The PCORnet Common Data Model (CDM) Glossary was developed to facilitate a common vocabulary among users of the PCORnet CDM.

Term	*Abbreviation*	*Definition*
Common Data Model	CDM	A common data model (CDM) standardizes the definition, format and content of data across participating data partners so that standardized applications, tools and methods can be applied.
Current Procedural Terminology ®	CPT®	CPT® (Current Procedural Terminology) is a set of detailed, standardized codes used primarily to identify medical services and procedures. These services may be ordered or provided by physicians and other health care professionals. CPT® codes are a subset of the HCPCS coding system, and are a registered trademark of the American Medical Association. http://goo.gl/oQAzR1
DataMart		A DataMart refers to a collection of data that will be queried and will return output via the PCORnet DRN Query Tool. Each PCORnet Network may have multiple data sources; these data sources could be represented as one or many DataMarts. PCORnet DataMarts are DataMarts that adhere to the PCORnet CDM.
Distributed Research Network	DRN	A distributed research network (DRN) is an approach to multi-site research that allows secure analysis of separate data resources held by data partners behind their firewalls. In a DRN there is no central data warehouse. Each data resource held locally consists of data collected, captured, or otherwise obtained by the local health system.
Electronic Health Record	EHR	An electronic health record (EHR) is a repository of electronic information about an individual's health status and health care. EHRs contain much of the same information that is found in a patient's (paper) medical chart, but because the records are digitized, the data can be viewed, transmitted, and/or integrated across settings (e.g. inpatient hospital, office) and between different health care providers (e.g. primary care physicians, specialists) and can capture far more extensive information. EHRs may contain administrative and billing data, patient demographics, progress notes, vital signs, medical histories, diagnoses, medications, immunization records, allergies, radiology images, laboratory and other test results, and much more.
Extract, Transform, and Load	ETL	Extract, transform and load (ETL) is a process in which programmers extract data from one or more data sources, transform the data to fit certain requirements or specifications, and then load the data into a desired location. In the context of PCORnet, programmers at the various CDRNs and PPRNs will extract the data needed to populate the PCORnet Common Data Model from the data sources which house the necessary information, transform their data to fit into the Common Data Model, and then load that transformed data into a defined location.
Healthcare Common Procedure Coding System	HCPCS	HCPCS (Healthcare Common Procedure Coding System) is a set of codes used to identify tasks and procedures performed by a health care practitioner. They include Level 1 codes (CPT codes) and Level II codes (codes that primarily represent non-physician services such as ambulance, durable medical equipment, and home health services). Level II codes are maintained by the Centers for Medicare and Medicaid. http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html

Term	*Abbreviation*	*Definition*
Health Care Systems Research Network Virtual Data Warehouse	HCSRN VDW	HCSRN (Health Care Systems Research Network) is a network comprised of research centers based in multiple health care systems. The VDW (Virtual Data Warehouse) is the Common Data Model used by the HCS Research Network. It contains data on enrollment, vital signs, pharmacy and other standardized data elements. Documentation about the VDW can be found at http://www.hcsrn.org/en/Tools%20&%20Materials/VDW/
Mini-Sentinel Common Data Model	MSCDM	Mini-Sentinel is a distributed research network sponsored by the U.S. Food and Drug Administration (FDA) to help monitor the safety of FDA-regulated medical products such as medications and vaccines. Mini-Sentinel has established a Common Data Model. Documentation about the distributed database and common data model can be found at http://www.mini-sentinel.org/data_activities/distributed_db_and_data/default.aspx
International Classification of Diseases	ICD	ICD (International Classification of Diseases) is the standard terminology used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records. ICD code sets include ICD-9-CM (Ninth International Classification of Diseases-Clinical Modification), ICD-10-CM (Tenth International Classification of Diseases-Clinical Modification), and ICD-10-PCS (Tenth International Classification of Diseases-Procedure Coding System). ICD codes are primarily used to record diagnoses, but a subset (ICD-9-CM volume 3 codes and ICD-10-PCS codes) is used to record procedures performed in an inpatient setting. These codes are maintained by the World Health Organization. http://www.who.int/classifications/icd/en/
PopMedNet ™		PopMedNet is an open-source software application that enables simple creation, operation, and governance of distributed health data networks. http://www.popmednet.org/
Source data		Source data is data residing in operational healthcare systems such as electronic health record systems, claims systems, patient registries, and databases containing survey data.
Systematized Nomenclature of Medicine-Clinical Terms	SNOMED CT	SNOMED (Systematized Nomenclature of Medicine-Clinical Terms) codes are used in electronic medical records to document diagnoses, procedures, drugs, and other health care interactions. These codes are maintained by International Health Terminology Standards Development Organization. The primary unit of measurement in SNOMED is called a concept. Each concept has a concept unique identifier (CUID), and concepts are related to one another in multiple ways. http://www.ihtsdo.org/snomed-ct/
Logical Observation Identifiers Names and Codes	LOINC	LOINC (Logical Observation Identifiers Names and Codes) is a coding system used by some health care systems for ordering and capturing results of laboratory tests and other measurement and observation data. https://loinc.org/
Common measures		A measure is an individual question or statement and its standardized response options. Common measures are standardized patient-reported outcome (PRO) measures that are defined in the same way across all PCORnet networks.

Term	*Abbreviation*	*Definition*
Proxy report		A proxy report is a measurement based on a report by someone other than the patient reporting as if he or she is the patient Proxy reports are usually completed by parents or caregivers of patients who are cognitively or developmentally unable to report for themselves.
Patient reported outcomes	PRO	Patient-reported outcomes (PROs) are defined by the Food and Drug Administration as a report of the status of a patient's health condition by the patient without interpretation by a clinician or anyone else. PCORnet also allows caregivers or people who support the patient to provide proxy reports, provided there isn't subjective interpretation of the patient's response leading to modification of data. Reports from non-clinician caregivers are accepted as PROs in instances where patients are incapable of direct communication via self-report (e.g. parent reports for neonatal patients).