E. Laboratory Results

Seq. #: 7542 **Name:** C-Peptide

Coding Instructions: Indicate all C-peptide values in ng/mL.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Cpeptide
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Decimal (5,2)
Default Value:	NULL
Usual Range:	0.8-3.1
Valid Range:	0.1-100
DataSource:	User

Seq. #: 7546 **Name:** C-Peptide Date

Coding Instructions: Indicate all dates for which C-peptide were recorded.

For measure calculation purposes indicate the most recent documented date where hematocrit count was recorded.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Cpeptide_Date
Parent Seq #:	7542
Parent Name:	C-Peptide
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 7548 **Name:** Insulin

Coding Instructions: Indicate all Insulin values in mIU/L. The insulin level being recorded is fasting insulin.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Insulin
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR)
Format:	Integer (2)
Default Value:	NULL
Usual Range:	0-25
Valid Range:	0-50
DataSource:	User

E. Laboratory Results

Seq. #: 7550 **Name:** Insulin Date

Coding Instructions: Indicate all dates for which insulin were recorded.

For measure calculation purposes indicate the most recent documented date where hematocrit count was recorded.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Insulin_Date
Parent Seq #:	7548
Parent Name:	Insulin
Parent Value:	Not Null
Missing Data:	No Action
Harvested:	Yes (DCR)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

F. Medications

Seq. #: 9300 **Name:** Medication ID

Coding Instructions: Indicate the NCDR-assigned IDs for the medications the patient was prescribed.

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

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	MedID
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Integer (3)
Default Value:	NULL
Usual Range:	
Valid Range:	1-999
DataSource:	User

Seq. #: 9301 **Name:** Dose Strength

Coding Instructions: Indicate the dosing strength for each medication that is prescribed/continued.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DoseStrength
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Decimal (6,2)
Default Value:	NULL
Usual Range:	
Valid Range:	0.01-9999.99
DataSource:	User

Seq. #: 9302 **Name:** Dosing Measure

Coding Instructions: Indicate the dosage measurement for each medication prescribed/continued (eg. g, mg).

Target Value: The last value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	mg	
2	g	
3	micrograms	
4	units	

Supporting Definitions: (none)

Technical Specifications

ShortName:	DosMeasure
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

F. Medications

Seq. #: 9303 **Name:** Dose Frequency

Coding Instructions: Indicate the frequency for which the patient should take the prescribed medication dosage.

Target Value: The last value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	once daily	
2	twice daily	
3	three times daily	
4	four times daily	
5	five times daily	
6	with meals	
7	once every other day	
8	once weekly	
9	twice weekly	
10	three times weekly	

Supporting Definitions: (none)

Technical Specifications

ShortName:	DoseFrqncy
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 9305 **Name:** Medication Administered

Coding Instructions: Indicate if the medication was prescribed/continued or was not prescribed for either a medical, system, or patient reason.

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

Selections:

Code	*Selection Text*	*Definition*
1	Yes	Medications was administered or prescribed.
4	No - Patient Reason	Unable to administer/prescribe due to a patient reason such as patient refusal of medication. Patient reason may include religious
5	No - Medical Reason	Unable to administer/prescribe due to a medical reason such as an allergies, contraindications side effects, intolerances, medical interactions, and safety concerns.
6	No - System Reason	Unable to administer/prescribe due to system reason such as not available in the formulary.

Supporting Definitions: (none)

Technical Specifications

ShortName:	MedAdmin
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

F. Medications

Seq. #: 9307 **Name:** Source Medication Code

Coding Instructions: Indicate the source medication code used to document the medication prescription in the native EHR encounter record.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	OtherMedCode
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 9309 **Name:** Source Medication Code System

Coding Instructions: Indicate the source medication code system used to code the medication prescription in the native EHR encounter record including the following coding systems: GPI, MMSL, NDC (NDDF), RxNorm, and SNOMED-CT coding devices.

Target Value: The last value on current encounter

Selections:

Code	*Selection Text*	*Definition*
1	GPI	
2	MMSL	
3	NDC	
4	RxNorm	
5	SNOMED-CT	
6	OTHER	

Technical Specifications

ShortName:	OtherMedCodeSys
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Supporting Definitions: **Other Medication Code System:**

EHRs use a range of medication coding systems to document prescribed medications. These coding systems have varying coding structures and include the following systems:

GPI (Generic Product Identifier) – “The Generic Product Identifier (GPI) from Medi-Span is 14 characters made up of 7 couplets.” Source: Pharmacy Healthcare Solutions, Inc. (http://phsirx.com/blog/gpi-vs-gsn)

MMSL (Multum MediSource Lexicon) – “The Multum Medisource Lexicon was created and is maintained by Multum, a medical information company. The Lexicon is a foundational database with comprehensive drug product and disease nomenclature information. It includes drug names, drug product information, disease names, coding systems such as ICD-9-CM and NDC, generic names, brand names and common abbreviations. A comprehensive list of standard or customized disease names and ICD-9 codes is also included.” Source: Unified Medical Language System (UMLS) (https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/MMSL/)

NDC (National Drug Code)/NDDF (FDB MedKnowledge (formerly NDDF Plus) – “The Drug Listing Act of 1972 requires registered drug establishments to provide the Food and Drug Administration (FDA) with a current list of all drugs manufactured, prepared, propagated, compounded, or processed by it for commercial distribution. (See Section 510 of the Federal Food, Drug, and Cosmetic Act (Act) (21 U.S.C. § 360)). Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for drugs. FDA publishes the listed NDC numbers and the information submitted as part of the listing information in the NDC Directory which is updated daily." Source: U.S Food and Drug Administration (http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm)

RxNorm – “RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Drug Database, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary.
RxNorm now includes the National Drug File - Reference Terminology (NDF-RT) from the Veterans Health Administration. NDF-RT is a terminology used to code clinical drug properties, including mechanism of action, physiologic effect, and therapeutic category.” Source U.S. National Library of Medicine (https://www.nlm.nih.gov/research/umls/rxnorm/)

SNOMED-CT: “SNOMED CT is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information and is also a required standard in interoperability specifications of the U.S. Healthcare Information Technology Standards Panel. The clinical terminology is owned and maintained by the International Health Terminology Standards Development Organisation (IHTSDO), a not-for-profit association.” Source U.S. National Library of Medicine (https://www.nlm.nih.gov/healthit/snomedct/)

Source:

G. Hospitalizations

Seq. #: 9315 **Name:** Most Recent Prescription Date

Coding Instructions: Indicate the most recent date for which the medication was prescribed or renewed.

Target Value: The last value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	RxDate
Parent Seq #:	9300
Parent Name:	Medication ID
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

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

ShortName:	HospitalAdmit_Date
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 9502 **Name:** Hospital Discharge Date

Coding Instructions: Indicate the date the patient was discharged from the most recent hospitalization admission.

Target Value: The last value between birth and current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	HospitalDCDate
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

G. Hospitalizations

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

ShortName:	Admission_Reason_Code
Parent Seq #:	9500
Parent Name:	Hospital Admission Date
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 9507 **Name:** Secondary Diagnosis

Coding Instructions: Indicate the secondary diagnosis of the even that prompted the most recent hospitalization admission, as determined by the judgement of the investigator if a secondary diagnosis is made. 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

ShortName:	SecondDiag
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 9510 **Name:** Coding Standard

Coding Instructions: Indicate the coding standard used in recording admission reason.

Target Value: The last value between birth and current encounter

Selections:

Code	*Selection Text*	*Definition*
1	ICD-9	
2	ICD-10	

Supporting Definitions: (none)

Technical Specifications

ShortName:	Coding_Standard
Parent Seq #:	9505
Parent Name:	Primary Reason for Admission
Parent Value:	Not Null
Missing Data:	Report
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Z. Administration

Seq. #: 1000 **Name:** Data File Name

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DataFile_Name
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Text (100)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1005 **Name:** Data File Creation Date Time

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	DataFile_CreationDtTime
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Date (mm/dd/yyyy)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1010 **Name:** Data File Total Visits

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Datafile_TotalVisits
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Integer (9)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Z. Administration

Seq. #: 1015 **Name:** Data File Source Identification Number

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Datafile_SourceID
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1020 **Name:** Practice Total Visits

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Practice_TotalVisits
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Integer (9)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1021 **Name:** Timeframe of Data Submission

Coding Instructions: Indicate the time frame of data included in the data submission. Format: YYYYQQ. e.g.,2013Q4

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Timeframe
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (6)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Z. Administration

Seq. #: 1025 **Name:** Location Total Visits

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	Location_TotalVisits
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	No Action
Harvested:	Yes (DCR,PINN)
Format:	Integer (9)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1030 **Name:** Encounter Unique Key

Coding Instructions: Indicate the unique key associated with each patient encounter as assigned by the EMR/EHR or your software application.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	EncounterKey
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1040 **Name:** Transmission Number

Coding Instructions: This is a unique number created, and automatically inserted by the software into export file. It identifies the number of times the software has created a data submission file. The transmission number should be incremented by one every time the data submission files are exported. The transmission number should never be repeated.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	XmsnId
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Integer (9)
Default Value:	NULL
Usual Range:	
Valid Range:	1-999999999
DataSource:	Automatic

Z. Administration

Seq. #: 1050 **Name:** Vendor Identifier

Coding Instructions: Vendor identification (agreed upon by mutual selection between the vendor and the NCDR) to identify software vendor. This is entered into the schema automatically by vendor software. Vendors must use consistent name identification across sites. Changes to vendor name identification must be approved by the NCDR.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	VendorId
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (15)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1060 **Name:** Vendor Software Version

Coding Instructions: Vendor's software product name and version number identifying the software which created this record (assigned by vendor). Vendor controls the value in this field. This is entered into the schema automatically by vendor software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	VendorVer
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1070 **Name:** Registry Identifier

Coding Instructions: The NCDR registry identifier describes the data registry to which these records apply. It is implemented in the software at the time the data is collected and records are created. This is entered into the schema automatically by software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	RegistryId
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (20)
Default Value:	ACC-NCDR-PINN
Usual Range:	
Valid Range:	
DataSource:	Automatic

Z. Administration

Seq. #: 1080 **Name:** Registry Version

Coding Instructions: Registry version describes the version number of the Data Specifications/Dictionary, to which each record conforms. It identifies which fields should have data, and what are the valid data for each field. It is the version implemented in the software at the time the data is collected and the records are created. This is entered into the schema automatically by software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	RegistryVer
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (10)
Default Value:	1.6
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1095 **Name:** Submission Type

Coding Instructions: Indicate if the data contained in the harvest/data file contains PINNACLE registry records, diabetic records, or all patient encounter records.

Target Value: N/A

Selections:

Code	*Selection Text*	*Definition*
1	All Encounter Records	Contains all patients and all encounter records with eligible visits to the physician office with an Encounter Date.
2	PINNACLE Encounter Records Only	Contains all completed PINNACLE dataset for all patients and all encounter records with eligible visits to the physician office with an Encounter Date.
3	Diabetes Encounter Records Only	Contains all completed PINN-Diabetes Collaborative Registry (DCR) dataset for all patients and all encounter records with eligible visits to the physician office with an Encounter Date.

Supporting Definitions: (none)

Technical Specifications

ShortName:	SubmissionType
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (Categorical)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	User

Seq. #: 1100 **Name:** Source EHR

Coding Instructions: Indicate the EHR system the data was extracted or provided from at the time of the data was extracted or provided from the EHR.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	SourceEHR
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Z. Administration

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

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

Note(s):

The Practice ID will display in the General Information Section of the data collection form however the coding instructions will move to Administration Section in the data dictionary.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PracticeID
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Integer (6)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic

Seq. #: 1521 **Name:** Practice Name

Coding Instructions: Indicate the full name of the practice.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Technical Specifications

ShortName:	PracName
Parent Seq #:	
Parent Name:	
Parent Value:	
Missing Data:	Illegal
Harvested:	Yes (DCR,PINN)
Format:	Text (50)
Default Value:	NULL
Usual Range:	
Valid Range:	
DataSource:	Automatic