

### 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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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 arrival at this facility

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

**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/CoMorbodies

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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/CoMorbodies

**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/CoMorbodies

**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/CoMorbidity

**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/CoMorbodies

**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/CoMorbodies

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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/CoMorbodies

**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/CoMorbodies

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	0	No	
	1	Yes	

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

Unstable angina requiring hospitalization is defined as:

- 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
- 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)
- At least one of the following:
  - 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.
  - 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.
  - 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.
  - 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.
- 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/CoMorbodies

**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  $\leq$  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/CoMorbodies

**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:** PADAcuteLimbsch

**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:** PADAcuteLimbsch\_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/CoMorbodies

**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:** PADCritLimblsch

**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/CoMorbodies

#### 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:** PADCritLimbsch\_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/CoMorbodies

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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



### B. Diagnoses/Conditions/CoMorbodies

#### 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

#### 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



### B. Diagnoses/Conditions/CoMorbodies

**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

**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

### B. Diagnoses/Conditions/CoMorbodies

**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

**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 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:** 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

### B. Diagnoses/Conditions/CoMorbodies

**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

**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 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:** 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

### B. Diagnoses/Conditions/CoMorbodies

#### 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 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:** 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

#### 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/CoMorbodies

**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/CoMorbodies

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

**Coding Instructions:** Indicate if the patient has documented chronic kidney disease.

**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 documented date of diagnosis of chronic kidney disease. If no diagnosis date is recorded, indicate the first encounter date where chronic kidney 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:** 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/CoMorbodies

**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

**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

### B. Diagnoses/Conditions/CoMorbodies

**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

**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



### B. Diagnoses/Conditions/CoMorbodies

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

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

**Target Value:** N/A

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

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

**Coding Instructions:** Indicate if the patient has documented gastroparesis.

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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

### B. Diagnoses/Conditions/CoMorbodies

**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

**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

B. Diagnoses/Conditions/CoMorbodities

**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

### 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  $\geq 0.02$  seconds or QS complex in leads V2 and V3.
- b. Q-wave  $\geq 0.03$  seconds and  $\geq 0.1$  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  $\geq 0.04$  seconds in V1-V2 and R/S  $\geq 1$  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:

**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:

#### 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

### **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 of 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 of 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

### C. Event

#### 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 I, 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

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

**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



### D. Encounter Information

**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

**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



### D. Encounter Information

**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

**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

### D. Encounter Information

**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

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

### D. Encounter Information

**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

**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

### D. Encounter Information

**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).

**Target Value:** The value on current encounter

Selections:	Code	Selection Text	Definition
	1	Never	
	2	Current	
	3	Quit within past 12 months	
	4	Quit more than 12 months ago	
	5	Tobacco Screening not performed for medical reasons	

**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

**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	
	1	Yes	

**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	
	1	Yes	

**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

### D. Encounter Information

**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	
	1	Yes	

**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

**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	
	1	Yes	

**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	
	1	Yes	

**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

### D. Encounter Information

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

**Coding Instructions:** Indicate if 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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

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

**Coding Instructions:** Indicate the patient estimate of alcohol consumption.

**Target Value:** The value on current encounter

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

### D. Encounter Information

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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.

**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

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

### D. Encounter Information

**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

**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	
	3	No Counseling or Education - Medical Reason	
	1	Yes	

**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



### D. Encounter Information

#### 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	

**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

#### 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	

**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	

**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	

**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	

**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

#### 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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	0	No	
	1	Yes	

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	0	No	
	1	Yes	

**Supporting Definitions:** (none)

#### Technical Specifications

**ShortName:** OtherHFActivityAssmntCompleted

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

**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

### D. Encounter Information

**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

**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



### D. Encounter Information

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

### D. Encounter Information

**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, 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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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	

**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

**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

### D. Encounter Information

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	0	No	
	1	Yes	

**Supporting Definitions:** (none)

#### 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

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	0	No	
	1	Yes	

**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

### D. Encounter Information

**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:** SAQAnginaStabilityScore  
**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. #: 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

### D. Encounter Information

**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

**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

### D. Encounter Information

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	0	No	
	1	Yes	

**Supporting Definitions:** (none)

#### Technical Specifications

**ShortName:** Afib\_Etiology\_rev\_c  
ause

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

### D. Encounter Information

**Seq. #: 6522 Name:** Etiology - Pregnancy

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

**Target Value:** N/A

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

**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

### D. Encounter Information

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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



### D. Encounter Information

**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

**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

### D. Encounter Information

**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

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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 Glucose 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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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:** SerumGlucoseTimin  
g

**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 (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 (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 (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 (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 (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 (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.

For measure calculation purposes indicate the most recent estimated glomerular filtration rate in ml/min.

**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:** Integer (3)

**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 (5,2)

**Default Value:** NULL

**Usual Range:** 0-0.3

**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 (4,2)

**Default Value:** NULL

**Usual Range:** 0.05-1.5

**Valid Range:** 0.01-30

**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/dL.

For measure calculation purposes indicate the most recent C-reactive protein in mg/dL.

**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 (5,2)  
**Default Value:** NULL  
**Usual Range:** 0.1-10  
**Valid Range:** 0.01-20  
**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 mg/dL values.

For measure calculation purposes indicate the most recent thyroid-stimulating hormone test in mg/dL.

**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 (5,2)

**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.

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:** Decimal (5,2)

**Default Value:** NULL

**Usual Range:** 1-10

**Valid Range:** 0.1-999.9

**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

**Seq. #: 7430 Name:** Urine albumin:creatinine ratio (UACR)

**Coding Instructions:** Indicate all urine albumin:creatinine ratio (UACR) values.

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



### E. Laboratory Results

**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

**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

### E. Laboratory Results

**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

**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

### E. Laboratory Results

**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

**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:** Decimal (4,1)  
**Default Value:** NULL  
**Usual Range:** 34.9-50  
**Valid Range:** 0.1-100  
**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

### 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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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

#### 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

### F. Medications

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
1		GPI	
2		MMSL	
3		NDC	
4		RxNorm	
5		SNOMED-CT	
6		OTHER	

**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://phsrx.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. #:** 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

**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



### G. Hospitalizations

**Seq. #:** 9507 **Name:** Secondary Diagnosis

**Coding Instructions:** Indicate the secondary diagnosis of the event 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\_CreationDt  
Time

**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

<b>Selections:</b>	<i>Code</i>	<i>Selection Text</i>	<i>Definition</i>
	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. #: 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

Z. Administration

**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