuals. These health plans may be known by different names in different states. (Non-Medicaid)

Source: U.S. Census Bureau

Technical Specifications

ShortName:	InsState
Parent Seq #:	3027
Parent Name:	Insurance - None
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 3025 **Name:** Insurance - Indian Health Service

Coding Instructions: Indicate if the patient's insurance payor(s) included Indian Health Service (IHS).

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Indian Health Service:**

Indian Health Service (IHS) is a health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected health care services provided at non-IHS facilities.

Source: U.S. Census Bureau

Technical Specifications

ShortName:	InsIHS
Parent Seq #:	3027
Parent Name:	Insurance - None
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 3026 **Name:** Insurance - Non-US Insurance

Coding Instructions: Indicate if the patient's insurance payor(s) included Non-US Insurance.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Non-US Insurance:**

Non-U.S. Insurance refers to individuals with a payor that does not originate in the United States.

Source: U.S. Census Bureau

Technical Specifications

ShortName:	InsNonUS
Parent Seq #:	3027
Parent Name:	Insurance - None
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 3027 **Name:** Insurance - None

Coding Instructions: Indicate if the patient has no insurance payor(s).

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **None:**

None refers to individuals with no or limited health insurance thus, the individual is the payor regardless of ability to pay.

Source: NCDR

Technical Specifications

ShortName:	InsNone
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 3028 **Name:** Insurance - Medicare (Fee for service)

Coding Instructions: Indicate if the patient's insurance payor(s) included Medicare Fee for Service.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Medicare:**

Medicare is the Federal program which helps pay health care costs for people 65 and older and for certain people under 65 with long-term disabilities.

The traditional system of reimbursement under health insurance and Medicare. Health care providers bill patients for services supplied, and costs are shared according to a contractual agreement between the patient and insurance company. A fee-for-service system allows patients maximum flexibility in the choice of providers and services.

Source: U.S. Census Bureau

Technical Specifications

ShortName:	InsMedicare_Feefor Ser
Parent Seq #:	3027
Parent Name:	Insurance - None
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 3029 **Name:** Insurance - Medicare (Managed care)

Coding Instructions: Indicate if the patient is insured by Medicare (managed care/HMO).

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Medicare:**

Medicare is the Federal program which helps pay health care costs for people 65 and older and for certain people under 65 with long-term disabilities.

A type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in Original Medicare.

Source: U.S. Census Bureau

Technical Specifications

ShortName:	InsMedicare_MngdCare
Parent Seq #:	3027
Parent Name:	Insurance - None
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 3030 **Name:** Insurance - Medicaid (Fee for service)

Coding Instructions: Indicate if the patient's insurance payor(s) included Medicaid Fee for Service.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Medicaid:**

Medicaid is a program administered at the state level, which provides medical assistance to the needy. Families with dependent children, the aged, blind, and disabled who are in financial need are eligible for Medicaid. It may be known by different names in different states.

Source: U.S. Census Bureau

Technical Specifications

ShortName:	InsMedicaid_FeeforSer
Parent Seq #:	3027
Parent Name:	Insurance - None
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 3031 **Name:** Insurance - Medicaid (Managed Care)

Coding Instructions: Indicate if the patient's insurance payor(s) included Medicaid (managed care/HMO).

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Medicaid:**

Medicaid is a program administered at the state level, which provides medical assistance to the needy. Families with dependent children, the aged, blind, and disabled who are in financial need are eligible for Medicaid. It may be known by different names in different states.

Source: U.S. Census Bureau

Technical Specifications

ShortName:	InsMedicaid_MngdCare
Parent Seq #:	3027
Parent Name:	Insurance - None
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 3100 **Name:** Payer ID

Coding Instructions: Indicate the Payer ID of the patient's primary insurance payer. Payer ID is a national numbering system that identifies healthcare payers authorized by CMS for healthcare claims processing and other electronic data interchange transactions.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PayerID
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6000 **Name:** Height (in)

Coding Instructions: Indicate the patient's Height in inches (in).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Ht_inches
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	
Valid Range:	7.87-102.36
DataSource:	User

D. Encounter Information

Seq. #: 6001 **Name:** Height (cm)

Coding Instructions: Indicate the patient's Height in centimeters (cm).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Ht_cms
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	
Valid Range:	20.00-260.00
DataSource:	User

Seq. #: 6010 **Name:** Systolic Blood Pressure

Coding Instructions: Indicate the patient's systolic blood pressure in mmHg.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SystolicBP
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	1-300
DataSource:	User

Seq. #: 6011 **Name:** Diastolic Blood Pressure

Coding Instructions: Indicate the patient's diastolic blood pressure in mmHg.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DiastolicBP
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	1-200
DataSource:	User

D. Encounter Information

Seq. #: 6015 **Name:** Heart Rate

Coding Instructions: Indicate the patient's heart rate in beats per minute.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	HeartRate
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	1-300
DataSource:	User

Seq. #: 6020 **Name:** Weight (lbs)

Coding Instructions: Indicate the patient's weight in pounds (lbs).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Wt_lbs
Parent Seq #:	6025
Parent Name:	Patient unable to be weighed
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (6,2)
Default Value:	NULL
Usual Range:	
Valid Range:	22.00-1540.00
DataSource:	User

Seq. #: 6021 **Name:** Weight (kg)

Coding Instructions: Indicate the patient's weight in kilograms (kg).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Wt_kgs
Parent Seq #:	6025
Parent Name:	Patient unable to be weighed
Parent Value:	No
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	
Valid Range:	10.00-700.00
DataSource:	User

D. Encounter Information

Seq. #: 6025 **Name:** Patient unable to be weighed

Coding Instructions: Indicate if the patient was unable to be weighed during the encounter.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName: CannotWeigh
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes (DCR,PINN)
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
DataSource: User

Seq. #: 6026 **Name:** Waist Circumference (in)

Coding Instructions: Indicate the patient's waist circumference in inches (in).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName: WaistCir_inches
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes (DCR)
Format: Decimal (5,2)
Default Value: NULL
Usual Range:
Valid Range:
DataSource: User

Seq. #: 6027 **Name:** Waist Circumference (cm)

Coding Instructions: Indicate the patient's waist circumference in centimeters (cm).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName: WaistCir_cm
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes (DCR)
Format: Decimal (5,2)
Default Value: NULL
Usual Range:
Valid Range:
DataSource: User

D. Encounter Information

Seq. #: 6028 **Name:** QRS Duration (Non-Ventricular Paced Complex)

Coding Instructions: Indicate if the patient had a history of a duration of the non-ventricular paced or intrinsic QRS complex, in milliseconds, that was derived from the surface electrocardiogram (ECG). Surface ECGs are obtained from the surface of the body and do not include intracardiac ECGs.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	QRSDuration
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	20-250
Valid Range:	10-300
DataSource:	User

Seq. #: 6030 **Name:** Tobacco Use

Coding Instructions: Indicate the patient's use of tobacco products. Tobacco products include smoke (cigarettes, cigars, pipe) and smokeless (chewing tobacco).

Note(s):

Current non tobacco user should be mapped to selection items "never", "quit within past 24 months" or "quit more than 24 months" for purposes of QPP measure #226.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Never	
2	Current	
3	Quit within past 12 months	Selection Retired (v1.7)
4	Quit more than 12 months ago	Selection Retired (v1.7)
5	Tobacco Screening not performed for medical reasons	
6	Quit within past 24 months	
7	Quit more than 24 months ago	

Supporting Definitions: (none)

Technical Specifications

ShortName:	TobaccoUse
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6035 **Name:** Cigarettes

Coding Instructions: Indicate if the patient is a cigarette smoker currently or quit within the past 12 months.

Target Value: The value between 12 months prior to current encounter and current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	Selection retired effective v1.7
1	Yes	Selection retired effective v1.7

Supporting Definitions: (none)

Technical Specifications

ShortName:	Cigarettes
Parent Seq #:	6030
Parent Name:	Tobacco Use
Parent Value:	Current, Quit within past 12 months
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6036 **Name:** Cigars

Coding Instructions: Indicate if the patient is a cigar smoker currently or quit within the past 12 months.

Target Value: The value between 12 months prior to current encounter and current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	Selection retired effective v1.7
1	Yes	Selection retired effective v1.7

Supporting Definitions: (none)

Technical Specifications

ShortName:	Cigars
Parent Seq #:	6030
Parent Name:	Tobacco Use
Parent Value:	Current, Quit within past 12 months
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6037 **Name:** Pipe

Coding Instructions: Indicate if the patient is a pipe smoker currently or quit within the past 12 months.

Target Value: The value between 12 months prior to current encounter and current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	Selection retired effective v1.7
1	Yes	Selection retired effective v1.7

Supporting Definitions: (none)

Technical Specifications

ShortName:	Pipe
Parent Seq #:	6030
Parent Name:	Tobacco Use
Parent Value:	Current, Quit within past 12 months
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6038 **Name:** Smokeless

Coding Instructions: Indicate if the patient uses smokeless tobacco currently or quit within the past 12 months.

Target Value: The value between 12 months prior to current encounter and current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	Selection retired effective v1.7
1	Yes	Selection retired effective v1.7

Supporting Definitions: (none)

Technical Specifications

ShortName:	Smokeless
Parent Seq #:	6030
Parent Name:	Tobacco Use
Parent Value:	Current, Quit within past 12 months
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6040 **Name:** Smoking Cessation Counseling

Coding Instructions: Indicate if the patient received smoking cessation counseling for smoking cessation if they are a current smoker or quit within 12 months.

Note(s):

Effective PINNACLE v1.3 this element is specific to counseling only. For pharmacological therapy code the specific medication prescribed.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	Selection retired effective v1.7
1	Yes	Selection retired effective v1.7

Supporting Definitions: (none)

Technical Specifications

ShortName:	SmokeCounsel
Parent Seq #:	6030
Parent Name:	Tobacco Use
Parent Value:	Current, Quit within past 12 months
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6045 **Name:** Patient asked during any previous encounter in the past 24 months about the use of tobacco

Coding Instructions: Indicate of the patient was asked, during any previous encounter in the past 24 months, about the use of tobacco.

Target Value: Any occurrence between 24 months prior to current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	UseofTobacco_24months
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6047 **Name:** Alcohol History

Coding Instructions: Indicate the patient estimate of alcohol consumption.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	None	
2	One or fewer alcoholic drinks per week	
3	2 to 7 alcoholic drinks per week	
4	8 to 14 alcoholic drinks per week	
5	15 or more alcoholic drinks per week	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Alcohol_Hist
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6050 **Name:** Advance Care Plan Discussed or Discussion of Advance Care Plan Documented

Coding Instructions: For patients 65 and older, indicate if an advance care plan was documented in the medical record or the creation of an advance care plan was discussed with the patient or surrogate decision maker.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	Selection Retired (v1.4)
1	Yes	There was documentation that Advance Care Planning was discussed or there is documentation of a advance care plan or surrogate decision maker in the medical record.
2	No - Not documented	There is no documentation as to the reason why advance care was not discussed.
3	No - patient reason	Patient reason could include a situation where the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship. This could also include documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan.
4	No - Other Reason	Other reason is intended to cover those instances where an advanced care plan was discussed with the patient, but the patient did not wish or was not able to name a surrogate decision maker or provider.

Supporting Definitions: (none)

Technical Specifications

ShortName:	AdvCarePlanDiscussed
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6055 **Name:** Patient screened for evidence of nephropathy

Coding Instructions: Indicate if the patient was screened or had evidence of nephropathy. Evidence of nephropathy can be considered if any of these apply:
microalbuminuria or macroalbuminuria test result documented and reviewed OR
documentation of treatment for nephropathy (e.g. patient receiving dialysis, patient being treated for End Stage Renal Disease, or any visit to a nephrologist in the chart) OR
patient receiving ACE or ARB therapy.

Target Value: The last value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	PatScrEviNephro
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6100 **Name:** Discussion of Lifestyle Modifications Documented

Coding Instructions: Indicate if the patient has a documented lifestyle modifications.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	LifeModify
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6105 **Name:** Patient enrolled in weight loss program

Coding Instructions: Indicate if the patient was enrolled in a weight loss program at the time of this current visit.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	WeightLossPrgm
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6110 **Name:** Patient Education

Coding Instructions: Indicate if the patient has received counseling or instruction for diabetes management, cardiac symptoms or primary prevention in the past 24 months.

Target Value: Any occurrence between 24 month prior to current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
2	No - Patient Not Counseled or Educated	Selection retired effective v1.7
3	No Counseling or Education - Medical Reason	Selection retired effective v1.7
1	Yes	Selection retired effective v1.7

Supporting Definitions: (none)

Technical Specifications

ShortName:	PatientEdu
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6120 **Name:** Healthy Diet Counseling

Coding Instructions: Indicate if the patient received healthy diet counseling within 24 months. Healthy Diet Counseling can include any of the below: • Eating a variety of fruits, vegetables, grains, low-fat or nonfat dairy products, fish, legumes, poultry, and lean meats •

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	No – Patient not Counseled or Educated	
3	No Counseling or Education – Medical Reason	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HealthDietCounsel
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6121 **Name:** Medication Instruction

Coding Instructions: Indicate if the patient has received patient education on medication instruction within the past 24 months.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	No – Patient not Counseled or Educated	
3	No Counseling or Education – Medical Reason	

Supporting Definitions: (none)

Technical Specifications

ShortName:	MedInstruct
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6122 **Name:** Physical Activity Counseling

Coding Instructions: Indicate if the patient received physical activity counseling within the past 24 months.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	No – Patient not Counseled or Educated	
3	No Counseling or Education – Medical Reason	

Supporting Definitions: **Physical Activity Counseling:**

Physical activity counseling includes all levels of physical activity, including leisure activities, recreational sports, and competitive professional performance.

Can include moderate-intensity aerobic physical activity or vigorous intensity aerobic physical activity.

Source: American Diabetes Association AHA/ACC 2010 Primary Prevention Performance Measures

Technical Specifications

ShortName:	PhyActCounsel
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6123 **Name:** Symptom Management

Coding Instructions: Indicate if the patient has received patient education on symptom management within the past 24 months.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	No – Patient not Counseled or Educated	
3	No Counseling or Education – Medical Reason	

Supporting Definitions: (none)

Technical Specifications

ShortName:	SymptMgmt
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6124 **Name:** Weight Monitoring

Coding Instructions: Indicate if the patient has received patient education on weight monitoring within the past 24 months.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	No – Patient not Counseled or Educated	
3	No Counseling or Education – Medical Reason	

Supporting Definitions: (none)

Technical Specifications

ShortName:	WeightMonitor
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6128 **Name:** Stage of Heart Failure

Coding Instructions: Indicate the patient's American College of Cardiology/American Heart Association stage of heart failure.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	A	Patient is at high risk for heart failure but without structural heart disease or symptoms of heart failure.
2	B	Patient has structural heart disease but without signs or symptoms of heart failure.
3	C	Patient has structural heart disease with prior or current symptoms of heart failure.
4	D	Patient has refractory heart failure requiring specialized interventions.

Supporting Definitions: (none)

Technical Specifications

ShortName:	StageHF
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6130 **Name:** New York Heart Association Functional Classification for Heart Failure

Coding Instructions: Indicate the patient's New York Heart Association functional classification for Heart Failure.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	I	Patient has cardiac disease but without resulting limitations of ordinary physical activity. Ordinary physical activity (e.g., walking several blocks or climbing stairs) does not cause undue fatigue, palpitation, dyspnea, or anginal pain. Limiting symptoms may occur with marked exertion.
2	II	Patient has cardiac disease resulting in slight limitation of ordinary physical activity. Patient is comfortable at rest. Ordinary physical activity such as walking more than two blocks or climbing more than one flight of stairs results in limiting symptoms (e.g., fatigue, palpitation, dyspnea, or anginal pain).
3	III	Patient has cardiac disease resulting in marked limitation of physical activity. Patient is comfortable at rest. Less than ordinary physical activity (e.g., walking one to two level blocks or climbing one flight of stairs) causes fatigue, palpitation, dyspnea, or anginal pain.
4	IV	Patient has dyspnea at rest that increases with any physical activity. Patient has cardiac disease resulting in inability to perform any physical activity without discomfort. Symptoms may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Supporting Definitions: (none)

Technical Specifications

ShortName:	NYHA
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6135 **Name:** Kansas City Cardiomyopathy Questionnaire Completed

Coding Instructions: Indicate if the patient has completed the Kansas City Cardiomyopathy Questionnaire (KCCQ).

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	No - Medical Reason	

Supporting Definitions: (none)

Technical Specifications

ShortName:	KCCQCompleted
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6136 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Overall Summary Score

Coding Instructions: Indicate the value of the patient overall summary score for the completed Kansas City Cardiomyopathy Questionnaire (KCCQ).

Note(s):

Either the full 23-item KCCQ instrument or 12-item instrument can be used. (Both instruments' scores are rescaled so that 0 denotes the worst and 100 the best possible health status).

Target Value: The value between birth and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	KCCQOverallScore
Parent Seq #:	6135
Parent Name:	Kansas City Cardiomyopathy Questionnaire Completed
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	0-100
Valid Range:	0-100
DataSource:	User

Seq. #: 6137 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Clinical Summary Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	KCCQClinSummScore
Parent Seq #:	6135
Parent Name:	Kansas City Cardiomyopathy Questionnaire Completed
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6138 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Physical Limitation Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	KCCQPhysLimitScore
Parent Seq #:	6135
Parent Name:	Kansas City Cardiomyopathy Questionnaire Completed
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6139 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Symptom Stability Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	KCCQSymStabScore
Parent Seq #:	6135
Parent Name:	Kansas City Cardiomyopathy Questionnaire Completed
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6140 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Self Efficacy Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	KCCQSelfEfficScore
Parent Seq #:	6135
Parent Name:	Kansas City Cardiomyopathy Questionnaire Completed
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6141 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Quality of Life Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	KCCQLifeQltyScore
Parent Seq #:	6135
Parent Name:	Kansas City Cardiomyopathy Questionnaire Completed
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6142 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Social Limitation Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	KCCQSocialLimitScore
Parent Seq #:	6135
Parent Name:	Kansas City Cardiomyopathy Questionnaire Completed
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6143 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Total Symptom Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	KCCQTotalSymScore
Parent Seq #:	6135
Parent Name:	Kansas City Cardiomyopathy Questionnaire Completed
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6145 **Name:** Chronic Heart Failure Questionnaire from Guyatt Completed

Coding Instructions: This element has been retired effective v1.5

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	GuyattCompleted
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6150 **Name:** Minnesota Living with Heart Failure Questionnaire Completed

Coding Instructions: This element has been retired effective v1.5

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	MLFHQCompleted
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6155 **Name:** Other Tool/Method used to assess Heart Failure Activity Completed

Coding Instructions: Indicate if another tool/method was used to assess the patient's heart failure symptoms and activity other than the NYHA, KCCQ, Minnesota Living with Heart Failure Questionnaire or Chronic Heart Failure Score from Guyatt.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	No - Medical Reason	

Supporting Definitions: (none)

Technical Specifications

ShortName:	OtherHFActvityAssmntCompleted
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6200 **Name:** Dyspnea Present

Coding Instructions: Indicate if the patient has dyspnea.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Dyspnea
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6210 **Name:** Orthopnea Present

Coding Instructions: Indicate if the patient has orthopnea.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Orthopnea
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6220 **Name:** Rales Present

Coding Instructions: Indicate if the patient has rales.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Rales
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6230 **Name:** Peripheral Edema Present

Coding Instructions: Indicate if the patient has peripheral edema.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	PeriEdema
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6240 **Name:** S3 Gallop Present

Coding Instructions: Indicate if the patient has an S3 gallop.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName: S3Gallop
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes (PINN)
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
DataSource: User

Seq. #: 6250 **Name:** Ascites Present

Coding Instructions: Indicate if the patient has Ascites.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName: Ascites
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes (PINN)
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
DataSource: User

Seq. #: 6260 **Name:** Hepatomegaly Present

Coding Instructions: Indicate if the patient has Hepatomegaly.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName: Hepatomegaly
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes (PINN)
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
DataSource: User

D. Encounter Information

Seq. #: 6270 **Name:** S4 Gallop Present

Coding Instructions: Indicate if the patient has an S4 gallop.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName: S4Gallop
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes (PINN)
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
DataSource: User

Seq. #: 6275 **Name:** Jugular Venous Distention Present

Coding Instructions: Indicate if the patient has jugular venous distention.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName: JVD
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes (PINN)
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
DataSource: User

Seq. #: 6278 **Name:** HF Education Completed/Documented

Coding Instructions: This element has been retired effective PINNACLE v1.2.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName: HFEduCompleted
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: No Action
Harvested: Yes (PINN)
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
DataSource: User

D. Encounter Information

Seq. #: 6280 **Name:** HF Education - All of the following

Coding Instructions: Indicate if the patient received all of the following education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HFEduAll
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6281 **Name:** HF Education - Weight Monitoring

Coding Instructions: Indicate if the patient received weight monitoring education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HFEduWtMonitoring
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6282 **Name:** HF Education - Diet (Sodium Restriction)

Coding Instructions: Indicate if the patient received a sodium-restricted dietary education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HFEduDiet
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6283 **Name:** HF Education - Symptom Management

Coding Instructions: Indicate if the patient received symptom management education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HFEduSympMgmt
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6284 **Name:** HF Education - Physical Activity

Coding Instructions: Indicate if the patient received physical activity education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HFEduPhyAct
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6285 **Name:** HF Education - Smoking Cessation

Coding Instructions: Indicate if the patient received smoking cessation education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HFEduSmokeCess
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6286 **Name:** HF Education - Medication Instruction

Coding Instructions: Indicate if the patient received medication instruction education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HFEduMedInstr
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6287 **Name:** HF Education - Prognosis/End-of-Life Issues

Coding Instructions: Indicate if the patient received prognosis/end-of-life issues education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HFEduPrognosis
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6288 **Name:** HF Education - Minimizing or Avoiding use of NSAIDs

Coding Instructions: Indicate if the patient received minimizing or avoiding use of NSAIDs education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HFEduNSAIDs
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6289 **Name:** HF Education - Referral for visiting nurse or specific education or management programs

Coding Instructions: Indicate if the patient received a referral for visiting nurse or specific education or management programs education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HFEduPgms
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6300 **Name:** ICD Counseling

Coding Instructions: Indicate if patient has been counseled regarding Implantable Cardioverter Defibrillator Implantation(ICD).

Note(s):

Code 'Yes' for single chamber ICD, dual chamber ICD, cardiac resynchronization therapy device and defibrillator (CRT-D).

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes - Patient Counseled	
2	No - Patient Not Counseled	
3	No Counseling - Medical Reason	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Counsel_ICD
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6310 **Name:** HF Plan of Care

Coding Instructions: Indicate if the patient has a documented plan of care for management of heart failure symptoms.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	Plan of care was documented

Supporting Definitions: **HF Plan of Care:**

A documented plan of care may include one or more of the following: reevaluation of medical therapy including up-titration of doses, consideration of electrical device therapy, recommended lifestyle modifications, initiation of palliative care, referral for more advanced therapies (e.g. transplant, ventricular assist device), or referral to disease management programs.

Source: 2012 ACCF/AHA/AMA-PCPI Heart Failure Performance Measures

Technical Specifications

ShortName:	HF_PlanCare
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6400 **Name:** Left Ventricular Ejection Fraction (LVEF) Date

Coding Instructions: Indicate the date of the most recent left ventricular ejection fraction.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LVEF_Date
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6410 **Name:** Left Ventricular Ejection Fraction (LVEF) Percent

Coding Instructions: Indicate the patient's left ventricular quantitative assessment.

Note(s):

The "LVEF percent" element should only be used if a single percentage is documented in the medical record.
If a LVEF range or a descriptive term (e.g. Moderately reduced) is documented in the medical record, then report the LV function using the "LV Qualitative Assessment" element.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LVEF
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (2)
Default Value:	NULL
Usual Range:	
Valid Range:	1-99
DataSource:	User

D. Encounter Information

Seq. #: 6420 **Name:** Left Ventricular Qualitative Assessment

Coding Instructions: Indicate the patient's LV Qualitative Assessment.

Note(s):

If a percentage is documented in the medical record, use the "LVEF Percent" element to document the percentage.

If a LVEF percentage range is documented in the medical record, average the percentages, round up and reference the "LV Qualitative Assessment" selections to report.

Target Value: The last value between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Normal: >=50	Selection Retired (v1.3)
2	Mildly reduced: 40 - 49	
3	Moderately reduced: 26 - 39	Selection Retired (v1.3)
4	Severely reduced: <=25	Selection Retired (v1.3)
5	Hyperdynamic: >70	
6	Normal: 50 - 70	
7	Moderately reduced: 30 - 39	
8	Severely reduced: <=29	

Supporting Definitions: (none)

Technical Specifications

ShortName:	LV_Qlty_Assemnt
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6430 **Name:** Canadian Cardiovascular Society (CCS) Class

Coding Instructions: Indicate the patient's Canadian Cardiovascular Society (CCS) classification for angina.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No angina	
1	I	Ordinary physical activity (for example, walking or climbing stairs) does not cause angina; angina occurs with strenuous or rapid or prolonged exertion at work or recreation,
2	II	Slight limitation of ordinary activity (for example, angina occurs walking or stair climbing after meals, in cold, in wind, under emotional stress, or only during the few hours after awakening; walking more than 2 blocks on the level or climbing more than
3	III	Marked limitation of ordinary activity (for example, angina occurs with walking 1 or 2 blocks on the level or climbing 1 flight of stairs in normal conditions and at a normal pace).
4	IV	Inability to perform any physical activity without discomfort; angina syndrome may be present at rest.

Supporting Definitions: (none)

Technical Specifications

ShortName:	CCSClass
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6435 **Name:** Seattle Angina Questionnaire (SAQ) Completed

Coding Instructions: Indicate if the patient has completed the Seattle Angina Questionnaire (SAQ).

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	SAQCompleted
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6440 **Name:** Other Tool/Method used to assess Angina Symptoms and Activity Completed

Coding Instructions: Indicate if another tool/method was used to assess the patient's angina symptoms and activity other than the CCS or SAQ.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	OtherAnginaToolCompleted
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6450 **Name:** Cardiac Rehabilitation Referral or Plan for Qualifying Event/Diagnosis

Coding Instructions: Indicate if the patient had a cardiac event within the past 12 months requiring cardiac rehabilitation. Cardiac events includes Myocardial Infarction, Valve Replacement, Heart Transplant, Heart Failure, CABG or PCI.

Note(s):

Cardiac rehabilitation is a medically supervised program to help cardiac patients slow and stabilize the progression of cardiovascular disease thus reducing the risk of heart disease, another cardiac event or death. Cardiac rehabilitation programs include patient counseling, an exercise program, nutrition counseling and risk factor education (smoking, obesity, high blood pressure, high cholesterol).

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes - Referral/Plan documented	
2	No qualifying event/diagnosis	
3	Patient already participating in rehab	
4	No Referral/Plan - Medical Reason	
5	No Referral/Plan - Patient Reason	Selection Retired (v1.3)
6	No Referral/Plan - System Reason	
7	Previous Cardiac Rehabilitation for Qualifying Cardiac Event Completed	

Technical Specifications

ShortName:	CardRehabReferral
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Supporting Definitions: **Referral:**

A referral is defined as an official communication between the health care provider and the patient to recommend and carry out a referral order to an outpatient CR program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in an outpatient CR program. This also includes a written or electronic communication between the healthcare provider or healthcare system and the cardiac rehabilitation program that includes the patient's enrollment information for the program. A hospital discharge summary or office note may potentially be formatted to include the necessary patient information to communicate to the CR program [the patient's cardiovascular history, testing, and treatments, for instance]. According to standards of practice for cardiac rehabilitation programs, care coordination communications are sent to the referring provider, including any issues regarding treatment changes, adverse treatment responses, or new non-emergency condition (new symptoms, patient care questions, etc.) that need attention by the referring provider. These communications also include a progress report once the patient has completed the program. All communications must maintain an appropriate level of confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act [HIPAA].)

Source: Thomas RJ, King M, Lui K, Oldridge N, Piña IL, Spertus J.AACVPR/ACCF/AHA 2010 Update: Performance Measures on Cardiac Rehabilitation for Referral to Cardiac Rehabilitation/Secondary Prevention Services: Endorsed by the American College of Chest Physicians, the American College of Sports Medicine, the American Physical Therapy Association, the Canadian Association of Cardiac Rehabilitation, the Clinical Exercise Physiology Association, the European Association for Cardiovascular Prevention and Rehabilitation, the Inter-American Heart Foundation, the National Association of Clinical Nurse Specialists, the Preventive Cardiovascular Nurses Association, and the Society of Thoracic Surgeons. J Am Coll Cardiol. 2010

Seq. #: 6460 **Name:** Referral for consideration for coronary revascularization

Coding Instructions: Indicate if the patient has a documented referral for consideration for coronary revascularization.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	No Referral - Patient Reason	
3	No Referral - System Reason	
4	No Referral - Medical Reason	

Technical Specifications

ShortName:	CorRevasReferral
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Supporting Definitions: (none)

D. Encounter Information

Seq. #: 6470 **Name:** Referral for additional evaluation/treatment of anginal symptoms

Coding Instructions: Indicate if the patient has a documented referral for additional evaluation/treatment of anginal symptoms.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	
2	No Referral - Patient Reason	
3	No Referral - System Reason	
4	No Referral - Medical Reason	

Supporting Definitions: (none)

Technical Specifications

ShortName:	EvalTreatReferral
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6481 **Name:** Seattle Angina Questionnaire (SAQ) - Physical Function Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SAQAnginaPhyFunc Score
Parent Seq #:	6105
Parent Name:	Patient enrolled in weight loss program
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	0-100
DataSource:	User

Seq. #: 6482 **Name:** Seattle Angina Questionnaire (SAQ) - Angina Stability Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SAQAnginaStability Score
Parent Seq #:	6105
Parent Name:	Patient enrolled in weight loss program
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	0-100
DataSource:	User

D. Encounter Information

Seq. #: 6483 **Name:** Seattle Angina Questionnaire (SAQ) - Angina Frequency Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SAQAnginaFreqScore
Parent Seq #:	6105
Parent Name:	Patient enrolled in weight loss program
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	0-100
DataSource:	User

Seq. #: 6484 **Name:** Seattle Angina Questionnaire (SAQ) - Treatment Satisfaction Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SAQAnginaTreatmentsatiScore
Parent Seq #:	6105
Parent Name:	Patient enrolled in weight loss program
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	0-100
DataSource:	User

Seq. #: 6485 **Name:** Seattle Angina Questionnaire (SAQ) - Quality of Life Score

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SAQAnginaQuallifeScore
Parent Seq #:	6105
Parent Name:	Patient enrolled in weight loss program
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	0-100
DataSource:	User

D. Encounter Information

Seq. #: 6490 **Name:** Hypertension Plan of Care Documented

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	HTPlanofCare
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6500 **Name:** AFib/Flutter Duration

Coding Instructions: Indicate the duration of the patient's AFib/Flutter.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	First diagnosed	
2	Paroxysmal	
3	Persistent	
4	Long-standing Persistent	
5	Permanent	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Afib_Dur
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6510 **Name:** AFib/Flutter Type

Coding Instructions: Indicate the if the patient has valvular of non-valvular AFib/Flutter

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Non - valvular	
2	Valvular	

Supporting Definitions: **AFib/Flutter Type:**

Valvular AF is defined as rheumatic mitral stenosis, a mechanical or bioprosthetic heart valve, or history of mitral valve repair.

Source: 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation

Technical Specifications

ShortName:	Afib_Type
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6520 **Name:** Etiology - Transient/reversible Cause

Coding Instructions: Indicate if the patient's AFib/Flutter is due to a transient and/or reversible cause.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Afib_Etiology_rev_cause
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6521 **Name:** Etiology - Cardiac Surgery within past 3 months

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Afib_Etiology_Card_Srg
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6522 **Name:** Etiology - Pregnancy

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Afib_Etiology_Pregnancy
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6530 **Name:** International Normalized Ratio (INR) Value

Coding Instructions: Indicate all values of the patient's International Normalized Ratio (INR).

Note(s):

All occurrences between birth and completion of current encounter

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	INR_Value
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Decimal (3,1)
Default Value:	NULL
Usual Range:	
Valid Range:	0.1-99.0
DataSource:	User

Seq. #: 6532 **Name:** International Normalized Ratio (INR) Date

Coding Instructions: Indicate all dates the patient's International Normalized Ratio (INR) was assessed.

Note(s):

All occurrences between birth and completion of current encounter

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	INR_Dt
Parent Seq #:	6530
Parent Name:	International Normalized Ratio (INR) Value
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6540 **Name:** Electrophysiology Study

Coding Instructions: Indicate if the patient received an electrophysiology study (EP study).

Note(s):

An EP study consists of one or more catheters capable of recording and pacing which are placed in one or more of the cardiac chambers. The catheters may be used to measure conduction of the impulse from the sinus node to the ventricle; induce a tachycardia; and/or localize (map) the location where the tachycardia originates.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	EPStudy
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6542 **Name:** Electrophysiology Study Date

Coding Instructions: Indicate all dates the patient received an electrophysiology study.

Note(s):

All occurrences between birth and completion of current encounter

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	EPStudy_Date
Parent Seq #:	6540
Parent Name:	Electrophysiology Study
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6550 **Name:** Atrial Ablation

Coding Instructions: Indicate if an atrial ablation was performed. Ablation is the application of an energy source delivered through a catheter to eliminate or modify a focus or re-entry circuit that causes an arrhythmia.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	AtrialAblation
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6552 **Name:** Atrial Ablation Date

Coding Instructions: Indicate all dates the patient received an atrial ablation.

Note(s):

All occurrences between birth and completion of current encounter

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	AtrialAblation_Date
Parent Seq #:	6550
Parent Name:	Atrial Ablation
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6560 **Name:** Atrial Fibrillation Recurrence

Coding Instructions: Indicate if the patient had a documented case of atrial fibrillation of any type after the performance of an atrial fibrillation ablation.

Target Value: Any occurrence between birth and current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	AFRecurrence
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6562 **Name:** Atrial Fibrillation Recurrence Date

Coding Instructions: Indicate all dates the patient had an atrial fibrillation recurrence.

Note(s):

All occurrences between birth and completion of current encounter

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	AFRecurrence_Date
Parent Seq #:	6560
Parent Name:	Atrial Fibrillation Recurrence
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6570 **Name:** Atrial Fibrillation Symptom Frequency

Coding Instructions: Indicate the patient estimate of average interval, in days, between symptomatic episodes of atrial fibrillation.

Target Value: Any occurrence between birth and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	AFSymptom_Frequency
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Integer (5)
Default Value:	No
Usual Range:	
Valid Range:	1-99999
DataSource:	User

D. Encounter Information

Seq. #: 6580 **Name:** Atrial Fibrillation Symptom Duration

Coding Instructions: Indicate the patient estimate of duration of usual symptomatic episodes for atrial fibrillation.

Target Value: Any occurrence between birth and current encounter

Selections:

Code	*Selection Text*	*Definition*
1	< 48 hours	
2	>= 48 hours to 7 days	
3	> 7 days to 3 months	
4	> 3 months	

Supporting Definitions: (none)

Technical Specifications

ShortName:	AFSymptom_Duration
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6590 **Name:** Rate Control (Therapy)

Coding Instructions: Indicate if the patient is currently on rate control therapy.

Rate control is the attempted control of ventricular rate with no commitment to restore or maintain sinus rhythm. (Strict rate control is generally defined as <80 bpm while lenient rate control is generally defined as <110 bpm.) Rate control may consist of:

- Pharmacological
- Non pharmacological
- Hybrid

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	RateControl
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6595 **Name:** Rhythm Control (Therapy)

Coding Instructions: Indicate if the patient is currently on rhythm control therapy.

Rhythm control is the attempted restoration and/or maintenance of sinus rhythm. Also requires attention to rate control. Rhythm control may consist of:

- Pharmacological
- Non pharmacological
- Hybrid

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	RhythmControl
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6596 **Name:** Thromboembolic Risk Factors Assessed

Coding Instructions: This element has been retired effective v1.4

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes (All risk factors assessed)	
2	No - Medical Reason	
3	No - Patient Reason	Selection Retired (v1.3)
4	No - System Reason	Selection Retired (v1.2)

Supporting Definitions: (none)

Technical Specifications

ShortName:	ThrombRskFact
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6600 **Name:** CHA2DS2 Score

Coding Instructions: Indicate the value of the patient's CHA2DS2 Score.

Target Value: The value between birth and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	CHA2DS2Score
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Integer (1)
Default Value:	NULL
Usual Range:	
Valid Range:	0-6
DataSource:	User

D. Encounter Information

Seq. #: 6610 **Name:** CHADS2-VASc Score

Coding Instructions: Indicate the value of the patient's CHADS2-VASc Score.

Target Value: The value between birth and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	CHA2DS2VScore
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Integer (1)
Default Value:	NULL
Usual Range:	
Valid Range:	0-9
DataSource:	User

Seq. #: 6620 **Name:** HAS-BLED Score

Coding Instructions: Indicate the value of the patient's HAS-BLED Score.

Target Value: The value between birth and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	HASBLEDScore
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Integer (1)
Default Value:	NULL
Usual Range:	
Valid Range:	0-9
DataSource:	User

Seq. #: 6630 **Name:** Foot Exam (Within the Past 12 Months)

Coding Instructions: Indicate if a patient received a foot exam within the past 12 months.

Target Value: Any occurrence between 12 month prior to current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No - Not documented	No documentation of a foot exam or the documentation does not include examination through visual inspection, sensory exam with monofilament, and pulse exam.
1	Yes	A foot exam should include these 3 elements: visual inspection, sensory exam with monofilament AND pulse exam.

Supporting Definitions: (none)

Technical Specifications

ShortName:	FootExam
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	Null
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6632 **Name:** Foot Exam Date

Coding Instructions: Indicate the date the patient received a foot exam.

Target Value: Any occurrence between 12 month prior to current encounter and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	FootExam_Date
Parent Seq #:	6630
Parent Name:	Foot Exam (Within the Past 12 Months)
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6640 **Name:** Monofilament Exam

Coding Instructions: Indicate if the patient received a monofilament exam within the past 12 months.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	MonofilExam
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	Null
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6650 **Name:** Pulse Exam

Coding Instructions: Indicate if the patient received a pulse exam within the past 12 months.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	PulseExam
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	Null
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6660 **Name:** Ankle Brachial Index Test

Coding Instructions: Indicate if the patient received an ankle brachial index test within the past 12 months.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	ABI_Performed
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	Null
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6670 **Name:** Negative dilated or retinal eye exam

Coding Instructions: Indicate if the patient has had a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) within the past 24 months.

Target Value: Any occurrence between 24 months prior to current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No - Not documented	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	NegRetDiaExam
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	Null
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6680 **Name:** Retinal or Dilated Eye Exam

Coding Instructions: Indicate if the patient has had an eye exam with an eye care provider within the past 12 months.

Target Value: Any occurrence between 12 month prior to current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No - Not documented	Indicate if there was no documentation of a retinal or dilated eye exam by an Eye Care Professional or the documentation did not include any of the following: 1) Retinal or dilated eye exam interpretation by an ophthalmologist or optometrist was documented and reviewed. 2) Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed. 3) Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed.
1	Yes	Indicate if the Retinal or Dilated Eye Exam was Performed by an Eye Care Professional. This must include one of the following: 1) Retinal or dilated eye exam interpretation by an ophthalmologist or optometrist was documented and reviewed. 2) Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed. 3) Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed.

Supporting Definitions: (none)

Technical Specifications

ShortName:	RetDiaExam
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	Null
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6682 **Name:** Retinal or Dilated Eye Exam Date

Coding Instructions: Indicate the date the patient received an eye exam.

Target Value: Any occurrence between 12 month prior to current encounter and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	EyeExam_Date
Parent Seq #:	6680
Parent Name:	Retinal or Dilated Eye Exam
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6700 **Name:** Insulin Pump

Coding Instructions: Indicate if a patient has been prescribed to start or continue to use an insulin pump.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: **Insulin Pump:**

The insulin pump is not an artificial pancreas (because you still have to monitor your blood glucose level).

Source: ADA

Technical Specifications

ShortName:	InsulinPmp
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6702 **Name:** Insulin Pump Date

Coding Instructions: Indicate the date the patient was prescribed to start or continue use of an insulin pump.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	InsulinPmp_Date
Parent Seq #:	6700
Parent Name:	Insulin Pump
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6710 **Name:** Continuous Glucose Monitoring

Coding Instructions: Indicate if the patient has been prescribed to start or continue continuous glucose monitoring.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	ContGluMonitor
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6712 **Name:** Continuous Clucose Monitoring Date

Coding Instructions: Indicate the date the patient was prescribed to start or continue continuous glucose monitoring.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	ContGluMonitor_Date
Parent Seq #:	6710
Parent Name:	Continuous Glucose Monitoring
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6720 **Name:** Device ID

Coding Instructions: Reserved for Future Use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DeviceID
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Integer (5)
Default Value:	NULL
Usual Range:	
Valid Range:	1-99999
DataSource:	User

Seq. #: 6730 **Name:** Device Manufacturer

Coding Instructions: Reserved for Future Use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DevMfr
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Text (100)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6740 **Name:** Device Model

Coding Instructions: Reserved for Future Use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DevModel
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Text (100)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6900 **Name:** Body Mass Index Screening

Coding Instructions: Indicate if the patient had a Body Mass Index screening was performed.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	BMIScreening
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 6902 **Name:** Body Mass Index Screening Date

Coding Instructions: Indicate the most recent documented date a Body Mass Index screening was performed.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	BMIScreening_Date
Parent Seq #:	6900
Parent Name:	Body Mass Index Screening
Parent Value:	Yes
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

D. Encounter Information

Seq. #: 6910 **Name:** Body Mass Index Management Plan

Coding Instructions: Indicate if the patient has a documented BMI management plan.

Note(s):

A BMI management plan may include the following: documentation of future appointment, education, referral, prescription/administration of medication/dietary supplements, weight loss surgery.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	BMIManagement_Plan
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 8000 **Name:** Prescription given for any Medication

Coding Instructions: This element has been retired effective v1.4.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	RxEncounter
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 8005 **Name:** Prescription generated and transmitted using an e-prescribing system

Coding Instructions: This element has been retired effective v1.4.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Erx
Parent Seq #:	8000
Parent Name:	Prescription given for any Medication
Parent Value:	Yes
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7000 **Name:** Lipid Panel Obtained Date

Coding Instructions: Indicate all dates lipid panels were obtained.

For measure calculation purposes use the patient's most recent lipid panel.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LipidPanelDate
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7005 **Name:** Lipid Panel Fasting

Coding Instructions: This element has been retired effective v1.4

Target Value: The last value between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	LipidPanelFasting
Parent Seq #:	7000
Parent Name:	Lipid Panel Obtained Date
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7010 **Name:** Total Cholesterol

Coding Instructions: Indicate all patient cholesterol levels in milligrams per deciliter (mg/dL) for lipid panels.

For measure calculation purposes use the patient's most recent cholesterol in milligrams per deciliter (mg/dL) for the most recent lipid panel.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	TotalCholesterol
Parent Seq #:	7000
Parent Name:	Lipid Panel Obtained Date
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (4)
Default Value:	NULL
Usual Range:	
Valid Range:	1-1000
DataSource:	User

E. Laboratory Results

Seq. #: 7020 **Name:** High Density Lipoprotein (HDL)

Coding Instructions: Indicate all patient high density lipoproteins (HDL) in milligrams per deciliter (mg/dL) for the lipid panels.

For measure calculation purposes use the patient's most recent high density lipoproteins (HDL) in milligrams per deciliter (mg/dL) for the most recent lipid panel.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	HDL
Parent Seq #:	7000
Parent Name:	Lipid Panel Obtained Date
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	1-300
DataSource:	User

Seq. #: 7030 **Name:** Low Density Lipoprotein (LDL)

Coding Instructions: Indicate all patient low density lipoproteins (LDL) in milligrams per deciliter (mg/dL) for lipid panels.

For measure calculation purposes use the patient's most recent low density lipoproteins (LDL) in milligrams per deciliter (mg/dL) for the most recent lipid panel.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LDL
Parent Seq #:	7000
Parent Name:	Lipid Panel Obtained Date
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	1-800
DataSource:	User

Seq. #: 7040 **Name:** Direct Low Density Lipoprotein (DLDL)

Coding Instructions: Indicate all patient direct low density lipoproteins (LDL) in milligrams per deciliter (mg/dL).

For measure calculation purposes use the patient's most recent direct low density lipoproteins (LDL) in milligrams per deciliter (mg/dL) for the most recent lipid panel.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DLDL
Parent Seq #:	7000
Parent Name:	Lipid Panel Obtained Date
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (4)
Default Value:	NULL
Usual Range:	
Valid Range:	1-7000
DataSource:	User

E. Laboratory Results

Seq. #: 7050 **Name:** Triglycerides

Coding Instructions: Indicate all patient triglycerides in milligrams per deciliter (mg/dL).

For measure calculation purposes use the patient's most recent triglycerides in milligrams per deciliter (mg/dL) for the most recent lipid panel.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Triglycerides
Parent Seq #:	7000
Parent Name:	Lipid Panel Obtained Date
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (4)
Default Value:	NULL
Usual Range:	
Valid Range:	1-7000
DataSource:	User

Seq. #: 7052 **Name:** Lipid Panel Ordered

Coding Instructions: This element has been retired effective v1.4

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	LipidPanelOrdered
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7054 **Name:** Serum Glucose Ordered

Coding Instructions: This element has been retired effective v1.4.

Target Value: The last value between birth and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	GlucoseOrdered
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7056 **Name:** Glucose Date

Coding Instructions: This element has been retired effective v1.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SerumGlucoseDate
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7058 **Name:** Glucose

Coding Instructions: This element has been retired effective v1.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SerumGlucose
Parent Seq #:	7056
Parent Name:	Glucose Date
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Integer (4)
Default Value:	NULL
Usual Range:	
Valid Range:	1-1500
DataSource:	User

Seq. #: 7060 **Name:** Glucose Timing

Coding Instructions: Indicate all patient timing of serum glucose tests with respect to food intake.

For measure calculation purposes use the patient's most recent serum glucose.

Target Value: Any occurrence between birth and start of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Fasting	
2	2 hr Glucose Tolerance Testing	Selection Retired (v1.4)
3	Random	
4	Unknown	Selection Retired (v1.4)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SerumGlucoseTiming
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7070 **Name:** Plasma Glucose Results

Coding Instructions: Indicate all patient plasma glucose levels in milligrams per deciliter (mg/dL) for all plasma glucose tests.

For measure calculation purposes indicate the patient's plasma glucose level in milligrams per deciliter (mg/dL) for the most recent plasma glucose test.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PlasGluRes
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (6,2)
Default Value:	NULL
Usual Range:	
Valid Range:	1.00-1500.00
DataSource:	User

Seq. #: 7072 **Name:** Plasma Glucose Results Date

Coding Instructions: Indicate all dates for plasma glucose tests.

For measure calculation purposes indicate the date blood was drawn for the most recent plasma glucose test.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PlasGluRes_Date
Parent Seq #:	7070
Parent Name:	Plasma Glucose Results
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7080 **Name:** HbA1c Percentage

Coding Instructions: Indicate all patient Hemoglobin A1c (HbA1c) percentages from Hemoglobin A1c (HbA1c) tests.

For measure calculation purposes indicate the patient's Hemoglobin A1c (HbA1c) percentage for the most recent Hemoglobin A1c (HbA1c) test.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	HbA1c
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (4,1)
Default Value:	NULL
Usual Range:	
Valid Range:	0.1-100.0
DataSource:	User

E. Laboratory Results

Seq. #: 7082 **Name:** HbA1c Date

Coding Instructions: Indicate all dates for which Hemoglobin A1c (HbA1c) percentage from Hemoglobin A1c (HbA1c) tests were given.

For measure calculation purposes indicate the date blood was drawn for the most recent Hemoglobin A1c (HbA1c) test.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	HbA1cDate
Parent Seq #:	7080
Parent Name:	HbA1c Percentage
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7090 **Name:** 2 Hour Plasma Glucose During Oral Glucose Tolerance Test

Coding Instructions: Indicate all patient 2 hour plasma glucose during oral glucose tolerance tests in mg/dL.

For measure calculation purposes indicate the patient's most recent 2 hour plasma glucose during oral glucose tolerance tests in mg/dL.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: **PAD:**

PAD excludes renal, coronary, cerebral, and mesenteric vessels and aneurysm. Major symptoms can include
- Asymptomatic (confirmed by noninvasive diagnostic test)
- Claudication relieved by rest
- Ischemic rest pain
- Tissue loss (including ischemic ulcer and/or gangrene)
- Amputation for critical limb ischemia
- Vascular reconstruction, bypass surgery, or percutaneous revascularization in the arteries of the lower extremities
- Positive noninvasive test (e.g., ABI 0.90, ultrasound, MR or CT imaging demonstrating 50% diameter stenosis in any peripheral artery, i.e., aorta, iliac, femoral, popliteal, tibial, peroneal)

Source: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease

Technical Specifications

ShortName:	PlasGluOralTest
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Integer (4)
Default Value:	NULL
Usual Range:	
Valid Range:	1-1500
DataSource:	User

E. Laboratory Results

Seq. #: 7092 **Name:** 2 Hour Plasma Glucose During Oral Glucose Tolerance Test Date

Coding Instructions: Indicate all the dates of the patient's 2 hour plasma glucose during oral glucose tolerance test. For measure calculation purposes indicate the most recent documented date where 2 hour plasma glucose during oral glucose tolerance test was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PlasGluOralTest_Date
Parent Seq #:	7090
Parent Name:	2 Hour Plasma Glucose During Oral Glucose Tolerance Test
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7100 **Name:** Initial Labs ordered for newly diagnosed Heart Failure or patient new to the practice

Coding Instructions: This element has been retired effective v1.5

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
0	No	
1	Yes	

Supporting Definitions: (none)

Technical Specifications

ShortName:	InitialLabsforHF
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (PINN)
Format:	Text (Categorical)
Default Value:	No
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7105 **Name:** Estimated Glomerular Filtration Rate Electronic Medical Record

Coding Instructions: This element has been retired effective v1.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	eGFR_Emr
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	
Valid Range:	0.01-999.99
DataSource:	User

E. Laboratory Results

Seq. #: 7110 **Name:** Potassium

Coding Instructions: Indicate all Potassium (K) levels, in mEq/L. For measure calculation purposes indicate the patient's most recent Potassium (K) level, in mEq/L.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Potassium
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (4,2)
Default Value:	NULL
Usual Range:	1.0-5.0
Valid Range:	0.1-30.0
DataSource:	User

Seq. #: 7112 **Name:** Potassium Date

Coding Instructions: Indicate all dates for which potassium levels were recorded.

For measure calculation purposes indicate the most recent documented date where potassium was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Potassium_Date
Parent Seq #:	7110
Parent Name:	Potassium
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7115 **Name:** Sodium

Coding Instructions: Indicate all sodium (Na) levels, in mEq/L.

For measure calculation purposes indicate the patient's most recent sodium (Na) level, in mEq/L

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Sodium
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	120-150
Valid Range:	1-300
DataSource:	User

E. Laboratory Results

Seq. #: 7117 **Name:** Sodium Date

Coding Instructions: Indicate all dates for which sodium were recorded.

For measure calculation purposes indicate most recent documented date where sodium was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Sodium_Date
Parent Seq #:	7115
Parent Name:	Sodium
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7120 **Name:** B-type Natriuretic Peptide

Coding Instructions: Indicate all patient's BNP levels in pg/mL.

For measure calculation purposes indicate the patient's most recent BNP levels in pg/mL

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Btype
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (5)
Default Value:	NULL
Usual Range:	50-5000
Valid Range:	0-50000
DataSource:	User

Seq. #: 7122 **Name:** B-type Natriuretic Peptide Date

Coding Instructions: Indicate all dates for which B-type Natriuretic Peptide were recorded. For measure calculation purposes indicate the most recent documented date where B-type Natriuretic Peptide was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Btype_Date
Parent Seq #:	7120
Parent Name:	B-type Natriuretic Peptide
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7125 **Name:** N-terminal pro b-type Natriuretic Peptide

Coding Instructions: Indicate all patient's N-terminal pro b-type Natriuretic Peptide levels in pg/mL For measure calculation purposes indicate the patient's most recent N-terminal pro b-type Natriuretic Peptide levels in pg/mL

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Nterminal
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (5)
Default Value:	NULL
Usual Range:	300-35000
Valid Range:	0-50000
DataSource:	User

Seq. #: 7127 **Name:** N-terminal pro b-type Natriuretic Peptide Date

Coding Instructions: Indicate all dates for which N-terminal pro b-type Natriuretic Peptide were recorded.

For measure calculation purposes indicate the most recent documented date where N-terminal pro b-type Natriuretic Peptide was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Nterminal_Date
Parent Seq #:	7125
Parent Name:	N-terminal pro b-type Natriuretic Peptide
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7200 **Name:** Estimated Glomerular Filtration Rate (eGFR)

Coding Instructions: Indicate all estimated glomerular filtration rates in ml/min/m2.

For measure calculation purposes indicate the most recent estimated glomerular filtration rate in ml/min/m2.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	eGFR
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (3,2)
Default Value:	No
Usual Range:	60-120
Valid Range:	1-999
DataSource:	User

E. Laboratory Results

Seq. #: 7202 **Name:** Estimated Glomerular Filtration Rate (eGFR) Date

Coding Instructions: Indicate all dates for which eGFR rates were recorded.
For measure calculation purposes indicate the date of the patient's most recent eGFR.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	eGFR_Date
Parent Seq #:	7200
Parent Name:	Estimated Glomerular Filtration Rate (eGFR)
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7212 **Name:** Evidence of nephropathy Date

Coding Instructions: Indicate all dates for which screening for evidence of nephropathy was recorded.

For measure calculation purposes indicate the date of the patient's most recent evidence of nephropathy.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	EviNephro_date
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7215 **Name:** Estimated Glomerular Filtration Rate Imputed

Coding Instructions: This element has been retired effective v1.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	eGFR_Imputed
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (PINN)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	
Valid Range:	0.01-999.99
DataSource:	User

E. Laboratory Results

Seq. #: 7220 **Name:** Creatinine Clearance

Coding Instructions: Indicate all creatinine clearance in mL/min values.

For measure calculation purposes indicate the most recent document creatinine clearance in mL/min.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	CreatinineClearance
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	
Valid Range:	0.01-999.99
DataSource:	User

Seq. #: 7222 **Name:** Creatinine Clearance Date

Coding Instructions: Indicate all dates for which creatinine clearance rates were recorded.

For measure calculation purposes indicate the most recent documented date where creatinine clearance rate was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	CreatinineClearance_Date
Parent Seq #:	7220
Parent Name:	Creatinine Clearance
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7225 **Name:** Creatinine Clearance Units

Coding Instructions: This element has been retired effective v1.4.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
1	mL/sec	
2	mL/min	
3	mL/hr	
4	mL/24hrs	
5	L/24hrs	
6	g/24hrs	
7	mg/kg/24hrs	

Supporting Definitions: (none)

Technical Specifications

ShortName:	CreatinineClearance_Units
Parent Seq #:	7220
Parent Name:	Creatinine Clearance
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7230 **Name:** Serum Creatinine

Coding Instructions: Indicate all serum creatinine in mg/dL values.

For measure calculation purposes indicate the most recent serum creatinine in mg/dL.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SerumCreatinine
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	
Valid Range:	0.01-999.99
DataSource:	User

Seq. #: 7232 **Name:** Serum Creatinine Date

Coding Instructions: Indicate all dates for which serum creatinine rates were recorded.

For measure calculation purposes indicate the most recent documented date where serum creatinine rate was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SerumCreatinine_Date
Parent Seq #:	7230
Parent Name:	Serum Creatinine
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7300 **Name:** Liver Function Tests - ALT

Coding Instructions: Indicate all patient's ALT (alanine transaminase) in U/L.

For measure calculation purposes indicate the most recent ALT (alanine transaminase) in U/L.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LiverFuncTestALT
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Integer (4)
Default Value:	NULL
Usual Range:	7-56
Valid Range:	1-2000
DataSource:	User

E. Laboratory Results

Seq. #: 7302 **Name:** Liver Function Tests - ALT Date

Coding Instructions: Indicate all dates for which ALT were recorded.

For measure calculation purposes indicate the most recent documented date where ALT test was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LiverFuncTestALT_Date
Parent Seq #:	7300
Parent Name:	Liver Function Tests - ALT
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7310 **Name:** Amylase

Coding Instructions: Indicate all Amylase levels in U/L.

For measure calculation purposes indicate the most recent document Amylase levels in U/L.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Amylase
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	23-140
Valid Range:	1-999
DataSource:	User

Seq. #: 7312 **Name:** Amylase Date

Coding Instructions: Indicate all dates of the patient's amylase result

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Amylase_Date
Parent Seq #:	7310
Parent Name:	Amylase
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7320 **Name:** Liver Function Tests - AST

Coding Instructions: Indicate all AST (aspartate transaminase) in U/L values.

For measure calculation purposes indicate the most recent AST (aspartate transaminase) in U/L.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LiverFuncTestAST
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Integer (4)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7322 **Name:** Liver Function Tests - AST Date

Coding Instructions: Indicate all dates for which AST test were recorded.

For measure calculation purposes indicate the most recent documented date where AST test was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LiverFuncTestAST_Date
Parent Seq #:	7320
Parent Name:	Liver Function Tests - AST
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7340 **Name:** Liver Function Tests - Direct Bilirubin

Coding Instructions: Indicate all Direct Bilirubin in mg/dL values.

For measure calculation purposes indicate the most recent Direct Bilirubin in mg/dL.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LiverFuncTestDB
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Decimal (3,2)
Default Value:	NULL
Usual Range:	0.1-0.3
Valid Range:	0-5
DataSource:	User

E. Laboratory Results

Seq. #: 7342 **Name:** Liver Function Tests - Direct Bilirubin Date

Coding Instructions: Indicate all dates for which Direct Bilirubin test were recorded.

For measure calculation purposes indicate the most recent documented date where Direct Bilirubin test was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LiverFuncTestDB_Date
Parent Seq #:	7340
Parent Name:	Liver Function Tests - Direct Bilirubin
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7350 **Name:** Liver Function Tests - Total Bilirubin

Coding Instructions: Indicate all Total Bilirubin in mg/dL values.

For measure calculation purposes indicate the most recent document Total Bilirubin in mg/dL.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LiverFuncTestTB
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Decimal (3,2)
Default Value:	NULL
Usual Range:	0.3-1.0
Valid Range:	0.1-30
DataSource:	User

Seq. #: 7352 **Name:** Liver Function Tests - Total Bilirubin Date

Coding Instructions: Indicate all dates for which Total Bilirubin test were recorded.

For measure calculation purposes indicate the most recent documented date where Total Bilirubin was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	LiverFuncTestTB_Date
Parent Seq #:	7350
Parent Name:	Liver Function Tests - Total Bilirubin
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7360 **Name:** Blood Urea Nitrogen (BUN)

Coding Instructions: Indicate all Blood Urea Nitrogen (BUN) levels. Blood urea nitrogen (BUN) is a waste product in the blood from the breakdown of protein. The kidneys filter blood to remove urea. As kidney function decreases, the BUN levels increase.

For measure calculation purposes indicate the most recent Blood Urea Nitrogen (BUN) level.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: **BUN:**

Blood urea nitrogen (BUN) is a waste product in the blood from the breakdown of protein. The kidneys filter blood to remove urea. As kidney function decreases, the BUN levels increase.

Source: ADA

Technical Specifications

ShortName:	BUN
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Integer (2)
Default Value:	NULL
Usual Range:	5-24
Valid Range:	1-99
DataSource:	User

Seq. #: 7362 **Name:** Blood Urea Nitrogen (BUN) Date

Coding Instructions: Indicate all dates for which Blood Urea Nitrogen (BUN) was recorded. For measure calculation purposes indicate the most recent documented date where Blood Urea Nitrogen (BUN) was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	BUN_Date
Parent Seq #:	7360
Parent Name:	Blood Urea Nitrogen (BUN)
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7370 **Name:** Cystatin-C (Cystatin)

Coding Instructions: Indicate all cystatin-C (cystatin) values.

For measure calculation purposes indicate the most recent cystatin-C.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Cystatin
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Decimal (3,2)
Default Value:	NULL
Usual Range:	0.57-1.52
Valid Range:	0.01-9.99
DataSource:	User

E. Laboratory Results

Seq. #: 7372 **Name:** Cystatin-C (Cystatin) Date

Coding Instructions: Indicate all dates for which Cystatin were recorded.

For measure calculation purposes indicate the date of the patient's most recent Cystatin.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Cystatin_Date
Parent Seq #:	7370
Parent Name:	Cystatin-C (Cystatin)
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7380 **Name:** High-Sensitivity C-Reactive Protein (hs-CRP)

Coding Instructions: Indicate all high-sensitivity C-reactive protein in mg/L.

For measure calculation purposes indicate the most recent C-reactive protein in mg/L.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	hsCRP
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Decimal (3,2)
Default Value:	NULL
Usual Range:	0.1-10
Valid Range:	0.01-50
DataSource:	User

Seq. #: 7382 **Name:** High-Sensitivity C-Reactive Protein (hs-CRP) Date

Coding Instructions: Indicate all dates for which hs-CRP test were recorded.

For measure calculation purposes indicate the most recent documented date where hs-CRP test was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	hsCRP_Date
Parent Seq #:	7380
Parent Name:	High-Sensitivity C-Reactive Protein (hs-CRP)
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7390 **Name:** Lipase

Coding Instructions: Indicate all Lipase levels in U/L.

For measure calculation purposes indicate the most recent Lipase level in U/L.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Lipase
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Integer (4)
Default Value:	NULL
Usual Range:	10-180
Valid Range:	1-3000
DataSource:	User

Seq. #: 7392 **Name:** Lipase Date

Coding Instructions: Indicate all dates for which lipase results were recorded.

For measure calculation purposes indicate the most recent documented date where lipase results was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Lipase_Date
Parent Seq #:	7390
Parent Name:	Lipase
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7400 **Name:** Thyroid-Stimulating Hormone (TSH)

Coding Instructions: Indicate all thyroid-stimulating hormone tests in mIU/L values.

For measure calculation purposes indicate the most recent thyroid-stimulating hormone test in mIU/L.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	TSH
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Decimal (3,2)
Default Value:	NULL
Usual Range:	0.4-2.5
Valid Range:	0.1-9.9
DataSource:	User

E. Laboratory Results

Seq. #: 7402 **Name:** Thyroid-Stimulating Hormone (TSH) Date

Coding Instructions: Indicate all dates for which TSH tests were recorded.

For measure calculation purposes indicate the most recent documented date where TSH test was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	TSH_Date
Parent Seq #:	7400
Parent Name:	Thyroid-Stimulating Hormone (TSH)
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7410 **Name:** Uric Acid

Coding Instructions: Indicate all uric acid values.

For measure calculation purposes indicate the most recent uric acid.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	UricAcid
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	2.4-7.2
Valid Range:	0.1-999.9
DataSource:	User

Seq. #: 7412 **Name:** Uric Acid Date

Coding Instructions: Indicate all dates for which Uric Acid tests were recorded.

For measure calculation purposes indicate the most recent documented date where Uric Acid test was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	UricAcid_Date
Parent Seq #:	7410
Parent Name:	Uric Acid
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7420 **Name:** 24 Hour Urine Protein

Coding Instructions: Indicate all 24 hour urine protein values in mg/24 hours.

For measure calculation purposes indicate the most recent 24 hour urine protein.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	UrineProtein
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	10-229
Valid Range:	1-600
DataSource:	User

Seq. #: 7422 **Name:** 24 Hour Urine Protein Date

Coding Instructions: Indicate all dates for which urine protein tests were recorded.

For measure calculation purposes indicate the most recent documented date where urine protein test was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	UrineProtein_Date
Parent Seq #:	7420
Parent Name:	24 Hour Urine Protein
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7430 **Name:** Urine albumin:creatinine ratio (UACR)

Coding Instructions: Indicate all urine albumin:creatinine ratio (UACR) values in mg/g for 24 hour period.

For measure calculation purposes indicate the most recent urine albumin:creatinine ratio.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: **Urine albumin:**

Creatinine ratio is a test for levels of albumin and creatinine in the blood as an indicator of nephropathy.
Albuminuria is a condition in which the urine has more than normal amounts of a protein called albumin.
Albuminuria may be a sign of nephropathy (kidney disease)

Source: ADA

Creatinine:

Creatinine is a waste product from protein in the diet and from the muscles of the body. Creatinine is removed from the body by the kidneys; as kidney disease progresses, the level of creatinine in the blood increases.

Source: ADA

Technical Specifications

ShortName:	UACR
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	1-30
Valid Range:	1-999
DataSource:	User

Seq. #: 7432 **Name:** Urine albumin:creatinine ratio (UACR) Date

Coding Instructions: Indicate all dates for which urine albumin tests were recorded.

For measure calculation purposes indicate the most recent documented date where urine albumin was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	UACR_Date
Parent Seq #:	7430
Parent Name:	Urine albumin:creatinine ratio (UACR)
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7500 **Name:** Complete Blood Count - White Blood Cells (WBC)

Coding Instructions: Indicate all white blood cell (WBC) counts.

For measure calculation purposes indicate the most recent white blood cell count.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	WBC
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Integer (5)
Default Value:	NULL
Usual Range:	3500-10500
Valid Range:	1-99999
DataSource:	User

Seq. #: 7502 **Name:** Complete Blood Count - White Blood Cells (WBC) Date

Coding Instructions: Indicate all dates for which white blood cell counts were recorded.

For measure calculation purposes indicate the most recent documented date where white blood cell count was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	WBC_Date
Parent Seq #:	7500
Parent Name:	Complete Blood Count - White Blood Cells (WBC)
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7510 **Name:** Complete Blood Count - Hemoglobin (HgB)

Coding Instructions: Indicate all Hemoglobin (HgB) counts.

For measure calculation purposes indicate the most recent Hemoglobin (HgB) count.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	HgB
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Decimal (3,1)
Default Value:	NULL
Usual Range:	12-17.5
Valid Range:	0.1-99.9
DataSource:	User

E. Laboratory Results

Seq. #: 7512 **Name:** Complete Blood Count - Hemoglobin (HgB) Date

Coding Instructions: Indicate all dates for which hemoglobin counts were recorded.

For measure calculation purposes indicate the most recent documented date where hemoglobin count was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	HgB_Date
Parent Seq #:	7510
Parent Name:	Complete Blood Count - Hemoglobin (HgB)
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7520 **Name:** Complete Blood Count - Hematocrit

Coding Instructions: Indicate all Hematocrit counts.

For measure calculation purposes indicate the most recent Hematocrit count.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Hematocrit
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Decimal (4,1)
Default Value:	NULL
Usual Range:	34.9-50
Valid Range:	0.1-100
DataSource:	User

Seq. #: 7522 **Name:** Complete Blood Count - Hematocrit Date

Coding Instructions: Indicate all dates for which hematocrit counts were recorded.

For measure calculation purposes indicate the most recent documented date where hematocrit count was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Hematocrit_Date
Parent Seq #:	7520
Parent Name:	Complete Blood Count - Hematocrit
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

E. Laboratory Results

Seq. #: 7530 **Name:** Complete Blood Count - Platelet

Coding Instructions: Indicate all platelet counts.

For measure calculation purposes indicate the most recent platelet count.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Platelet
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Integer (6)
Default Value:	NULL
Usual Range:	150000-400000
Valid Range:	1000-900000
DataSource:	User

Seq. #: 7532 **Name:** Complete Blood Count - Platelet Date

Coding Instructions: Indicate all dates for which hematocrit counts were recorded.

For measure calculation purposes indicate the most recent documented date where hematocrit count was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Platelet_Date
Parent Seq #:	7530
Parent Name:	Complete Blood Count - Platelet
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7542 **Name:** C-Peptide

Coding Instructions: Indicate all C-peptide values in ng/mL.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Cpeptide
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	0.8-3.1
Valid Range:	0.1-100
DataSource:	User

E. Laboratory Results

Seq. #: 7546 **Name:** C-Peptide Date

Coding Instructions: Indicate all dates for which C-peptide were recorded.

For measure calculation purposes indicate the most recent documented date where hematocrit count was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Cpeptide_Date
Parent Seq #:	7542
Parent Name:	C-Peptide
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7548 **Name:** Insulin

Coding Instructions: Indicate all Insulin values in mIU/L. The insulin level being recorded is fasting insulin.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Insulin
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Integer (2)
Default Value:	NULL
Usual Range:	0-25
Valid Range:	0-50
DataSource:	User

Seq. #: 7550 **Name:** Insulin Date

Coding Instructions: Indicate all dates for which insulin were recorded.

For measure calculation purposes indicate the most recent documented date where hematocrit count was recorded.

Target Value: Any occurrence between birth and start of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Insulin_Date
Parent Seq #:	7548
Parent Name:	Insulin
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

F. Medications

Seq. #: 9300 **Name:** Medication ID

Coding Instructions: Indicate the NCDR-assigned IDs for the medications the patient was prescribed.

Target Value: The value between start of current encounter and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	MedID
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	1-999
DataSource:	User

Seq. #: 9301 **Name:** Dose Strength

Coding Instructions: Indicate the dosing strength for each medication that is prescribed/continued.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DoseStrength
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (6,2)
Default Value:	NULL
Usual Range:	
Valid Range:	0.01-9999.99
DataSource:	User

Seq. #: 9302 **Name:** Dosing Measure

Coding Instructions: Indicate the dosage measurement for each medication prescribed/continued (eg. g, mg).

Target Value: The last value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	mg	
2	g	
3	micrograms	
4	units	

Supporting Definitions: (none)

Technical Specifications

ShortName:	DosMeasure
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

F. Medications

Seq. #: 9303 **Name:** Dose Frequency

Coding Instructions: Indicate the frequency for which the patient should take the prescribed medication dosage.

Target Value: The last value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	once daily	
2	twice daily	
3	three times daily	
4	four times daily	
5	five times daily	
6	with meals	
7	once every other day	
8	once weekly	
9	twice weekly	
10	three times weekly	

Supporting Definitions: (none)

Technical Specifications

ShortName:	DoseFrqncy
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 9305 **Name:** Medication Administered

Coding Instructions: Indicate if the medication was prescribed/continued or was not prescribed for either a medical, system, or patient reason.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	Medications was administered or prescribed.
4	No - Patient Reason	Unable to administer/prescribe due to a patient reason such as patient refusal of medication. Patient reason may include religious
5	No - Medical Reason	Unable to administer/prescribe due to a medical reason such as an allergies, contraindications side effects, intolerances, medical interactions, and safety concerns.
6	No - System Reason	Unable to administer/prescribe due to system reason such as not available in the formulary.

Supporting Definitions: (none)

Technical Specifications

ShortName:	MedAdmin
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

F. Medications

Seq. #: 9307 **Name:** Source Medication Code

Coding Instructions: Indicate the source medication code used to document the medication prescription in the native EHR encounter record.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	OtherMedCode
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 9309 **Name:** Source Medication Code System

Coding Instructions: Indicate the source medication code system used to code the medication prescription in the native EHR encounter record including the following coding systems: GPI, MMSL, NDC (NDDF), RxNorm, and SNOMED-CT coding devices.

Target Value: The last value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	GPI	
2	MMSL	
3	NDC	
4	RxNorm	
5	SNOMED-CT	
6	OTHER	

Technical Specifications

ShortName:	OtherMedCodeSys
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Supporting Definitions: **Other Medication Code System:**

EHRs use a range of medication coding systems to document prescribed medications. These coding systems have varying coding structures and include the following systems:

GPI (Generic Product Identifier) – "The Generic Product Identifier (GPI) from Medi-Span is 14 characters made up of 7 couplets." Source: Pharmacy Healthcare Solutions, Inc. (http://phsirx.com/blog/gpi-vs-gsn)

MMSL (Multum MediSource Lexicon) – "The Multum Medisource Lexicon was created and is maintained by Multum, a medical information company. The Lexicon is a foundational database with comprehensive drug product and disease nomenclature information. It includes drug names, drug product information, disease names, coding systems such as ICD-9-CM and NDC, generic names, brand names and common abbreviations. A comprehensive list of standard or customized disease names and ICD-9 codes is also included." Source: Unified Medical Language System (UMLS) (https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/MMSL/)

NDC (National Drug Code)/NDDF (FDB MedKnowledge (formerly NDDF Plus) – "The Drug Listing Act of 1972 requires registered drug establishments to provide the Food and Drug Administration (FDA) with a current list of all drugs manufactured, prepared, propagated, compounded, or processed by it for commercial distribution. (See Section 510 of the Federal Food, Drug, and Cosmetic Act (Act) (21 U.S.C. § 360)). Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for drugs. FDA publishes the listed NDC numbers and the information submitted as part of the listing information in the NDC Directory which is updated daily." Source: U.S Food and Drug Administration (http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm)

RxNorm – "RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Drug Database, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary.
RxNorm now includes the National Drug File - Reference Terminology (NDF-RT) from the Veterans Health Administration. NDF-RT is a terminology used to code clinical drug properties, including mechanism of action, physiologic effect, and therapeutic category." Source U.S. National Library of Medicine (https://www.nlm.nih.gov/research/umls/rxnorm/)

SNOMED-CT: "SNOMED CT is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information and is also a required standard in interoperability specifications of the U.S. Healthcare Information Technology Standards Panel. The clinical terminology is owned and maintained by the International Health Terminology Standards Development Organisation (IHTSDO), a not-for-profit association." Source U.S. National Library of Medicine (https://www.nlm.nih.gov/healthit/snomedct/)

Source:

G. Hospitalizations

Seq. #: 9315 **Name:** Most Recent Prescription Date

Coding Instructions: Indicate the most recent date for which the medication was prescribed or renewed.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	RxDate
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 9500 **Name:** Hospital Admission Date

Coding Instructions: Indicate the most recent date of admission to a hospital or other acute healthcare facility for the patient.

Target Value: The last value between birth and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	HospitalAdmit_Date
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 9502 **Name:** Hospital Discharge Date

Coding Instructions: Indicate the date the patient was discharged from the most recent hospitalization admission.

Target Value: The last value between birth and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	HospitalDCDate
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

G. Hospitalizations

Seq. #: 9505 **Name:** Primary Reason for Admission

Coding Instructions: Indicate the primary diagnosis of the event that prompted the most recent hospitalization admission, as determined by the judgment of the investigator. Utilize latest ICD code (e.g., ICD-9 or ICD-10). May be the same as principal discharge diagnosis.

Target Value: The last value between birth and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Admission_Reason_Code
Parent Seq #:	9500
Parent Name:	Hospital Admission Date
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 9507 **Name:** Secondary Diagnosis

Coding Instructions: Indicate the secondary diagnosis of the even that prompted the most recent hospitalization admission, as determined by the judgement of the investigator if a secondary diagnosis is made. Utilize latest ICD code (e.g., ICD-9 or ICD-10). May be the same as principal discharge diagnosis.

Target Value: The last value between birth and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SecondDiag
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 9510 **Name:** Coding Standard

Coding Instructions: Indicate the coding standard used in recording admission reason.

Target Value: The last value between birth and current encounter

Selections:

Code	*Selection Text*	*Definition*
1	ICD-9	
2	ICD-10	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Coding_Standard
Parent Seq #:	9505
Parent Name:	Primary Reason for Admission
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Z. Administration

Seq. #: 1000 **Name:** Data File Name

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DataFile_Name
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Text (100)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1005 **Name:** Data File Creation Date Time

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DataFile_CreationDtTime
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1010 **Name:** Data File Total Visits

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Datafile_TotalVisits
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Integer (9)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Z. Administration

Seq. #: 1015 **Name:** Data File Source Identification Number

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Datafile_SourceID
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1020 **Name:** Practice Total Visits

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Practice_TotalVisits
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Integer (9)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1021 **Name:** Timeframe of Data Submission

Coding Instructions: Indicate the time frame of data included in the data submission. Format: YYYYQQ. e.g.,2013Q4

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Timeframe
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (6)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Z. Administration

Seq. #: 1025 **Name:** Location Total Visits

Coding Instructions: This element has been retired effective PINNACLE v1.3.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Location_TotalVisits
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Integer (9)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1030 **Name:** Encounter Unique Key

Coding Instructions: Indicate the unique key associated with each patient encounter as assigned by the EMR/EHR or your software application.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	EncounterKey
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1040 **Name:** Transmission Number

Coding Instructions: This is a unique number created, and automatically inserted by the software into export file. It identifies the number of times the software has created a data submission file. The transmission number should be incremented by one every time the data submission files are exported. The transmission number should never be repeated.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	XmsnId
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Integer (9)
Default Value:	NULL
Usual Range:	
Valid Range:	1-999999999
DataSource:	Automatic

Z. Administration

Seq. #: 1050 **Name:** Vendor Identifier

Coding Instructions: Vendor identification (agreed upon by mutual selection between the vendor and the NCDR) to identify software vendor. This is entered into the schema automatically by vendor software. Vendors must use consistent name identification across sites. Changes to vendor name identification must be approved by the NCDR.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	VendorId
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (15)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1060 **Name:** Vendor Software Version

Coding Instructions: Vendor's software product name and version number identifying the software which created this record (assigned by vendor). Vendor controls the value in this field. This is entered into the schema automatically by vendor software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	VendorVer
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1070 **Name:** Registry Identifier

Coding Instructions: The NCDR registry identifier describes the data registry to which these records apply. It is implemented in the software at the time the data is collected and records are created. This is entered into the schema automatically by software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	RegistryId
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	ACC-NCDR-PINN
Usual Range:	
Valid Range:	
DataSource:	Automatic

Z. Administration

Seq. #: 1080 **Name:** Registry Version

Coding Instructions: Registry version describes the version number of the Data Specifications/Dictionary, to which each record conforms. It identifies which fields should have data, and what are the valid data for each field. It is the version implemented in the software at the time the data is collected and the records are created. This is entered into the schema automatically by software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	RegistryVer
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (10)
Default Value:	1.5
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1095 **Name:** Submission Type

Coding Instructions: Indicate if the data contained in the harvest/data file contains PINNACLE registry records, diabetic records, or all patient encounter records.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
1	All Encounter Records	Contains all patients and all encounter records with eligible visits to the physician office with an Encounter Date.
2	PINNACLE Encounter Records Only	Contains all completed PINNACLE dataset for all patients and all encounter records with eligible visits to the physician office with an Encounter Date.
3	Diabetes Encounter Records Only	Contains all completed PINN-Diabetes Collaborative Registry (DCR) dataset for all patients and all encounter records with eligible visits to the physician office with an Encounter Date.

Supporting Definitions: (none)

Technical Specifications

ShortName:	SubmissionType
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 1100 **Name:** Source EHR

Coding Instructions: Indicate the EHR system the data was extracted or provided from at the time of the data was extracted or provided from the EHR.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SourceEHR
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Z. Administration

Seq. #: 1520 **Name:** Practice ID

Coding Instructions: Indicate the Practice Identification number assigned to the Practice by the ACC-NCDR.

Note(s):

The Practice ID will display in the General Information Section of the data collection form however the coding instructions will move to Administration Section in the data dictionary.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PracticeID
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Integer (6)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1521 **Name:** Practice Name

Coding Instructions: Indicate the full name of the practice.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PracName
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic