**CAPriCORN Variable Tables of Available Data**

The tables below provide a description of variables with available data. Please select variables from the tables that meet the needs of your data request.

**DEMOGRAPHIC TABLE**

“Demographics record the direct attributes of individual patients.”

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| CAP\_ID | Patient-level identifier used to link across tables.  CAP\_ID is a pseudoientifier with a consistent crosswalk to the true identifier retained by the source Data Partner. |  |
| BIRTH\_DATE | Date of birth |  |
| SEX | Administrative sex. The “Ambiguous” category may be used for individuals who are physically undifferentiated from birth. The “Other” category may be used for individuals who are undergoing gender re-assignment. | AMBIGUOUS  Male  Female  NO INFORMATION  UNKNOWN  OTHER |
| ZIP | Zip Code |  |
| ZIPPREFIX | First 3 digits of Zip Code |  |
| RACE | Please use only one race value per patient. Details of categorical definitions: American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.  Asian: A person 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.  Black or African American: A person having origins in any of the black racial groups of Africa.  Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.  White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. | AMERICAN INDIAN ALASKAN NATIVE  ASIAN  BLACK OR AA  NATIVE HAWAIIAN OR PACIFIC ISLANDER  WHITE  Multiple Race  REFUSE TO ANSWER  NO INFORMATION  UNKNOWN  OTHER |
| HISPANIC | A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. | YES  NO  NO INFORMATION  UNKNOWN  Refuse to answer  OTHER |
| PREFFERED\_LANGUAGE | Preferred language of patient |  |

**Encounter Table**

“Encounters are interactions between patients and providers within the context of healthcare delivery.”

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| ENCOUNTERID | Arbitrary encounter-level ientifier. Used to link across tables including CAP\_ENCOUNTERS, CAP\_DIAGNOSES, CAP\_PROCEDURES |  |
| VISIT\_NUMBER | Ordered number of encounter in a particular MONTH.  Only necessary if more than one visit occurs in a month- otherwise this variable will always be 1. |  |
| INSURANCE | Insurance Type of the patient | MEDICARE  MEDICAID  PRIVATE INSURANCE  SELF PAY  NO CHARGE  OTHER |
| ENC\_TYPE | Encounter type.  Details of categorical definitions: Ambulatory Visit: Includes visits at outpatient clinics, physician offices, same day/ambulatory surgery centers, urgent care facilities, and other same-day ambulatory hospital encounters, but excludes emergency department encounters.  Emergency Department (ED): Includes ED encounters that become inpatient stays (in which case inpatient stays would be a separate encounter). Excludes urgent care visits. ED claims should be pulled before hospitalization claims to ensure that ED with subsequent admission won't be rolled up in the hospital event.  Emergency Department Admit to Inpatient Hospital Stay: Permissible substitution for preferred state of separate ED and IP records. Only for use with data sources where the individual records for ED and IP cannot be distinguished.  Inpatient Hospital Stay: Includes all inpatient stays, including: same-day hospital discharges, hospital transfers, and acute hospital care where the discharge is after the admission date.  Non-Acute Institutional Stay: Includes hospice, skilled nursing facility (SNF), rehab center, nursing home, residential, overnight non-hospital dialysis and other non-hospital stays.  Other Ambulatory Visit: Includes other non-overnight AV encounters such as hospice visits, home health visits, skilled nursing facility visits, other non-hospital visits, as well as telemedicine, telephone and email consultations. May also include "lab only" visits (when a lab is ordered outside of a patient visit), "pharmacy only" (e.g., when a patient has a refill ordered without a face-to-face visit), "imaging only", etc. | AMBULATORY VISIT  EMERGENCY DEPARTMENT  EMERGENCY DEPARTMENT TO INPATIENT HOSPITAL STAY  INPATIENT HOSPITAL STAY  NON-ACUTE INSTITUTIONAL STAY  OTHER AMBULATORY VISIT  NO INFORMATION  UNKNOWN  OTHER |
| ADMIT\_DATE | Encounter of admission time |  |
| DISCHARGE\_DATE | Date and time of Discharge.   Should be populated for all Inpatient Hospital Stay (IP) and Non-Acute Institutional Stay (IS) encounter types. May be populated for Emergency Department (ED) and ED-to-inpatient (EI) encounter types. Should be missing for ambulatory visit (AV or OA) encounter types. |  |
| DISCHARGE\_DISPOSITION | Vital status at discharge. Should be populated for Inpatient Hospital Stay (IP) and Non-Acute Institutional Stay (IS) encounter types. May be populated for Emergency Department (ED) and ED-to-Inpatient (EI) encounter types. Should be missing for ambulatory visit (AV or OA) encounter types. (Additional guidance added in v3.0 for the EI encounter type.) | DISCHARGED ALIVE  EXPIRED  NO INFORMATION  UNKNOWN  OTHER |
| DISCHARGE\_STATUS | Discharge status. Should be populated for Inpatient Hospital Stay (IP) and Non-Acute Institutional Stay (IS) encounter types. May be populated for Emergency Department (ED) and ED-to-Inpatient (EI) encounter types. Should be missing for ambulatory visit (AV or OA) encounter types. (Additional guidance added in v3.0 for the EI encounter type.) | ADULT FOSTER HOME  ASSISTED LIVING FACILITY  AGAINST MEDICAL ADVICE  ABSENT WITHOUT LEAVE  EXPIRED  HOME HEALTH  HOME / SELF CARE  HOSPICE  OTHER ACUTE INPATIENT HOSPITAL  NURSING HOME (INCLUDING ICF)  REHABILITATION FACILITY  RESIDENTIAL FACILITY  STILL IN HOSPITAL  SKILLED NURSING FACILITY  NO INFORMATION  UNKNOWN  OTHER |
| DRG | 3-digit Diagnosis Related Group (DRG). Should be populated for IP and IS encounter types. May be populated for Emergency Department (ED) and ED-to-Inpatient (EI) encounter types. Should be missing for AV or OA encounters. Use leading zeroes for codes less than 100.   The DRG is used for reimbursement for inpatient encounters. It is a Medicare requirement that combines diagnoses into clinical concepts for billing. Frequently used in observational data analyses. |  |
| DRG\_TYPE | DRG code version. MS-DRG (current system) began on 10/1/2007. Should be populated for IP and IS encounter types. May be populated for Emergency Department (ED) and ED-to-Inpatient (EI) encounter types. Should be missing for AV or OA encounters. (Additional guidance added in v3.0 for the EI encounter type.) | CMS-DRG (Old System)  MS-DRG (current system)  NO INFORMATION  UNKNOWN  OTHER |
| FACILITY\_ID | Arbitrary local facility code that identifies the hospital or clinic. Used for chart abstraction and validation.  FACILITYID can be a true identifier, or a pseudoidentifier with a consistent crosswalk to the true identifier retained by the source Data Partner. |  |
| FACILITY\_LOCATION | Geographic location (3 digit zip code). Should be null if not recorded in source system. |  |
| PROVIDERID | Provider code for the provider who is most responsible for this encounter. For encounters with multiple providers choose one so the encounter can be linked to the diagnosis and procedure tables. As with the PATID, the provider code is a pseudoidentifier with a consistent crosswalk to the real identifier. |  |
| ADMITTING\_SOURCE | Admitting source. Should be populated for Inpatient Hospital Stay (IP) and Non-Acute Institutional Stay (IS) encounter types. May be populated for Emergency Department (ED) and ED-to-Inpatient (EI) encounter types. Should be missing for ambulatory visit (AV or OA) encounter types. | ADULT FOSTER HOME  ASSISTED LIVING FACILITY  AMBULATORY VISIT  EMERGENCY DEPARTMENT  HOME HEALTH  HOME / SELF CARE  HOSPICE  OTHER ACUTE INPATIENT HOSPITAL  NURSING HOME (INCLUDING ICF)  REHABILITATION FACILITY  RESIDENTIAL FACILITY  SKILLED NURSING FACILITY  NO INFORMATION  UNKNOWN  OTHER |

**Diagnosis Table**

“Diagnosis codes indicate the results of diagnostic processes and medical coding within healthcare delivery. Data in this table are expected to be from healthcare-mediated processes and reimbursement drivers.”

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| DIAGNOSISID | Arbitary identifier for each unique record. May be generated sequentially. |  |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| ENCOUNTERID | Arbitrary encounter-level ientifier. Used to link across tables including CAP\_ENCOUNTERS, CAP\_DIAGNOSES, CAP\_PROCEDURES |  |
| VISIT\_NUMBER | Please note: This is a field replicated from the ENCOUNTER table. See the ENCOUNTER table for definitions. |  |
| ENC\_TYPE | Please note: This is a field replicated from the ENCOUNTER table. See the ENCOUNTER table for definitions. | AMBULATORY VISIT  EMERGENCY DEPARTMENT  EMERGENCY DEPARTMENT TO INPATIENT HOSPITAL STAY  INPATIENT HOSPITAL STAY  NON-ACUTE INSTITUTIONAL STAY  OTHER AMBULATORY VISIT  NO INFORMATION  UNKNOWN  OTHER |
| ADMIT\_DATE | Please note: This is a field replicated from the ENCOUNTER table. See the ENCOUNTER table for definitions. |  |
| PROVIDERID | Please note: This is a field replicated from the ENCOUNTER table. See the ENCOUNTER table for definitions. |  |
| DX | Diagnosis code.   Leading zeroes and different levels of decimal precision are permissible in this field. Please populate the exact textual value of this diagnosis code, but remove source-specific suffixes and prefixes. Other codes should be listed as recorded in the source data. |  |
| DX\_TYPE | Diagnosis code type.   We provide values for ICD and SNOMED code types. Other code types will be added as new terminologies are more widely used.  Please note: The “Other” category is meant to identify internal use ontologies and codes. | ICD-9  ICD-10  ICD-11  SNOMED  NO INFORMATION  UNKNOWN  OTHER |
| DX\_SOURCE | Classification of diagnosis source. We include these categories to allow some flexibility in implementation. The context is to capture available diagnoses recorded during a specific encounter. It is not necessary to populate interim diagnoses unless readily available.  Ambulatory encounters would generally be expected to have a source of “Final.” | Admitting  Discharge  Final  Interim  No information  Unknown  Other |
| PDX | Classification of diagnosis source. We include these categories to allow some flexibility in implementation. The context is to capture available diagnoses recorded during a specific encounter. It is not necessary to populate interim diagnoses unless readily available.  Ambulatory encounters would generally be expected to have a source of “Final.” | Principal  Secondary  Unable to Classify  No information  Unknown  Other |
| PRESENT\_ON\_ADMISSION | Flag to indicate if Diagnosis (DX) was present on admission. "1" indicates present | PRESENT ON ADMISSION  NOT PRESENT ON ADMISSION |

**Procedures Table**

“Procedure codes indicate the discreet medical interventions and diagnostic testing, such as surgical procedures and lab orders, delivered within a healthcare context.”

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| PROCEDURESID | Arbitary identifier for each unique record. May be generated sequentially. |  |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| ENCOUNTERID | Arbitrary encounter-level ientifier. Used to link across tables including CAP\_ENCOUNTERS, CAP\_DIAGNOSES, CAP\_PROCEDURES |  |
| VISIT\_NUMBER | Please note: This is a field replicated from the ENCOUNTER table. See the ENCOUNTER table for definitions. |  |
| ENC\_TYPE | Please note: This is a field replicated from the ENCOUNTER table. See the ENCOUNTER table for definitions. | AMBULATORY VISIT  EMERGENCY DEPARTMENT  EMERGENCY DEPARTMENT TO INPATIENT HOSPITAL STAY  INPATIENT HOSPITAL STAY  NON-ACUTE INSTITUTIONAL STAY  OTHER AMBULATORY VISIT  NO INFORMATION  UNKNOWN  OTHER |
| ADMIT\_DATE | Please note: This is a field replicated from the ENCOUNTER table. See the ENCOUNTER table for definitions. |  |
| PROVIDERID | Please note: This is a field replicated from the ENCOUNTER table. See the ENCOUNTER table for definitions. |  |
| PX\_DATE | Date and time when procedure was performed |  |
| PX | Procedure code |  |
| PX\_TYPE | Procedure code type.  We include a number of code types for flexibility, but the basic requirement that the code refer to a medical procedure remains.  Revenue codes are a standard concept in Medicare billing and can be useful for defining care settings. If those codes are available they can be included.  Medications administered by clinicians can be captured in billing data and Electronic Health Records (EHRs) as HCPCS procedure codes. Administration (infusion) of chemotherapy is an example.   We are now seeing NDCs captured as part of procedures because payers are demanding it for payment authorization. Inclusion of this code type enables those data partners that capture the NDC along with the procedure to include the data.  Please note: The “Other” category is meant to identify internal use ontologies and codes. | ICD-9-CM  ICD-10-PCS  ICD-11-PCS  CPT Category II  CPT Category III  CPT-4(i.e. HCPCS Level I)  HCPCS Level III  HCPCS (i.e. HCPCS Level II)  LOINC  NDC  Revenue  NO INFORMATION  UNKNOWN  OTHER |
| PX\_SOURCE | Source of the procedure information.  Order and billing pertain to internal healthcare processes and data sources. Claim pertains to data from the bill fulfillment, generally data sources held by insurers and other health plans. | Order  Billing  Claim  No information  Unknown  Other |

**Vitals Table**

“Vital signs (such as height, weight, and blood pressure) directly measure an individual’s current state of attributes.”

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| VITALID | Arbitary identifier for each unique record. May be generated sequentially. |  |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| ENCOUNTERID | Arbitrary encounter-level ientifier. Used to link across tables including CAP\_ENCOUNTERS, CAP\_DIAGNOSES, CAP\_PROCEDURES |  |
| VITAL\_SOURCE | Please note: The “Patient-reported” category can include reporting by patient’s family or guardian.  The new categorical value of PD and HD have been added. If unknown whether data are received directly from a device feed, use the more general context (such as patient-reported or healthcare delivery setting). | PATIENT REPORTED  Patient device direct feed  HEALTHCARE DELIVERY  Healthcare device direct feed  NO INFORMATION  UNKNOWN  OTHER |
| OBSERVATION\_TYPE | Indicator for type of Vitals being recorded | HEIGHT  WEIGHT  BMI  SBP  DBP  HR  Smoking |
| OBSERVATION\_METHOD | Method for Observation measurement | BP ARM CUFF  BP OTHER |
| OBSERVATION\_POSITION | For BP, position for orthostatic blood pressure. Null for all other observations. | UNKNOWN  SITTING  STANDING  SUPINE  NO INFORMATION  UNKNOWN  OTHER |
| SMOKING | Indicator for any form of tobacco that is smoked | Current every day smoker  Current some day smoker  Former Smoker  Never Smoked  Smoker, current status unknown  Unknown if ever smoked  HEAVY TOBACCO SMOKER  LIGHT TOBACCO SMOKER  NO INFORMATION  Unknown  OTHER |
| MEASURE\_DATE | Date and time of Vitals measure |  |
| OBSERVATION | Value of Vitals measure. |  |
| UNITS | Units of Vitals measure |  |
| TOBACCO | Indicator for any form of tobacco | Current User  Never  Quit/Former User  Passive or environmental exposure  Not Asked  NO INFORMATION  Unknown  OTHER |
| TOBACCO\_TYPE | Type(s) of tobacco used | Smoked tobacco only  Non-smoked tobacco only  Use both smoked and non-smoked tobacco products  None  Use of smoked but no information about non-smoked tobacco use  NO INFORMATION  Unknown  OTHER |
| RAW\_TOBACCO\_TYPE | Optional field for originating value of field, prior to mapping to CDM value set. |  |

**Lab Result Table**

“Laboratory result Common Measures (CM) use specific types of quantitative and qualitative measurements from blood and other body specimens. The common measures are defined in the same way across all PCORnet networks, but this table can also

include other types of lab results.”

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| LAB\_RESULT\_CM\_ID | Arbitary identifier for each unique record. May be generated sequentially. |  |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| ENCOUNTERID | Arbitrary encounter-level ientifier. Used to link across tables including CAP\_ENCOUNTERS, CAP\_DIAGNOSES, CAP\_PROCEDURES |  |
| ORDERID | Order Number for test |  |
| TESTDATETIME | Date and time when test was ordered |  |
| SPECIMEN\_SOURCE | Specimen source. All records will have a specimen source; some tests have several possible values for SPECIMEN\_SOURCE. |  |
| SPECIMEN\_SOURCE\_CODED | Code representing Specimen Source |  |
| SPECIMEN\_SOURCE\_CODE\_SYSTEM | Code system for Specimen Source | HL7  INTERNAL  SNOMED |
| PCORI\_SPECIMEN\_SOURCE | Specimen source as listed in PCORI CDM v3.0 | Blood  Cerebrospinal fluid  Plasma  Platelet poor plasma  Serum  Serum/plasma  Urine  No information  Unknown  Other |
| LAB\_CODE | Local code related to an individual lab test. |  |
| LAB\_CODING\_SYSTEM | Coding system used to identify laboratory tests. | LOINC  INTERNAL |
| TESTNAME | Name of the lab order. Report as recorded, with no prefixes or any other attributes, in text format |  |
| TESTVALUE | Value of Lab test in text format |  |
| VALUE\_NUMERIC | Value of Lab test if result is numeric. Decimal values are permissable |  |
| RESULT\_NUMERIC | Indicator if result is numeric. If "Y", result value should be populated in VALUE\_NUMERIC field. If "No", result is populated in TESTVALUE field | Yes  No |
| INTERPRETATION TEXT | Interpretation of Result |  |
| INTERPRETATION\_CODING\_SYSTEM | Coding system used for Interpretation of results | SNOMED  INTERNAL |
| UNIT | Units for the test results |  |
| RESULT\_UNIT | Units for the test results |  |
| VALUE\_LOW | Lower bound of the normal range assigned by the laboratory. Value should only contain the value of the lower bound. The symbols >, <, >=, <= should be removed. For example, if the normal range for a test is >100 and <300, then "100" should be entered. |  |
| VALUE\_HIGH | Upper bound of the normal range assigned by the laboratory. Value should only contain the value of the upper bound. The symbols >, <, >=, <= should be removed. For example, if the normal range for a test is >100 and <300, then "300" should be entered. |  |
| PCORI\_LAB\_NAME | Laboratory result common measure, a categorical identification for the type of test, which is harmonized across all contributing data partners. | Hemoglobin A1c  Creatine Kinase total  Creatine Kinase MB  Creatine Kinase MD/total  Creatinine  Hemoglobin  INR  LDL  Troponin I cardiac  Troponin T cardiac quant  Troponin T cardiac qual |
| LAB\_NAME | Laboratory result common measure, a categorical identification for the type of test. |  |
| LAB\_LOINC | Logical Observation Identifiers, Names, and Codes (LOINC) from the Regenstrief Institute. Results with local versions of LOINC codes (e.g., LOINC candidate codes) should be included in the RAW\_table field, but the LOINC variable should be set to missing. Current LOINC codes are from 3-7 characters long but Regenstrief suggests a length of 10 for future growth. The last digit of the LOINC code is a check digit and is always preceded by a hyphen. All parts of the LOINC code, including the hyphen, must be included. Do not pad the LOINC code with leading zeros. |  |
| PRIORITY | Immediacy of test. The intent of this variable is to determine whether the test was obtained as part of routine care or as an emergent/urgent diagnostic test (designated as Stat or Expedite). | Expedite  Routine  Stat  No Information  Unknown  Other |
| RESULT\_LOC | Location of the test result. Point of Care locations may include anticoagulation clinic, newborn nursery, finger stick in provider office, or home. The default value is ‘L’ unless the result is Point of Care. There should not be any missing values. | Lab  Point of Care  No Information  Unknown  other |
| LAB\_PX | Optional variable for local and standard procedure codes, used to identify the originating order for the lab test. |  |
| LAB\_PX\_TYPE | Procedure code type, if applicable. | ICD-9-CM  ICD-10-PCS  ICD-11-PCS  CPT Category II  CPT Category III  CPT-4(i.e.HCPCS Level I)  HCPCS III  HCPCS(i.e.HCPCS Level II)  Loinc  NDC  Revenue  No Information  Unknown  Other |
| LAB\_ORDER\_DATE | Date test was ordered |  |
| SPECIMEN\_DATE | Date and Time specimen was collected |  |
| RESULT\_DATE | Date and Time of Lab test results |  |
| RESULT\_QUAL | Standardized result for qualitative results. This variable should be NI for quantitative results. | Border Line  Positive  Negative  Undetermined  No Information  Unknown  Other |
| RESULT\_MODIFIER | Modifier for result values. Any symbols in the RAW\_RESULT value should be reflected in the RESULT\_MODIFIER variable.  For example, if the original source data value is "<=200" then RAW\_RESULT=200 and RESULT\_MODIFIER=LE. If the original source data value is text then RESULT\_MODIFIER=TX. If the original source data value is | Equal  Greater Than or Equal To  Greater Than  Less than or equal to  less than  Text  No Information  Unknown  Other |
| MODIFIER\_LOW |  | Equal  Greater Than or Equal To  Greater Than  Less than or equal to  less than  Text  No Information  Unknown  Other |
| MODIFIER\_HIGH | a numeric value then RESULT\_MODIFIER=EQ. | Equal  Greater Than or Equal To  Greater Than  Less than or equal to  less than  Text  No Information  Unknown  Other |
| ABN\_IND | Abnormal result indicator. This value comes from the source data; do not apply logic to create it. | Abnormal  Abnormal High  Abnormal Low  Critically High  Critically Low  Critical  Inconclusive  Normal  No Information  Unknown  Other |

**Medications Table**

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| ENCOUNTERID | Arbitrary encounter-level ientifier. Used to link across tables including CAP\_ENCOUNTERS, CAP\_DIAGNOSES, CAP\_PROCEDURES |  |
| ORDERDATE | Date and Time of Medication order |  |
| MEDICATION | Medication name - no prefixes or any attributes other than the name itself – can be multiple words separated by spaces (no – or /) |  |
| DOSAGE | Dosage information |  |
| ROUTE | Route information |  |
| MEDICATION\_CODE | Coded value of Medication |  |
| MEDICATION\_CODING\_SYSTEM | Coding System used to represent a Medication | RXNORM  NDC  NDFRT  GPI  INTERNAL |
| RxNORM\_INGREDIENT1 | Ingredient 1 in medication - RxNorm code |  |
| RxNORM\_INGREDIENT2 | Ingredient 2 in medication - RxNorm |  |
| RxNORM\_INGREDIENT3 | Ingredient 3 in medication - RxNorm |  |
| STRENGTH\_VALUE | Amount of active ingredient |  |
| STRENGTH\_UNITS | Coded list of units | MG  ML |
| DOSE\_VALUE | Quantity taken at given strength |  |
| DOSE\_UNITS | Coded value of dose units | TABLET  CAPSULE  VIAL |
| FREQUENCY\_VALUE | How often dose is administered |  |
| FREQUENCY\_UNIT | coded value of frequency |  |

**Active Medications Table**

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| ENCOUNTERID | Arbitrary encounter-level ientifier. Used to link across tables including CAP\_ENCOUNTERS, CAP\_DIAGNOSES, CAP\_PROCEDURES |  |
| ORDERDATE | Date and Time of Medication order |  |
| DATAREFRESHDATE | Date and Time of Medication order |  |
| MEDICATION | Medication name - no prefixes or any attributes other than the name itself – can be multiple words separated by spaces (no – or /) |  |
| DOSAGE | Text of Dose |  |
| ROUTE | Text of Route |  |
| MEDICATION\_CODE | Coded Value of the Medication |  |
| MEDICATION\_CODING\_SYSTEM | Coding System of the Medication |  |
| RxNORM\_INGREDIENT1 | Ingredient 1 in medication - RxNorm code |  |
| RxNORM\_INGREDIENT2 | Ingredient 2 in medication - RxNorm |  |
| RxNORM\_INGREDIENT3 | Ingredient 3 in medication - RxNorm |  |
| STRENGTH\_VALUE | Amount of active ingredient |  |
| STRENGTH\_UNITS | Coded list of units |  |
| DOSE\_VALUE | Quantity taken at given strength |  |
| DOSE\_UNITS | Coded value of dose units |  |
| FREQUENCY\_VALUE | How often dose is administered |  |
| FREQUENCY\_UNIT | coded value of frequency | SECONDS  MINUTES  HOURS  DAYS  WEEKS  MONTHS |

**Social History Table**

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| ENCOUNTERID | Arbitrary encounter-level ientifier. Used to link across tables including CAP\_ENCOUNTERS, CAP\_DIAGNOSES, CAP\_PROCEDURES |  |
| ENTRYDATE | Date and Time entry was recorded |  |
| DATA\_SOURCE | Source of Observation | PATIENT REPORTED  EHR  UNKNOWN |
| SOC\_HX\_DOMAIN | Social History Question Domain | ALCOHOL  SEXUAL HX  DRUG USE  OTHER |
| SOC\_HX\_Q\_CODED | Social History Question | TYPE OF SMOKER  DURATION OF TOBACCO USE  TYPE OF TOBACCO PRODUCT  DAILY QUANTITY |
| SOC\_HX\_A\_CODED | Social History Answer |  |
| SOC\_HX\_A\_NUMERIC | Numeric Response to Social History |  |
| SOC\_HX\_A\_UNITS | Units for Numeric response |  |
| SOC\_HX\_Q\_TEXT | Free Text Question for Social History |  |
| SOC\_HX\_A\_TEXT | Free Text Response for Social History |  |

**Enrollment Table**

“Enrollment is a concept that defines a period of time during which a person is expected to have complete data capture. This concept is often insurance-based, but other methods of defining enrollment are possible.”

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| ENR\_START\_DATE | Start date of patient enrollment |  |
| ENR\_END\_DATE | End date of patient enrollment |  |
| CHART | Request and review charts for this person (Y/N) | Yes  No |
| ENR\_BASIS | Property of the time period. Each patient can have multiple entries in this table. | Insurance  Geography  Algorithmic  Encounter-based |

**Condition Table**

“A condition represents a patient’s diagnosed and self-reported health conditions and diseases. The patient’s medical history and current state may both be represented.”

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| CONDITIONID | Arbitary identifier for each unique record. May be generated sequentially. |  |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| ENCOUNTERID | Arbitrary encounter-level identifier used to link across tables. This is an optional field, and should only be populated if the item was collected as part of a healthcare encounter.  If more than one encounter association is present, this field should be populated with the ID of the encounter when the condition was first entered into the system. However, please note that many conditions may be recorded outside of an encounter context. |  |
| REPORT\_DATE | Date condition was noted, which may be the date when it was recorded by a provider or nurse, or the date on which the patient reported it. Please note that this date may not correspond to onset date. |  |
| RESOLVE\_DATE | Date condition was resolved, if resolution of a transient condition has been achieved. A resolution date is not generally expected for chronic conditions, even if the condition is managed. |  |
| ONSET\_DATE | Please note that onset date is a very precise concept. Please do not map data unless they precisely match this definition. The REPORT\_DATE concept may be a better fit for many systems. |  |
| CONDITION\_STATUS | Condition status corresponding with REPORT\_DATE.  Guidance: The value of IN=Inactive may be used in situations where a condition is not resolved, but is not currently active (for example, psoriasis). | Active  Resolved  Inactive  No Information  Unknown  Other |
| CONDITION | Condition code.   Leading zeroes and different levels of decimal precision are permissible in this field. Please populate the exact textual value of this diagnosis code, but remove source-specific suffixes and prefixes. Other codes should be listed as recorded in the source data. |  |
| CONDITION\_TYPE | Condition code type.  Please note: The “Other” category is meant to identify internal use ontologies and codes. | ICD-9-CM  ICD-10-CM  ICD-11-CM  SNOMED CT  Human Phenotype Ontology  No Information  Unknown  Other  Algorithmic |
| CONDITION\_SOURCE | Please note: The “Patient-reported” category can include reporting by a proxy, such as patient’s family or guardian. Guidance: “Registry cohort” generally refers to cohorts of patients flagged with a certain set of characteristics for management within a health system. “Patient-reported” can include self-reported medical history and/or current medical conditions, not captured via healthcare problem lists or registry cohorts. | Patient-reported medical history  Healthcare problem list  Registry cohort  No Information  Unknown  Other |
| RAW\_CONDITION\_STATUS | Optional field for originating value of field, prior to mapping into the PCORnet CDM value set. |  |
| RAW\_CONDITION | Optional field for originating value of field, prior to mapping into the PCORnet CDM value set. |  |
| RAW\_CONDITION\_TYPE | Optional field for originating value of field, prior to mapping into the PCORnet CDM value set. |  |
| RAW\_CONDITION\_SOURCE | Optional field for originating value of field, prior to mapping into the PCORnet CDM value set. |  |

**Prescribing Table**

“Provider orders for medication dispensing and/or administration. These orders may take place in any setting, including the inpatient or outpatient basis.”

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| PRESCRIBINGID | Arbitary identifier for each unique record. May be generated sequentially. |  |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| ENCOUNTERID | Arbitrary encounter-level identifier used to link across tables. This is an optional field, and should only be populated if the item was collected as part of a healthcare encounter. |  |
| RX\_PROVIDERID | Provider code for the provider who prescribed the medication. The provider code is a pseudoidentifier with a consistent crosswalk to the real identifier. |  |
| RX\_ORDER\_DATE | Order date and time of the prescription by the provider. |  |
| RX\_START\_DATE | Start date and time of order. This attribute may not be consistent with the date on which the patient actually begin taking the medication. |  |
| RX\_END\_DATE | End date of order (if available). |  |
| RX\_QUANTITY | Quantity ordered |  |
| RX\_REFILLS | Number of refills ordered (not including the original prescription). If no refills are ordered, the value should be zero. |  |
| RX\_DAYS\_SUPPLY | Number of days supply ordered, as specified by the prescription. |  |
| RX\_FREQUENCY | Specified frequency of medication. | Every day  Two times a day (BID)  Three times a day (TID)  Four times a day (QID)  Every morning  Every afternoon  Before meals  After meals  As needed (PRN)  No information  Unknown  Other |
| RX\_BASIS | Basis of the medication order | Dispensing  Administration  No information  Unknown  Other |
| RXNORM\_CUI | Where an RxNorm mapping exists for the source medication, this field contains the RxNorm concept identifier (CUI) at the highest possible specificity.  If more than one option exists for mapping, the following ordered strategy may be adopted: 1)Semantic generic clinical drug 2)Semantic Branded clinical drug 3)Generic drug pack 4)Branded drug pack |  |

**Death Table**

“Reported mortality information for patients.”

|  |  |  |
| --- | --- | --- |
| Variable Name | Variable Definition/ Notes | Categorical Variable Values |
| CAP\_ID | Patient-level identifier used to link across tables. |  |
| DEATH\_DATE | Date of death |  |
| DEATH\_DATE\_IMPUT | When date of death is imputed, this field indicates which parts of the date were imputed. | Both month and day  Day imputed  Month imputed  Not Imputed  No Information  Unknown  Other |
| DEATH\_SOURCE | Guidance: “Other, locally defined” may be used to indicate presence of deaths reported from EHR systems, such as in-patient hospital deaths or dead on arrival. | Other, Locally defined  Nation death index  Social Security  State Death Files  Tumor Data  No Information  Unknown  Other |
| DEATH\_MATCH\_CONFIDENCE | "For situations where a probabilistic patient matching strategy is used, this field indicates the confidence that the patient drawn from external source data represents the actual patient. | Excellent  Fair  Poor  No Information  Unknown  Other |

\*Information taken directly from CAPriCORN and PCORnet materials.