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

Short Name: Patient_MRN
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Illegal
Harvested: Yes
Format: Text (20)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: 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

Short Name: EncounterDate
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Illegal
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 1520 **Name:** Practice ID

Coding Instructions: Indicate the Practice Identification number assigned to the Practice by the ACC-NCDR.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: PracticeID
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Illegal
Harvested: Yes
Format: Integer (6)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: Auto

1. General Information

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

Short Name: LocationID
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Illegal
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: Auto

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

Coding Instructions: Indicate the evaluating provider's last name.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: Physician_LastName
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (50)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

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

Coding Instructions: Indicate the evaluating provider's first name.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: Physician_FirstName
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (50)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

1. General Information

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

Coding Instructions: Indicate the evaluating provider's middle name.

Note(s):

It is acceptable to specify the provider's middle initial.

If the provider does not have a middle name, leave field blank.

If the provider 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

Short Name: Physician_MidName
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (50)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 1550 **Name:** 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

Short Name: Physician_NPI
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Illegal
Harvested: Yes
Format: Text (10)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 1555 **Name:** EncounterTIN

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 between current enconter and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: EncounterTIN
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: No Action
Harvested: Yes
Format: Integer (9)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

1. General Information

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

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

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

Short Name: PatNew
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

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

Coding Instructions: Indicate the primary symptom or condition that prompted patient to seek medical attention

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Encounter_Reason
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: 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

Short Name: LastName
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (50)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: 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

Short Name: FirstName
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (50)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

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

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

Note(s):

It is acceptable to specify the patient's middle initial.

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

Short Name: MidName
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (50)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

A. Patient Demographics

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

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

Note(s):

If the patient does not have a US Social Security Number (SSN), leave blank.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: SSN
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (9)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

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

Short Name: DOB
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Illegal
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

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

Short Name: Sex
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

A. Patient Demographics

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

Short Name: Death_Ind
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: 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

Short Name: Death_Date
Parent Seq #: 2065
Parent Name: Patient Deceased
Parent Value: Yes
Missing Data: Report
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: 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 arrival at this facility

Selections:

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

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

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

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

Technical Specifications

Short Name: RaceWhite
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: 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 arrival at this facility

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

Short Name: RaceBlack
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: 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 arrival at this facility

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

Short Name: RaceAsian
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

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 arrival at this facility

Selections:

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

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

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

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

Technical Specifications

Short Name: RaceAmIndian
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

A. Patient Demographics

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 arrival at this facility

Selections:

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

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

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

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

Technical Specifications

Short Name: RaceNatHaw
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

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.

Target Value: The value on arrival at this facility

Selections:

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

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

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

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

Technical Specifications

Short Name: HispOrig
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: 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):

If the patient does not have a U.S residence, or is homeless, leave blank.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: ZipCode
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (10)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

A. Patient Demographics

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 insurace.

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: **Private Health Insurance:**

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

Source: U.S.Census Bureau

Technical Specifications

Short Name: InsPrivate
Parent Seq #: 3027
Parent Name: Insurance - None
Parent Value: No
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

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

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

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

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

Short Name: InsMedicaid
Parent Seq #: 3027
Parent Name: Insurance - None
Parent Value: No
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

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

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

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: **Military Health Care:**

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

Source: U.S.Census Bureau

Technical Specifications

Short Name: InsMilitary
Parent Seq #: 3027
Parent Name: Insurance - None
Parent Value: No
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

A. Patient Demographics

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

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

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

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

Short Name: InsState
Parent Seq #: 3027
Parent Name: Insurance - None
Parent Value: No
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

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

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

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

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

Short Name: InsIHS
Parent Seq #: 3027
Parent Name: Insurance - None
Parent Value: No
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

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

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

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

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

Short Name: InsNonUS
Parent Seq #: 3027
Parent Name: Insurance - None
Parent Value: No
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

A. Patient Demographics

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

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

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has any form of insurance.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: **None:**

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

Source: NCDR

Technical Specifications

Short Name: InsNone
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

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

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

Note(s):

This is one of the 9 selections for the Insurance element, mutually exclusive with the selection of None.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: **Medicare:**

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

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

Source: U.S.Census Bureau

Technical Specifications

Short Name: InsMedicare_FeeforSer
Parent Seq #: 3027
Parent Name: Insurance - None
Parent Value: No
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

A. Patient Demographics

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

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

Note(s):

This is one of the 9 selections for the Insurance element, mutually exclusive with the selection of None.

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

Short Name: InsMedicare_MngdCare
Parent Seq #: 3027
Parent Name: Insurance - None
Parent Value: No
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

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

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

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: PayerID
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (5)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

B. Diagnoses/Conditions/Comorbidities

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

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

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

Selections:

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

Supporting Definitions: **Coronary Artery Disease:**
A history of coronary artery disease (CAD) is evidenced by one of the following:

1. Currently receiving medical treatment for CAD
2. History of Myocardial Infarction
3. Prior CV intervention including, but not limited to, CABG and/or PCI

Source: STS

Technical Specifications

Short Name: CAD
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

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

Coding Instructions: Indicate the documented date of diagnoisis 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

Short Name: CAD_Date
Parent Seq #: 4000
Parent Name: Coronary Artery Disease
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 4005 **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::**
Atrial Fibrillation is a supraventricular tachyarrhythmia characterized by uncoordinated atrial activity with consequent deterioration of atrial mechanical function. On the electrocardiogram (ECG), atrial fibrillation is characterized by the replacement of consistent P waves with rapid oscillations or fibrillation waves that vary in amplitude, shape and timing, associated with an irregular, frequently rapid ventricular response when atrioventricular conduction is intact.

Atrial Flutter is characterized by a sawtooth pattern of regular atrial activation called flutter waves on the ECG, particularly visible in leads II, III, aVF and v1.

Source: ACC/AHA 2006 Data Standards for Measuring Clinical Management and Outcomes of Patients with Atrial Fibrillation

Technical Specifications

Short Name: Afib
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4007 **Name:** Atrial Fibrillation or Flutter Date

Coding Instructions: Indicate the documented date of diagnoisis 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

Short Name: Afib_Date
Parent Seq #: 4005
Parent Name: Atrial Fibrillation or Flutter
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 4010 **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:**

Dyslipidemia is defined by the 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: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons

Technical Specifications

Short Name: Dyslipidemia
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 4012 **Name:** Dyslipidemia Date

Coding Instructions: Indicate the documented date of diagnoisis 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

Short Name: Dyslipidemia_Date
Parent Seq #: 4010
Parent Name: Dyslipidemia
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4015 **Name:** Diabetes Mellitus

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

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

Selections:

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

Supporting Definitions: **Diabetes Mellitus:**

Diabetes mellitus is diagnosed by a physician or can be defined as a fasting blood sugar greater than 7 mmol/l or 126 mg/dL. It does not include gestational diabetes.

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons

Technical Specifications

Short Name: Diabetes
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 4017 **Name:** Diabetes Mellitus Date

Coding Instructions: Indicate the documented date of diagnoisis 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

Short Name: Diabetes_Date
Parent Seq #: 4015
Parent Name: Diabetes Mellitus
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 4020 **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: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons

Technical Specifications

Short Name: Hypertension
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

B. Diagnoses/Conditions/Comorbidities

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

Coding Instructions: Indicate the documented date of diagnoisis 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

Short Name: Hypertension_Date
Parent Seq #: 4020
Parent Name: Hypertension
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 4025 **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

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

Seq. #: 4030 **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: **PAD:**

Peripheral arterial disease can include:
1. Claudication, either with exertion or at rest.
2. Amputation for arterial vascular insufficiency.
3. Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities (excluding dialysis fistulas and vein stripping).
4. Documented aortic aneurysm with or without repair.
5. Positive non-invasive test (e.g., ankle brachial index <=0.9); ultrasound, magnetic resonance, computed tomography, or angiographic imaging of > 50% diameter stenosis in any peripheral artery (e.g., renal, subclavian, femoral, iliac).

For purposes of the Registry, peripheral arterial disease excludes disease in the carotid and cerebrovascular arteries.

Source: ACC Clinical Data Standards, The Society of Thoracic Surgeons

Technical Specifications

Short Name: PAD
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4032 **Name:** Peripheral Arterial Disease Date

Coding Instructions: Indicate the documented date of diagnoisis of peripheral aretery 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

Short Name: PAD_Date
Parent Seq #: 4030
Parent Name: Peripheral Arterial Disease
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 4035 **Name:** Prior Stroke or TIA

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

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Technical Specifications

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

Seq. #: 4040 **Name:** Unstable Angina

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

Note(s):

There are three principal presentations of unstable angina: 1. Rest angina (occurring at rest and prolonged, usually >20 minutes); 2. Newonset angina (within the past 2 months, of at least Canadian Cardiovascular Society Class III severity); or 3. Increasing angina (previously diagnosed angina that has become distinctly more frequent, longer in duration, or increased by 1 or more Canadian Cardiovascular Society class to at least CCS III severity).

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

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

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4042 **Name:** Unstable Angina Date

Coding Instructions: Indicate the documented date of diagnoisis 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

Short Name: UnstableAngina_Date
Parent Seq #: 4040
Parent Name: Unstable Angina
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 4045 **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:**

Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention; or the description of rales, jugular venous distension, pulmonary edema on physical exam, or pulmonary edema on chest x-ray presumed to be cardiac dysfunction. A low ejection fraction without clinical evidence of heart failure does not qualify as heart failure.

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons

Technical Specifications

Short Name: HF
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 4047 **Name:** Heart Failure Date

Coding Instructions: Indicate the documented date of diagnoisis 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

Short Name: HF_Date
Parent Seq #: 4045
Parent Name: Heart Failure
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

B. Diagnoses/Conditions/Comorbidities

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: **Heart Failure:**

Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention; or the description of rales, jugular venous distension, pulmonary edema on physical exam, or pulmonary edema on chest x-ray presumed to be cardiac dysfunction. A low ejection fraction without clinical evidence of heart failure does not qualify as heart failure.

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons

Technical Specifications

Short Name: HF_New_Dia
Parent Seq #: 4045
Parent Name: Heart Failure
Parent Value: Yes
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 4055 **Name:** Stable Angina

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

Note(s):

Angina without a change in frequency or pattern for the 6 weeks prior to this visit. Angina is controlled by rest and/or oral or transcutaneous medications.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: StableAngina
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 4057 **Name:** Stable Angina Date

Coding Instructions: Indicate the documented date of diagnoisis 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: (none)

Technical Specifications

Short Name: StableAngina_Date
Parent Seq #: 4055
Parent Name: Stable Angina
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4060 **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

Short Name: StableAngina_New_Dia
Parent Seq #: 4055
Parent Name: Stable Angina
Parent Value: Yes
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 4065 **Name:** Ischemic Vascular Disease

Coding Instructions: Indicate if the patient has documented 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.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

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

Seq. #: 4067 **Name:** Ischemic Vascular Disease Date

Coding Instructions: Indicate the documented date of diagnoisis 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

Short Name: IVD_Date
Parent Seq #: 4065
Parent Name: Ischemic Vascular Disease
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4070 **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: (none)

Technical Specifications

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

Seq. #: 4072 **Name:** Peripheral Vascular Disease Date

Coding Instructions: Indicate the documented date of diagnoisis 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

Short Name: PVD_Date
Parent Seq #: 4070
Parent Name: Peripheral Vascular Disease
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 4075 **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:**

Patient has reduced glomerular filtration rate (GFR) for at least 3 months. Degree of renal insufficiency may be further defined according to degree of depression in GFR:

Mild renal insufficiency: GFR 60 to 89 ml/min/1.73 m2.

Moderate renal insufficiency: GFR 30 to 59 ml/min/1.73 m2.

Severe renal insufficiency: GFR 15 to 29 ml/min/1.73 m2.

Renal failure: GFR 15 ml/min/1.73 m2, or patient requires chronic dialysis treatment.

Source: ACC-AHA Clinical Data Standards

Technical Specifications

Short Name: CKD_History
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4077 **Name:** Chronic Kidney Disease Date

Coding Instructions: Indicate the documented date of diagnoisis 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

Short Name: CKD_Date
Parent Seq #: 4075
Parent Name: Chronic Kidney Disease
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 4080 **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

Short Name: CLD_History
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 4082 **Name:** Chronic Liver Disease Date

Coding Instructions: Indicate the documented date of diagnoisis 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

Short Name: CLD_Date
Parent Seq #: 4080
Parent Name: Chronic Liver Disease
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

C. Cardiac Events

Seq. #: 5000 **Name:** Myocardial Infarction (any history of)

Coding Instructions: Indicate if the patient was diagnosed with having a myocardial infarction (MI).

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

Selections:

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

Supporting Definitions:

Myocardial Infarction:

A myocardial infarction is evidenced by any of the following:

1. A rise and fall of cardiac biomarkers (preferably troponin) with at least one of the values in the abnormal range for that laboratory [typically above the 99th percentile of the upper reference limit (URL) for normal subjects] together with at least one of the following manifestations of myocardial ischemia:

a. Ischemic symptoms.

b. ECG changes indicative of new ischemia (new ST-T changes, new left bundle branch block, or loss of R- wave voltage).

c. Development of pathological Q- waves in 2 or more contiguous leads in the ECG (or equivalent findings for true posterior MI).

d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

e. Documentation in the medical record of the diagnosis of acute myocardial infarction based on the cardiac biomarker pattern in the absence of any items enumerated in a-d due to conditions that may mask their appearance (e.g., peri-operative infarct when the patient cannot report ischemic symptoms; baseline left bundle branch block or ventricular pacing).

2. ECG changes associated with prior myocardial infarction can include the following (with or without prior symptoms):

a. Any Q-wave in leads V2-V3 >=0.02 seconds or QS complex in leads V2 and V3.

b. Q-wave >=0.03 seconds and >=0.1 mV deep or QS complex in leads I, II, aVL, aVF, or V4-V6 in any two leads of a contiguous lead grouping (I, aVL, V6; V4-V6; II, III, and aVF).

c. R-wave >=0.04 seconds in V1-V2 and R/S >=1 with a concordant positive Twave in the absence of a conduction defect.

3. Imaging evidence of a region with new loss of viable myocardium at rest in the absence of a non-ischemic cause. This can be manifest as:

a. Echocardiographic, CT, MR, ventriculographic or nuclear imaging evidence of left ventricular thinning or scarring and failure to contract appropriately (i.e., hypokinesis, akinesis, or dyskinesis).

b. Fixed (non-reversible) perfusion defects on nuclear radioisotope imaging (e.g., MIBI, thallium).

4. Medical record documentation of prior myocardial infarction.

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

Technical Specifications

Short Name: MI_History
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5005 **Name:** Myocardial Infarction (within 12 months)

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

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: MI_12months
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5007 **Name:** Myocardial Infarction Date

Coding Instructions: Indicate all dates that the patient had a Myocardial Infarction.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: MI_Date
Parent Seq #: 5000
Parent Name: Myocardial Infarction (any history of)
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5010 **Name:** Coronary Artery Bypass Graft (CABG) (within 12 months)

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

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: CABG_12months
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5011 **Name:** Coronary Artery Bypass Graft (CABG)

Coding Instructions: Indicate if the patient had coronary artery bypass graft (CABG) surgery.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: CABG
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5012 **Name:** Coronary Artery Bypass Graft (CABG) Date

Coding Instructions: Indicate all dates that the patient had a Coronary Artery Bypass Graft (CABG).

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: CABG_Date
Parent Seq #: 5011
Parent Name: Coronary Artery Bypass Graft (CABG)
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5015 **Name:** PCI - Bare Metal Stent Implant (within 12 months)

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

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: PCIBareMetal_12months
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5016 **Name:** PCI - Bare Metal Stent Implant

Coding Instructions: Indicate if the patient had a percutaneous coronary intervention (PCI) that resulted in the implant of a bare metal stent.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: PCIBareMetal
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5017 **Name:** Percutaneous Coronary Intervention (PCI) - Bare Metal Stent Implant Date

Coding Instructions: Indicate all dates the patient had a Percutaneous Coronary Intervention (PCI) that involved the implantation of a Bare Metal Stent (BMS).

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: PCI_BMS_Date
Parent Seq #: 5016
Parent Name: PCI - Bare Metal Stent Implant
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5020 **Name:** Cardiac Valve Surgery (within 12 months)

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

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: CVSrg_12months
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5021 **Name:** Cardiac Valve Surgery

Coding Instructions: Indicate if the patient had cardiac valve surgery.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: CVSrg
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5022 **Name:** Cardiac Valve Surgery Date

Coding Instructions: Indicate all dates the patient had Cardiac Valve Surgery.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: Card_Valve_Srgry_Date
Parent Seq #: 5021
Parent Name: Cardiac Valve Surgery
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5025 **Name:** PCI - Drug Eluting Stent Implant (within 12 months)

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

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: PCIDrugElu_12months
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5026 **Name:** PCI - Drug Eluting Stent Implant

Coding Instructions: Indicate if the patient had a percutaneous coronary intervention (PCI) that resulted in the implant of a drug eluting stent (DES)

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: PCIDrugElu
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5027 **Name:** Percutaneous Coronary Intervention (PCI) - Drug Eluting Stent Implant Date

Coding Instructions: Indicate all dates the patient had a Percutaneous Coronary Intervention (PCI) that involved the implantation of a Drug Eluting Stent (DES).

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: PCI_DES_Date
Parent Seq #: 5026
Parent Name: PCI - Drug Eluting Stent Implant
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5030 **Name:** Heart Transplantation (within 12 months)

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

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: HeartTran_12months
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5031 **Name:** Heart Transplantation

Coding Instructions: Indicate if the patient had a heart transplantation surgery.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: HeartTran
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5032 **Name:** Heart Transplantation Date

Coding Instructions: Indicate all dates the patient had a Heart Transplant.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: Heart_Transplant_Date
Parent Seq #: 5031
Parent Name: Heart Transplantation
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5035 **Name:** PCI - Other (non-stent) Intervention (within 12 months)

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

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: PCINonStent_12months
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5036 **Name:** PCI - Other (non-stent) Intervention

Coding Instructions: Indicate if the patient had percutaneous coronary intervention (PCI) that did not include a stent implant.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: PCINonStent
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5037 **Name:** Percutaneous Coronary Intervention (PCI) - Other (non-stent) Intervention Date

Coding Instructions: Indicate all dates 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.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: PCI_Angioplasty_Date
Parent Seq #: 5036
Parent Name: PCI - Other (non-stent) Intervention
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5040 **Name:** Cardiac Therapeutic Procedure

Coding Instructions: Indicate if the patient had any procedure to treat a pathologic structural, or pathophysiological functional, disorder of the heart.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: CardiacTherapeutic
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5042 **Name:** Cardiac Therapeutic Procedure Date

Coding Instructions: Indicate all dates the patient had a cardiac therapeutic procedure.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: CardiacTherapeutic_Date
Parent Seq #: 5040
Parent Name: Cardiac Therapeutic Procedure
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5045 **Name:** Systemic Embolism

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

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Systemic_Embo
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5047 **Name:** Systemic Embolism Date

Coding Instructions: Indicate all dates the patient had a systemic embolism.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: Systemic_Embo_Date
Parent Seq #: 5045
Parent Name: Systemic Embolism
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

C. Cardiac Events

Seq. #: 5050 **Name:** Cardioversion

Coding Instructions: Indicate if the patient received an electrical or pharmacological cardioversion, whether successful or unsuccessful.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Cardioversion
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5052 **Name:** Cardioversion Date

Coding Instructions: Indicate all dates the patient had a cardioversion performed, whether successful or unsuccessful.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: Cardioversion_Date
Parent Seq #: 5050
Parent Name: Cardioversion
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5055 **Name:** Minor Hemorrhage

Coding Instructions: Indicate if 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".

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: MinorHemorrhage
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5057 **Name:** Minor Hemorrhage Date

Coding Instructions: Indicate the most recent documented date of a minor hemorrhage.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: MinorHemorrhage_Date
Parent Seq #: 5055
Parent Name: Minor Hemorrhage
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5060 **Name:** Left Ventricular Assist Device

Coding Instructions: Indicate if the patient has a left ventricular assist device (LVAD).

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

Code 'No' if the the patient had the device previously, but the device is no longer in place.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: LVAD
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5062 **Name:** Left Ventricular Assist Device Date

Coding Instructions: Indicate all dates the patient received a left ventricular assist device.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: LVAD_Date
Parent Seq #: 5060
Parent Name: Left Ventricular Assist Device
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

C. Cardiac Events

Seq. #: 5065 **Name:** Intracranial Hemorrhage

Coding Instructions: Inidicate 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

Code 'Yes' to intracranial hemorrhage and hemorrhagic stroke if the patient had an intracranial hemorrhage with a loss off brain function. If the patient had an intracranial hemorrhage without loss of brain function only code 'Yes' to intracranial hemorrhage.

Target Value: Any occurrence between birth and current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: IntracranialHem
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5067 **Name:** Intracranial Hemorrhage Date

Coding Instructions: Indicate the most recent documented date of a intracranial hemorrhagic.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: IntracranialHem_Date
Parent Seq #: 5065
Parent Name: Intracranial Hemorrhage
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5070 **Name:** Cardiac Resynchronization Therapy Device

Coding Instructions: 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.If the patient received a cardiac resynchronization therapy device and defibrillator (CRT-D) code 'No' to Cardiac Resyncrhonization Device and 'Yes' to Cardiac Resynchronization Therapy Device and Defibrillator.

Target Value: Any occurrence between birth and current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: CRT_Device
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5072 **Name:** Cardiac Resynchronization Therapy Device Date

Coding Instructions: Indicate all dates the patient received a cardiac resynchronization therapy device (CRT).

If the patient received a cardiac resynchronization therapy device and defibrillator (CRT-D) code the procedure date as the Cardiac Resynchronization Therapy Device and Defibrillator Date; do not code Cardiac Resynchronization Therapy Device Date.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: CRT_Device_Date
Parent Seq #: 5070
Parent Name: Cardiac Resynchronization Therapy Device
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5075 **Name:** Non-intracranial Major Hemorrhage

Coding Instructions: Indicate if the patient had a documented major hemorrhage - outside of the cranium.

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".

Target Value: Any occurrence between birth and current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: NICMHemorrhage
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5077 **Name:** Non-intracranial Major Hemorrhage Date

Coding Instructions: Indicate all dates the patient had a non-intracranial major hemorrhage.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: NICMHemorrhage_Date
Parent Seq #: 5075
Parent Name: Non-intracranial Major Hemorrhage
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

C. Cardiac Events

Seq. #: 5080 **Name:** Non-intracranial Major Hemorrhage Location

Coding Instructions: Indicate the location of all documented non-intracranial major hemorrhages.

Target Value: The last value between birth and current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Intra-articular (Atraumatic)	Within a joint.
2	Intra-ocular	Bleeding associated with abrupt deterioration of visual acuity.
3	Intra-spinal	
4	Pericardial	
5	Retroperitoneal/Abdominal	

Supporting Definitions: (none)

Technical Specifications

Short Name: NICMHemorrhage_Location
Parent Seq #: 5075
Parent Name: Non-intracranial Major Hemorrhage
Parent Value: Yes
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5090 **Name:** Cardiac Resynchronization Therapy Device and Defibrillator

Coding Instructions: Indicate if 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.Code 'No' if the the patient had the device previously, but the device is no longer in place.Code 'No' if the the patient had the device previously, but the device is no longer in place.

Target Value: Any occurrence between birth and current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: CRTD_Device
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5092 **Name:** Cardiac Resynchronization Therapy Device and Defibrillator Date

Coding Instructions: Indicate all dates the patient received a cardiac resynchronization therapy device and defibrillator (CRT-D).

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: CRTD_Device_Date
Parent Seq #: 5090
Parent Name: Cardiac Resynchronization Therapy Device and Defibrillator
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

C. Cardiac Events

Seq. #: 5095 **Name:** Transient Ischemic Attack

Coding Instructions: Indicate if the patient had a tranisent 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 iclude:
- Numbness or weakness, especially on one side of the body
- Confusion or trouble speaking or understanding speech
- Trouble seeing in one or both eyes
- Loss of balance or coordination

Target Value: Any occurrence between birth and current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: TIA
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5097 **Name:** Transient Ischemic Attack Date

Coding Instructions: Indicate all dates the patient had a transient ischemic attack.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: TIA_Date
Parent Seq #: 5095
Parent Name: Transient Ischemic Attack
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5100 **Name:** ICD Implant

Coding Instructions: Indicate if the patient has an implantable cardioverter defibrillator (ICD).

Code 'No' if the the patient had the device previously, but the device is no longer in place.

Target Value: Any occurrence between birth and current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: ICDImplant
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5102 **Name:** ICD Implant Date

Coding Instructions: Indicate all dates the patient received an implantable cardioverter defibrillator (ICD).

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: ICDImplant_Date
Parent Seq #: 5100
Parent Name: ICD Implant
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5105 **Name:** Ischemic Stroke

Coding Instructions: Indicate if the patient had a documented ischemic stroke.

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

Target Value: Any occurrence between birth and current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: IschemicStroke
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5107 **Name:** Ischemic Stroke Date

Coding Instructions: Indicate all dates the patient had an ischemic stroke.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: IschemicStroke_Date
Parent Seq #: 5105
Parent Name: Ischemic Stroke
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

C. Cardiac Events

Seq. #: 5110 **Name:** Percutaneous Transluminal Coronary Angioplasty

Coding Instructions: Indicated 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.

Target Value: Any occurrence between birth and current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: PTCA
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5112 **Name:** Percutaneous Transluminal Coronary Angioplasty Date

Coding Instructions: Indicate all dates the patient received percutaneous transluminal coronary angioplasty.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: PTCA_Date
Parent Seq #: 5110
Parent Name: Percutaneous Transluminal Coronary Angioplasty
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5115 **Name:** Hemorrhagic Stroke

Coding Instructions: Indicate if 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. Code 'Yes' to intracranial hemorrhage and hemorrhagic stroke if the patient had an intracranial hemorrhage with a loss off brain function. If the patient had an intracranial hemorrhage without loss of brain function only code 'Yes' to intracranial hemorrhage.

Target Value: Any occurrence between birth and current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: HemorrhagicStroke
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

C. Cardiac Events

Seq. #: 5117 **Name:** Hemorrhagic Stroke Date

Coding Instructions: Indicate all dates the patient had a hemorrhagic stroke.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: HemorrhagicStroke_Date
Parent Seq #: 5115
Parent Name: Hemorrhagic Stroke
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 5120 **Name:** Permanent Pacemaker

Coding Instructions: Indicate if the patient has a permanent pacemaker.

Code 'No' if the the patient had the device previously, but the device is no longer in place.

Target Value: The last value between birth and current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: PermanentPacemaker
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5122 **Name:** Permanent Pacemaker Date

Coding Instructions: Indicate all dates the patient received a permanent pacemaker.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: PermanentPacemaker_Date
Parent Seq #: 5120
Parent Name: Permanent Pacemaker
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

C. Cardiac Events

Seq. #: 5130 **Name:** Vascular Complication Requiring Intervention

Coding Instructions: 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.

A retroperitoneal bleed or hematoma requring transfusion is not a vascular complication under this data element.

Target Value: Any occurrence between birth and current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: VCRIntervention
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 5132 **Name:** Vascular Complication Requiring Intervention Date

Coding Instructions: Indicate all dates the patient had a vascular complication intervention.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: VCRIntervention_Date
Parent Seq #: 5130
Parent Name: Vascular Complication Requiring Intervention
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

D. Encounter Information

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

Short Name: Ht_inches
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Decimal (5,2)
Default Value: NULL
Usual Range:
Valid Range: 7.87 - 102.36
Data Source: 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

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

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

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

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: SystolicBP
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range: 1 - 300
Data Source: User

D. Encounter Information

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

Short Name: DiastolicBP
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range: 1 - 200
Data Source: 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

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

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

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

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

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

D. Encounter Information

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

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: CannotWeigh
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

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

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

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

Short Name: TobaccoUse
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

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

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

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

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

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

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

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

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

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

D. Encounter Information

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

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

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Smokeless
Parent Seq #: 6030
Parent Name: Tobacco Use
Parent Value: Current, Quit within past 12 months
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: 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 2.0 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

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

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

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

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: UseofTobacco_24months
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

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

Coding Instructions: Indicate the patient estimate of alcohol consumption.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Alcohol_Hist
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6050 **Name:** Advance Care Plan Discussed or Discussion of Advance Care Plan Documented

Coding Instructions: For patients 65 and older,indicate if an advance care plan was documented in the medical record or the creation of an advance care plan was discussed with the patient or surrogate decision maker.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: AdvCarePlanDiscussed
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6100 **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 1 flight of ordinary stairs at a normal pace; and in normal conditions).
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

Short Name: CCSClass
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6105 **Name:** Seattle Angina Questionnaire (SAQ) Completed

Coding Instructions: Indicate if the patient has completed the Seattle Angina Questionnaire (SAQ).

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: SAQCompleted
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6106 **Name:** Seattle Angina Questionnaire (SAQ) - Physical Function Score

Coding Instructions: Indicate the patient's Seattle Angina Questionnaire (SAQ) - Physical Function Score.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: SAQAnginaPhyFuncScore
Parent Seq #: 6105
Parent Name: Seattle Angina Questionnaire (SAQ) Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range: 0 - 100
Data Source: User

Seq. #: 6107 **Name:** Seattle Angina Questionnaire (SAQ) - Angina Stability Score

Coding Instructions: Indicate the patient's Seattle Angina Questionnaire (SAQ) - Angina Stability Score.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: SAQAnginaStabilityScore
Parent Seq #: 6105
Parent Name: Seattle Angina Questionnaire (SAQ) Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range: 0 - 100
Data Source: User

Seq. #: 6108 **Name:** Seattle Angina Questionnaire (SAQ) - Angina Frequency Score

Coding Instructions: Indicate the patient's Seattle Angina Questionnaire (SAQ) - Angina Frequency Score.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: SAQAnginaFreqScore
Parent Seq #: 6105
Parent Name: Seattle Angina Questionnaire (SAQ) Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range: 0 - 100
Data Source: User

D. Encounter Information

Seq. #: 6109 **Name:** Seattle Angina Questionnaire (SAQ) - Treatment Satisfaction Score

Coding Instructions: Indicate the patient's Seattle Angina Questionnaire (SAQ) - Treatment Satisfaction Score.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: SAQAnginaTreatmentsatiScore
Parent Seq #: 6105
Parent Name: Seattle Angina Questionnaire (SAQ) Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range: 0 - 100
Data Source: User

Seq. #: 6110 **Name:** Seattle Angina Questionnaire (SAQ) - Quality of Life Score

Coding Instructions: Indicate the patient's Seattle Angina Questionnaire (SAQ) - Quality of Life Score.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: SAQAnginaQuallifeScore
Parent Seq #: 6105
Parent Name: Seattle Angina Questionnaire (SAQ) Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range: 0 - 100
Data Source: User

Seq. #: 6115 **Name:** Other Tool/Method used to assess Angina Symptoms and Activity Completed

Coding Instructions: Indicate if another tool/method was used to assess the patient's angina symptoms and activity other than the CCS or SAQ.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: OtherAnginaToolCompleted
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6200 **Name:** New York Heart Association Functional Classification for Heart Failure

Coding Instructions: Indicate the patient's New York Heart Association functional classification for Heart Failure.

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	I	Patient has cardiac disease but without resulting limitations of ordinary physical activity. Ordinary physical activity (e.g., walking several blocks or climbing stairs) does not cause undue fatigue, palpitation, dyspnea, or anginal pain. Limiting symptoms may occur with marked exertion.
2	II	Patient has cardiac disease resulting in slight limitation of ordinary physical activity. Patient is comfortable at rest. Ordinary physical activity such as walking more than two blocks or climbing more than one flight of stairs results in limiting symptoms (e.g., fatigue, palpitation, dyspnea, or anginal pain)
3	III	Patient has cardiac disease resulting in marked limitation of physical activity. Patient is comfortable at rest. Less than ordinary physical activity (e.g., walking one to two level blocks or climbing one flight of stairs) causes fatigue, palpitation, dyspnea, or anginal pain.
4	IV	Patient has dyspnea at rest that increases with any physical activity. Patient has cardiac disease resulting in inability to perform any physical activity without discomfort. Symptoms may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Supporting Definitions: (none)

Technical Specifications

Short Name: NYHA
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6205 **Name:** Kansas City Cardiomyopathy Questionnaire Completed

Coding Instructions: Indicate if the patient has completed the Kansas City Cardiomyopathy Questionnaire (KCCQ).

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: KCCQCompleted
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6206 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Overall Summary Score

Coding Instructions: Indicate the patient's Kansas City Cardiomyopathy Questionnaire (KCCQ) - Overall Summary Score.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: KCCQOverallScore
Parent Seq #: 6205
Parent Name: Kansas City Cardiomyopathy Questionnaire Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6207 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Clinical Summary Score

Coding Instructions: Kansas City Cardiomyopathy Questionnaire (KCCQ) - Clinical Summary Score

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: KCCQClinSummScore
Parent Seq #: 6205
Parent Name: Kansas City Cardiomyopathy Questionnaire Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6208 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Physical Limitation Score

Coding Instructions: Kansas City Cardiomyopathy Questionnaire (KCCQ) - Physical Limitation Score

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: KCCQPhysLimitScore
Parent Seq #: 6205
Parent Name: Kansas City Cardiomyopathy Questionnaire Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6209 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Symptom Stability Score

Coding Instructions: Kansas City Cardiomyopathy Questionnaire (KCCQ) - Symptom Stability Score

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: KCCQSymStabScore
Parent Seq #: 6205
Parent Name: Kansas City Cardiomyopathy Questionnaire Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6210 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Self Efficacy Score

Coding Instructions: Kansas City Cardiomyopathy Questionnaire (KCCQ) - Self Efficacy Score

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: KCCQSelfEfficScore
Parent Seq #: 6205
Parent Name: Kansas City Cardiomyopathy Questionnaire Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6211 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Quality of Life Score

Coding Instructions: Kansas City Cardiomyopathy Questionnaire (KCCQ) - Quality of Life Score

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: KCCQLifeQltyScore
Parent Seq #: 6205
Parent Name: Kansas City Cardiomyopathy Questionnaire Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6212 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Social Limitation Score

Coding Instructions: Kansas City Cardiomyopathy Questionnaire (KCCQ) - Social Limitation Score

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: KCCQSocialLimitScore
Parent Seq #: 6205
Parent Name: Kansas City Cardiomyopathy Questionnaire Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6213 **Name:** Kansas City Cardiomyopathy Questionnaire (KCCQ) - Total Symptom Score

Coding Instructions: Kansas City Cardiomyopathy Questionnaire (KCCQ) - Total Symptom Score

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: KCCQTotalSymScore
Parent Seq #: 6205
Parent Name: Kansas City Cardiomyopathy Questionnaire Completed
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6220 **Name:** Chronic Heart Failure Questionnaire from Guyatt Completed

Coding Instructions: Indicate if the patient completed the Chronic Heart Failure Questionnaire from Guyatt.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: GuyattCompleted
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6225 **Name:** Minnesota Living with Heart Failure Questionnaire Completed

Coding Instructions: Indicate if the patient has completed the Minnesota Living with Heart Failure Questionnaire.

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

Short Name: MLFHQCompleted
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6230 **Name:** Other Tool/Method used to assess Heart Failure Activity Completed

Coding Instructions: Indicate if another tool/method was used to assess the patient's heart failure symptoms and activity other than the NYHA, KCCQ, Minnesota Living with Heart Failure Questionnaire or Chronic Heart Failure Score from Guyatt.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: OtherHFActvityAssmntCompleted
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6300 **Name:** Dyspnea Present

Coding Instructions: Indicate if the patient has dyspnea.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Dyspnea
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6305 **Name:** Orthopnea Present

Coding Instructions: Indicate if the patient has orthopnea.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Orthopnea
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6400 **Name:** Rales Present

Coding Instructions: Indicate if the patient has rales.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Rales
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6405 **Name:** Peripheral Edema Present

Coding Instructions: Indicate if the patient has peripheral edema.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: PeriEdema
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6410 **Name:** S3 Gallop Present

Coding Instructions: Indicate if the patient has an S3 gallop.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: S3Gallop
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6420 **Name:** Ascites Present

Coding Instructions: Indicate if the patient has Ascites.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Ascites
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6425 **Name:** Hepatomegaly Present

Coding Instructions: Indicate if the patient has Hepatomegaly.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Hepatomegaly
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6430 **Name:** S4 Gallop Present

Coding Instructions: Indicate if the patient has an S4 gallop.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: S4Gallop
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6435 **Name:** Jugular Venous Distention Present

Coding Instructions: Indicate if the patient has jugular venous distention.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: JVD
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6450 **Name:** Body Mass Index Screening

Coding Instructions: Indicate if the patient had a Body Mass Index screening was performed.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: BMIScreening
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6452 **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

Short Name: BMIScreening_Date
Parent Seq #: 6450
Parent Name: Body Mass Index Screening
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 6455 **Name:** Body Mass Index Management Plan

Coding Instructions: Indicate if the patient has a documented BMI management plan.

A BMI management plan may include the following: documentation of future appointment, education, referral, perscription/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

Short Name: BMIManagement_Plan
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6500 **Name:** Hypertension Plan of Care Documented

Coding Instructions: Indicate if the patient has a documented plan of care for hypertension.

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

Short Name: HTPlanofCare
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6505 **Name:** Cardiac Rehabilitation Referral or Plan for Qualifying Event/Diagnosis in past 12 months

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

Selections:

Code	*Selection Text*	*Definition*
1	Yes - Referral/Plan documented	
2	No qualifying event/diagnosis	
3	Patient already participating in rehab	
4	No Referral/Plan - Medical Reason	
5	No Referral/Plan - Patient Reason	
6	No Referral/Plan - System Reason	

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, et al."AACVPR/ACC/AHA 2007Performance Measures on Cardiac Rehabilitation for Referral to and Deliveryof Cardiac Rehabilitation/Secondary Prevention Services." Journal ofAmerican College of Cardiology. 2007: 50(14), pp 1400-1433

Technical Specifications

Short Name: CardRehabReferral
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6509 **Name:** HF Education Completed/Documented

Coding Instructions: Element retired (v1.2)

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: HFEduCompleted
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: No Action
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6510 **Name:** HF Education - All of the following

Coding Instructions: Indicate if the patient received all of the following education for heart failure.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: HFEduAll
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6511 **Name:** HF Education - Weight Monitoring

Coding Instructions: Indicate if the patient received weight monitoring education for heart failure.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: HFEduWtMonitoring
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6512 **Name:** HF Education - Diet (Sodium Restriction)

Coding Instructions: Indicate if the patient received a sodium-restricted dietary education for heart failure.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: HFEduDiet
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6513 **Name:** HF Education - Symptom Management

Coding Instructions: Indicate if the patient received symptom management education for heart failure.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: HFEduSympMgmt
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6514 **Name:** HF Education - Physical Activity

Coding Instructions: Indicate if the patient received physical activityeducation 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

Short Name: HFEduPhyAct
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6515 **Name:** HF Education - Smoking Cessation

Coding Instructions: Indicate if the patient received smoking cessation education for heart failure.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: HFEduSmokeCess
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6516 **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

Short Name: HFEduMedInstr
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6517 **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

Short Name: HFEduPrognosis
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6518 **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

Short Name: HFEduNSAIDs
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6519 **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

Short Name: HFEduPgms
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6600 **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 episode detected	
2	Chronic - paroxysmal	
3	Chronic - persistent/permanent	

Supporting Definitions: (none)

Technical Specifications

Short Name: Afib_Dur
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6605 **Name:** AFib/Flutter Type

Coding Instructions: Indicate the if the patient has valvular of non-valvular AFib/Flutter

Target Value: The value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Non - valvular	
2	Valvular	

Supporting Definitions: (none)

Technical Specifications

Short Name: Afib_Type
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6610 **Name:** Etiology - Transient/reversible Cause

Coding Instructions: Indicate if the patient's AFib/Flutter is due to a transient and/or reversible cause.

Note(s):

Effective PINNACLE 2.0 code 'Yes' for all transient and/or reversible causes of atrial fibrillation/flutter. This includes cardiac surgery, hyperthyroidism, pregnancy, pneumonia.

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Afib_Etiology_rev_cause
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6611 **Name:** Etiology - Cardiac Surgery within past 3 months

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

Code 'Yes' for transient/reversible causes of atrial fibrillation/flutter due to cardiac surgery.

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Afib_Etiology_Card_Srg
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6612 **Name:** Etiology - Pregnancy

Coding Instructions: This element has been retired effective PINNACLE 1.3. Code 'Yes' for transient/reversible causes of atrial fibrillation/flutter due to pregnancy.

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: Afib_Etiology_Pregnancy
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6615 **Name:** Thromboembolic Risk Factors Assessed

Coding Instructions: Indicate if the patient's thromboembolic risk factors for atrial fibrillation or flutter were assessed and documented in the chart.

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

Selections:

Code	*Selection Text*	*Definition*
1	Yes (All risk factors assessed)	
2	No - Medical Reason	
3	No - Patient Reason	
4	No - System Reason	Selection Retired (v1.2)

Supporting Definitions: (none)

Technical Specifications

Short Name: ThrombRskFact
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6617 **Name:** International Normalized Ratio (INR) Date

Coding Instructions: Indicate all dates the patient's International Normalized Ratio (INR) was assessed.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: INR_Dt
Parent Seq #: 6618
Parent Name: International Normalized Ratio (INR) Value
Parent Value: Not Nulll
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

D. Encounter Information

Seq. #: 6618 **Name:** International Normalized Ratio (INR) Value

Coding Instructions: Indicate all values of the patient's International Normalized Ratio (INR).

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: INR_Value
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: No Action
Harvested: Yes
Format: Decimal (3,1)
Default Value: NULL
Usual Range:
Valid Range: 0.1 - 99.0
Data Source: User

Seq. #: 6620 **Name:** Electrophysiology Study

Coding Instructions: Indicate if the patient received an electrohysiology study (EP study).

An EP study consists of one or more catheters capable of recording and pacing which are placed in one or more of the cardiac chambers. The catheters may be used to measure conduction of the impulse from the sinus node to the ventricle; induce a tachycardia; and/or localize (map) the location where the tachycardia originates.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: EPStudy
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6622 **Name:** Electrophysiology Study Date

Coding Instructions: Indicate all dates the patient received an electrophysiology study.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: EPStudy_Date
Parent Seq #: 6620
Parent Name: Electrophysiology Study
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

D. Encounter Information

Seq. #: 6625 **Name:** Atrial Ablation

Coding Instructions: Indicate if an atrial ablation was performed.

Ablation is the application of an energy source delivered through a catheter to eliminate or modify a focus or re-entry circuit that causes an arrhythmia.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: AtrialAblation
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6627 **Name:** Atrial Ablation Date

Coding Instructions: Indicate all dates the patient received an atrial ablation.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: AtrialAblation_Date
Parent Seq #: 6625
Parent Name: Atrial Ablation
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 6630 **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

Short Name: AFRecurrence
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6632 **Name:** Atrial Fibrillation Recurrence Date

Coding Instructions: Indicate all dates the patienthad an atrial fibrillation recurrence.

Target Value: Unable to produce target value = value of interest not recognized.

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: AFRecurrence_Date
Parent Seq #: 6630
Parent Name: Atrial Fibrillation Recurrence
Parent Value: Yes
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 6635 **Name:** Atrial Fibrillation Symptom Frequency

Coding Instructions: Indicate the patient estimate of average interval, in days, between symptomatic episodes of atrial fibrillation.

Target Value: The value between birth and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: AFSymptom_Frequency
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Integer (5)
Default Value: No
Usual Range:
Valid Range: 1 - 99999
Data Source: User

Seq. #: 6640 **Name:** Atrial Fibrillation Symptom Duration

Coding Instructions: Indicate the patient estimate of duration of usual symptomatic episodes for atrial fibrillation.

Target Value: The value 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

Short Name: AFSymptom_Duration
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

D. Encounter Information

Seq. #: 6645 **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
- Nonpharmacological
- Hybrid

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: RateControl
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 6650 **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
- Nonpharmacological
- Hybrid

Target Value: The value on current encounter

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: RhythmControl
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

E. Laboratory Results

Seq. #: 7000 **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

Short Name: LVEF_Date
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 7005 **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

Short Name: LVEF
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Integer (2)
Default Value: NULL
Usual Range:
Valid Range: 1-99
Data Source: User

Seq. #: 7010 **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	
2	Mildly reduced: 40 - 49	
3	Moderately reduced: 26 - 39	
4	Severely reduced: <=25	

Supporting Definitions: (none)

Technical Specifications

Short Name: LV_Qlty_Assemnt
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

E. Laboratory Results

Seq. #: 7015 **Name:** Lipid Panel Obtained Date

Coding Instructions: Indicate the date blood was drawn for the most recent lipid panel.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: LipidPanelDate
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

Seq. #: 7020 **Name:** Lipid Panel Fasting

Coding Instructions: Indicate if the patient fasted or not prior to having blood drawn for the most recent lipid panel.

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

Selections:

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

Supporting Definitions: (none)

Technical Specifications

Short Name: LipidPanelFasting
Parent Seq #: 7015
Parent Name: Lipid Panel Obtained Date
Parent Value: Not Null
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 7025 **Name:** Total Cholesterol

Coding Instructions: Indicate the patient's most recent cholesterol in milligrams per deciliter (mg/dL) for the most recent lipid panel.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: TotalCholesterol
Parent Seq #: 7015
Parent Name: Lipid Panel Obtained Date
Parent Value: Not Null
Missing Data: Report
Harvested: Yes
Format: Integer (4)
Default Value: NULL
Usual Range:
Valid Range: 1 - 1000
Data Source: User

E. Laboratory Results

Seq. #: 7030 **Name:** High Density Lipoprotein (HDL)

Coding Instructions: Indicate the patient's most recent high density lipoproteins (HDL) in milligrams per deciliter (mg/dL) for the most recent lipid panel.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: HDL
Parent Seq #: 7015
Parent Name: Lipid Panel Obtained Date
Parent Value: Not Null
Missing Data: Report
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range: 1-300
Data Source: User

Seq. #: 7035 **Name:** Low Density Lipoprotein (LDL)

Coding Instructions: Indicate the patient's most recent low density lipoproteins (LDL) in milligrams per deciliter (mg/dL) for the most recent lipid panel.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: LDL
Parent Seq #: 7015
Parent Name: Lipid Panel Obtained Date
Parent Value: Not Null
Missing Data: Report
Harvested: Yes
Format: Integer (3)
Default Value: NULL
Usual Range:
Valid Range: 1 - 800
Data Source: User

Seq. #: 7040 **Name:** Triglycerides

Coding Instructions: Indicate the patient's most recent triglycerides in milligrams per deciliter (mg/dL) for the most recent lipid panel.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: Triglycerides
Parent Seq #: 7015
Parent Name: Lipid Panel Obtained Date
Parent Value: Not Null
Missing Data: Report
Harvested: Yes
Format: Integer (4)
Default Value: NULL
Usual Range:
Valid Range: 1 - 7000
Data Source: User

E. Laboratory Results

Seq. #: 7045 **Name:** Lipid Panel Ordered

Coding Instructions: Indicate if the physician ordered a lipid panel.

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

Short Name: LipidPanelOrdered
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 7050 **Name:** Serum Glucose Ordered

Coding Instructions: Indicate if the physician ordered a serum glucose test.

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

Short Name: GlucoseOrdered
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 7055 **Name:** Glucose Date

Coding Instructions: Indicate the date blood was drawn for the most recent serum glucose test.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: SerumGlucoseDate
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

E. Laboratory Results

Seq. #: 7060 **Name:** Glucose

Coding Instructions: Indicate the patient's serum glucose level in milligrams per deciliter (mg/dL) for the most recent serum glucose test..

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: SerumGlucose
Parent Seq #: 7055
Parent Name: Glucose Date
Parent Value: Not Null
Missing Data: Report
Harvested: Yes
Format: Integer (4)
Default Value: NULL
Usual Range:
Valid Range: 1 - 1500
Data Source: User

Seq. #: 7065 **Name:** Glucose Timing

Coding Instructions: Indicate the timing of the serum glucose test with respect to food intake for the most recent serum glucose test.

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

Selections:

Code	*Selection Text*	*Definition*
1	Fasting	
2	2 hr Glucose Tolerance Testing	
3	Random	
4	Unknown	

Supporting Definitions: (none)

Technical Specifications

Short Name: SerumGlucoseTiming
Parent Seq #: 7055
Parent Name: Glucose Date
Parent Value: Not Null
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 7070 **Name:** HbA1c Date

Coding Instructions: Indicate the date blood was drawn for the most recent Hemoglobin A1c (HbA1c) test.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: HbA1cDate
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

E. Laboratory Results

Seq. #: 7075 **Name:** HbA1c Percentage

Coding Instructions: Indicate the patient's Hemoglobin A1c (HbA1c) percentage for the most recent Hemoglobin A1c (HbA1c) test.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: HbA1c
Parent Seq #: 7070
Parent Name: HbA1c Date
Parent Value: Not Null
Missing Data: Report
Harvested: Yes
Format: Decimal (4,1)
Default Value: NULL
Usual Range:
Valid Range: 0.1-100.0
Data Source: User

Seq. #: 7080 **Name:** Initial Labs ordered for newly diagnosed Heart Failure (within past 12 months) or patient new to the practice

Coding Instructions: Indicate if the physician ordered Initial Labs for newly diagnosed Heart Failure. Newly diagnosed Heart Failure is defined as HF diagnosed within the past 12 months.

Target Value: The value 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

Short Name: InitialLabsforHF
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: No
Usual Range:
Valid Range:
Data Source: User

Seq. #: 7090 **Name:** Estimated Glomerular Filtration Rate Electronic Medical Record

Coding Instructions: Indicate the most recent estimated glomerular filtration rate in ml/min as recorded in electronic medical record.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: eGFR_Emr
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Decimal (5,2)
Default Value: NULL
Usual Range:
Valid Range: 0.01 - 999.99
Data Source: User

E. Laboratory Results

Seq. #: 7095 **Name:** Estimated Glomerular Filtration Rate Imputed

Coding Instructions: Indicate the most recent imputed glomerular filtration rate in ml/min.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: eGFR_Imputed
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Decimal (5,2)
Default Value: NULL
Usual Range:
Valid Range: 0.01 - 999.99
Data Source: User

Seq. #: 7100 **Name:** Creatinine Clearance

Coding Instructions: Indicate the most recent document creatinine clearance rate.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: CreatinineClearance
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Decimal (5,2)
Default Value: NULL
Usual Range:
Valid Range: 0.01 - 999.99
Data Source: User

Seq. #: 7102 **Name:** Creatinine Clearance Date

Coding Instructions: Indicate the most recent documented date where creatinine clearance rate was recorded.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: CreatinineClearance_Date
Parent Seq #: 7100
Parent Name: Creatinine Clearance
Parent Value: Not Null
Missing Data: No Action
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: User

E. Laboratory Results

Seq. #: 7105 **Name:** Creatinine Clearance Units

Coding Instructions: Indicate the units used to record the creatinine clearance rate.

Target Value: The value on current encounter

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

Short Name: CreatinineClearance_Units
Parent Seq #: 7100
Parent Name: Creatinine Clearance
Parent Value: Not Null
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

F. Prescriptions

Seq. #: 8000 **Name:** Prescription given for any Medication

Coding Instructions: Indicate if at least one prescription was given for any medication to the patient during the encounter.

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

Short Name: RxEncounter
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 8005 **Name:** Prescription generated and transmitted using an e-prescribing system

Coding Instructions: Indicate if at least one prescription was generated and transmitted using a qualified e-prescribing system during the encounter.

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

Short Name: Erx
Parent Seq #: 8000
Parent Name: Prescription given for any Medication
Parent Value: Yes
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9000 **Name:** ACE Inhibitor prescribed or continued

Coding Instructions: Indicate if the patient had an ACE Inhibitor prescribed or continued.

Note(s):

An Angiotensin-Converting Enzyme inhibitor (ACE inhibitor) reduces the conversion of angiotensin I to
angiotensin II, a potent vasoconstrictor and is also involved in the inactivation of bradykinin, a potent vasodilator.

Examples of ACE Inhibitors include benazopril (Lotensin), fosinopril (Monopril), enalapril (Vasotec), lisinopril (Prinivil, Zestril), moexipril (Univasc), perindopril (Aceon), quinapril (Accupril), ramipril (Altace), and trandolapril
(Mavik).

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: ACEInhibitor
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9005 **Name:** Clopidogrel prescribed or continued

Coding Instructions: Indicate if the patient had Clopidogrel prescribed or continued.

Note(s):

Clopidogrel, an adenosine diphosphate (ADP) receptor inhibitor, is an antiplatelet agent. The brand name for
Clopidogrel is Plavix.

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Clopidogrel
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9010 **Name:** Ticlopidine prescribed or continued

Coding Instructions: Indicate if the patient had Ticlopidine prescribed or continued.

Note(s):

Ticlopidine, an adenosine diphosphate (ADP) receptor inhibitor, is an antiplatelet agent. The brand name for Ticlopidine is Ticlid.

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Ticlopidine
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9015 **Name:** Prasugrel prescribed or continued

Coding Instructions: Indicate if the patient had Prasugrel prescribed or continued.

Note(s):

Prasugrel, an adenosine diphosphate (ADP) receptor inhibitor, is an antiplatelet agent. The brand name for Prasugrel is Effient.

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Prasugrel
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9020 **Name:** Aggrenox prescribed or continued

Coding Instructions: Indicate if the patient had Aggrenox prescribed or continued.

Note(s):

Aggrenox is an a combination antiplatelet agent that contains Dipyridamole and Aspirin.

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Aggrenox
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9025 **Name:** Angiotensin Receptor Blocker (ARB) prescribed or continued

Coding Instructions: Indicate if the patient had an ARB prescribed or continued.

Note(s):

Angiotensin receptor blockers (ARBs) are medications that block the action of angiotensin II which is a very potent chemical that causes the muscles surrounding the blood vessels to contract, thereby narrowing the blood vessels. Examples of Angiotensin Receptor Blockers include irbesartan (Avapro), candesartan (Atacand), losartan (Cozaar), valsartan (Diovan), telmisartan (Micardis), eprosartan (Tevetan), and olmesartan (Benicar).

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: ARB
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9030 **Name:** Aspirin prescribed or continued

Coding Instructions: Indicate if the patient had Aspirin prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Aspirin
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9035 **Name:** Beta Blocker prescribed or continued

Coding Instructions: Indicate if the patient had a Beta Blocker prescribed or continued.

Note(s):

Beta blockers are a class of drugs used for various indications, but particularly for the management of cardiac arrhythmias and cardio protection after myocardial infarction.

Examples of Beta blockers include acebutolol (Sectral), atenolol (Tenormin), bisoprolol (Zebeta), metoprolol (Lopressor, Lopressor LA, Toprol XL), nadolol (Corgard) and timolol (Blocadren).

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: BetaBlocker
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9040 **Name:** Calcium Channel Blockers

Coding Instructions: Indicate if the patient had a Calcium Channel Blocker prescribed or continued.

Note(s):

Calcium channel blockers are a class of drugs that block the entry of calcium into the muscle cells of the heart and the arteries.

Examples of CCBs include nisoldipine (Sular), nifedipine (Adalat, Procardia), nicardipine (Cardene), bepridil (Vascor), isradipine (Dynacirc), nimodipine (Nimotop), felodipine (Plendil), amlodipine (Norvasc), diltiazem (Cardizem), and verapamil (Calan, Isoptin).

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: CaChaBlocker
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9045 **Name:** Diuretics prescribed or continued

Coding Instructions: Indicate if the patient had a Diuretic prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Diuretics
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9050 **Name:** Lipid-lowering Non-Statin Medication prescribed or continued

Coding Instructions: Indicate if the patient had a Non-Statin Lipid-lowering Medication prescribed or continued.

Note(s):

Lipid-lowering non-statin medications assist in lowering lipid levels. Examples of non-statin lipid lowering agents include fibrates (e.g. Clofibrate, Bezafibrate, or Ciprofibrate), colestyramine (Questran/Questran Light), colestipol (Colestid), and nicotinic acid (Niacin).

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: LipidLoweringNonStatin
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9055 **Name:** Lipid-lowering Statin Medication prescribed or continued

Coding Instructions: Indicate if the patient had a Statin Lipid-lowering Medication prescribed or continued.

Note(s):

Lipid-lowering statin medications assist in lowering lipid levels. Examples of statin lipid lowering agents include lovastatin (Mevacor), pravastatin (Pravachol), simvastatin (Zocor), atorvastatin (Lipitor) and rosuvastatin (Crestor).

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: LipidLoweringStatin
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9060 **Name:** Warfarin prescribed or continued

Coding Instructions: Indicate if the patient had Warfarin prescribed or continued.

Note(s):

Warfarin is an anticoagulant. Examples of Warfarin include Coumadin, Jantoven, Marevan, and Waran.

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Warfarin
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9065 **Name:** Varenicline presecribed or continued

Coding Instructions: Indicate if the patient had Varenicline prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Varenicline
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9070 **Name:** Nicotine Replacement Therapy presecribed or continued

Coding Instructions: Indicate if the patient had a nicotine replacement prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Nicotine_Replacement
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9075 **Name:** Bupropion presecribed or continued

Coding Instructions: Indicate if the patient had Buproprion prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Bupropion
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9080 **Name:** Apixaban prescribed or continued

Coding Instructions: Indicate if the patient had Apixaban prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Apixaban
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9085 **Name:** Dabigatran prescribed or continued

Coding Instructions: Indicate if the patient had Dabigatran prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Dabigatran
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9090 **Name:** Rivaroxaban prescribed or continued

Coding Instructions: Indicate if the patient had Rivaroxaban prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Rivaroxaban
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9095 **Name:** Combination Antihypertensive presecribed or continued

Coding Instructions: Indicate if the patient had a combination antihypertensive prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Combination_Antihypertensive
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9100 **Name:** Nitroglycerin prescribed or continued

Coding Instructions: Indicate if the patient had Nitroglycerin prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Nitroglycerin
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9105 **Name:** Ranolazine prescribed or continued

Coding Instructions: Indicate if the patient had Ranolazine prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Ranolazine
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9115 **Name:** Antiarrythmic prescribed or continued

Coding Instructions: Indicate if the patient had Antiarrythmic prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Antiarrythmic
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9120 **Name:** Amiodarone prescribed or continued

Coding Instructions: Indicate if the patient had Amiodarone prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Amiodarone
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9125 **Name:** Dronedarone prescribed or continued

Coding Instructions: Indicate if the patient had Dronedarone prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Dronedarone
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9130 **Name:** Ticagrelor prescribed or continued

Coding Instructions: Indicate if the patient had Ticagrelor prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Ticagrelor
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9135 **Name:** Insulin prescribed or continued

Coding Instructions: Indicate if the patient had Insulin prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Insulin
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9140 **Name:** Metformin prescribed or continued

Coding Instructions: Indicate if the patient had Metformin prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Metformin
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9145 **Name:** Pioglitazone prescribed or continued

Coding Instructions: Indicate if the patient had Pioglitazone prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Pioglitazone
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9150 **Name:** Rosiglitazone prescribed or continued

Coding Instructions: Indicate if the patient had Rosiglitazone prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Rosiglitazone
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9155 **Name:** Atenolol prescribed or continued

Coding Instructions: Indicate if the patient had Atenolol prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Atenolol
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9160 **Name:** Metroprolol prescribed or continued

Coding Instructions: Indicate if the patient had Metroprolol prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Metroprolol
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9165 **Name:** Nebivolol prescribed or continued

Coding Instructions: Indicate if the patient had Nebivolol prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Nebivolol
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9170 **Name:** Atorvastatin prescribed or continued

Coding Instructions: Indicate if the patient had Atorvastatin prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Atorvastatin
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9175 **Name:** Rosuvastatin prescribed or continued

Coding Instructions: Indicate if the patient had Rosuvastatin prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Rosuvastatin
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9180 **Name:** Simvastatin prescribed or continued

Coding Instructions: Indicate if the patient had Simvastatin prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Simvastatin
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9185 **Name:** Corticosteriods prescribed or continued

Coding Instructions: Indicate if the patient had Corticosteriods prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Corticosteriods
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9190 **Name:** Digoxin prescribed or continued

Coding Instructions: Indicate if the patient had Digoxin prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: Digoxin
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9195 **Name:** NSAID prescribed or continued

Coding Instructions: Indicate if the patient had a Non-Steroidal Anti-Inflammatory Drug (NSAID) prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: NSAID
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

G. Medications

Seq. #: 9200 **Name:** Proton Pump Inhibitor prescribed or continued

Coding Instructions: Indicate if the patient had a Proton Pump Inhibitor prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: PPInhibitor
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9205 **Name:** SSRI prescribed or continued

Coding Instructions: Indicate if the patient had a Selective Serotonin Reuptake Inhibitor (SSRI) prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Code	*Selection Text*	*Definition*
1	Yes	
2	No - Medical reason	
3	No - Patient reason	
4	No - System reason	

Supporting Definitions: (none)

Technical Specifications

Short Name: SSRI
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

H. 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

Short Name: HospitalAdmit_Date
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Date (mm/dd/yyyy)
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: 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

Short Name: Admission_Reason_Code
Parent Seq #: 9500
Parent Name: Hospital Admission Date
Parent Value: Not Null
Missing Data: Report
Harvested: Yes
Format: Text (20)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Seq. #: 9510 **Name:** Coding Standard

Coding Instructions: Indicate the coding standard used in recording admission reason.

Target Value: The value between birth and current encounter

Selections:

Code	*Selection Text*	*Definition*
1	ICD-9	
2	ICD-10	

Supporting Definitions: (none)

Technical Specifications

Short Name: Coding_Standard
Parent Seq #: 9505
Parent Name: Primary Reason for Admission
Parent Value: Not Null
Missing Data: Report
Harvested: Yes
Format: Text (Categorical)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: User

Z. Administration

Seq. #: 1000 **Name:** Data File Name

Coding Instructions: Indicate the name of the XML export data file.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: DataFile_Name
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Illegal
Harvested: Yes
Format: Text (100)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: Auto

Seq. #: 1005 **Name:** Data File Creation Date Time

Coding Instructions: Indicate the date and time the XML file was created.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: DataFile_CreationDtTime
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Illegal
Harvested: Yes
Format: DateTime (yyyy-mm-d
Default Value: NULL
Usual Range:
Valid Range: 01/01/1850 -
Data Source: Auto

Seq. #: 1010 **Name:** Data File Total Visits

Coding Instructions: Indicate the total number of patient encounters in the export file.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: Datafile_TotalVisits
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Illegal
Harvested: Yes
Format: Integer (9)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: Auto

Z. Administration

Seq. #: 1015 **Name:** Data File Source Identification Number

Coding Instructions: Indicate the identifier associated with the Electronic Medical Record vendor that created the XML file. Please contact the NCDR to obtain your data source identifier.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: Datafile_SourceID
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (20)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: Auto

Seq. #: 1020 **Name:** Practice Total Visits

Coding Instructions: Indicate the total number of patient encounters for the practice.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: Practice_TotalVisits
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Illegal
Harvested: Yes
Format: Integer (9)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: Auto

Seq. #: 1025 **Name:** Location Total Visits

Coding Instructions: Indicate the total number of patient encounters for the location.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: Location_TotalVisits
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Illegal
Harvested: Yes
Format: Integer (9)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: Auto

Z. Administration

Seq. #: 1030 **Name:** Encounter Unique Key

Coding Instructions: If applicable, indicate the unique key associated with each patient encounter as assigned by your software application.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

Short Name: EncounterKey
Parent Seq #:
Parent Name:
Parent Value:
Missing Data: Report
Harvested: Yes
Format: Text (50)
Default Value: NULL
Usual Range:
Valid Range:
Data Source: Auto