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care experience			Care experience is information that indicates the degree to which a patient's encounter with the healthcare system was patient-centered. It is the result of the interaction between the various people, processes, and communications undertaken in order to meet the individual's care needs, and is a reflection of the degree to which the patient's needs, preferences and values were incorporated into care decisions. Care experience should include patient and family involvement in the design of care, the extent to which the care meets the patient's needs and preferences, and whether decision making is informed and shared with patients (consumers).[i]	*Added category definition to improve clarity*
care experience	patient care experience	Care experience is measured most often with a validated survey tool. The most common tool is the Consumer Assessment of Healthcare Providers and Systems[ii]. A time/date stamp is required.		*No changes*
care experience	provider care experience	Provider care experience gauges provider satisfaction with key structures, processes, and outcomes in the healthcare delivery system. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to gain quantifiable data on provider satisfaction with the performance of Medicare fee-for-service contractors. Most care experience surveys are local. Provider care experience is a factor in provider turnover. A time/date stamp is required.		*No changes*
care goal			A goal is a defined target or measure to be achieved in the process of patient care. A typical goal is expressed as an observation scheduled for some time in the future with a particular value. A goal can be found in the plan of care (care plan). The plan of care (care plan) is the structure used by all stakeholders, including the patient, to define the management actions for	*Added category definition to improve clarity*

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			the various conditions, problems, or issues identified for the target of the plan. It is the structure through which the goals and care planning actions and processes can be organized, planned, communicated, and checked for completion. A time/date stamp is required. Specifically, a care plan is composed of the following elements: - "Problem," which is managed by another standard category (condition/diagnosis/problem) and its related data types. - "Intervention" which is managed by other standard categories (may be a procedure, diagnostic test, medication, substance) and their related data types. - The "goal" is what is expected to happen. - The "outcome" is what happened which can be shown by other standard categories and their related data types.	
care goal	care goal	A goal is a defined target or measure to be achieved in the process of patient care. A typical goal is expressed as an observation scheduled for some time in the future with a particular value.	A goal is a defined target or measure to be achieved in the process of patient care. A typical goal is expressed as an observation scheduled for some time in the future with a particular value. A goal can be found in the plan of care (care plan). The plan of care (care plan) is the structure used by all stakeholders, including the patient, to define the management actions for the various conditions, problems, or issues identified for the target of the plan. It is the structure through which the goals and care planning actions and processes can be organized, planned, communicated, and checked for completion. A time/date stamp is required.	*Definition modified to improve clarity*

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			Specifically, a care plan is composed of the following elements: - "Problem," which is managed by another standard category (condition/diagnosis/problem) and its related data types. - "Intervention" which is managed by other standard categories (may be a procedure, diagnostic test, medication, substance) and their related data types. - The "goal" is what is expected to happen. - The "outcome" is what happened which can be shown by other standard categories and their related data types.	
communication			Communication is the transmission, receipt, and/or acknowledgement of information sent from a source to a recipient.	*Added category definition to improve clarity*
communication	communication: provider to provider	The provision of any communication from one clinician to another regarding findings, assessments, plans of care, consultative advice, instructions, educational resources, etc.		*No changes*
communication	communication: from patient	The receipt of response from a patient with respect to any aspect of the care provided.		*No changes*
communication	communication: from provider to patient	The provision of any communication to the patient. (e.g., results, findings, plans for care, medical advice, instructions, educational resources, appointments, result).		*No changes*
condition/diagnosis/problem		A problem, diagnosis, or condition is a scientific interpretation of result, assessment, and treatment response data that persists over time and tends to require intervention or management. It is used to guide planning, implementation, treatment, and evaluation. A problem or condition includes, but is not limited to chronic conditions, diagnoses, or symptoms, functional limitations, or visit- or stay-specific conditions.		*No changes*

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condition/ diagnosis/ problem	diagnosis, active	An active diagnosis is a problem, diagnosis or condition that is currently monitored, tracked or is a factor that must be considered as part of the treatment plan in progress. A time/date stamp is required.		*No changes*
~~condition/ diagnosis/ problem~~	~~diagnosis, factored risk~~	~~Potential for development of problems or conditions determined by specific factors defined within the measure by the measure developer. Most often these risks can be defined as a composite of several QDS elements that, based on evidence, in combination represent a risk of a specific condition or negative outcome.~~		*Removed data type:* The specific factors used to calculate a patient's risk can each be defined using other existing data types. Factored risk can be managed by a logic statement using existing data types and did not require its own category.
condition/ diagnosis/ problem	diagnosis, family history	Problems, conditions, and diagnoses experienced by a patient's family members whether existing currently or in the past. A time/date stamp is required.		*No changes*
condition/ diagnosis/ problem	diagnosis, inactive		An inactive diagnosis is a problem, diagnosis, or condition that has been present in the past and is currently not under active treatment or causing clinical manifestations, but may require treatment or monitoring in the future (e.g., a cancer diagnosis in remission). A date/time stamp is required.	*Added data type*: "Diagnoses, Conditions or Problems" are expected to be present in the Problem List in an electronic health record. Problem lists

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				should have an attribute of status, specifically active, inactive, and resolved. "Diagnosis past history" is removed and split into two data types ("diagnosis, inactive" and "diagnosis, resolved").
condition/ diagnosis/ problem	diagnosis, resolved		A resolved diagnosis is a problem, diagnosis, or condition that no longer requires treatment and, by its nature is unlikely to recur. A date/time stamp is required.	*Added data type:* "Diagnoses, Conditions, or Problems" are expected to be present in the Problem List in an electronic health record. Problem lists should have an attribute of status, specifically active, inactive, and resolved. "Diagnosis resolved" and "diagnosis inactive" are the two elements derived from the removal of "diagnosis, past history."

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~~condition/ diagnosis/ problem~~	~~diagnosis, past history~~	~~Problems, conditions and diagnoses that have occurred in the past for the patient under treatment.~~		*Removed data type:* "Diagnoses, Conditions or Problems" are expected to be present in the problem list in an electronic health record. Problem lists should have an attribute of status, specifically active, inactive, and resolved. To represent these concepts, the "diagnosis past history" data type is removed and replaced by two data types (diagnosis, inactive and diagnosis resolved).
condition/ diagnosis/ problem	diagnosis, risk-of	Potential for development of problems or conditions, often determined by a risk calculator scale (See: Risk Category/Assessment). A time/date stamp is required.		*Modified definition to improve clarity:* To highlight the distinction between "diagnosis, risk-of" and "risk category/ assessment."

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device		Device has been defined by the Food and Drug Administration (FDA), Department of Health and Human Services. A device is "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is: recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes." This definition provides a clear distinction between a medical device and other FDA-regulated products such as drugs. If the primary intended use of the product is achieved through chemical action or by being metabolized by the body, the product is usually a drug.		*No changes*
device	device, adverse event	In the instance of a quality measure, a device adverse event is an unexpected or dangerous reaction to a device. Serious adverse events are those that are fatal, life-threatening, permanently/significantly disabling, those that require or prolong hospitalization, and those that require intervention to prevent permanent impairment or damage. A time/date stamp is required as are notations indicating whether item is patient reported and/or provider verified.		*No changes*
device	device, allergy	A device allergy is an immunologically mediated reaction that exhibits specificity and recurrence on re-exposure to the		*No changes*

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		offending device (e.g., implanted device). A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.		
device	device, applied	Indication that equipment designed to treat, monitor, or diagnose a patient's status is in use. (e.g., an antithrombotic device has been placed on the patient's legs to prevent thromboembolism, or a cardiac pacemaker is in place.) A time/date stamp is required.		*No changes*
device	device, intolerance	Device intolerance is a reaction in specific patients representing a low threshold to the normal actions of a device. Intolerance is generally based on patient report and perception of his or her ability to tolerate a device that was properly applied. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.		*Definition modified to improve clarity*
~~device~~	~~device, offered~~	~~Equipment designed to treat, monitor or diagnose a patient's status is offered to the patient.~~		*Removed data type:* Anything that is offered to a patient either occurs or it does not occur because a patient has not yet agreed to it. Therefore, a single method for documentation would allow a clinician or patient to indicate a process was not done for a patient reason. If something did not occur, it can be

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				managed by the "negation rationale" data type category. Alternately, if it did occur, then it means it was offered and completed, and hence can be represented by the "result/finding," "order," or "performed" data types.
device	device, order	Equipment designed to treat, monitor, or diagnose a patient's status is ordered. A time/date stamp is required.		*No changes*
diagnostic study			A diagnostic test is any kind of medical test performed as a specific test or series of steps to aid in the diagnosis or detection of disease (e.g., to establish a diagnosis, to measure the progress or recovery from disease, or to confirm that a person is free from disease).[iii] The QDS defines diagnostic studies as those that are not performed in the clinical laboratory. They may make use of digital images and textual reports. Such studies include but are not limited to imaging studies, cardiology studies (electrocardiogram, treadmill stress testing), pulmonary function testing, vascular laboratory testing, and others.	*Added category definition to improve clarity*
diagnostic study	diagnostic study, adverse event	In the instance of a quality measure, a diagnostic study adverse event is an unexpected or dangerous reaction to a diagnostic study. Serious adverse events include those that are disabling, require hospitalization, lead to congenital anomaly, or require intervention to prevent permanent impairment or damage. A time/date stamp is required, as are		*No changes*

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		notations indicating whether the item is patient reported and/or provider verified.		
diagnostic study	diagnostic study, intolerance	Diagnostic study intolerance is a reaction in specific patients who have a low threshold to the normal reported or expected reactions of the study. Intolerance is generally dependent on patient report and patient's perception of his or her ability to tolerate a properly executed diagnostic study. A time/date stamp is required, as are notations indicating whether the item is patient reported and/or provider verified.		*Definition modified to improve clarity*
~~diagnostic study~~	~~diagnostic study, offered~~	~~An offer or suggestion to a patient for a diagnostic study. Diagnostic studies are those that are not performed in the clinical laboratory. Such studies include but are not limited to imaging studies, cardiology studies (electrocardiogram, treadmill stress testing), pulmonary function testing, vascular laboratory testing, and others.~~		*Removed data type:* Anything that is offered to a patient either occurs or does not occur because a patient has not yet agreed to it. A single method for documentation would allow a clinician or patient to indicate a process was not done as a result of a patient opting out of treatment. Offered treatments are managed by negation option.
diagnostic study	diagnostic study, order	A request by a physician or appropriately licensed care provider to an appropriate provider or facility to perform a diagnostic on a patient. The request may be in the form of a		*No changes*

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		consultation or a direct order to the facility or organization that performs the diagnostic study. Diagnostic studies are those that are not performed in the clinical laboratory. Such studies include but are not limited to imaging studies, cardiology studies (electrocardiogram, treadmill stress testing), pulmonary function testing, vascular laboratory testing, and others. A time/date stamp is required.		
diagnostic study	diagnostic study, performed	A diagnostic study has been completed. Diagnostic studies are those that are not performed in the clinical laboratory. Such studies include but are not limited to imaging studies, cardiology studies (electrocardiogram, treadmill stress testing), pulmonary function testing, vascular laboratory testing, and others. A time/date stamp is required.		*No changes*
diagnostic study	diagnostic study, result	The result, described in concepts or numerical values of a diagnostic on a patient. Diagnostic studies are those that are not performed in the clinical laboratory. Such studies include but are not limited to imaging studies, cardiology studies (electrocardiogram, treadmill stress testing), pulmonary function testing, vascular laboratory testing, and others.		*No changes*
encounter			An encounter is an identifiable grouping of healthcare-related activities characterized by the entity relationship between the subject of care and a healthcare provider, such grouping determined by the healthcare provider.[iv] A patient encounter represents interaction between a healthcare provider and a patient as with a face-to-face patient visit to a clinician's office for any form of diagnostic treatment and/or therapeutic event. Encounters can be billable events but are not limited to billable interactions. Each encounter has an associated location and or modality within which it occurred (such as an office, home, electronic methods, phone encounter, and/or telemedicine methods). The encounter location is the	*Added category definition to improve clarity*

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			patient's location at the time of measurement. A time/date stamp is required.	
encounter	encounter	A patient encounter represents interaction between a healthcare provider and a patient as with a face-to-face or otherwise billable visit for any form of diagnostic treatment and/or therapeutic event. Each encounter has an associated location within which it occurred. The encounter location is the patient's locality at the time of measurement.	An encounter is an identifiable grouping of healthcare-related activities characterized by the entity relationship between the subject of care and a healthcare provider, such grouping determined by the healthcare provider.[v] A patient encounter represents interaction between a healthcare provider and a patient as with a face-to-face patient visit to a clinician's office for any form of diagnostic treatment and/or therapeutic event. Encounters can be billable events but are not limited to billable interactions. Each encounter has an associated location and or modality within which it occurred (such as an office, home, electronic methods, phone encounter, and/or telemedicine methods). The encounter location is the patient's location at the time of measurement. A time/date stamp is required.	*Expanded data type definition for greater clarity and accuracy*
functional status			Functional status is an individual's ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being. Decline in functional status is measured by an individual's loss of independence in activities of daily living (ADLs) over a period of time.[vi]	*Added category definition to improve clarity*
functional status	functional status	The capacity to engage in activities of daily living and social role activities. A time/date stamp is required.	Functional status is an individual's ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being. Decline in functional status is measured by an individual's loss of independence in activities of daily living (ADLs) over a period of time.[vii]	*No changes*
Individual characteristic			Specific information about the patient, clinician provider, or the facility caring for the patient.	*Added category definition to improve clarity*

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individual characteristic	patient characteristics	Specific information about the patient, including demographics.	Specific information about the patient, such as demographics, religion, income, clinical trial, and comfort measures only. Excludes diagnoses or other concepts more specifically defined by other categories and associated data types.	*Definition modified to improve clarity*
individual characteristic	provider characteristics	Specific information about the clinician provider or the facility caring for the patient.		*No changes*
Intervention			An intervention is an influencing force or act that occurs in order to modify a given state of affairs. An intervention is any action carried out (by a healthcare provider or a consumer) to improve or maintain the health of a subject of care with the expectation of producing an outcome. Interventions also include patient care processes provided directly to a patient by a care provider to assist or direct a patient with activity or to apply single use or durable medical equipment. Examples include assisted ambulation, behavioral interventions (e.g., counseling), dressing changes, placement of antithrombotic devices, and / or insertion or removal of intravascular access. In the context of behavioral health, an intervention may be any outside process that has the effect of modifying an individual's behavior, cognition, or emotional state. Examples include: Consumer—deep breathing (e.g., for anxiety), vigorous exercise, and other predetermined activities. Note that intervention specifically excludes procedures (e.g., colonoscopy), diagnostic tests (e.g., imaging procedures), treatment with medications, and laboratory testing.	*New QDS category and data types added to provide greater clarity and accuracy*
intervention	intervention, adverse event		In the instance of a quality measure, an intervention adverse event is an unexpected or dangerous reaction to an intervention. Serious adverse events are those that are fatal, life-threatening, permanently/significantly disabling, those that require or prolong hospitalization, and those that require intervention to prevent permanent impairment or damage. A	*Added data type*

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			time/date stamp is required, as are notations indicating whether an item is patient-reported and/or provider-verified.	
intervention	intervention, intolerance		Intervention intolerance is a reaction in specific patients representing a low threshold to the normal execution of an intervention. Intolerance is generally based on patient report and perception of his or her ability to tolerate a properly executed intervention. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.	*Added data type*
intervention	intervention, order		A request by a physician or appropriately licensed care provider to an appropriate provider or facility to perform a service and/or other type of action necessary for care. A time/date stamp is required.	*Added data type*
intervention	intervention, performed		An intervention has been completed. A time/date stamp is required.	*Added data type*
intervention	intervention, result		Intervention results are the findings identified as a result of the intervention. A time/date stamp is required.	*Added data type*
laboratory test			A medical procedure that involves testing a sample of blood, urine, or other substance from the body. Tests can help determine a diagnosis, plan treatment, check to see if treatment is working, or monitor the disease over time.[viii]	*Added category definition to improve clarity*
laboratory test	laboratory test, adverse event		In the instance of a quality measure, a laboratory test adverse event is an unexpected or dangerous reaction to a laboratory test. Serious adverse events are those that are fatal, life-threatening, permanently/significantly disabling, those that require or prolong hospitalization, and those that require intervention to prevent permanent impairment or damage. A time/date stamp is required, as are notations indicating whether an item is patient-reported and/or provider-verified.	*Added data type:* Adverse events should apply to lab tests.
laboratory test	laboratory test, intolerance		Laboratory test intolerance is a reaction in specific patients representing a low threshold to the normal reported or	*Added data type*

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			expected reactions of the study. Intolerance is generally based on patient report and patient's perception of his or her ability to tolerate a properly executed laboratory study. A time/date stamp is required, as are notations indicating whether the item is patient reported and/or provider verified.	
~~laboratory test~~	~~laboratory test, offered~~	~~A study in the clinical laboratory (traditionally Chemistry, Hematology, Microbiology, Serology, Urinalysis, Blood Bank) has been offered to the patient or patient proxy. Depending on the point in the clinical workflow desired by the measure, various options are provided -offered, declined, ordered, performed and resulted.~~		*Removed data type*: Using only the "offered" data type does not provide sufficient clarity as to whether or not the final outcome of the action or event actually "occurred." Specifically, anything that is "offered" and actually "occurred" can be semantically represented by the data types "order/performed/applied," and/or "result/finding," if a result is present. On the other hand, if an entity is "not offered," it can be captured by the data types under the "negation rationale" category. Therefore,

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				using only the "offered" data type to capture whether something took place is insufficient.
laboratory test	laboratory test, order	A request for a study in the clinical laboratory (traditionally chemistry, hematology, microbiology, serology, urinalysis, blood bank) has been ordered. A time/date stamp is required.		*No changes*
laboratory test	laboratory test, performed	A study in the clinical laboratory (traditionally chemistry, hematology, microbiology, serology, urinalysis, blood bank) has been performed. A time/date stamp is required.		*No changes*
laboratory test	laboratory test, result	The result of a study in the clinical laboratory (traditionally chemistry, hematology, microbiology, serology, urinalysis, blood bank). A time/date stamp is required.		*No changes*
medication			A medication refers to clinical drugs or chemical substances intended for use in the medical diagnosis, cure, treatment, or prevention of disease. A medication contains a code derived from code systems such as RxNorm.	*Added category definition to improve clarity*
medication	medication, active	Medications currently taken by a patient. A time/date stamp is required.		*No changes*
medication	medication, administered	A record by the care provider that a medication actually was administered and whether or not this fact conforms to the order. Appropriate time/date stamps for all medication administration are generated.		*No changes*
medication	medication, adverse effects	~~Medication Adverse Event: In the instance of a quality measure, a medication adverse event is an unexpected or dangerous reaction to a medication. Serious adverse events are those that are fatal, life-threatening, permanently/significantly disabling, those that require or prolongs hospitalization, those that lead to congenital~~	Medication adverse effects refer to conditions that are due to drugs and medical and biological substances when the correct substance was administered as prescribed.[ix] These are generally clinician-identified effects. Medication adverse effects are distinct from medication allergy and intolerance. A time/date stamp is required as are notations indicating	*Modified data type to improve clarity:* Changed from "adverse event" to "adverse effect." The category of

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		~~anomaly or require intervention to prevent permanent impairment or damage. A time/date stamp is required as are notations indicating whether item is patient reported and/or provider verified.~~	whether item is patient reported and/or provider verified.	"adverse events" is not the convention used for classifying the actual unintended condition resulting from proper administration of a medication; it is more commonly used to describe the negative impact of a provision of care in terms of safety reporting and monitoring.
medication	medication, allergy	A medication allergy is an immunologically mediated reaction that exhibits specificity and recurs on re-exposure to the offending drug. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.		*No changes*
medication	medication, dispensed	A medication prescription is filled by a pharmacy and the medication has been provided to the patient or patient proxy. In the ambulatory setting, medications are primarily taken directly by patients and not directly observed. Hence, dispensed is the closest health provider documentation of medication compliance. In settings where patients attest to taking medications in electronic format (perhaps a Personal Health Record) patient attestation of “medication taken” may be available. A time/date stamp is required.		*No changes*
medication	medication, history	Medications taken by a patient in the past.	Medications taken by a patient in the past; includes discontinued or completed medications.	*Modified definition for clarity*
medication	medication,	Medication intolerance is a reaction in specific patients	Medication intolerance is a reaction in specific patients	*Modified definition*

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	intolerance	representing a low threshold to the normal pharmacological action of a drug. Side effects experienced do not represent adverse events or allergies. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.	representing a low threshold to the normal pharmacological action of a drug. Intolerance is generally based on patient report and perception of his or her ability to tolerate proper administration of a medication. Medication intolerance is distinct from medication allergy and medication adverse effects. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.	*for clarity*
~~medication~~	~~medication offered~~	~~A specific medication has been offered to the patient or patient proxy.~~		*Removed data type:* Anything that is offered to a patient either occurs or it does not occur because a patient has not yet agreed to it. Therefore, a single method for documentation would allow a clinician or patient to indicate a process was not done for a patient reason. If something did not occur, it can be managed by the "negation rationale" data type category. Alternately, if it did occur, then it means it was offered and completed, and can

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				be represented by the "result/finding," "order," or "performed" data types.
medication	medication, order	A request by a physician or appropriately licensed care provider to a pharmacy to provide medication to a patient. The request is in the form of prescriptions or other medication orders with detail adequate for correct filling and administration. A time/date stamp is required.		*No changes*
negation rationale			The reasons why an event or service was negated, including a procedure or test that was not given, or a device or substance that was not given or applied. These reasons for negation are typically subdivided to patient, medical, and/or system reasons that are general and non-specific, where a specific QDS data type such as "condition/problem/diagnosis" cannot be pinpointed. Note in the case when a specific condition/problem/diagnosis can be identified as part of the exclusion criteria, then the data type for this specific condition/diagnosis must be added to the measure, simply using the non-specific medical reasons negation rationale data type would be insufficient. Sometimes a measure may require both the general medical reasons as well as the specific medical conditions to be part of the exclusion criteria. Then in such cases, both the negation rationale data types (patient and medical reasons) as well as the condition/problem/diagnosis data types (for the specified medical conditions) must be added.	*Added category to increase clarity and accuracy*
negation rationale	communication, not done	A communication has been declined by the patient or patient proxy.	The reasons why a set of information was not communicated, transmitted, received, and/or acknowledged. The data type is	*Added data type to improve clarity*

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			used when a clear clinical reason cannot otherwise be specified (e.g. such as by using diagnosis, device, diagnostic test, lab test, medication, physical exam, procedure, substance).	
negation rationale	device, not done	Equipment designed to treat, monitor, or diagnose a patient's status has been declined.	The reasons why a device or equipment designed to treat, monitor, or diagnose a patient's status was not followed through as ordered. The data type is used when a clear clinical reason cannot otherwise be specified (e.g. such as by using diagnosis, device, diagnostic test, lab test, medication, physical exam, procedure, substance).	*Added data type to improve clarity*
negation rationale	diagnostic study, not done	A diagnostic study has been declined. This may also include the scenario where the diagnostic study is ordered but is not completed. Due to following reasons: Not scheduled, cancelled, not tolerated, rescinded, no-show, equipment /system failure due to "Reason(s)" listed in the Constraints.	The reasons why a diagnostic study was not done. The data type is used when a clear clinical reason cannot otherwise be specified (e.g. such as by using diagnosis, device, diagnostic test, lab test, medication, physical exam, procedure, substance).	*Added data type to improve clarity*
negation rationale	laboratory test, not done	A study in the clinical laboratory (traditionally chemistry, hematology, microbiology, serology, urinalysis, blood bank) has been declined by the patient or patient proxy. Depending on the point in the clinical workflow desired by the measure, various options are provided -offered, declined, ordered, performed and resulted. (NOTE: proposed to include in the definition the following.) This may also include the scenario where the stated entity is ordered but is not completed because it was not scheduled, cancelled, not tolerated, rescinded, no-show, equipment /system failure due to "Reason(s)" listed in the Constraints.	The reasons why a laboratory test, or study in the clinical laboratory (traditionally chemistry, hematology, microbiology, serology, urinalysis, blood bank) was not done. The data type is used when a clear clinical reason cannot otherwise be specified (e.g. such as by using diagnosis, device, diagnostic test, lab test, medication, physical exam, procedure, substance).	*Added data type to improve clarity*
negation rationale	medication, not done	A medication has been declined by the patient or patient proxy.	The reasons why a medication was not done. The data type is used when a clear clinical reason cannot otherwise be specified (e.g., such as by using diagnosis, device, diagnostic test, lab test, medication, physical exam, procedure, substance).	*Added data type to improve clarity*

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negation rationale	physical exam, not done		The reasons why a physical exam was not done. The data type is used when a clear clinical reason cannot otherwise be specified (e.g., such as by using diagnosis, device, diagnostic test, lab test, medication, physical exam, procedure, substance).	*Added data type to improve clarity*
negation rationale	procedure, not done	A procedure has been declined by the patient or patient proxy	The reasons why a procedure was not done. The data type is used when a clear clinical reason cannot otherwise be specified (e.g., such as by using diagnosis, device, diagnostic test, lab test, medication, physical exam, procedure, substance).	*Added data type to improve clarity*
negation rationale	substance, not done	A substance has been declined by the patient or patient proxy	The reasons why a substance administration was not done. The data type is used when a clear clinical reason cannot otherwise be specified (e.g., such as by using diagnosis, device, diagnostic test, lab test, medication, physical exam, procedure, substance).	*Added data type to improve clarity*
physical exam		A physical examination is the evaluation of the patient's body to determine its state of health. The techniques of inspection include palpation (feeling with the hands and/or fingers), percussion (tapping with the fingers), auscultation (listening), and smell. Measurements may include vital signs (blood pressure, pulse, respirations) as well as other clinical measures (such as expiratory flow rate, size of lesion, etc.).	A physical examination is the evaluation of the patient's body to determine its state of health. The techniques of inspection include palpation (feeling with the hands and/or fingers), percussion (tapping with the fingers), auscultation (listening), and smell. Measurements may include vital signs (blood pressure, pulse, respirations) as well as other clinical measures (such as expiratory flow rate, size of lesion, etc.). In addition, this includes psychiatric examinations. (Note: Other social assessments that may pertain to psychiatric conditions belong in the Patient Characteristics category.)	*Added category definition to improve clarity*
physical exam	physical exam, finding	A physical examination is the evaluation of the patient's body to determine its state of health. The techniques of inspection include palpation (feeling with the hands and/or fingers), percussion (tapping with the fingers), auscultation (listening), and smell. Measurements may include vital signs (blood pressure, pulse, respirations) as well as other clinical measures (such as expiratory flow rate, size of lesion, etc.).	The result or finding of a physical exam. A time/date stamp is required.	*Modified definition for clarity*

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physical exam	physical exam, ordered		A request by a physician or appropriately licensed care provider to order a physical exam for the patient. A time/date stamp is required.	*Added data type*
physical exam	physical exam, performed		A physical exam has been completed. A time/date stamp is required.	*Added data type*
preference			Preference refers to the healthcare treatment choices influenced, but not limited to, language, religious, or cultural preferences. Preference can be driven as well by utility measurement. A health utility index (HUI) is a family of generic health profiles and preference-based systems for the purposes of measuring health status, reporting health-related quality of life, and producing utility scores. Health-related quality of life (HRQL), as defined by Patrick and Erickson, "is the value assigned to duration of life as modified by the impairments, functional states, perceptions, and social opportunities that are influenced by disease, injury, treatment, or policy". HUI questionnaires, designed to elicit responses from a wide variety of subjects, make it easy to incorporate such a patient-reported outcome (PRO) and utility instrument into a clinical study. HUI evolved in response to the need for a standardized system to measure health status and HRQL to describe: 1) the experience of patients undergoing therapy; 2) long-term outcomes associated with disease or therapy; 3) the efficacy, effectiveness, and efficiency of healthcare interventions; and 4) the health status of general populations.[x]	*Added category definition*
preference	patient preference	Health care treatment choices influenced by but not limited to language, religious, or cultural preferences selected by the patient and family.		*No changes*
preference	provider preference	Health care treatment choices by the care provider based on knowledge of the patient's clinical status and findings.		*No changes*

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		Synonymous with 'medical reason' for inclusion or exclusion of a patient in a measure population.		
procedure			A procedure is a course of action intended to achieve a result in the care of persons with health problems. It is generally invasive and involves physical contact. A procedure may be a surgery or other type of physical manipulation of a person's body in whole or in part for purposes of making observations and diagnoses and/or providing treatment.[xi] Some of these procedures are not reimbursed. Note that procedure is distinct from intervention.	*Added category definition to improve clarity*
procedure	procedure, adverse event	In the instance of a quality measure, a procedure adverse event is an unexpected or dangerous reaction to a procedure. Serious adverse events are those that are fatal, life-threatening, permanently/significantly disabling, those that require or prolong hospitalization, and those that require intervention to prevent permanent impairment or damage. A time/date stamp is required, as are notations indicating whether an item is patient-reported and/or provider-verified.		*No changes*
~~procedure~~	~~procedure, history~~	~~A procedure has been completed in the past and includes a time/date stamp. Chargeable vs. non-chargeable.~~		*Removed data type:* 'Procedure, history' is removed because it may be sufficiently represented by 'procedure, performed' with appropriate date/time stamp (or where date/time stamp is not available, the usage of simply the date, year, or 'in the past'

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				is acceptable).
procedure	procedure, intolerance		Procedure intolerance is a reaction in specific patients representing a low threshold to the normal execution of a procedure. Intolerance is generally based on patient report and perception of his or her ability to tolerate a properly-executed procedure. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.	*Added data type to improve clarity*
~~procedure~~	~~procedure, offered~~	~~A procedure is suggested or recommended to a patient.~~		*Removed data type:* Anything that is offered to a patient either occurs or it does not occur because a patient has not yet agreed to it. Therefore, a single method for documentation would allow a clinician or patient to indicate a process was not done for a patient reason. If something did not occur, it can be managed by the "negation rationale" data type category. Alternately, if it did occur, then it means it was offered, completed, and can

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				be represented by the "result/finding," "order," or "performed" data types.
procedure	procedure, order	A request by a physician or appropriately licensed care provider to an appropriate provider or facility to perform.		*No changes*
procedure	procedure, performed	A procedure has been completed. Depending on the point in the clinical workflow desired by the measure, various options are provided—ordered, declined, performed, and resulted. Procedures also include patient care processes provided directly to a patient by a care provider to assist or direct a patient with activity or to apply single use or durable medical equipment. Examples include assisted ambulation, behavioral interventions (e.g., counseling provided), dressing changes, placement of antithrombotic devices, insertion or removal of intravascular access. Some of these procedures are not reimbursed. A time/date stamp is required.		*No changes*
procedure	procedure, result	Procedure results are the findings identified as a result of the procedure. The result of a surgical procedure documents the actual procedure performed and the findings of the procedure. These findings are usually present in the operative note (e.g., lymph node dissection with 15 lymph nodes obtained for biopsy). The procedure result is distinct from the pathology report which is a laboratory result data type which could state 2 of 15 nodes positive for malignancy. It is also distinct from clinical outcome which could use various data types (e.g., patient characteristic "alive" at 18 months post-operatively, or functional status data type required pre-operatively and at 6, 12, and 18 months post-operatively). A time/date stamp is required.		*No changes*
risk category/assessment			Risk category assessments include tools and calculators that	*Added category*

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			suggest vulnerabilities for any given patient. Distinct from functional status, risk categorization uses findings, observations, results and sometimes judgments and patient generated information for use within clinical care algorithms, clinical decision support, and severity analysis. A time/date stamp is required. Examples: Braden Score for Predicting Pressure Score Risk,[xii] Morse Fall Risk Scale, Pneumonia Severity Index[xiii]	*definition to improve clarity*
risk category/assessment	risk category/assessment	Risk category assessments include tools and calculators that suggest vulnerabilities for any given patient. Distinct from functional status, risk categorization uses findings, observations, results, and sometimes judgments and patient generated information for use within clinical care algorithms, clinical decision support and severity analysis.		*No changes*
substance			A chemical element and its compounds in the natural state or obtained by any manufacturing process (other than pharmaceutical drugs), including any additive necessary to preserve its stability and any impurity deriving from the process used, but excluding any solvent which may be separated without affecting the stability of the substance or changing its composition.[xiv] Substance may or may not have a code or be classified by a code system such RxNorm. Examples of a substance may include but not limited to: environmental agents (e.g. pollen, dust) and food (e.g., vitamins).	*Added category definition to improve clarity*
substance	substance, administered	A record by the care provider that a food or other substance actually was given to the patient and whether or not these facts conform to the order. A time/date stamp is required.		*No changes*
substance	substance, adverse event	In the instance of a quality measure, a substance adverse event is an unexpected or dangerous reaction to a substance (e.g., food, environmental agent). Serious adverse events are		*No changes*

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		those that are fatal, life-threatening, permanently/significantly disabling, those that require or prolong hospitalization, and those that lead to congenital anomaly or require intervention to prevent permanent impairment or damage. A time/date stamp is required as are notations indicating whether item is patient reported and/or provider verified.		
substance	substance, allergy	A substance allergy is an immunologically mediated reaction that exhibits specificity and recurrence on re-exposure to the offending substance. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.		*No changes*
substance	substance, intolerance	Substance intolerance is a reaction in specific patients representing a low threshold to the normal effects of a substance. Side effects experienced do not represent adverse events or allergies. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.	Substance intolerance is a reaction in specific patients representing a low threshold to the normal effects of a substance. Intolerance is generally based on patient report and perception of his or her ability to proper administer a substance. Substance intolerance is distinct from substance allergy and adverse event. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.	*Modified definition for clarity*
substance	substance, ordered	A request by a physician or appropriately licensed care provider to provide food or other substance to a patient. A time/date stamp is required.		*No changes*
symptom		A symptom is an indication that a person has a condition or disease. Some examples are headache, fever, fatigue, nausea, vomiting, and pain. [Source: UMLS]. Also, subjective of disease perceived by the patient. [Source: NCI] As an example to differentiate symptom from finding, the patient's subjective symptom of fever is distinguished from the temperature (a finding) which has a source of temperature measuring device and recorder of the device (electronically) or an individual (healthcare provider, patient, etc.).		*No changes*

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symptom	symptom, active		An active symptom is a patient's reported perception of departure from normal functioning that is present at the time indicated. A time/date stamp is required.	*Added data type definition*
symptom	symptom, assessed	The patient's reported perception of departure from normal functioning is evaluated. A time/date stamp is required.		*No changes*
system characteristic			The structural configuration of an organization, e.g., nursing staff ratios, availability of durable medical equipment, health information technology structures (e.g., e-prescribing), and invasive procedure capabilities.	*Added category definition to improve clarity*
system characteristic	system characteristic	The structural configuration of an organization, for example nursing staff ratios, availability of durable medical equipment, health information technology structures (e.g., e-prescribing and invasive procedure capabilities).		*No changes*
transfer of care			Transfer of care refers to the different locations or settings a patient is released to, or received from, in order to ensure the coordination and continuity of healthcare.* Such transfers involve a handoff process, whereby there is an exchange of patient information as well as a transfer of accountability and responsibility for patient care.**[xv]	*Added category definition to improve clarity*
transfer of care	transfer from	The setting from which a patient is received (e.g., home, acute care hospital, skilled nursing) to the current location, A time/date stamp is required.		*No changes*
transfer of care	transfer to	The setting from which a patient is released (e.g., home, acute care hospital, skilled nursing) to the current location. A time/date stamp is required.		*No changes*

[i] Care experience definition references:

a. Patient experience is a synchronicity of people, processes, interactions, and communication designed around a common vision that is clearly communicated throughout the organization and accessible to staff in any role. This includes the perception of the organization (the brand promise), the first interaction, the environment, all aspects of any visit, the ongoing relationship, inspiration, the roles and behaviors of the staff, as well as other issues. (Adapted from: HealthLeaders Media. *MarketShare guest post: the difference between patient-centered care and patient experience,* April 27, 2009. Available at: http://blogs.healthleadersmedia.com/marketshare/2009/04/patient-centered-care-and-patient-experience/. Accessed 17 May 2010.
b. Merriam-Webster Online Dictionary. *Experience definition,* available at: http://www.merriam-webster.com/dictionary/experience, accessed 17 May 2010.
    1. a. direct observation of or participation in events as a basis of knowledge b : the fact or state of having been affected by or gained knowledge through direct observation or participation
    2. a: practical knowledge, skill, or practice derived from direct observation of or participation in events or in a particular activity b : the length of such participation <has 10 years' experience in the job>
    3. a: the conscious events that make up an individual life b : the events that make up the conscious past of a community or nation or humankind generally
    4. something personally encountered, undergone, or lived through
    5. the act or process of directly perceiving events or reality
c. The Institute for Healthcare Improvement, with the support of the Rx Foundation and The Robert Wood Johnson Foundation, is working to identify best practices and promising system changes that enable patient-centered care in three areas:*
d. The Institute for Healthcare Improvement, with the support of the Rx Foundation and The Robert Wood Johnson Foundation, is working to identify best practices and promising system changes that enable patient-centered care in three areas (Institute for Healthcare Improvement. *Patient- Centered Care: General,* available at: http://www.ihi.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/, Accessed 17 May 2010.):*
    - Involving patients and families in the design of care
    - Reliably meeting patient's needs and preferences
    - Informed shared decision making

[ii] Consumer Assessment of Healthcare Providers and Systems (CAHPS). Rockville, MD:Agency for Healthcare Research and Quality (AHRQ). - Available at www.cahps.ahrq.gov/default.asp. Last accessed May 2010.
[iii] (i) Canada Health Infoway EHR Glossary; (ii) Wikipedia, available at: http://en.wikipedia.org/wiki/Diagnostic_test.
[iv] International Organization for Standardization (ISO), *Health Informatics – Requirements for an Electronic Health Record Architecture ISO/TS 18308*. Geneva, Switzerland:ISO, 2004. Available at www.iso.org/iso/home.htm. Last accessed May 2010.
[v] International Organization for Standardization (ISO), *Health Informatics – Requirements for an Electronic Health Record Architecture ISO/TS 18308*. Geneva, Switzerland:ISO, 2004. Available at www.iso.org/iso/home.htm. Last accessed May 2010.
[vi] National Palliative Care Research Center (NPCRC). New York, NY:NPCRC, 2010. Available at www.npcrc.org/. Last accessed May 2010.
[vii] National Palliative Care Research Center (NPCRC). New York, NY:NPCRC, 2010. Available at www.npcrc.org/. Last accessed May 2010.
[viii] National Cancer Institute (NCI). Bethesda, MD:NCI, 2010. Available at www.cancer.gov/. Last accessed May 2010.
[ix] Brown F, Leon-Chisen N. *ICD-9-CM Coding Handbook 2009*. Chicago, IL: American Hospital Association, 2009. Available at www.ahacentraloffice.org/ahacentraloffice/html/icd9cm.html. Last accessed May 2010.
[x] (i) Patrick DL, Erickson P. *Health Status and Health Policy: Quality of Life in Health Care Evaluation and Resource Allocation.* NewYork: Oxford University Press; 1993. (ii) Horsman J, Furlong W, Feeny D, et al. The health utilities index (HUI): concepts, measurement properties and applications, *Health and Quality of Life Outcomes.* 2003;1-54. Abstract available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC293474/
[xi] Modified from Canada Health Infoway
[xii] Braden B, Bergstrom N. *Braden Scale for Predicting Pressure Sore Risk*. Available at http://bradenscale.com/. Last accessed May 2010.
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