# Appendix A: Documentation of CDA Document Section Tables in eMaRC Plus Database

## Data\_ActiveProblems

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| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| ConcernID\_Root | Allows related acts to be grouped. Can represent history of problem as a series of observations over time |
| ConcernID\_Extension | Extension that allows related acts to be grouped. Can represent history of problem as a series of observations over time |
| Concern\_Status\_Code | Active (ongoing clinical activity is expected), suspended (concern that is set aside, period of remission), aborted (left against Medical Advice) completed (resolved, no longer tracked except for historical purposes) |
| Concern\_Effect\_Time\_Low | Earliest time that the concern was active |
| Concern\_Effect\_Time\_High | Date the concern was completed or aborted |
| Problem\_Ref\_Root | Unique ID Root that identifies the problem |
| Problem\_Ref\_Ext | Unique ID Extension that identifies the problem |
| Problem\_Code | Coded value for the condition (e.g., diabetes, apnea, low blood count etc.) |
| Problem\_DisplayName | Name given to the coded problem value (e.g., diabetes, apnea, low blood count etc.) |
| Problem\_CodesystemOID | Code System OID for the problem code |
| NAACCRProblem\_Code\_ICD9 | NAACCR problem code translation (before Version 13, Comorbidities) |
| NAACCRProblem\_Code\_ICD10 | NAACCR problem code translation (Version 13, Secondary Diagnoses) |
| Problem\_ProblemType | Indicates the type of problem (e.g., Symptom, Problem, Finding, Diagnosis, etc.) |
| Problem\_Effect\_Time\_Low | Earliest point for which the condition is known to have existed (implied: Date of onset) |
| Problem\_Effect\_Time\_High | Time at which the condition was no longer known to be true (implied: Date of resolution) |

## Data\_Address

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| --- | --- |
| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| PatientStreetAddress1 | Patient's street address, first line |
| PatientStreetAddress2 | Patient's street address, second line |
| PatientCity | Patient's city |
| PatientState | Patient's state |
| PatientZipcode | Patient's zip code |
| PatientCounty | Patient's county |
| PatientCountry | Patient's country |
| PatientAddressBegin\_Date | The date the patient began living at the address |
| PatientAddressEnd\_Date | The date the patient stopped living at the address |

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| **Data element name** | **Data element description** |  |
| PatientAddressUse\_Code | How the address is used by the patient (e.g., home, work, vacation) |
| PatientPhone\_Number | Patient's phone number |
| PatientEmail | Patient's email address |

## Data\_CancerDiagnosis

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| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| Dx\_Effect\_Time\_Low | Cancer diagnosis date |
| Histo\_Code | Coded value for the histology |
| Histo\_DisplayName | Name given to the coded histology value |
| Histo\_OID | Code System Object Identifier (OID) for the histology code |
| NAACCRHisto\_Code | NAACCR histology code translation |
| Behavior\_Code | Coded value for the behavior |
| Behavior\_DisplayName | Name given to the coded behavior value |
| Behavior\_OID | Code System OID for the behavior code |
| DiagConf\_Code | Coded value for diagnostic confirmation (best method used to confirm the presence of the cancer being reported) |
| DiagConf\_DisplayName | Name given to the coded diagnostic confirmation value |
| DiagConf\_OID | Code System OID for the diagnostic confirmation code |
| PrimarySite\_Code | Coded value for primary site (anatomic location where the primary tumor originated) |
| PrimarySite\_DisplayName | Name given to the coded primary site value |
| PrimarySite\_OID | Code System OID for the primary site code |
| NAACCRPrimarySite\_Code | NAACCR primary site code translation |
| Laterality\_Code | Coded value for the laterality (side of a paired organ or side of the body on which the reportable tumor originated) code |
| Laterality\_DisplayName | Name given to the coded laterality value |
| Laterality\_OID | Code System OID for the laterality code |
| TNMGroup\_Code | Coded value for the TNM Clinical Stage Group of the tumor/cancer |
| TNMGroup\_DisplayName | Name given to the coded TNM Clinical Stage Group value |
| TNMGroup\_OID | Code System OID for the TNM Clinical Stage Group code |
| TNMDescriptor\_Code | Coded value for the TNM Clinical Stage Descriptor (identifies special cases that need separate data analysis) |
| TNMDescriptor\_DisplayName | Name given to the coded TNM Clinical Stage Descriptor value |
| TNMDescriptor\_OID | Code System OID for the TNM Clinical Stage Descriptor code |
| TNMEdition\_Code | Coded value for the TNM Edition Number of the AJCC Staging Manual |
| TNMEdition\_DisplayName | Name given to the coded TNM Edition Number value |
| TNMEdition\_OID | Code System OID for the TNM Edition Number code |
| TNMStagedBy\_Code | Coded value for TNM Clinical Staged By (the person who recorded the AJCC staging elements and stage group in the patient's medical record) |
| TNMStagedBy\_DisplayName | Name given to the coded TNM Clinical Staged By value |
| TNMStagedBy\_OID | Code System OID for the TNM Clinical Staged By code |
| TNMClinicalT\_Code | Coded value for the TNM Clinical Tumor |

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| **Data element name** | **Data element description** |  |
| TNMClinicalT\_DisplayName | Name given to the coded TNM Clinical Tumor value |
| TNMClinicalT\_OID | Code System OID for the TNM Clinical Tumor Code |
| TNMClinicalN\_Code | Coded value for the TNM Clinical Node |
| TNMClinicalN\_DisplayName | Name given to the coded TNM Clinical Node value |
| TNMClinicalN\_OID | Code System OID for the TNM Clinical Node Code |
| TNMClinicalM\_Code | Coded value for the TNM Clinical Metastasis |
| TNMClinicalM\_DisplayName | Name given to the coded TNM Clinical Metastasis value |
| TNMClinicalM\_OID | Code System OID for the TNM Clinical Metastasis Code |

## Data\_Medications

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| --- | --- |
| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| Med\_Effect\_Time\_Low | Start time of the medication |
| Med\_Effect\_Time\_High | End time of the medication regimen according to the information provided in the prescription or order |
| Med\_FreqValue | Value that indicates the frequency of administration of the medication (taken together with the frequency units. E.g., Value=4, Units=Hours) |
| Med\_FreqUnit | Units that indicate the frequency of administration of the medication (taken together with the frequency value. E.g., Value=4, Units=Hours) |
| Med\_RouteCode | Coded value that indicates how the medication is received by the patient (by mouth, IV, etc.) |
| Med\_RouteDisplayName | Name given to the coded route value |
| Med\_RouteOID | Code System Object Identifier (OID) for the route code |
| Med\_SiteCode | Coded value for the site of the body where the medication is administered |
| Med\_SiteDisplayName | Name given to the coded body site value |
| Med\_SiteOID | Code System Object Identifier (OID) for the body site code |
| Med\_DoseValue | Value that indicates medication dose when a single dose is taken (used together with dose units. E.g., Value=2, Units=mg) |
| Med\_DoseUnit | Units that indicate medication dose when a single dose is taken (used together with dose value. E.g., Value=2, Units=mg) |
| Med\_DoseLow | Low value that indicates a medication dose range (used together with high dose value and units. E.g., Low value=1, High value=2, Units=Tablet) |
| Med\_DoseHigh | High value that indicates a medication dose range (used together with low dose value and units. E.g., Low value=1, High value=2, Units=Tablet) |
| Med\_DoseLowUnits | Units that indicate a medication dose range (used together with low and high dose values. E.g., Low value=1, High value=2, Units=Tablet) |
| Med\_DoseHighUnits | Units that indicate a medication dose range (used together with low and high dose values. E.g., Low value=1, High value=2, Units=Tablet) |
| Med\_RateLow | Low value that indicates a measurement of how fast the dose is given to the patient over time |
| Med\_RateHigh | High value that indicates a measurement of how fast the dose is given to the patient over time |
| Med\_RateLowUnits | Time unit for the low value that indicates a measurement of how fast the dose is given to the patient over time |
| Med\_RateHighUnits | Time unit for the high value that indicates a measurement of how fast the dose is given to the patient over time |
| Med\_ProductCode | Coded value that represents the generic medication name (and strength if relevant) |

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| **Data element name** | **Data element description** |  |
| Med\_ProductDisplayName | Name given to the coded medication value |
| Med\_ProductOID | Code System Object Identifier (OID) for the medication (product) code |
| Med\_BrandName | Free text that indicates the brand name of the medication |
| Med\_NameOriginalText | Corresponding narrative text for coded medication name |
| Med\_Category | Indicates whether the medication has been determined to be chemo, BRM, or hormone according to NAACCR translation |

## Data\_Medications\_Admin

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| --- | --- |
| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| MedAdmin\_Effect\_Time\_Low | Start time of the medication administered |
| MedAdmin\_Effect\_Time\_High | End time of the medication admininstered according to the information provided in the prescription or order |
| MedAdmin\_FreqValue | Value that indicates the frequency of administration of the medication (taken together with the frequency units. E.g., Value=4, Units=Hours) |
| MedAdmin\_FreqUnit | Units that indicate the frequency of administration of the medication (taken together with the frequency value. E.g., Value=4, Units=Hours) |
| MedAdmin\_RouteCode | Coded value that indicates how the medication administered is received by the patient (by mouth, IV, etc.) |
| MedAdmin\_RouteDisplayName | Name given to the coded route value |
| MedAdmin\_RouteOID | Code System Object Identifier (OID) for the route code |
| MedAdmin\_SiteCode | Coded value for the site of the body where the medication is administered |
| MedAdmin\_SiteDisplayName | Name given to the coded body site value |
| MedAdmin\_SiteOID | Code System Object Identifier (OID) for the body site code |
| MedAdmin\_DoseValue | Value that indicates medication dose when a single dose is administered (used together with dose units. E.g., Value=2, Units=mg) |
| MedAdmin\_DoseUnit | Units that indicate medication dose when a single dose is administered (used together with dose value. E.g., Value=2, Units=mg) |
| MedAdmin\_DoseLow | Low value that indicates a medication dose range (used together with high dose value and units. E.g., Low value=1, High value=2, Units=Tablet) |
| MedAdmin\_DoseHigh | High value that indicates a medication dose range (used together with low dose value and units. E.g., Low value=1, High value=2, Units=Tablet) |
| MedAdmin\_DoseLowUnits | Units that indicate a medication dose range (used together with low and high dose values. E.g., Low value=1, High value=2, Units=Tablet) |
| MedAdmin\_DoseHighUnits | Units that indicate a medication dose range (used together with low and high dose values. E.g., Low value=1, High value=2, Units=Tablet) |
| MedAdmin\_RateLow | Low value that indicates a measurement of how fast the dose is given to the patient over time |
| MedAdmin\_RateHigh | High value that indicates a measurement of how fast the dose is given to the patient over time |
| MedAdmin\_RateLowUnits | Time unit for the low value that indicates a measurement of how fast the dose is given to the patient over time |
| MedAdmin\_RateHighUnits | Time unit for the high value that indicates a measurement of how fast the dose is given to the patient over time |

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| MedAdmin\_ProductCode | Coded value that represents the generic name (and strength if relevant) of the medication administered |  |
| MedAdmin\_ProductDisplayName | Name given to the coded medication value |
| MedAdmin\_ProductOID | Code System Object Identifier (OID) for the medication (product) code |
| MedAdmin\_BrandName | Free text that indicates the brand name of the medication administered |
| MedAdmin\_NameOriginalText | Corresponding narrative text for coded name of the medication administered |
| MedAdmin\_Category | Indicates whether the medication has been determined to be chemo, BRM, or hormone according to NAACCR translation |

## Data\_Narrative

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| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| CancerDiagnosis\_Text | Narrative description of the information about cancer diagnosis(es) that are currently being monitored for the patient |
| TNMStageGroup\_Text | Narrative description of the Stage Group for the cancer diagnosis |
| ActiveProblems\_Text | Narrative description of the conditions currently being monitored for the patient |
| CodedResults\_Text | Narrative description of the relevant diagnostic procedures the patient received in the past |
| Procedures\_Text | Narrative description of all interventional, surgical, diagnostic, or therapeutic procedures or treatments, pertinent to the patient historically at the time the document is generated |
| RadiationOncology\_Text | Narrative description of the radiation treatment performed by a Radiation Oncologist |
| Medications\_Text | Narrative description of the relevant medications for the patient, e.g., an ambulatory prescription list |
| MedicationsAdministered\_Text | Narrative description of the relevant medications administered to a patient during the course of an encounter |
| ProgressNote\_Text | Narrative description of the sequence of events from initial assessment to discharge for an encounter |
| CarePlan\_Text | Narrative description of the expectations for care including proposals, goals, and order requests for monitoring, tracking, or improving the condition of the patient |
| CodedSocialHistory\_Text | Narrative description of the person’s beliefs, home life, community life, work life, hobbies, and risky habits |
| Payers\_Text | Narrative description of the patient’s payers, whether a ‘third party’ insurance, self-pay, other payer or guarantor, or some combination |

## Data\_Patient

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| --- | --- |
| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| Patient\_FN | Patient's first name |
| Patient\_LN | Patient's last name |
| Patient\_MN | Patient's middle name |
| Patient\_Suffix | Patient's name suffix |
| Patient\_Maiden | Patient's maiden name |

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| **Data element name** | **Data element description** |  |
| Patient\_Alias | Patient's name alias |
| Patient\_GenderCode | Coded value for patient's gender |
| Patient\_GenderDisplayName | Name given to the coded gender value |
| Patient\_GenderOID | Coding System Object Identifier (OID) for the gender code |
| NAACCRPatient\_GenderCode | NAACCR gender code translation |
| Patient\_DOB | Patient's date of birth |
| Patient\_SSN | Patient's social security number |
| Patient\_EthnicCode | Coded value for patient's ethnicity |
| Patient\_EthnicDisplayName | Name given to the coded ethnicity value |
| Patient\_EthnicOID | Coding System Object Identifier (OID) for the ethnicity code |
| NAACCRPatient\_EthnicCode | NAACCR ethnicity code translation |
| Patient\_StateOfBirth | Patient's state of birth |
| Patient\_CountryOfBirth | Patient's country of birth |
| Patient\_MaritalCode | Coded value for patient's marital status |
| Patient\_MaritalDisplayName | Name given to the coded marital status value |
| Patient\_MaritalOID | Coding System Object Identifier (OID) for the marital status code |
| NAACCRPatient\_MaritalCode | NAACCR marital status code translation |

**Data\_Payers**

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| --- | --- |
| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| SeqNum | Number that indicates the priority of the payment source (with 1 as the highest priority) |
| Payer\_Type\_Code | Coded value for the type of payer |
| Payer\_Type\_DisplayName | Name given to the payer type value |
| Payer\_Type\_CodeSystemOID | Code System Object Identifier (OID) for the payer type code |
| NAACCRPayer\_Type\_Code | NAACCR payer type code translation |

**Data\_Procedures**

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| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| Procedure\_Code | Coded value for the procedure |
| Procedure\_DisplayName | Name given to the coded procedure value |
| Procedure\_CodeSystemOID | Coding System Object Identifier (OID) for the procedure code |
| NAACCRProcedure\_Code | NAACCR procedure code translation |
| Procedure\_Status | Indicates whether the procedure is completed, active (in progress), aborted, or cancelled |

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| **Data element name** | **Data element description** |  |
| Procedure\_EffectTime\_Low | Date/time the procedure began |
| Procedure\_EffectTime\_High | Date/time the procedure ended |
| Procedure\_EffectiveTime | Date/time the procedure occurred |
| Procedure\_TargetSite\_Code | Coded value for the part of the body where the procedure was performed |
| Procedure\_TargetSite\_DisplayName | Name given to the coded body site value by the Coding system |
| Procedure\_TargetSite\_CodeSystemOID | Code System Object Identifier (OID) for the body site code |
| Procedure\_Problem\_Ref\_Root | ID root that links the procedure to the problem |
| Procedure\_Problem\_Ref\_Ext | ID extension that links the procedure to the problem |
| Procedure\_Performer\_Entity\_NPI | NPI of individual provider who performed the procedure |
| Procedure\_Performer\_Organization\_NPI | NPI of organization that performed the procedure |

## Data\_Provider

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| --- | --- |
| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| Author\_NPI | NPI number of the human that authored the document |
| Author\_FirstName | First name of the human that authored the document |
| Author\_LastName | Last name of the human that authored the document |
| Author\_Name\_Person | Full name of the human that authored the document (when not split out into first and last name) |
| Author\_Suffix | Name suffix of the human that authored the document |
| Author\_Specialty\_Code | Coded value for the specialty of the human that authored the document |
| Author\_Specialty\_DisplayName | Name given to the specialty value of the human that authored the document |
| Author\_Specialty\_OID | Code System Object Identifier (OID) for specialty code of the human that authored the document |
| Author\_StreetAddress\_Person | Street address of the human that authored the document |
| Author\_City\_Person | City of the human that authored the document |
| Author\_State\_Person | State of the human that authored the document |
| Author\_Zip\_Person | Zip code of the human that authored the document |
| Author\_Country\_Person | Country of the human that authored the document |
| Author\_Phone\_Person | Phone number of the human that authored the document |
| Author\_Organization\_NPI | NPI number for the organization that authored the document |
| Author\_Organization\_Name | Name of the organization that authored the document |
| Author\_StreetAddress\_Organization | Street address of the organization that authored the document |
| Author\_City\_Organization | City of the organization that authored the document |
| Author\_State\_Organization | State of the organization that authored the document |
| Author\_Zip\_Organization | Zip code of the organization that authored the document |
| Author\_Country\_Organization | Country of the organization that authored the document |
| Author\_Phone\_Organization | Phone number of the organization that authored the document |
| Custodian\_NPI | NPI number of the organization that is in charge of maintaining the document |

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| **Data element name** | **Data element description** |
| Custodian\_Name | Name of the organization that is in charge of maintaining the document |
| Custodian\_StreetAddress | Street address of the organization that is in charge of maintaining the document |
| Custodian\_City | City of the organization that is in charge of maintaining the document |
| Custodian\_State | State of the organization that is in charge of maintaining the document |
| Custodian\_Zip | Zip code of the organization that is in charge of maintaining the document |
| Custodian\_Country | Country of the organization that is in charge of maintaining the document |
| Custodian\_Phone | Phone number of the organization that is in charge of maintaining the document |
| ServiceEv\_Effect\_Time\_Low | Start time of the main act being documented |
| ServiceEv\_Effect\_Time\_High | End time of the main act being documented |
| ServiceEv\_PhysNPI | NPI number of the clinician who actually and principally carried out the service event |
| ServiceEv\_PhysLastName | Last name of the clinician who actually and principally carried out the service event |
| ServiceEv\_PhysFirstName | First name of the clinician who actually and principally carried out the service event |
| ServiceEv\_PhysName | Full name of the clinician who actually and principally carried out the service event (when not split out into first and last name) |
| ServiceEv\_PhysSuffix | Name suffix of the clinician who actually and principally carried out the service event |
| ServiceEv\_PhysSpecialty\_Code | Coded value for the specialty of the clinician who actually and principally carried out the service event |
| ServiceEv\_PhysSpecialty\_DisplayName | Name given to the coded specialty value of the clinician who actually and principally carried out the service event |
| ServiceEv\_PhysSpecialty\_OID | Code System Object Identifier (OID) for the specialty code of the clinician who actually and principally carried out the service event |
| ServiceEv\_Phys\_StreetAddress | Street address of the clinician who actually and principally carried out the service event |
| ServiceEv\_Phys\_City | City of the clinician who actually and principally carried out the service event |
| ServiceEv\_Phys\_State | State of the clinician who actually and principally carried out the service event |
| ServiceEv\_Phys\_Zip | Zip code of the clinician who actually and principally carried out the service event |
| ServiceEv\_Phys\_Country | Country of the clinician who actually and principally carried out the service event |
| ServiceEv\_Phys\_Phone | Phone number of the clinician who actually and principally carried out the service event |
| ServiceEv\_OrgNPI | NPI number of the organization of the clinician who actually and principally carried out the service event |
| ServiceEv\_OrgName | Name of the organization associated with the clinician who actually and principally carried out the service event |
| ServiceEv\_Org\_StreetAddress | Street address of the organization associated with clinician who actually and principally carried out the service event |
| ServiceEv\_Org\_City | City of the organization associated with the clinician who actually and principally carried out the service event |
| ServiceEv\_Org\_State | State of the organization associated with the clinician who actually and principally carried out the service event |
| ServiceEv\_Org\_Zip | Zip code of the organization associated with the clinician who actually and principally carried out the service event |

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| **Data element name** | **Data element description** |  |
| ServiceEv\_Org\_Country | Country of the organization associated with the clinician who actually and principally carried out the service event |
| ServiceEv\_Org\_Phone | Phone number of the organization associated with the clinician who actually and principally carried out the service event |
| Encounter\_EffectiveTime | Date/time of the encompassing encounter, which represents the setting of the clinical encounter during which the documented act(s) or ServiceEvent occurred |
| Encounter\_Effect\_Time\_Low | Start date/time of the encompassing encounter |
| Encounter\_Effect\_Time\_High | End date/time of the encompassing encounter |
| Encounter\_PhysNPI | NPI number of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_PhysLastName | Last name of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_PhysFirstName | First name of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_PhysName | Full name of the provider having primary legal responsibility for the encompassing encounter (when not split out into first and last name) |
| Encounter\_PhysSuffix | Name suffix of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_PhysSpecialty\_Code | Coded value for the specialty of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_PhysSpecialty\_DisplayName | Name given to the coded specialty value of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_PhysSpecialty\_OID | Code System OID for the specialty code of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_Phys\_StreetAddress | Street address of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_Phys\_City | City of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_Phys\_State | State of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_Phys\_Zip | Zip code of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_Phys\_Country | Country of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_Phys\_Phone | Phone number of the provider having primary legal responsibility for the encompassing encounter |
| Encounter\_OrgNPI | NPI number of the organization having primary legal responsibility for the encompassing encounter |
| Encounter\_OrgName | Name of the organization having primary legal responsibility for the encompassing encounter |
| Encounter\_Org\_StreetAddress | Street address of the organization having primary legal responsibility for the encompassing encounter |
| Encounter\_Org\_City | City of the organization having primary legal responsibility for the encompassing encounter |
| Encounter\_Org\_State | State of the organization having primary legal responsibility for the encompassing encounter |
| Encounter\_Org\_Zip | Zip code of the organization having primary legal responsibility for the encompassing encounter |
| Encounter\_Org\_Country | Country of the organization having primary legal responsibility for the encompassing encounter |
| Encounter\_Org\_Phone | Phone number of the organization having primary legal responsibility for the encompassing encounter |

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| **Data element name** | **Data element description** |
| ProvReferredFrom\_NPI | NPI number of the provider that referred the patient to the reporting facility |
| ProvReferredFrom\_LastName | Last name of the provider that referred the patient to the reporting facility |
| ProvReferredFrom\_FirstName | First name of the provider that referred the patient to the reporting facility |
| ProvReferredFrom\_Name | Full name of the provider that referred the patient to the reporting facility (when not split out into first and last name) |
| ProvReferredFrom\_Suffix | Name suffix of the provider that referred the patient to the reporting facility |
| ProvReferredFrom\_StreetAddress | Street address of the provider that referred the patient to the reporting facility |
| ProvReferredFrom\_City | City of the provider that referred the patient to the reporting facility |
| ProvReferredFrom\_State | State of the provider that referred the patient to the reporting facility |
| ProvReferredFrom\_Zip | Zip code of the provider that referred the patient to the reporting facility |
| ProvReferredFrom\_Country | Country of the provider that referred the patient to the reporting facility |
| ProvReferredFrom\_Phone | Phone number of the provider that referred the patient to the reporting facility |
| ProvReferredFrom\_OrgNPI | NPI number of the organization that referred the patient to the reporting facility |
| ProvReferredFrom\_OrgName | Name of the organization that referred the patient to the reporting facility |
| ProvReferredFrom\_Org\_StreetAddress | Street address of the organization that referred the patient to the reporting facility |
| ProvReferredFrom\_Org\_City | City of the organization that referred the patient to the reporting facility |
| ProvReferredFrom\_Org\_State | State of the organization that referred the patient to the reporting facility |
| ProvReferredFrom\_Org\_Zip | Zip code of the organization that referred the patient to the reporting facility |
| ProvReferredFrom\_Org\_Country | Country of the organization that referred the patient to the reporting facility |
| ProvReferredFrom\_Org\_Phone | Phone number of the organization that referred the patient to the reporting facility |
| ProvReferredTo\_NPI | NPI number of the provider to whom the patient was referred |
| ProvReferredTo\_LastName | Last name of the provider to whom the patient was referred |
| ProvReferredTo\_FirstName | First name of the provider to whom the patient was referred |
| ProvReferredTo\_Name | Full name of the provider to whom the patient was referred (when not split out into first and last name) |
| ProvReferredTo\_Suffix | Name suffix of the provider to whom the patient was referred |
| ProvReferredTo\_StreetAddress | Street address of the provider to whom the patient was referred |
| ProvReferredTo\_City | City of the provider to whom the patient was referred |
| ProvReferredTo\_State | State of the provider to whom the patient was referred |
| ProvReferredTo\_Zip | Zip code of the provider to whom the patient was referred |
| ProvReferredTo\_Country | Country of the provider to whom the patient was referred |
| ProvReferredTo\_Phone | Phone number of the provider to whom the patient was referred |
| ProvReferredTo\_OrgNPI | NPI number of the organization to whom the patient was referred |
| ProvReferredTo\_OrgName | Name of the organization to whom the patient was referred |
| ProvReferredTo\_Org\_StreetAddress | Street address of the organization to whom the patient was referred |
| ProvReferredTo\_Org\_City | City of the organization to whom the patient was referred |
| ProvReferredTo\_Org\_State | State of the organization to whom the patient was referred |

|  |  |
| --- | --- |
| **Data element name** | **Data element description** |
| ProvReferredTo\_Org\_Zip | Zip code of the organization to whom the patient was referred |
| ProvReferredTo\_Org\_Country | Country of the organization to whom the patient was referred |
| ProvReferredTo\_Org\_Phone | Phone number of the organization to whom the patient was referred |

## Data\_Race

|  |  |
| --- | --- |
| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| Patient\_RaceCode | Coded value for patient's race |
| Patient\_RaceDisplayName | Name given to the coded race value |
| Patient\_RaceOID | Coding System Object Identifier (OID) for the race code |
| NAACCRPatient\_RaceCode | NAACCR race code translation |

## Data\_Results

|  |  |
| --- | --- |
| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| Results\_Procedure\_Code | Coded value for the type of procedure performed to obtain the test result |
| Results\_Procedure\_DisplayName | Name given to the coded procedure value |
| Results\_Procedure\_CodeSystemOID | Code System Object Identifier (OID) for the procedure code |
| Results\_Procedure\_Effect\_Time\_Low | Earliest time that the procedure was performed |
| Results\_Procedure\_Effect\_Time\_High | Latest time that the procedure was performed |
| TestType\_Code | Coded value for the type of test performed |
| TestType\_DisplayName | Name given to the test type code |
| TestType\_CodeSystemOID | Code System OID for the test type code |
| Result\_Value\_Text | Text test result for non-quantitative tests |
| Result\_Value\_Quant | Test result value for quantitative tests |
| Result\_Value\_Units | Test result units that go with value for quantitative tests |
| Result\_InterpretationCode | Coded value for a qualitative interpretation of the observation |
| Result\_InterpretationCode\_DisplayName | Name given to the interpretation code |
| Result\_InterpretationCode\_OID | Code System OID for the interpretation code |
| Result\_EffectTime | Date/time of test result |
| LabName | Name of the author of the observation (e.g., the Laboratory that performed the test) |
| LabID\_Root | ID root of the author of the observation. The root indicates the "assigning authority" (e.g., CLIA) of the ID |
| LabID\_Extension | ID extension of the author of the observation (e.g., CLIA # of the Laboratory that performed the test) |

## Data\_SocialHistory

|  |  |
| --- | --- |
| **Data element name** | **Data element description** |
| Document\_Date | Date the CDA Document is created by the Physician EHR |
| DocumentID | Unique identifier for the CDA Document created by the Physician EHR |
| FacilityID | NPI or other unique ID number for the facility |
| Patient\_MRN | Unique identifier for the patient created by the facility (Medical Record Number) |
| SocialHx\_LOINC | Coded value that identifies the data element (occupation, industry, or smoking status) |
| SocialHx\_Code | Coded value for the data element (occupation, industry, or smoking status) |
| SocialHx\_DisplayName | Name given to the coded data value |
| SocialHx\_OID | Code System Object Identifier (OID) for the occupation, industry, or smoking status code |
| SocialHx\_OriginalText | Corresponding narrative text for coded information ( occupation, industry, or smoking status) |
| SocialHx\_Effect\_Low | Earliest date the data value was known by the facility |
| SocialHx\_Effect\_High | Most recent date the data value was known by the facility |
| SocialHx\_Effect\_Time | Date the data value was known by the facility |