# CPCSSN Administrative Section

**CPCSSN ID:** \_\_\_\_\_\_\_ \_\_ **Complete DAR package received: (dd-mmm-yyyy)**

**CPCSSN Dictionary (DAR) Variable Request**

|  |  |
| --- | --- |
| **Project Title** |  |
| **Principal Investigator** |  |

Please check off all variables requested that apply to your project. Please refer to the CPCSSN Data Dictionary and Entity Relationship Diagram to guide your choices.

**We do not typically release any .orig (original information extracted from participating EMR’s) or open text fields. If you require any of these variable types, you must provide a justification in your protocol as well as the DAR. Permission will be provided once the CPCSSN Data Access Committee reviews your application.**

We will not release any information on Networks, Sites or Providers without prior justification and permission from the Data Access Committee.

**DATA SPECIFICATIONS**

Data Requirements (Please refer to the CPCSSN Data Dictionary for a detailed description of the data elements)

**PRIVACY AND SECURITY POLICY**

We do not typically release any \_orig (original information extracted from participating EMR’s) or open text fields.

We also do not release any information on Networks, Sites, or Providers.

CPCSSN will only release age (Birthyear) and location (FSA) data in specific combinations:

* Birthyear and Urban/Rural status
* Age Brackets and FSA

1. **Data Request Date (which years are you requesting data for?)**

From: (dd/mmm/yyyy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: (dd/mmm/yyyy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Patient Age**

Your study requires:

\_\_\_ All patients

\_\_\_ All patients with Birthyear ≥ \_\_\_\_\_\_\_\_\_ AND ≤ \_\_\_\_\_\_\_\_\_

1. **Birthyear and Location**

Your study requires the following variable combinations (see note in box above):

\_\_\_ Birthyear | Urban/Rural

\_\_\_ Five-year age brackets | FSA (3 digit postal code)

If age brackets, please provide year at which age is calculated: \_\_\_\_\_\_\_\_\_\_

Age Brackets:

0-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85+

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Some variables within some tables are sparsely populated. Variables that are ≤ 30% populated are marked with an asterisk (\*) beside the variable name.

**Table: Provider**

**Table notes:**

* Information on participating providers.
* Data are only collected for providers while they participate in the CPCSSN project. When a provider no longer participates in the CPCSSN project, no new data are collected from them.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| Provider\_ID | Unique ID for each provider |  |
| Network\_ID | Unique ID for each Network |  |
| BirthYear | Provider’s year of birth |  |
| Sex | Provider’s sex |  |
| ProviderType | Role of provider |  |
| StartDate | Date that the provider began participating in CPCSSN at this site |  |

**Table: GroupInfo**

**Table notes:**

* All defined groups/teams.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| GroupInfo\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| GroupType | Type of group |  |
| PaymentModel | Capitation model |  |
| CareModel | How care is provided |  |
| GovernanceModel | How the group is managed |  |
| Description | Other descriptions that may not fit in the above categories |  |

**Table: ProviderGroup**

**Table notes:**

* All of the Provider-Group pairings.
* The Provider\_ID, GroupInfo\_ID pairing is unique.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| ProviderGroup\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Provider\_ID | Unique ID from the Provider table |  |
| GroupInfo\_ID | Unique ID from the GroupInfo table |  |

**Table: Patient**

**Table notes:**

* List of patients whose primary provider is a consenting physician in the CPCSSN project (has an entry in the Provider table).
* Variables list in **bold**: see Privacy and Security Policy on Page 7 – can only request Birthyear OR FSA

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| Patient\_ID | Unique ID for each Patient |  |
| Network\_ID | Unique ID for each Network |  |
| Provider\_ID | Unique ID from the Provider table |  |
| PatientType | How the patient is identified in the provider’s roster |  |
| StartDate | Date that the provider starts providing care to the patient at this site |  |
| Sex | Patient’s sex (M/F) |  |
| **BirthYear** | 4-digit year of patient's birth date |  |
| **AgeCat** | Five-year age brackets |  |
| BirthMonth | Numerical value of patient’s birth month |  |
| Occupation\_calc\* | Patient’s occupation recoded into consistent text |  |
| HighestEducation\* | Patient’s highest education |  |
| HousingStatus\* | Patient’s housing status |  |
| **ResidencePostalCode** | FSA (first three digits of the postal code) |  |
| **Location** | Urban/Rural Status as derived from second digit of FSA. |  |
| Status\_calc | Patient’s EMR status recoded into consistent text |  |
| PrimaryLanguage\* | Patient’s primary language |  |
| Ethnicity\* | Patient’s ethnicity (limited availability) |  |
| DeceasedYear\* | The year in which the patient became deceased |  |
| DateCreated | EMR date stamp of the record |  |

**Table: AllergyIntolerance**

**Table notes:**

* All allergy and intolerance data for the patient.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| AllergyIntolerance\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Encounter\_ID\* | Unique ID for each Encounter |  |
| StartDate | Date that the allergy was first identified |  |
| StopDate\* | Date that the allergy noted as inactive |  |
| DIN\* | DIN for the medication |  |
| Name\_calc | Standardized description of original allergy name |  |
| CodeType\_calc | Standardized description of allergy code type (ATC) |  |
| Code\_calc | Standardized allergy code |  |
| Category\_calc\* | The category of the allergy |  |
| Severity | The severity of the reaction |  |
| AllergyStatus | Current status of the allergy |  |
| ReactionType\_calc\* | Type of reaction that occurs with allergy |  |
| DateCreated | EMR date stamp of the record |  |

**Table: Billing**

**Table notes:**

* All billing data submitted to the province for the patient.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| Billing\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Encounter\_ID | Unique ID for each Encounter |  |
| ServiceDate | Date the billing was performed/submitted |  |
| ServiceCode | Service code associated with the billing |  |
| DiagnosisText\_calc | Standardized description of original diagnosis |  |
| DiagnosisCodeType\_calc | Standardized description of diagnosis code type (ICD-9) |  |
| DiagnosisCode\_calc | Standardized diagnosis code |  |
| DateCreated | EMR date stamp of the record |  |

**Table: Deprivation**

**Table notes:**

* Pampolon Deprivation Index: Material, Social and combined Materia/Social dimensions.
* Probability a patient is in a Material and/or Social Deprivation quintile.
* This table depends on the availability of a full postal code.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| Deprivation\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| MaterialQ1 | Probability a patient is in quintile 1 of Material Deprivation |  |
| MaterialQ2 | Probability a patient is in quintile 2 of Material Deprivation |  |
| MaterialQ3 | Probability a patient is in quintile 3 of Material Deprivation |  |
| MaterialQ4 | Probability a patient is in quintile 4 of Material Deprivation |  |
| MaterialQ5 | Probability a patient is in quintile 5 of Material Deprivation |  |
| SocialQ1 | Probability a patient is in quintile 1 of Social Deprivation |  |
| SocialQ2 | Probability a patient is in quintile 2 of Social Deprivation |  |
| SocialQ3 | Probability a patient is in quintile 3 of Social Deprivation |  |
| SocialQ4 | Probability a patient is in quintile 4 of Social Deprivation |  |
| SocialQ5 | Probability a patient is in quintile 5 of Social Deprivation |  |
| MaterialSocialQ1 | Probability a patient is in quintile 1 of combined Social/Material Deprivation |  |
| MaterialSocialQ2 | Probability a patient is in quintile 2 of combined Social/Material Deprivation |  |
| MaterialSocialQ3 | Probability a patient is in quintile 3 of combined Social/Material Deprivation |  |
| MaterialSocialQ4 | Probability a patient is in quintile 4 of combined Social/Material Deprivation |  |
| MaterialSocialQ5 | Probability a patient is in quintile 5 of combined Social/Material Deprivation |  |

#### 

**Table: Encounter**

**Table notes:**

* All encounters of the patient.
* An encounter is defined as an interaction between the patient with a provider.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| Encounter\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Provider\_ID | Responsible provider for this encounter |  |
| EncounterDate | Date the encounter occurred |  |
| Reason\_calc\* | Standardized description of original reason for visit. |  |
| EncounterType\_calc | How or where the encounter was conducted |  |
| DateCreated | Date the record was created in the EMR |  |

**Table: EncounterDiagnosis**

**Table notes:**

* All diagnoses resulting from an encounter with the patient.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| EncounterDiagnosis\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Encounter\_ID | Unique ID for each Encounter |  |
| DiagnosisText\_calc | Standardized description of original diagnosis text. |  |
| DiagnosisCodeType\_calc | Standardized description of diagnosis code type (ICD9) |  |
| DiagnosisCode\_calc | Standardized diagnosis code |  |
| DateCreated | EMR date stamp of the record |  |

**Table: Exam**

**Table notes:**

* Results of physical exams performed on the patient.
* Exams limited to:
  + BMI
  + Foot exam
  + Height
  + PEFR
  + sBP
  + Waist circumference
  + Waist-hip ratio
  + Weight

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| Exam\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient table |  |
| Encounter\_ID | Unique ID for each Encounter |  |
| Exam1 | Name of the physical exam; standardized into consistent text |  |
| Result1\_calc | Standardized description of exam result 1 |  |
| Exam2 | Name of the paired physical exam; standardized into consistent text |  |
| Result2\_calc | Standardized description of exam result 2 |  |
| UnitOfMeasure\_calc | Standardized description of original unit of measure |  |
| PairingMethod | Pairing method for physical exam (if appropriate) |  |
| DateCreated | EMR date stamp of the record |  |

**Table: FamilyHistory**

**Table notes:**

* Family history of the patient.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| FamilyHistory\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Encounter\_ID\* | Unique ID for each Encounter |  |
| DiagnosisText\_calc | Standardized description of original diagnosis text. |  |
| DiagnosisCodeType\_calc | Standardized description of diagnosis code type (ICD9) |  |
| DiagnosisCode\_calc | Standardized diagnosis code |  |
| Relationship\_calc | Coded CPCSSN relationship type |  |
| RelationshipSide\_calc | Coding of side of the relationship |  |
| RelationshipDegree\_calc | Genetic degree of the relationship |  |
| AgeAtOnset\* | Age of onset of the condition |  |
| VitalStatus\* | Whether relative is alive or deceased |  |
| WasCauseOfDeath | Was this condition the cause of death |  |
| AgeAtDeath\* | Relation’s age at death |  |
| DateCreated | EMR date stamp of the record |  |

**Table: HealthCondition**

**Table notes:**

* All health conditions of the patient.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| HealthCondition\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Encounter\_ID\* | Unique ID for each Encounter |  |
| DiagnosisText\_calc | Standardized description of original diagnosis text |  |
| DiagnosisCodeType\_calc | Standardized description of diagnosis code type (ICD9) |  |
| DiagnosisCode\_calc | Standardized diagnosis code |  |
| DateOfOnset | Date that the health condition began |  |
| Status | Does the patient currently suffer from this health condition |  |
| DateCreated | EMR date stamp of the record |  |

**Table: Lab**

**Table notes:**

* Results of lab tests.
* Not all labs are coded and standardized.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| Lab\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Encounter\_ID\* | Unique ID for each Encounter |  |
| PerformedDate | Date that the lab test was done |  |
| Name\_calc | Standardized description of original lab name |  |
| CodeType\_calc | Standardized description of code type (LOINC) |  |
| Code\_calc | Standardized lab code |  |
| TestResult\_calc | Standardized description of the original Test Result |  |
| UpperNormal | Highest lab result value that is considered normal |  |
| LowerNormal | Lowest lab result value that is considered normal |  |
| NormalRange | Original text containing upper and lower lab ranges in one record from the EMR |  |
| UnitOfMeasure\_calc | Standardized description of original unit of measure |  |
| DateCreated | EMR date stamp of the record |  |

**Table: Medication**

**Table notes:**

* All medications prescribed for the patient.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| Medication\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Encounter\_ID\* | Unique ID for each Encounter |  |
| StartDate | Date that the Patient started taking the medication |  |
| StopDate | Date that the Patient stopped taking the medication |  |
| Reason\_calc\* | Reason that Patient was prescribed the medication |  |
| DIN | DIN number for the medication |  |
| Name\_calc | Standardized description of the original medication name |  |
| CodeType\_calc | Standardized medication code type (ATC) |  |
| Code\_calc | Standardized medication code |  |
| Strength\_calc\* | Concentration of the medication |  |
| Dose\_calc\* | Number of units of the medication to be taken |  |
| UnitOfMeasure\_calc\* | Units of medication strength |  |
| Frequency\_calc\* | Frequency at which medication to be taken |  |
| DurationCount | Length of time that the patient should take the medication |  |
| DurationUnit | The units of measure for the DurationCount |  |
| DispensedCount | Number of units (as defined in DispensedForm) to be dispensed |  |
| DispensedForm\_calc | Form of dispensed medication |  |
| RefillCount | Number of refills |  |
| DateCreated | EMR date stamp of the record |  |

**Table: Referral**

**Table notes:**

* All referrals made for the patient.
* Includes only referrals made by this provider/practice. Excludes referrals made by specialists to another provider.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| Referral\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Encounter\_ID\* | Unique ID for each Encounter |  |
| CompletedDate\* | Date when the patient saw the provider to whom they were referred |  |
| Name\_calc | Standardized description of referral |  |
| ConceptCode\_calc | SNOMED concept code |  |
| DateCreated | EMR date stamp of the record |  |

**Table: RiskFactor**

**Table notes:**

* Risk factors recorded for the patient.
* Available risk factors are
  + Alcohol
  + Diet
  + Exercise
  + Obesity
  + Psychosocial stress
  + Smoking

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| RiskFactor\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Encounter\_ID\* | Unique ID for each Encounter |  |
| StartDate\* | Date that the risk factor began |  |
| EndDate\* | Date that the risk factor ended |  |
| Name\_calc | Standardized description of the risk factor (see list above) |  |
| Frequency\* | How often the patient is currently affected by the specified risk factor |  |
| FrequencyType\* | For entries where a specific value is not provided, allows a comparative description of frequency length |  |
| FrequencyUnit\* | Frequency Unit of Measure |  |
| Duration\* | Amount of time that the person has been affected by the specified risk factor |  |
| DurationType\* | For entries where a specific value is not provided, allows for the entry of a comparative description of Duration length |  |
| DurationUnit\* | Duration Unit of Measure |  |
| EndDuration\* | Period of time since the person is no longer affected by the specified risk factor |  |
| EndDurationType\* | For entries where a specific value is not provided, allows for the entry of a comparative description of EndDuration length |  |
| EndDurationUnit\* | EndDuration Unit of Measure |  |
| DateCreated | EMR date stamp of the record |  |

**Table: Vaccine**

**Table notes:**

* All vaccinations given to the patient.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| Vaccine\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Encounter\_ID\* | Unique ID for each Encounter |  |
| GivenDate | Date of vaccine administration |  |
| ExpiryDate\* | Vaccine expiry date |  |
| Name\_calc | Standardized description of vaccine name |  |
| CodeType\_calc | Standardized vaccine code type (ATC) |  |
| Code\_calc | Standardized vaccine code |  |
| DIN\* | DIN number for the vaccine |  |
| Dose\_calc\* | Number of units/volumes of the administered vaccine |  |
| UnitOfMeasure\_calc\* | Units used for the vaccine |  |
| NotGiven | Identifies if vaccination was prevented |  |
| NotGivenReason\_calc\* | Represents the reason a vaccine was not administered to a patient |  |
| Reaction\_calc\* | Adverse reaction related to immunization |  |
| AdminSite\_calc\* | Site of vaccine administration |  |
| Route\* | Route of vaccine administration |  |
| Lot | The vaccine lot number |  |
| DateCreated | EMR date stamp of the record |  |

**Table: DiseaseCase**

**Table notes:**

* Patients in the Patient table who have one or more of the Index Diseases.
* Populated by the case detection algorithm.

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| DiseaseCase\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Disease | The Patient's chronic condition of interest to this database |  |
| Version | Version of the case detection algorithm |  |
| IsDefaultDefinition | Flag to indicate if the Version is the default |  |
| DateCaseDetected | Date of the earliest indicator for the case |  |

**Table: DiseaseCaseIndicator**

**Table notes:**

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

|  |  |  |
| --- | --- | --- |
| Variable | Definition | Check if required |
| DiseaseCaseIndicator\_ID | Internal Database ID |  |
| Network\_ID | Unique ID for each Network |  |
| Patient\_ID | Unique ID for each Patient |  |
| Disease | The Patient's chronic condition of interest to this database |  |
| IndicatorType | General category that the indicator falls under |  |
| IndicatorValue | Data value from the original record |  |
| TableName | Name of the table storing the original record |  |
| TableKey | Primary key of the original record in the original table |  |
| DateCreated | EMR date stamp of the original record |  |
| ExcludeFlag | Flag for whether an indicator was excluded |  |
| ExcludeReason | Reason an indicator was excluded |  |