General Information

Data-types used in this document:
- Auto Integer: An auto-incrementing integer value. Generally used as a primary key.
- Integer: Contains an integer. Can be used as a primary key for a value that cannot be auto-incremented (like ProviderID) and must be manually assigned.
- Text: UTF-8 text field. Should assume that these hold, at most, 255 ASCII characters. The Text type in SQLite allows an unlimited number of characters.
- RefSet: Fields of this type are only allowed to take on values from a set of pre-determined values. Also known as a ‘Reference Set’.
- Date: Contains dates and times. If the exact time is unknown, only the date should be filled in or, if a date and time are required, the time should be 12:01:00 AM.
- Boolean: Contains True or False values. NULLs are considered false. If NULLs need to be distinguished from True/False, a tri-state data-type must be used.
- Number: Contains a numeric value. Whether this is an integer or a float is specified in the definition of the field.

Highlighting
Table fields that are highlighted in blue are filled in by algorithms or are auto-incrementing values and are not filled in by Data Managers. Any values in these fields will be overwritten by the algorithm results.

Table and Column Naming Style Guide
- Short, descriptive names.
- Try not to abbreviate.
- CamelCase for both table and column names.
- Primary and foreign keys are both named as: TableName_ID
- Foreign keys have the same name as the primary key that they point to.
- Columns that contain original text have "_orig" appended to their name. The field that they are coded into have the "_orig" replaced with "_calc".
- The only 'underscore' extensions that are used are "_ID", "_orig", and "_calc".
- Column names are not preceded by the table name unless they improve readability (or are the primary/foreign key)
- Column names should make sense when read out loud in the "TableName.ColumnName" format.
- No SQL keywords can be used as table/column names.
- No pluralization

Revision Notes:
- The CaseDetectionExcludeDiagnosisInDiagnosis, CaseDetectionExcludeDiagnosisInMeds, CaseDetectionReferral, and CaseDetectionSetup tables were added/modified to support the new CaseDetection algorithm.
- The PSCoding table was added to support the PatientStatus coding algorithm.
**Table: Network**

**Table Notes:**
- This table is filled by Central prior to database distribution amongst data managers
- Reference table for Network specific information

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Unique identifier for each Network</td>
<td>● Unique number assigned to each network from the central repository.</td>
</tr>
<tr>
<td></td>
<td>Primary Key</td>
<td></td>
<td>● e.g. ‘9’ for NS</td>
</tr>
<tr>
<td>NetworkName</td>
<td>Text</td>
<td>Name of the Network (ie. SAPCReN, MaRNet)</td>
<td>● Name of the Network in Acronym form</td>
</tr>
<tr>
<td>GeographicArea</td>
<td>Text</td>
<td>Geographical area of the Network.</td>
<td>● Examples... Southern Alberta; Northern Alberta; Maritimes, etc.</td>
</tr>
</tbody>
</table>
Table: Site

Table Notes:
- A master list of all the sites within the each network whose data has been sent to the central repository.
- This table will be maintained manually at each network.
  - New sites are added as they join the project.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Unique identifier for each Network</td>
<td>● Unique number assigned to each network from the central repository.</td>
</tr>
<tr>
<td></td>
<td>Primary Key</td>
<td></td>
<td>● e.g. ‘9’ for NS</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Unique identifier for each Site in the Site_ID format</td>
<td>● Site_ID: Unique number assigned by the network to identify each of its sites.</td>
</tr>
<tr>
<td></td>
<td>Primary Key</td>
<td></td>
<td>● e.g. ‘1’ for first site</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Site_ID remains constant across cycles</td>
</tr>
<tr>
<td>LocationType</td>
<td>RefSet</td>
<td>Type of location of the provider's practice.</td>
<td>● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'Site', ColumnName = 'LocationType'</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● e.g. ‘Primary Care Clinic’, ‘Walk-in Clinic’</td>
</tr>
<tr>
<td>LocationFSA</td>
<td>Text</td>
<td>First 3 digits of the postal code of the Site location.</td>
<td>● e.g. ‘X2X’</td>
</tr>
<tr>
<td>Province</td>
<td>RefSet</td>
<td>A unique 2-character province name.</td>
<td>● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'Site', ColumnName = 'Province'</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● e.g. ‘AB’, ‘NS’</td>
</tr>
</tbody>
</table>
Table: Cycle

Table Notes:
- This table is filled by Central repository prior to database distribution amongst data managers
- Reference table for Cycle specific information.
- Details for all past cycles held in this table. Future cycles populated if required.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
</table>
| Cycle_ID       | Text      | Name of the Cycle | ● Follows the regular naming schema.  
                  | Primary Key | ● 2010-Q3, 2010-Q4, 2011-Q1, etc. |
| SequenceNumber | Number    | Order in which the cycles appear chronologically | ● ie. Cycle 1 = 1; Cycle 2010-Q4 = 8; etc. |
| SchemaVersion  | Text      | The version of the database schema used for the cycle | ● 1.8; 2.0; etc. |
| CutoffDate     | Date      | Cut off date for which data will be extracted from the EMR | ● All data occurring before the cut-off date is to be extracted. Any data after the cut-off date is to be dropped. |
| SubmissionDate | Date      | Date in which the local databases are to be submitted to the Central repository | ● This is the FINAL submission date, not the trial submission. |
| CurrentCycle   | Boolean   | Identification whether or not the cycle is the current cycle for the database | ● True or False |
**Table:** SiteCycle

**Table Notes:**
- This table stores Cycle's information for each site within Network
- It allows to save extraction date for each cycle

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>SiteCycle_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign Key from the Network table</td>
<td>Only a Network_ID that exists in the Network table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>Cannot be null</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Foreign Key from the Site table</td>
<td>Only a Site_ID that exists in the Site table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>Cannot be null</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text</td>
<td>Foreign Key from the Cycle table</td>
<td>Only a Cycle_ID that exists in the Cycle table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>Cannot be null</td>
</tr>
<tr>
<td>ExtractionDate</td>
<td>Date</td>
<td>Data extraction date for specified Site</td>
<td></td>
</tr>
</tbody>
</table>
**Table**: SiteEMR

**Table Notes:**
- This table is used to track EMR utilization by site
- Allows for tracking of EMR changes within sites

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>SiteEMR_ID</td>
<td>Auto Integer Primary Key</td>
<td>Auto-incrementing integer</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number Foreign Key</td>
<td>Foreign Key from the Network table</td>
<td>● Only a Network_ID that exists in the Network table can be referenced here.</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number Foreign Key</td>
<td>Foreign Key from the Site table</td>
<td>● Only a Site_ID that exists in the Site table can be referenced here.</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text Foreign Key</td>
<td>Foreign Key from the Cycle table</td>
<td>● Only a Cycle_ID that exists in the Cycle table can be referenced here.</td>
</tr>
<tr>
<td>EMRName</td>
<td>RefSet</td>
<td>Name of the EMR used by the participating site</td>
<td>● Med Access; WOLF; Jonoke; Nightingale; etc.</td>
</tr>
<tr>
<td>Version</td>
<td>Text</td>
<td>Version of the EMR used for Cycle data</td>
<td>● EMR system version</td>
</tr>
<tr>
<td>StartDate</td>
<td>Date</td>
<td>Date the site implemented the EMR</td>
<td></td>
</tr>
<tr>
<td>EndDate</td>
<td>Date</td>
<td>Date the site stopped using the EMR</td>
<td></td>
</tr>
</tbody>
</table>
**Table: Provider**

**Table Notes:**
- A master list of all providers whose data has been sent to the central repository.
- This table will be maintained manually at each network.
  - New providers are added as they join the project.
  - As providers leave the project, previously submitted data will be maintained in the database, however no new information will be added from that time forward.
  - All collected records of all patients of past providers are imported from the databases generated in previous cycles. New records on those patients are ONLY collected if they transfer to a new, participating provider.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
</table>
| Provider_ID | Number    | Unique identifier for each provider in the Provider_ID format.             | ● Provider_ID: Unique number assigned by each network to the providers in its sites.  
  ● e.g. ‘15’                                                |
| BirthYear | Number    | Provider's year of birth.                                                 |                                                                            |
| Sex     | RefSet    | Provider's sex.                                                           | ● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'Provider', ColumnName= 'Sex'  
  ● e.g. "Male" or "Female".                                |
## Table: SiteProvider

### Table Notes:
- This table will be maintained manually at each network.
- As new providers are added to the project or move between sites, changes are made to this table.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>SiteProvider_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign Key from the Network table</td>
<td>Only a Network_ID that exists in the Network table can be referenced here. Cannot be null</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Foreign Key from the Site table</td>
<td>Only a Site_ID that exists in the Site table can be referenced here. Cannot be null</td>
</tr>
<tr>
<td>Provider_ID</td>
<td>Text</td>
<td>Foreign Key from the Provider table</td>
<td>Only a Provider_ID that exists in the Provider table can be referenced here. Cannot be null</td>
</tr>
<tr>
<td>ProviderType</td>
<td>RefSet</td>
<td>Role of this provider</td>
<td>Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'SiteProvider', ColumnName= 'ProviderType'</td>
</tr>
<tr>
<td>Role</td>
<td>RefSet</td>
<td>Role of this provider</td>
<td>For now, Role = ProviderType</td>
</tr>
<tr>
<td>StartDate</td>
<td>Date</td>
<td>Date that the provider starts participating in CPCSSN at the site</td>
<td>Can either be the date the provider began with CPCSSN or the date that the provider moved to a new site.</td>
</tr>
<tr>
<td>EndDate</td>
<td>Date</td>
<td>Date that the provider stops participating in CPCSSN at the site</td>
<td>Can either be the date the provider left CPCSSN or the date that the provider left the existing site.</td>
</tr>
</tbody>
</table>
Table: Patient

Table Notes:
- List of EMR patients whose primary provider is a consenting physician in the CPCSSN project (has an entry in the Provider table).

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient_ID</td>
<td>Number</td>
<td>Must be in this format: Patient_ID</td>
<td>● Assign each patient a meaningless number. e.g. '123456'</td>
</tr>
</tbody>
</table>
| Sex         | RefSet    | Patient’s sex.                                      | ● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'Patient', ColumnName= ‘Sex’
                               | ● e.g. ‘Male’ or ‘Female’.                                         |
| BirthYear   | Number    | 4-digit year of patient's birth date.               | ● Not null. ● Must be greater than or equal to 1850.                        |
| OptedOut    | Boolean   | Has the patient opted out in any extraction         | ● True or False                                                            |
| OptOutDate  | Date      | Date patient has opted out                          |                                                                            |
### Table: PatientProvider

**Table Notes:**
- This table identifies which patients are assigned to which providers.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PatientProvider_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign Key from the Network table</td>
<td>Only a Network_ID that exists in the Network table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>Cannot be null</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Foreign Key from the Site table</td>
<td>Only a Site_ID that exists in the Site table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>Cannot be null</td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Text</td>
<td>Foreign Key from the Patient table</td>
<td>Only a Patient_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>Cannot be null</td>
</tr>
<tr>
<td>Provider_ID</td>
<td>Text</td>
<td>Foreign Key from the Provider table</td>
<td>Only a Provider_ID that exists in the Provider table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>Cannot be null</td>
</tr>
<tr>
<td>StartDate</td>
<td>Date</td>
<td>Date that the provider starts providing care to the patient at this site.</td>
<td></td>
</tr>
<tr>
<td>EndDate</td>
<td>Date</td>
<td>Date that the provider stops providing care to the patient at this site.</td>
<td></td>
</tr>
</tbody>
</table>
### Table: PatientDemographic

#### Table Notes:
- Changeable characteristics/demographics of the patients are stored here.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PatientDemographic_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign Key from the Network table</td>
<td>● Only a Network_ID that exists in the Network table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Foreign Key from Site table</td>
<td>● Only a Site_ID that exists in the Site table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be</td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number</td>
<td>Foreign Key from Patient table</td>
<td>● Only a Patient_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text</td>
<td>Foreign Key from Cycle table</td>
<td>● Only a Cycle_ID that exists in the Cycle table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be</td>
</tr>
<tr>
<td>Occupation</td>
<td>Text</td>
<td>Patient's occupation.</td>
<td>● Extract this from the EMR if it is available.</td>
</tr>
<tr>
<td>HighestEducation</td>
<td>Text</td>
<td>Patient's highest education</td>
<td>● Extract this from the EMR if it is available.</td>
</tr>
<tr>
<td>HousingStatus</td>
<td>Text</td>
<td>Patient's housing status.</td>
<td>● Extract this from the EMR if it is available.</td>
</tr>
<tr>
<td>ResidenceFSA</td>
<td>Text</td>
<td>First 3 digits of the postal code of the patient.</td>
<td>● e.g. 'X2X'</td>
</tr>
<tr>
<td>PatientStatus_orig</td>
<td>Text</td>
<td>Status of the patient</td>
<td>● e.g: deceased, expired, active, hospital, transient, senior clinic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● If both codes and description of codes are available(e.g. code=1, description=active), only use enter the description.</td>
</tr>
<tr>
<td>PatientStatus_calc</td>
<td>RefSet</td>
<td>Re-coding of PatientStatus_orig into consistent text.</td>
<td>● Valid values are in the 'ColumnValue' field of the 'MasterLookup' table, TableName = 'PatientDemographic', ColumnName = 'PatientStatus_calc'</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● e.g. ‘Active’, ‘Deceased’, etc.</td>
</tr>
<tr>
<td>Language</td>
<td>Text</td>
<td>Patient's primary language.</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Text</td>
<td>Patient's ethnicity.</td>
<td>● Extract this from the EMR if it is available.</td>
</tr>
<tr>
<td>DeceasedYear</td>
<td>Number</td>
<td>The Deceased year of a patient</td>
<td></td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>EMR date stamp of the record.</td>
<td></td>
</tr>
</tbody>
</table>
### Table: AllergyIntolerance

#### Table Notes:
- All allergy and intolerance data for the patient.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AllergyIntolerance_ID</strong></td>
<td>Auto Integer</td>
<td>Primary Key Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign Key from Network table.</td>
<td>● Only a Network_ID that exists in the Network table can be referenced here. ● Cannot be null</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Foreign Key from Site table.</td>
<td>● Only a Site_ID that exists in the Site table can be referenced here. ● Cannot be null</td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number</td>
<td>Foreign Key from Patient table.</td>
<td>● Only a Patient_ID that exists in the Patient table can be referenced here. ● Cannot be null</td>
</tr>
<tr>
<td>Encounter_ID</td>
<td>Number</td>
<td>Foreign Key from Encounter table.</td>
<td>● Only an Encounter_ID that exists in the Encounter table can be used. ● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text</td>
<td>Foreign Key from Cycle table.</td>
<td>● Only a Cycle_ID that exists in the Cycle table can be used. ● Cannot be null</td>
</tr>
<tr>
<td>StartDate</td>
<td>Date</td>
<td>Date that the allergy was first identified.</td>
<td></td>
</tr>
<tr>
<td>StopDate</td>
<td>Date</td>
<td>Date that the allergy was noted as inactive.</td>
<td>● If an allergy is inactive and a StopDate cannot be found, the Status field must still be set to 'Inactive'.</td>
</tr>
<tr>
<td>DIN</td>
<td>Text</td>
<td>DIN number for the medication.</td>
<td>● Extract this where available</td>
</tr>
<tr>
<td>Name_orig</td>
<td>Text</td>
<td>Name of the allergy exactly as it appears in the EMR.</td>
<td></td>
</tr>
<tr>
<td>Name_calc</td>
<td>RefSet</td>
<td>Re-coded original text into consistent text.</td>
<td>● To be coded in the future.</td>
</tr>
<tr>
<td>CodeType_orig</td>
<td>Text</td>
<td>CodeType of the allergy exactly as it appears in the EMR</td>
<td>● e.g. ‘ATC’</td>
</tr>
<tr>
<td>CodeType_calc</td>
<td>RefSet</td>
<td>Name of the code set that the Name_calc uses.</td>
<td>● To be coded in the future.</td>
</tr>
<tr>
<td>Code_orig</td>
<td>Text</td>
<td>Code of the allergy exactly as it appears in the EMR</td>
<td></td>
</tr>
<tr>
<td>Code_calc</td>
<td>RefSet</td>
<td>Code for the allergy in the CodeType_calc code set.</td>
<td>● To be coded in the future.</td>
</tr>
<tr>
<td>Category</td>
<td>RefSet</td>
<td>The category of the allergy.</td>
<td>● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'AllergyIntolerance', ColumnName= 'Category' ● e.g. 'Medication’, ‘Non-Medication’, ‘Medication Intolerance’</td>
</tr>
<tr>
<td>Severity</td>
<td>RefSet</td>
<td>The severity of the reaction.</td>
<td>● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'AllergyIntolerance', ColumnName= 'Severity' ● e.g. ‘Mild’, ‘Moderate’, ‘Severe’</td>
</tr>
<tr>
<td>AllergyStatus</td>
<td>RefSet</td>
<td>Current status of the allergy.</td>
<td>● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'AllergyIntolerance', ColumnName= 'Status' ● e.g. ‘Active’, ‘Inactive’ ● If an allergy is inactive, this field is always filled in, even if no StopDate exists.</td>
</tr>
<tr>
<td>ReactionType</td>
<td>Text</td>
<td>The type of reaction that occurs with allergy.</td>
<td>● e.g. ‘Rash’, ‘Anaphylaxis’, etc.</td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>EMR date stamp of the record.</td>
<td></td>
</tr>
</tbody>
</table>
### Table: Billing

**Table Notes:**  
- All billing data submitted to the province for the patient.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign Key from Network table.</td>
<td>● Only a Network_ID that exists in the Network table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Foreign Key from Site table.</td>
<td>● Only a Site_ID that exists in the Site table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number</td>
<td>Foreign Key from Patient table.</td>
<td>● Only a Patient_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Encounter_ID</td>
<td>Number</td>
<td>Foreign Key from Encounter table.</td>
<td>● Only an Encounter_ID that exists in the Encounter table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text</td>
<td>Foreign Key from Cycle table.</td>
<td>● Only an Cycle_ID that exists in the Cycle table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>ServiceDate</td>
<td>Date</td>
<td>Date the billing was performed/submitted.</td>
<td></td>
</tr>
<tr>
<td>ServiceCode</td>
<td>Text</td>
<td>Service code associated with the billing.</td>
<td>● e.g. ‘03.03A’ in Alberta.</td>
</tr>
<tr>
<td>DiagnosisText_orig</td>
<td>Text</td>
<td>Text exactly as it appears in the EMR.</td>
<td></td>
</tr>
<tr>
<td>DiagnosisText_calc</td>
<td>Text</td>
<td>Re-coding of DiagnosisText_orig into consistent text.</td>
<td>● To be coded in future</td>
</tr>
<tr>
<td>DiagnosisCodeType_orig</td>
<td>Text</td>
<td>Type of code for any diagnosis codes attached to the billing as it appears in the EMR.</td>
<td>● e.g. “ICD9”</td>
</tr>
<tr>
<td>DiagnosisCodeType_calc</td>
<td>Text</td>
<td>Re-coding of DiagnosisCodeType_orig into consistent text.</td>
<td>● To be coded in future</td>
</tr>
<tr>
<td>DiagnosisCode_orig</td>
<td>Text</td>
<td>Diagnosis code associated with the billing as it appears in the EMR.</td>
<td>● e.g. “250.0”</td>
</tr>
<tr>
<td>DiagnosisCode_calc</td>
<td>Text</td>
<td>Re-coding of DiagnosisCode_orig into consistent text.</td>
<td>● To be coded in future</td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>EMR date stamp of the record.</td>
<td></td>
</tr>
</tbody>
</table>
### Table: DiseaseCase

#### Table Notes:
- Patients in the Patient table who have one or more of the Index Diseases.
- Populated by the case detection algorithm.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>DiseaseCase_ID</td>
<td>Auto Integer Primary Key</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number Foreign Key</td>
<td>Foreign Key from Patient table.</td>
<td>Only a Patient_ID that exists in the Patient table can be referenced here. Only a Patient_ID that exists in the Patient table can be referenced here. Cannot be null</td>
</tr>
<tr>
<td>Disease</td>
<td>RefSet</td>
<td>The Patient's chronic condition of interest to this database.</td>
<td>Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'DiseaseCase', ColumnName= 'Disease' e.g. 'COPD', 'Depression', 'Diabetes Mellitus'</td>
</tr>
<tr>
<td>DateOfOnset</td>
<td>Date</td>
<td>Date that the health condition began.</td>
<td></td>
</tr>
</tbody>
</table>
**Table:** DiseaseCaseIndicator

**Table Notes:**
- Collects all of the reasons that a patient has been identified as having an index disease.
- Populated by the case detection algorithm.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>DiseaseCaseIndicator_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number</td>
<td>Foreign Key from Patient table.</td>
<td>Only a Patient_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>Cannot be null</td>
</tr>
<tr>
<td>Disease</td>
<td>RefSet</td>
<td>The Patient's chronic condition of interest to this database</td>
<td>Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'DiseaseCase', ColumnName= 'Disease'</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>e.g. 'COPD', 'Depression', 'Diabetes Mellitus'</td>
</tr>
<tr>
<td>IndicatorType</td>
<td>RefSet</td>
<td>General category that the indicator falls under.</td>
<td>e.g. &quot;HealthCondition&quot;, &quot;Medication&quot;, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>RefSet values are NOT in the MasterLookup table, they are the names of the table where the original record can be found.</td>
</tr>
<tr>
<td>IndicatorValue</td>
<td>Text</td>
<td>Data value from the original record.</td>
<td></td>
</tr>
<tr>
<td>TableName</td>
<td>RefSet</td>
<td>Name of the table storing the original record.</td>
<td></td>
</tr>
<tr>
<td>TableKey</td>
<td>Text</td>
<td>Primary key of the original record in the original table.</td>
<td></td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>EMR date stamp of the original record.</td>
<td></td>
</tr>
</tbody>
</table>
**Table: Encounter**

**Table Notes:**
- All encounters of the patient.
- An encounter is an interaction of the patient with a provider in some fashion. The provider does not need to be a participating provider.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign key from the Network table</td>
<td>● Only a Network_ID that exists in the Network table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Foreign key from the Site table</td>
<td>● Only a Site_ID that exists in the Site table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number</td>
<td>Foreign Key from the Patient table.</td>
<td>● Only a Patient_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Provider_ID</td>
<td>Number</td>
<td>Responsible Provider for this encounter.</td>
<td>● When the provider for the encounter is a provider in the Provider table, MUST use the same ID.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● If the provider for the encounter is not a CPCSSN-consenting provider, the value of ‘0’ is assigned.</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text</td>
<td>Foreign key from the Cycle table</td>
<td>● Only a Cycle_ID that exists in the Cycle table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>EncounterDate</td>
<td>Date</td>
<td>Date the encounter occurred</td>
<td></td>
</tr>
<tr>
<td>Reason_orig</td>
<td>Text</td>
<td>Text exactly as it appears in the EMR.</td>
<td>● If there is more than one source of this data, then precede the entry with 'Patient: ' and 'Provider: ' as appropriate.</td>
</tr>
<tr>
<td>Reason_calc</td>
<td>RefSet</td>
<td>Re-coded or cleaned version of Reason_orig.</td>
<td>● We will recode this in a future cycle, do not fill in.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● RefSet values are NOT in the MasterLookup table, they are the name of the coding set.</td>
</tr>
<tr>
<td>EncounterType</td>
<td>RefSet</td>
<td>How or where the encounter was conducted.</td>
<td>● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'Encounter', ColumnName= 'EncounterType'</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● e.g. 'Phone', 'Walk-In', 'ER Visit'</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Extract this data if available.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● If recoding is not straight forward, populate with original text and indicate this in the extraction notes.</td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>Date the record was created in the EMR</td>
<td></td>
</tr>
</tbody>
</table>
Table: EncounterDiagnosis

Table Notes:
● All diagnoses resulting from an encounter with the patient.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>EncounterDiagnosis_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign key from the Network table</td>
<td>● Only an Network_ID that exists in the Network table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Foreign Key from Site table.</td>
<td>● Only an Site_ID that exists in the Site table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number</td>
<td>Foreign Key from the Patient table</td>
<td>● Only an Patient_ID that exists in the Patient table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Encounter_ID</td>
<td>Number</td>
<td>Foreign Key from the Encounter table</td>
<td>● Only an Encounter_ID that exists in the Encounter table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Provider_ID</td>
<td>Number</td>
<td>Responsible Provider for this encounter.</td>
<td>● When the provider for the encounter is a provider in the Provider table, MUST use the same ID.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● If the provider for the encounter is not a CPCSSN-consenting provider, the value of ‘0’ is assigned.</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text</td>
<td>Foreign key from the Cycle table</td>
<td>● Only an Cycle_ID that exists in the Cycle table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>DiagnosisText_orig</td>
<td>Text</td>
<td>Text exactly as it appears in the EMR.</td>
<td>● This is the final physician diagnosis, not the presenting complaint of the visit.</td>
</tr>
<tr>
<td>DiagnosisText_calc</td>
<td>RefSet</td>
<td>Re-coding of DiagnosisText_orig into consistent text.</td>
<td>● To be coded in the future.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● RefSet values are NOT in the MasterLookup table, they are from the associated coding set.</td>
</tr>
<tr>
<td>DiagnosisCodeType_orig</td>
<td>Text</td>
<td>Name of the code set from which the original diagnosis code was taken.</td>
<td>● Populate this field ONLY if there is a value in the DiagnosisCodeOriginal field for this record.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>e.g. ‘ICD9’, ‘SNOMED’</td>
</tr>
<tr>
<td>DiagnosisCodeType_calc</td>
<td>RefSet</td>
<td>Re-coding of DiagnosisCodeType_orig into consistent text.</td>
<td>● To be coded in the future.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● RefSet values are NOT in the MasterLookup table, they are from the associated coding set.</td>
</tr>
<tr>
<td>DiagnosisCode_orig</td>
<td>Text</td>
<td>Original diagnosis code from EMR.</td>
<td>● Populate this only if it is already available in the EMR. Do not clean any data.</td>
</tr>
<tr>
<td>DiagnosisCode_calc</td>
<td>RefSet</td>
<td>Re-coding of DiagnosisCode_orig into consistent text.</td>
<td>● To be coded in the future.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● RefSet values are NOT in the MasterLookup table, they are from the associated coding set.</td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>EMR date stamp of the record.</td>
<td></td>
</tr>
</tbody>
</table>
### Table: Exam

**Table Notes:**
- Results of physical exams performed on the patient.
- Extract only the designated physical exams (see the MasterLookup Exam list).

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam_ID</td>
<td>Auto Integer</td>
<td>Primary Key</td>
<td>Auto-incrementing integer.</td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign Key</td>
<td>Foreign Key from the Network table. Only a Network_ID that exists in the Network table can be referenced here. Cannot be null.</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Foreign Key</td>
<td>Foreign Key from the Site table. Only a Site_ID that exists in the Site table can be referenced here. Cannot be null.</td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number</td>
<td>Foreign Key</td>
<td>Foreign Key from Patient table. Only a Patient_ID that exists in the Patient table can be referenced here. Cannot be null.</td>
</tr>
<tr>
<td>Encounter_ID</td>
<td>Number</td>
<td>Foreign Key</td>
<td>Foreign Key from Encounter table. Only an Encounter_ID that exists in the Encounter table can be used. May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text</td>
<td>Foreign Key</td>
<td>Foreign Key from the Cycle table. Only an Cycle_ID that exists in the Cycle table can be used. Cannot be null.</td>
</tr>
<tr>
<td>Exam1</td>
<td>RefSet</td>
<td>Name of the physical exam; recoded into consistent text. Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'Exam', ColumnName= 'Exam1' e.g. 'BMI (kg/m^2)', 'dBP (mmHg)', 'Foot Exam', 'sBP (mmHg)'</td>
<td></td>
</tr>
<tr>
<td>Result1_orig</td>
<td>Text</td>
<td>Result of the physical exam. Convert exam result into consistent units. Units are contained in the 'Exam' name.</td>
<td></td>
</tr>
<tr>
<td>Result1_calc</td>
<td>Text</td>
<td>Re-coding of Result1_orig. Populated by Exam Coding algorithm.</td>
<td></td>
</tr>
<tr>
<td>Exam2</td>
<td>RefSet</td>
<td>Name of the paired physical exam. Currently the only paired exam is blood pressure. 'Exam1' must be 'sBP (mmHg)' and 'Exam2' must be 'dBP (mmHg)'. Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'Exam', ColumnName= 'Exam2' e.g. 'dBP (mmHg)'</td>
<td></td>
</tr>
<tr>
<td>Result2_orig</td>
<td>Text</td>
<td>Second result of paired physical exam. Currently the only paired exam is blood pressure. 'Result1' must be the systolic result and 'Result2' must be the diastolic result.</td>
<td></td>
</tr>
<tr>
<td>Result2_calc</td>
<td>Text</td>
<td>Re-coding of Result2_orig. Populated by Exam Coding algorithm.</td>
<td></td>
</tr>
<tr>
<td>UnitOfMeasure_orig</td>
<td>Text</td>
<td>Units that accompany the ExamResult. Convert exam result into consistent units. Units are contained in the 'Exam' name.</td>
<td></td>
</tr>
<tr>
<td>UnitOfMeasure_calc</td>
<td>Text</td>
<td>Re-coding of UnitOfMeasure_orig. Populated by Exam Coding algorithm.</td>
<td></td>
</tr>
<tr>
<td>PairingMethod</td>
<td>PairingMethod</td>
<td>For physical exam. Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'Exam', ColumnName= 'PairingMethod' The PairingMethod is only filled in for exams that have paired results, e.g. blood pressures. This is only filled in when both Exam1 and Exam2 fields are populated. e.g. 'Algorithm', 'Pre-paired'</td>
<td></td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>EMR date stamp of the record.</td>
<td></td>
</tr>
</tbody>
</table>
### Table: HealthCondition

#### Table Notes:
- All health conditions of the patient.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthCondition_ID</td>
<td>Auto Integer</td>
<td>Primary Key</td>
<td>Auto-incrementing integer.</td>
</tr>
</tbody>
</table>
| Network_ID        | Number    | Foreign Key from the Network table.                                         | ● Only a Network_ID that exists in the Network table can be referenced here.  
 ● Cannot be null                                                                                                  |
| Site_ID           | Number    | Foreign Key from the Site table.                                            | ● Only a Site_ID that exists in the Site table can be referenced here.  
 ● Cannot be null                                                                                                  |
| Patient_ID        | Number    | Foreign Key from the Patient table.                                         | ● Only a Patient_ID that exists in the Patient table can be referenced here.  
 ● Cannot be null                                                                                                  |
| Encounter_ID      | Number    | Foreign Key from Encounter table.                                           | ● Only an Encounter_ID that exists in the Encounter table can be used.  
 ● May be null if the EMR does not have the data.                                                                 |
| Cycle_ID          | Text      | Foreign Key from the Cycle table.                                           | ● Only a Cycle_ID that exists in the Cycle table can be referenced here.  
 ● Cannot be null                                                                                                  |
| DiagnosisText_orig| Text      | Text exactly as it appears in the EMR.                                      |                                                                                                                                                 |
| DiagnosisText_calc| RefSet    | Re-coding of DiagnosisText_orig into consistent text.                      | ● Populated by health condition coding algorithm.  
 ● RefSet values are NOT in the MasterLookup table, they are from the associated coding set.                                           |
| DiagnosisCodeType_orig| Text   | Name of the code set from which the original diagnosis code was taken.      | ● Populate this field ONLY if there is a value in the DiagnosisCodeOriginal field for this record.  
 ● e.g. 'ICD9', 'SNOMED'                                                                                           |
| DiagnosisCodeType_calc| RefSet| Re-coding of DiagnosisCodeType_orig into consistent text.                 | ● Populated by health condition coding algorithm.                                                                                          |
| DiagnosisCode_orig| Text      | Original diagnosis code from EMR.                                           | ● Populate this only if it is already available in the EMR. Do not clean any data.                                                         |
| DiagnosisCode_calc| RefSet    | Re-coding of DiagnosisCode_orig into consistent text.                      | ● Populated by health condition coding algorithm.  
 ● RefSet values are NOT in the MasterLookup table, they are from the associated coding set.                                           |
| DateOfOnset       | Date      | Date that the health condition began.                                       |                                                                                                                                                 |
| SignificantNegativeFlag| Boolean | An indicator that the Patient does NOT have this health condition.        | ● ‘True’: does not have this condition.  
 ● ‘False'/NULL: has this condition.                                                                                       |
| ActiveInactiveFlag| RefSet    | An indicator that the condition is active at the time of data extraction.  | ● Valid options are in the 'Value' field of the 'MasterLookup' table, Category = 'ActiveInactiveFlag'  
 ● If it is in the problem list, it is likely to be Active. If it is in the Past Medical History, it is likely to be Inactive. |
| DateCreated       | Date      | EMR date stamp of the record.                                               |                                                                                                                                                 |
Table: Lab

Table Notes:
- Results of lab tests relevant to Index Diseases.
- Extract only the designated lab tests (see the MasterLookup Lab.Name_calc list).
  - Currently the collected lab tests are only applicable to diabetes mellitus, but may be expanded in the future.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign Key from the Network table.</td>
<td>Only a Network_ID that exists in the Network table can be referenced here.</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Foreign Key from the Site table.</td>
<td>Only a Site_ID that exists in the Site table can be referenced here.</td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number</td>
<td>Foreign Key from the Patient table.</td>
<td>Only a Patient_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td>Encounter_ID</td>
<td>Number</td>
<td>Foreign Key from the Encounter table.</td>
<td>Only an Encounter_ID that exists in the Encounter table can be used.</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text</td>
<td>Foreign Key from the Cycle table.</td>
<td>Only a Cycle_ID that exists in the Cycle table can be referenced here.</td>
</tr>
<tr>
<td>PerformedDate</td>
<td>Date</td>
<td>Date that the lab test was done.</td>
<td></td>
</tr>
<tr>
<td>Name_orig</td>
<td>Text</td>
<td>Text exactly as it appears in the EMR.</td>
<td></td>
</tr>
<tr>
<td>Name_calc</td>
<td>RefSet</td>
<td>Re-coded Name_orig into consistent Name_calc</td>
<td>Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'Lab', ColumnName= 'Name_calc'</td>
</tr>
<tr>
<td>CodeType_orig</td>
<td>Text</td>
<td>CodeType text exactly as it appears in the EMR</td>
<td></td>
</tr>
<tr>
<td>CodeType_calc</td>
<td>RefSet</td>
<td>Re-coded CodeType_orig into consistent CodeType_calc</td>
<td>Populated by lab result coding algorithm.</td>
</tr>
<tr>
<td>Code_orig</td>
<td>Text</td>
<td>Code text exactly as it appears in the EMR</td>
<td>Populated by lab result coding algorithm.</td>
</tr>
<tr>
<td>Code_calc</td>
<td>RefSet</td>
<td>Re-coded Code_orig into consistent Code_calc</td>
<td>Populated by lab result coding algorithm.</td>
</tr>
<tr>
<td>TestResult</td>
<td>Text</td>
<td>Result of the lab test</td>
<td></td>
</tr>
<tr>
<td>UpperNormal</td>
<td>Text</td>
<td>The highest lab result value that is considered normal.</td>
<td>May not be available.</td>
</tr>
<tr>
<td>LowerNormal</td>
<td>Text</td>
<td>The lowest lab result value that is considered normal.</td>
<td>May not be available.</td>
</tr>
<tr>
<td>NormalRange</td>
<td>Text</td>
<td>The original text containing both the upper and lower lab ranges in one record from the EMR</td>
<td>If upper and lower ranges are already given in separate fields, this field can be left blank</td>
</tr>
<tr>
<td>UnitOfMeasure</td>
<td>Text</td>
<td>Unit of measure for the value in the Name_calc field.</td>
<td>May not be available.</td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>EMR date stamp of the record.</td>
<td></td>
</tr>
</tbody>
</table>
Table: MedicalProcedure

Table Notes:
● All procedures performed on the patient.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>MedicalProcedure_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign Key from the Network table.</td>
<td>● Only an Network_ID that exists in the Network table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number</td>
<td>Foreign Key from the Site table.</td>
<td>● Only an Site_ID that exists in the Site table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>CPCSSNPatientID</td>
<td>Number</td>
<td>Foreign Key from the Patient table.</td>
<td>● Only a Patient_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Encounter_ID</td>
<td>Number</td>
<td>Foreign Key from the Encounter table.</td>
<td>● Only an Encounter_ID that exists in the Encounter table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text</td>
<td>Foreign Key from the Cycle table.</td>
<td>● Only an Cycle_ID that exists in the Cycle table can be used.</td>
</tr>
<tr>
<td></td>
<td>Foreign Key</td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>PerformedDate</td>
<td>Date</td>
<td>Date that the procedure was performed.</td>
<td></td>
</tr>
<tr>
<td>Name_orig</td>
<td>Text</td>
<td>Procedure text exactly as it appears in the EMR.</td>
<td></td>
</tr>
<tr>
<td>Name_calc</td>
<td>RefSet</td>
<td>Re-coded Name_orig into consistent Name_calc.</td>
<td>● Re-coding will be done in a future cycle.</td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>EMR date stamp of the record.</td>
<td></td>
</tr>
</tbody>
</table>
### Table: Medication

**Table Notes:**
- All medications prescribed for the patient.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication_ID</td>
<td>Auto Integer Primary Key</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number Foreign Key</td>
<td>Foreign Key from the Network table.</td>
<td>● Only a Network_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number Foreign Key</td>
<td>Foreign Key from the Site table.</td>
<td>● Only a Site_ID that exists in the Site table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number Foreign Key</td>
<td>Foreign Key from the Patient table.</td>
<td>● Only a Patient_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Encounter_ID</td>
<td>Number Foreign Key</td>
<td>Foreign Key from the Encounter table.</td>
<td>● Only an Encounter_ID that is in the Encounter table can be used.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text Foreign Key</td>
<td>Foreign Key from the Cycle table.</td>
<td>● Only a Cycle_ID that exists in the Cycle table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>StartDate</td>
<td>Date</td>
<td>Date that the Patient started taking the medication</td>
<td></td>
</tr>
<tr>
<td>StopDate</td>
<td>Date</td>
<td>Date that the Patient stopped taking the medication.</td>
<td></td>
</tr>
<tr>
<td>Reason</td>
<td>Text</td>
<td>Reason that Patient was prescribed the medication.</td>
<td>● Exact text as in the EMR, no cleaning for now.</td>
</tr>
<tr>
<td>DIN</td>
<td>Text</td>
<td>DIN number for the medication.</td>
<td>● Extract this where available</td>
</tr>
<tr>
<td>Name_orig</td>
<td>Text</td>
<td>Text exactly as it appears in the EMR.</td>
<td></td>
</tr>
<tr>
<td>Name_calc</td>
<td>RefSet</td>
<td>Re-coded Name_orig into consistent Name_calc.</td>
<td>● Populated by medication coding algorithm.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● RefSet values are NOT in the MasterLookup table, they are from the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>associated coding set.</td>
</tr>
<tr>
<td>CodeType_orig</td>
<td>Text</td>
<td>Original code set used in the EMR.</td>
<td>● e.g. ‘ATC’</td>
</tr>
<tr>
<td>CodeType_calc</td>
<td>RefSet</td>
<td>Re-coded CodeType_orig into consistent CodeType_calc.</td>
<td>● Populated by medication coding algorithm.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● RefSet values are NOT in the MasterLookup table, they are the name of</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>the coding set.</td>
</tr>
<tr>
<td>Code_orig</td>
<td>Text</td>
<td>Original code used in the EMR.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● RefSet values are NOT in the MasterLookup table, they are from the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>associated coding set.</td>
</tr>
<tr>
<td>Strength</td>
<td>Text</td>
<td>Concentration of the medication.</td>
<td>● e.g. 40</td>
</tr>
<tr>
<td>Dose</td>
<td>Text</td>
<td>Number of units of the medication to be taken.</td>
<td>● e.g. 2</td>
</tr>
<tr>
<td>UnitOfMeasure</td>
<td>Text</td>
<td>Units used for the medication.</td>
<td>● e.g. mg, ml</td>
</tr>
<tr>
<td>Frequency</td>
<td>Text</td>
<td>Frequency with which medication is to be taken.</td>
<td>● e.g. bid, tid, q4hr</td>
</tr>
<tr>
<td>DurationCount</td>
<td>Number</td>
<td>Length of time that the patient should take the medication.</td>
<td>● e.g. 10</td>
</tr>
<tr>
<td>DurationUnit</td>
<td>Text</td>
<td>The units of measure for the DurationCount.</td>
<td>● e.g. ‘days’</td>
</tr>
<tr>
<td>Field</td>
<td>Type</td>
<td>Description</td>
<td>Example</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>DispensedCount</td>
<td>Number</td>
<td>Number of units (as defined in DispensedForm) to be dispensed.</td>
<td>e.g. 90</td>
</tr>
<tr>
<td>DispensedForm</td>
<td>RefSet</td>
<td>Form of dispensed medication.</td>
<td>e.g. 'Vial', 'Tab', 'Capsule'</td>
</tr>
<tr>
<td>RefillCount</td>
<td>Number</td>
<td>Number of refills.</td>
<td>e.g. 3</td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>EMR date stamp of the record.</td>
<td></td>
</tr>
</tbody>
</table>
Table: Referral

Table Notes:
● All referrals made for the patient.
● Include only referrals made by this provider/practice. Exclude referrals made by specialists to another provider.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral_ID</td>
<td>Auto Integer Primary Key</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number Foreign Key</td>
<td>Foreign Key from the Network table.</td>
<td>● Only an Network_ID that exists in the Network table can be used.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number Foreign Key</td>
<td>Foreign Key from the Site table.</td>
<td>● Only an Site_ID that exists in the Site table can be used.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number Foreign Key</td>
<td>Foreign Key from the Patient table.</td>
<td>● Only a Patient_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Encounter_ID</td>
<td>Number Foreign Key</td>
<td>Foreign Key from the Encounter table.</td>
<td>● Only an Encounter_ID that exists in the Encounter table can be used.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text Foreign Key</td>
<td>Foreign Key from the Cycle table.</td>
<td>● Only an Cycle_ID that exists in the Cycle table can be used.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>CompletedDate</td>
<td>Date</td>
<td>Date when the patient saw the provider to whom they were referred.</td>
<td>● Extract if available in your EMR.</td>
</tr>
<tr>
<td>Name_orig</td>
<td>Text</td>
<td>Referral Text exactly as it appears in the EMR.</td>
<td>● We want the reason for referral, not the entire referral letter.</td>
</tr>
<tr>
<td>Name_calc</td>
<td>RefSet</td>
<td>Re-code Name_orig into consistent Name_calc</td>
<td>● Populated by the Referral Cleaning algorithm.</td>
</tr>
<tr>
<td>ConceptCode</td>
<td>RefSet</td>
<td>SNOMED concept code.</td>
<td>● Populated by the Referral Cleaning algorithm.</td>
</tr>
<tr>
<td>DescriptionCode</td>
<td>RefSet</td>
<td>SNOMED description code.</td>
<td>● Populated by the Referral Cleaning algorithm.</td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>EMR date stamp of the record.</td>
<td></td>
</tr>
</tbody>
</table>
### Table: RiskFactor

#### Table Notes:
- Risk factors recorded for the patient.
- Extract only the designated risk factors (see the MasterLookup RiskFactor list).

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>RiskFactor_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
</tbody>
</table>
| Network_ID    | Number        | Foreign Key from the Network table.                                       | ● Only a Network_ID that exists in the Network table can be referenced here.  
   Foreign Key                                      | ● Cannot be null                                                          |
| Site_ID       | Number        | Foreign Key from the Site table.                                          | ● Only a Site_ID that exists in the Site table can be referenced here.  
   Foreign Key                                      | ● Cannot be null                                                          |
| Patient_ID    | Number        | Foreign Key from the Patient table.                                       | ● Only a Patient_ID that exists in the Patient table can be referenced here.  
   Foreign Key                                      | ● Cannot be null                                                          |
| Encounter_ID  | Number        | Foreign Key from Encounter table.                                         | ● Only an Encounter_ID that exists in the Encounter table can be used.  
   Foreign Key                                      | ● May be null if the EMR does not have the data.                          |
| Cycle_ID      | Text          | Foreign Key from the Cycle_ID table.                                      | ● Only a Cycle_ID that exists in the Cycle table can be referenced here.  
   Foreign Key                                      | ● Cannot be null                                                          |
| StartDate     | Date          | The date that the risk factor began.                                      |                                                                      |
| EndDate       | Date          | The date that the risk factor ended.                                      |                                                                      |
| Name_orig     | Text          | Risk factor name exactly as it appears in the EMR.                        |                                                                      |
| Name_calc     | RefSet        | Re-code Name_orig into consistent Name_calc.                             | ● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'RiskFactor', ColumnName= 'RiskFactorName'  
   |               |                                                                          | ● Re-coding is currently performed by the individual Data Managers..    |
| RiskFactorValue | Text     | Measure of the risk factor                                               | ● For example, if Risk Factor is ‘smoker’, value might be ‘3 pk/week’ or ‘7/day’ |
| RiskFactorStatus | RefSet | Is this a current or past risk?                                          | ● Valid options are in the 'Value' field of the 'MasterLookup' table, Category = 'RiskStatus' |
| Frequency     | Number        | How often the patient is currently affected by the specified risk factor | ● For example, if the person currently smokes less than 3 packs per day, value would be “3”  
| FrequencyType | Text          | For entries where a specific value is not provided, allows for the entry of a comparative description of frequency length | ● Possible values include: Greater than; Less than  
   |               |                                                                          | ● For example, if the person currently smokes less than 3 packs per day, value would be “Less than” |
| FrequencyUnit | Text          | Frequency Unit of Measure                                                 | ● For example, if the person currently smokes less than 3 packs per day, value would be “Packs per day” |
| Duration      | Number        | Amount of time that the person has been affected by the specified risk factor | ● For example, if the person has been smoking for more than 10 years, value would be “10”  
| DurationType  | Text          | For entries where a specific value is not provided, allows for the entry of a comparative description of Duration length | ● Possible values include: Greater than; Less than  
   |               |                                                                          | ● For example, if the person has been smoking for more than 10 years, value would be “Greater than”  
| DurationUnit  | Text          | Duration Unit of Measure                                                  | ● For example, if the person has been smoking for more than 10 years, value would be “Years” |

*Table created by an AI assistant.*
<table>
<thead>
<tr>
<th>Field</th>
<th>Type</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>EndDuration</td>
<td>Number</td>
<td>Period of time since the person is no longer affected by the specified risk factor</td>
<td>● For example, if the person has not had a drink for more than 5 years, value would be “5”</td>
</tr>
</tbody>
</table>
| EndDurationType       | Text  | For entries where a specific value is not provided, allows for the entry of a comparative description of EndDuration length | ● Possible values include: Greater than; Less than  
● For example, if the person has not had a drink for more than 5 years, value would be “Greater than” |
| EndDurationUnit       | Text  | EndDuration Unit of Measure                                                 | For example, if the person has not had a drink for more than 5 years, value would be “Years”                                          |
| RiskDetails           | Text  | Any additional details regarding the risk factor                            | Possible entries include details regarding cessation attempts and type; relevant details to risk which currently may not fit structured fields, etc. |
| DateCreated           | Date  | EMR date stamp of the record.                                               |                                                                                                                                      |
### Vaccine Table

**Table Notes:**
- All vaccinations given to the patient.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine_ID</td>
<td>Auto Integer&lt;br&gt;Primary Key</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number&lt;br&gt;Foreign Key</td>
<td>Foreign Key from the Network table.</td>
<td>● Only a Network_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Site_ID</td>
<td>Number&lt;br&gt;Foreign Key</td>
<td>Foreign Key from the Site table.</td>
<td>● Only a Site_ID that exists in the Site table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Patient_ID</td>
<td>Number&lt;br&gt;Foreign Key</td>
<td>Foreign Key from the Patient table.</td>
<td>● Only a Patient_ID that exists in the Patient table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>Encounter_ID</td>
<td>Number&lt;br&gt;Foreign Key</td>
<td>Foreign Key from the Encounter table.</td>
<td>● Only an Encounter_ID that is in the Encounter table can be used.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● May be null if the EMR does not have the data.</td>
</tr>
<tr>
<td>Cycle_ID</td>
<td>Text&lt;br&gt;Foreign Key</td>
<td>Foreign Key from the Cycle table.</td>
<td>● Only a Cycle_ID that exists in the Cycle table can be referenced here.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Cannot be null</td>
</tr>
<tr>
<td>GivenDate</td>
<td>Date</td>
<td>Date of vaccine administration.</td>
<td></td>
</tr>
<tr>
<td>ExpiryDate</td>
<td>Date</td>
<td>Vaccine expiry date.</td>
<td>● The vaccine-batch expiry date, printed on the box, not the end-date of vaccine efficacy.</td>
</tr>
<tr>
<td>Name_orig</td>
<td>Text</td>
<td>Text exactly as it appears in the EMR.</td>
<td></td>
</tr>
<tr>
<td>Name_calc</td>
<td>RefSet</td>
<td>Re-coded Name_orig into consistent Name_calc.</td>
<td>● Populated by vaccine coding algorithm.</td>
</tr>
<tr>
<td>CodeType_orig</td>
<td>Text</td>
<td>Original code set used in the EMR.</td>
<td>● e.g. ‘ATC’</td>
</tr>
<tr>
<td>CodeType_calc</td>
<td>RefSet</td>
<td>Re-coded CodeType_orig into consistent CodeType_calc.</td>
<td>● Populated by vaccine coding algorithm.</td>
</tr>
<tr>
<td>Code_orig</td>
<td>Text</td>
<td>Original code used in the EMR.</td>
<td></td>
</tr>
<tr>
<td>DIN</td>
<td>Text</td>
<td>DIN number for the vaccine.</td>
<td>● Extract this where available.</td>
</tr>
<tr>
<td>Dose</td>
<td>Text</td>
<td>Number of units/volumes of the administered vaccine.</td>
<td>● e.g. 0.1</td>
</tr>
<tr>
<td>UnitOfMeasure</td>
<td>Text</td>
<td>Units used for the vaccine.</td>
<td>● e.g. mL</td>
</tr>
<tr>
<td>NotGiven</td>
<td>Boolean</td>
<td>Identifies whether vaccine administration was prevented.</td>
<td>● e.g. ‘Yes’, ‘No’</td>
</tr>
<tr>
<td>NotGivenReason</td>
<td>Text</td>
<td>Represents the reason a vaccine was not administered to a patient.</td>
<td>● e.g. ‘Patient Objection’, ‘Allergy’, ‘history of severe reaction’</td>
</tr>
<tr>
<td>Reaction</td>
<td>Text</td>
<td>Adverse reaction or event related to immunization.</td>
<td>● e.g. ‘Allergic’, ‘idiosyncratic’, ‘Intolerance’, ‘Overdose’</td>
</tr>
<tr>
<td>AdminSite</td>
<td>Text</td>
<td>Site of vaccine administration.</td>
<td>● e.g. ‘Left deltoid’, ‘Right gluteus’</td>
</tr>
<tr>
<td>Route</td>
<td>Text</td>
<td>Route of vaccine administration.</td>
<td>● e.g. ‘PO’, ‘IM’, ‘SC’</td>
</tr>
<tr>
<td>Lot</td>
<td>Text</td>
<td>The vaccine lot number.</td>
<td>● e.g. ‘C2274AA’, ‘M005060’</td>
</tr>
<tr>
<td>DateCreated</td>
<td>Date</td>
<td>EMR date stamp of the record</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>------</td>
<td>------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
**Table: CaseDetectionDemographics**

**Table Notes:**
- Includes demographics criteria for case detection algorithm.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaseDetectionDemographics_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Disease</td>
<td>RefSet</td>
<td>The Patient's chronic condition of interest to this database.</td>
<td>● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'DiseaseCase', ColumnName='Disease' ● e.g. 'COPD', 'Depression', 'Diabetes Mellitus'</td>
</tr>
<tr>
<td>Criteria</td>
<td>Text</td>
<td>Type of criteria</td>
<td>● e.g. 'Age'</td>
</tr>
<tr>
<td>ComparisonOperator</td>
<td>Text</td>
<td>The Comparison operator of criteria</td>
<td>● e.g. '=&gt;'</td>
</tr>
<tr>
<td>ComparisonValue</td>
<td>Text</td>
<td>The value of the operator</td>
<td></td>
</tr>
</tbody>
</table>
Table: CaseDetectionDiagnosis

Table Notes:
● Includes Diagnosis codes for case detection algorithm

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaseDetectionDiagnosis_ID</td>
<td>Auto Integer</td>
<td>Primary Key Auto-incrementing integer.</td>
<td></td>
</tr>
</tbody>
</table>
| Disease                      | RefSet       | The Patient’s chronic condition of interest to this database             | ● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'DiseaseCase', ColumnName='Disease'  
|                              |              |                                                                          | ● e.g. 'COPD', 'Depression', 'Diabetes Mellitus'                      |
| DiagnosisCodeType_calc       | Text         | Type of Diagnosis                                                         | ● e.g. 'ICD9'                                                         |
| DiagnosisCode_calc           | Text         | Diagnosis code used in Case detection                                     |                                                                       |
| DiagnosisText_calc           | Text         | Standard text for diagnosis                                               |                                                                       |
| MinBillingOccurrences        | Number       | Minimum incidents of diagnosis in billing records                         |                                                                       |
| WithinBillingYears           | Number       | Time period that the diagnosis occurs                                     |                                                                       |
Table: CaseDetectionExcludeDiagnosisInDiagnosis

Table Notes:
● Includes list of diagnosis that will cause medication criteria if used alone not be sufficient criteria.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaseDetectionExcludeDiagnosisID</td>
<td>Auto Integer</td>
<td>Primary Key</td>
<td>Auto-incrementing integer.</td>
</tr>
<tr>
<td>Disease</td>
<td>RefSet</td>
<td></td>
<td>● Valid values are in the 'Value' field of the 'MasterLookup' table,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>TableName = 'DiseaseCase', ColumnName= 'Disease'</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● e.g. 'COPD', 'Depression', 'Diabetes Mellitus'</td>
</tr>
<tr>
<td>DiagnosisCodeType_calc</td>
<td>Text</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DiagnosisCode_calc</td>
<td>Text</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DiagnosisText_calc</td>
<td>Text</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ExcludeIfMednotPresent</td>
<td>Boolean</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table: CaseDetectionExcludeDiagnosisInMeds

Table Notes:
- Includes list of diagnosis that will cause medication criteria if used alone not be sufficient criteria.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaseDetectionExcludeDiagnosisInMeds_ID</td>
<td>Auto Integer</td>
<td>Primary Key auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>Disease</td>
<td>RefSet</td>
<td></td>
<td>● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'DiseaseCase', ColumnName= 'Disease' e.g. 'COPD', 'Depression', 'Diabetes Mellitus'</td>
</tr>
<tr>
<td>DiagnosisCodeType_calc</td>
<td>Text</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DiagnosisCode_calc</td>
<td>Text</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DiagnosisText_calc</td>
<td>Text</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### CaseDetectionLab

**Table Notes:**
- Includes list of labs used in case definition

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaseDetectionLab_ID</td>
<td>Auto Integer Primary Key</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
</tbody>
</table>
| Disease             | RefSet    | The Patient's chronic condition of interest to this database              | • Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'DiseaseCase', ColumnName= 'Disease'  
• e.g. 'COPD', 'Depression', 'Diabetes Mellitus' |
| Name_calc           | Text      | Name of Standadrd Lab test                                               |                                                                                                                                       |
| Code_calc           | Text      | Lab code                                                                  |                                                                                                                                       |
| ComparisonOperator  | Text      | The Comparison operator of criteria                                       |                                                                                                                                       |
| ComparisonValue     | Text      | The Value of the operator                                                 |                                                                                                                                       |
| MinOccurrences      | Number    | Minimum incidents of lab tests in lab records                             |                                                                                                                                       |
| WithinYears         | Number    | Time period that the lab test occurs                                      |                                                                                                                                       |
**Table:** CaseDetectionMedication

**Table Notes:**
- Includes list of medication used in case definition

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaseDetectionMedication_ID</td>
<td>Auto Integer Primary Key</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
</tbody>
</table>
| Disease                | RefSet    | The Patient's chronic condition of interest to this database               | • Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'DiseaseCase', ColumnName= 'Disease'
|                        |           |                                                                             | • e.g. 'COPD', 'Depression', 'Diabetes Mellitus'                      |
| DrugClass              | Text      | Class of medication                                                         |                                                                       |
| Name_calc              | Text      | Name of medication                                                          |                                                                       |
| Code_calc              | Text      | ATC code of medication                                                       |                                                                       |
| Relevance              | Text      | Specificity of the medication                                              | e.g. 'Highly Specific', 'Specific'                                    |
**Table: CaseDetectionReferral**

**Table Notes:**
- FILL ME IN

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaseDetectionReferral_ID</td>
<td>Auto Integer Primary Key</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
</tbody>
</table>
| Disease           | RefSet       |                                                 | ● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'DiseaseCase', ColumnName= 'Disease'  
|                   |              |                                                 | ● e.g. ‘COPD’, ‘Depression’, ‘Diabetes Mellitus’                                               |
| Name_calc         | Text         |                                                 |                                                                                                |
### Table: CaseDetectionSetup

#### Table Notes:
- Includes list of medication used in case definition

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaseDetectionSetup_ID</td>
<td>Auto Integer Primary Key</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
</tbody>
</table>
| Disease                                      | RefSet    | The Patient's chronic condition of interest to this database                | ● Valid values are in the 'Value' field of the 'MasterLookup' table, TableName = 'DiseaseCase', ColumnName= 'Disease'  
  ● e.g. 'COPD', 'Depression', 'Diabetes Mellitus' |
| BillingCriteria                              | Boolean   | If billing is used in Case Definition                                       |                                                                      |
| HealthConditionCriteria                     | Boolean   | If health condition is used in Case Definition                              |                                                                      |
| EncounterDiagnosisCriteria                  | Boolean   |                                                                              |                                                                      |
| MedicationCriteria                          | Boolean   | If medication is used in Case Definition                                    |                                                                      |
| LabCriteria                                 | Boolean   | If Lab tests is used in Case Definition                                     |                                                                      |
| AgeCriteria                                 | Boolean   | If age is used in Case Definition                                           |                                                                      |
| ExcludeDiagnosisCriteriaInMedsSearch         | Boolean   | If diagnosis exclusion is used in Case Definition                           |                                                                      |
| ExcludeDiagnosisCriteriaInDiagnosisSearch   | Boolean   |                                                                              |                                                                      |
| ReferralCriteria                            | Boolean   |                                                                              |                                                                      |
| ExcludeCaseDiagnosedOnlyThroughMed          | Boolean   |                                                                              |                                                                      |
**Table: PSCoding**

**Table Notes:**
- Includes mapping between raw patient status data(PatientStatus_orig) and CPCSSN categories for patient status; will be used to code PatientStatus_calc.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSCoding_ID</td>
<td>Auto Integer</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary Key</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network_ID</td>
<td>Number</td>
<td>Foreign Key from the Network table.</td>
<td></td>
</tr>
<tr>
<td>PatientStatus_orig</td>
<td>Text</td>
<td>Status of the patient</td>
<td></td>
</tr>
<tr>
<td>PatientStatus_calc</td>
<td>RefSet</td>
<td>Re-coding of PatientStatus_orig into consistent text.</td>
<td></td>
</tr>
</tbody>
</table>
Table: ReferralSNOMEDCoding

Table Notes:
- Includes SNOMED codes for referral cleaning algorithm.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data-type</th>
<th>Definition</th>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ReferralSNOMEDCoding_ID</td>
<td>Auto Integer Primary Key</td>
<td>Auto-incrementing integer.</td>
<td></td>
</tr>
<tr>
<td>QueryCode</td>
<td>Text</td>
<td>ID of the source query.</td>
<td>● Will only be used by code developer for future enhancements.</td>
</tr>
<tr>
<td>ItemText</td>
<td>Text</td>
<td>Text of the SNOMED item used to describe the referral.</td>
<td>● e.g. 'referral to plastic surgery service'</td>
</tr>
<tr>
<td>ConceptCode</td>
<td>Text</td>
<td>Concept Code of the SNOMED item used to describe the referral.</td>
<td>● e.g. 'referral to plastic surgery service'</td>
</tr>
<tr>
<td>DescriptionCode</td>
<td>Text</td>
<td>Description Code of the SNOMED item used to describe the referral.</td>
<td>● e.g. '306198005'</td>
</tr>
</tbody>
</table>