Stanford MEDICINE | Research IT
Information Resources & Technology

STARR Anonymized Dataset Data Dictionary

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1 Introduction

The **Sta**nford medicine **R**esearch data **R**epository (STARR) is a database resource including not only current Epic data from both SHC and SCH (fka Lucile Packard Children's Hospital) but also imaging data from Radiology and historic clinical data from earlier EMRs that is not present in the current EMR systems. If it's in Epic, we have it, and more! See https://med.stanford.edu/researchit/services/clinical-data-warehouse.html for a more infomation.

This sample is designed to give you a flavor for the kind of information available to you as a Stanford Medicine researcher. The most commonly requested data items are included, but if the data you are looking for is not here, it can be readily produced with a custom research report specific to your needs. See the Research Informatics Center website for consultation request (http://med.stanford.edu/ric.html), or request assistance by filling out the short online form at https://redcap.stanford.edu/plugins/gethelp/.

STARR is fully identified. This extract has been anonymized for data security reasons, but if you need identified data, it is readily obtained with suitable IRB documents and Privacy Office approval as described here: http://med.stanford.edu/ric/services/consultation-service.html

Two anonymization techniques are employed for this data set: identifier coding and date jittering.

In identifier coding, a codebook keeps track of the mapping between the study specific code and the original identifier. With suitable permission the codebook can be used to look up the original identifying information, given a study-specific code.

In date jittering, a random number which can be either positive or negative but is guaranteed to be non-zero is associated with the patient in the same codebook used to associate the patient's identity with a study specific code. This random number is used to offset all dates of service associated with that patient record. So even though the supplied dates look like real dates, the systematic shifting (or "jittering") in time ensures patient privacy. Note that because the same offset is used for all dates for a given patient, the clinical history timeline is perfectly preserved. But since there is a different offset for each patient, it becomes practically impossible for a bad actor to determine the offset for all patients by guessing and checking in the EMR.

Note that the dates of birth of all patients whose date of birth is more than 90 years ago have all been moved to Jan 1st of 90 years ago. This is because ages older than 90 are considered identifying by HIPAA.

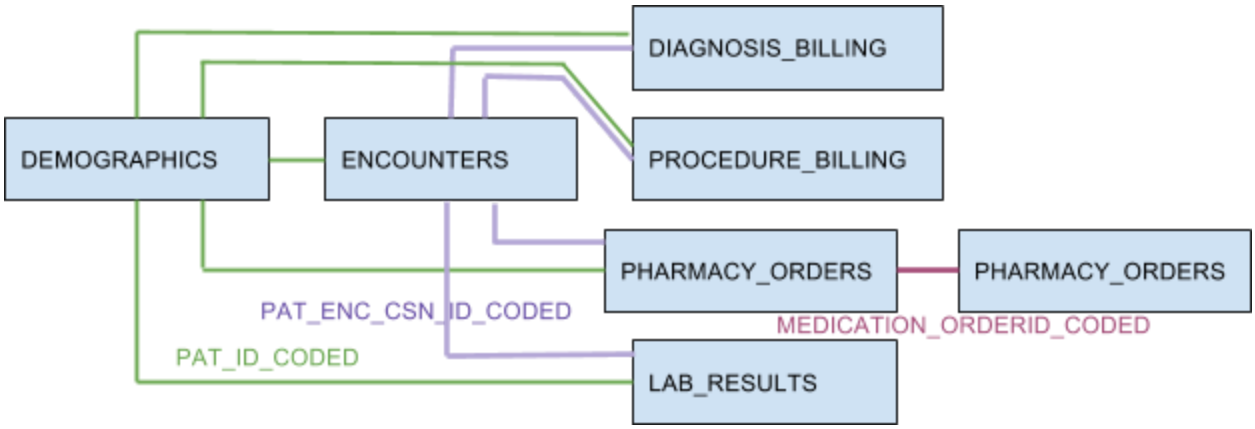
2 Glossary

Term	Description
PHS	Population Health Sciences
SHC	Stanford Hospitals and Clinics
SCH	Stanford Children's Health (includes LPCH and outpatient clinics)
LPCH	Lucile Packard Children's Hospital
STARR	Stanford Research Repository
PHI	Protected Health Information
EMR	Electronic Medical Record also known as EHR (Electronic Health Record)
HL7	Health Level-7 is a global standard for transfer of clinical data between applications.
Epic	Epic is the vendor for the principal clinical record at both Stanford hospitals.
CLARITY	CLARITY is the reporting relational database by Epic.

3 Version Control

Version	Date of release	Description of release
1.0	9/15/2017	Version 1.0 . Contains E/R diagrams along with documentation on all variables in the following tables DEMOGRAPHICS ENCOUNTERS DIAGNOSIS_BILLING_CODES PROCEDURE_BILLING_CODES LAB_RESULTS PATHOLOGY_REPORTS IMAGING_REPORTS CLINICAL_DOCUMENTATION PHARMACY_ORDERS PHARMACY_MAR FLOWSHEET_MEASURES PROV_MAP (provider reference data) DEP_MAP (department reference data) FLOWSHEET_MEASURE_FREQ

4 Entity Relationship Diagram



Patient and Encounter Relationship diagram with billing codes, pharmacy orders and lab results used to exemplify all data table relationships. Flowsheet measures, clinical documentation, imaging and pathology reports all follow the same pattern as billing codes, pharmacy orders and lab results.

We have four sources of data in STARR

1) Adult Epic (2008 ff)
2) Pediatric Epic (2014 ff)
3) Pediatric Cerner (2008-2014)
4) HL7 messages from CareCast/LastWord (2000-2008)

The four sources have differences that affect certain variables. Where significant differences exist for a given variable across the historical record these differences are documented in the 'Source' column.

5 Data Table Specifications

5.1 DEMOGRAPHICS

Field Name	List of values	Definition	Source
{Prefix}_PAT_ID_CODED		Unique identifier (primary key) for the patient. This is a foreign key reference to DEMOGRAPHICS.PAT_ID_CODED	{Prefix}: Used for tracking the data download source. For example, if Prefix=SP, the 'S' in the 'SP' prefix stands for STARR and the 'P' is for PHS. The codebook maintaining the mapping from this study ID back to the patient's real identity is maintained in STARR.
BIRTH_DATE_JITTERED		Anonymized date of birth of the patient.	CLARITY → patient.birth_date
DEATH_DATE_JITTERED		Anonymized death of death of the patient.	CLARITY → patient.death_date
GENDER	Male Female Other Unknown	Gender of the patient.	CLARITY → zc_sex.name corresponding to patient.sex_c
PRIMARY_RACE	White Pacific Islander Asian Black Native American Other Unknown	Primary race of the patient.	CLARITY → zc_patient_race.name
ETHNICITY	Hispanic/Latino Non-Hispanic Unknown	Ethnicity of the patient	CLARITY → zc_ethnic_group.name
MARITAL_STATUS		Marital status of the patient.	CLARITY → zc_marital_status.name
RELIGION		Religion of the patient.	CLARITY → zc_religion.name
LANGUAGE		Language of the patient.	CLARITY → zc_language.name

INTRPTR_NEEDED_YN	Y N	Indicates whether patient needs an interpreter.	CLARITY → patient.intrptr_needed_yn
INSURANCE_PAYOR_NAME		Insurance payor name of the patient.	CLARITY → coverage.payor_name
CUR_PCP_PROV_MAP_ID		Current primary care provider of the patient.	CLARITY → patient.cur_pcp_prov_id
RECENT_CONF_ENC_JITTERED		Most recent confirmed encounter date for the patient.	CLARITY → maximum of pat_enc.contact_date for the patient
RECENT_HT_IN_CMS		Recent height in centimeters for the patient.	CLARITY → most recent value for ip_flwsht_meas.meas_value corresponding to ip_flo_gp_data.flo_meas_id = 11 (height)
RECENT_WT_IN_KGS		Recent weight in kilograms for the patient.	CLARITY → most recent value for ip_flwsht_meas.meas_value corresponding to ip_flo_gp_data.flo_meas_id = 14 (weight)
BMI		BMI for the patient.	CLARITY → This is calculated as round(nvl((recent_wt_in_kgs / ((recent_ht_in_cms/100) * (recent_ht_in_cms/100))), 0), 2)
N_HOSPITALIZATIONS		Number of hospitalizations for the patient	RIT_ENCOUNTER
DAYS_IN_HOSPITAL		Number of days the patient has stayed overnight at the hospital	RIT_ENCOUNTER
CHARLSON_SCORE	1-41 based on: Each condition is assigned a score of 1, 2, 3 or 6, depending on the risk of dying associated with each condition. 1 point each: Myocardial infarct, congestive heart failure, peripheral vascular disease, dementia, cerebrovascular disease, chronic lung disease, connective tissue disease, ulcer, chronic liver disease, diabetes. 2 points each: Hemiplegia, moderate or severe kidney disease, diabetes with end organ damage, tumor, leukemia, lymphoma. 3 points each: Moderate or	Comorbidities are chronic diseases or conditions that co-occur with a primary disease. The Charlson comorbidity index predicts the one-year mortality for a person and is used to measure the overall disease burden. The Charlson index has scores associated with certain types of comorbidities and the total score is an indication of mortality.	The Charlson points table was based on the following two sources: - http://www.bgs.org.uk/pdfs/assessment/cci.pdf Charlson Comorbidity Index by Mary E. Charlson MD at Weill Cornell Medical College - http://ncdbpuf.facs.org/content/charlsondeyo-comorbidity-index Charlson/Deyo (1992) descriptions of the comorbid conditions The Charlson/Deyo value is a weighted score derived from the sum of the scores for each of the comorbid conditions listed in the Charlson Comorbidity Score Mapping table. The Charlson codes table was based on the following sources: - https://www.ncbi.nlm.nih.gov/pubmed/16

	severe liver disease. 6 points each: Malignant tumor, metastasis, AIDS.		224307 Hude Quan MD article on Coding Algorithms for Defining Comorbidities in ICD9CM and ICD10 Administrative Data - http://www.lexjansen.com/wuss/2013/119_Paper.pdf Irena Cenzer of UCSF, Macro computing Charlson Comorbidity Index from CMS Claims Data

5.2 ENCOUNTERS

Field Name	List of values	Definition	Source
{Prefix}_PAT_ID_CODED		Unique coded identifier for the patient. This is a foreign key reference to DEMOGRAPHICS.PAT_ID_CODED	{Prefix}: Used for tracking the data download source. For example, if Prefix=SP, the 'S' in the 'SP' prefix stands for STARR and the 'P' is for PHS. The codebook maintaining the mapping from this study ID back to the patient's real identity is maintained in STARR.
PAT_ENC_CSN_ID_CODED		A coded unique serial number for this encounter.	Mapped as follows: HL7 → visit.visit_id PAT_ENC_CSN_ID is null for HL7 CLARITY → pat_enc.pat_enc_csn_id
CONTACT_DATE_JITTERED		The jittered date of this contact in DD-MMM-YYYY format.	HL7 → null CLARITY → pat_enc.contact_date
ADT_ARRIVAL_TIME_JITTERED		Jittered date and time of arrival.	pat_enc_hsp.adt_arrival_time
HOSP_ADMSN_TIME_JITTERED		Jittered date and time that the patient was first admitted to the facility, bedded in the ED, or confirmed for an HOV for this contact, regardless of patient's base patient class.	HL7 → null CLARITY → pat_enc.hosp_admsn_time
APPT_TIME_JITTERED		The scheduled appointment date and time for the encounter recorded using a twenty-four hour clock.	HL7 → null CLARITY → pat_enc.appt_time

APPT_WHEN_JITTERED			HL7 → visit.effective_time CLARITY → pat_enc.hosp_admsn_time or pat_enc.appt_time or pat_enc contact_date, whichever is not null
HOSP_DISCHRG_TIME_JITTERED		The hospital discharge date and time for this patient contact.	HL7 → visit.activity_time CLARITY → pat_enc.hosp_dischrg_time
APPT_TYPE		The visit type name on reports and letters sent to patients.	HL7 → null CLARITY → clarity_prc.external_name for pat_enc.enc_type_c = 3 or zc_pat_status.name or zc_disp_enc_type.name
OVERNIGHT_YN	Y – Yes N – No Null - unknown	Is this an overnight stay?	Set depending on expression (pat_enc. hosp_disch_time-pat_enc.hosp_admsn_time > 24 hours).
ENC_TYPE	Hospital Encounter Appointment Surgery Telephone Hospice Admission Billing Encounter Office Visit External Hospital Admission Hospital Refill Pharmacy Visit … and so on	Encounter type	HL7 → null CLARITY → zc_disp_enc_type.name
APPT_STATUS	Scheduled Completed Canceled No Show Left without seen Arrived	Appointment status	HL7 → null CLARITY → zc_appt_status.name
APPT_DESCRIPTION		Appointment description	HL7 → null CLARITY → enc_dx_appt_desc.description or zc_appt_status.name or zc_cancel_reason.name
VISIT_PROV_MAP_ID		The unique ID for the visit provider associated with this encounter. In cases where there are multiple providers for one encounter, this is the ID of the first provider in the list. This item may be NULL if	Derived by joining these to PROV_MAP: HL7 → visit_eav_participation.evalue for value_type_id = '223366009' CLARITY → pat_enc.visit_prov_id Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.

		there is no provider for this encounter.	
ADMN_PROV_MAP_ID		The unique ID of the provider who admitted the patient for this patient contact.	Derived by joining these to PROV_MAP: HL7 → visit_eav_participation.evalue for value_type_id = 'IRT_ADMITTING_PHYSICIAN' CLARITY → pat_enc_hsp.admission_prov_id Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
DEPT_ID		The ID of the department for the encounter. If there are multiple departments for the encounter, this is the ID of the first department in the list.	HL7 → null CLARITY → pat_enc.department_id
VISIT_TYPE		Type of visit e.g., office visit.	HL7 → null CLARITY → clarity_prc.prc_name
DATA_SOURCE	CLARITY_SHC CLARITY_LPCH HL7_SHC HL7_LPCH	Indicates whether the record came from CLARITY / HL7 and SHC/LPCH.	This is a hard coded value

5.3 DIAGNOSIS_BILLING_CODES

DIAGNOSIS_BILLING_CODES contains diagnosis codes resulting from both clinical coding and coding for billing/reimbursement purposes. While clinical codes are entered at the time of the care encounter, reimbursement codes are typically generated weeks, sometimes months, after the procedure actually takes place, due to the longer timelines used for revenue collection.

This dataset aggregates data from the following Clarity tables: HSP_ACCT_DX_LIST and ARPB_TRANSACTIONS for billing, HSP_ADMIT_DIAG and HSP_ACCT_ADMIT_DX for admit diagnosis, PROBLEM_LIST for the problem list,, PAT_ENC_DX for encounter-level clinical coding and HSP_ACCT_EXTINJ_CD for external injuries.

Field Name	List of values	Definition	Source
{Prefix}_PAT_ID_CODED		Unique coded identifier for the patient. This is a foreign key reference to DEMOGRAPHICS.PAT_ID_CODED	{Prefix}: Used for tracking the data download source. For example, if Prefix=SP, the 'S' in the 'SP' prefix stands for STARR and the 'P' is for PHS. The codebook maintaining the mapping from this study ID back to the patient's real identity is maintained in STARR.
LINE		Line number of the diagnosis code in case of multiple diagnoses.	Mapped to visit_eav_coded_value.sequence_number, pat_enc_dx.line, proble_list. line, arpb_transactions.line hsp_acct_dx_list. line, hsp_acct_extinj_cd.line, hsp_acct_admit_dx.line, hsp_admit_diag. line
PAT_ENC_CSN_ID_CODED		Coded unique serial number for the encounter.	pat_enc_dx.pat_enc_csn_id, problem_list.problem_ept_csn, arpb_transactions.pat_enc_csn_id, hsp_account. prim_enc_csn_id, hsp_admit_diag. pat_enc_csn_id
DX_ID		Unique ID of the diagnosis.	pat_enc_dx.dx_id,problem_list.dx_id, arpb_transactions.primary_dx_id, arpb_transactions. dx_two_id, arpb_transactions. dx_three_id, arpb_transactions. dx_four_id, arpb_transactions. dx_five_id, arpb_transactions. dx_six_id, hsp_acct_dx_list.dx_id, hsp_acct_extinj_cd. ext_injury_dx_id, hsp_acct_admit_dx.admit_dx_id, hsp_admit_diag.dx_id
DX_NAME		The name of the diagnosis.	clarity_edg.dx_name
ICD9		Comma separated list of current ICD9 codes.	clarity_edg. current_icd9_list
ICD10		Comma separated list of current ICD10 codes.	clarity_edg.current_icd10_list

START_DATE_JITTERED		Jittered date when the diagnosis was made.	pat_enc_hsp.adt_arrival_time, pat_enc.hosp_admsn_time, pat_enc.contact_date, problem_list.noted_date, problem_list_hx.hx_date_of_entry, pat_enc..hosp_admsn_time, arpb_transactions.service_date, hsp_account.adm_date_time
NOTED_DATE_JITTERED		Jittered date when the problem was first diagnosed.	problem_list.noted_date
HX_DATE_OF_ENTRY_JITTERED		Jittered date the problem was added to patient's problem list.	problem_list_hx.hx_date_of_entry
RESOLVED_DATE_JITTERED		Jittered date when the problem was resolved.	problem_list.resolved_date
END_DATE_JITTERED		Jittered date when the diagnosis ended.	problem_list.resolved_date, pat_enc.hosp_dischrg_time
PERF_PROV_MAP_ID		Performing provider.	pat_enc.visit_prov_id, arpb_transactions.serv_provider_id. Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
BILLING_PROV_MAP_ID		Billing provider..	arpb_transactions. billing_prov_id. Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
ENTRY_PROV_MAP_ID		Provider map id of the user that last edited the record.	problem_list.entry_user_id, hsp_account. coding_sts_user_id. Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
DEPT_ID		The ID of the department.	pat_enc.department_id, arpb_transactions.department_id, hsp_account.disch_dept_id
PRIMARY	Y-Yes N-No	Is this a primary diagnosis?	pat_enc_dx.primary_dx_yn or set to 'Y' if the diagnosis was from arpb_transactions.primary_dx_id
CHRONIC	Y-Yes N-No	Is this a chronic condition?	pat_enc.dx_chronic_yn, problem_list.chronic_yn
PRINCIPAL	Y-Yes N-No	Is this problem the principal problem?	problem_list.principal_pl_yn
HOSPITAL_PL	Y-Yes N-No	Is this problem a hospital problem?	problem_list.hospital_pl_yn
PROBLEM_STATUS	Active, Resolved	Problem's current status.	zc_problem_status.name
ED	Y-Yes N-No	Identifies an encounter diagnosis as being an ED clinical impression.	pat_enc_dx.dx_ed_yn
POA	1 -Yes 2-No 3-Unknown	Present on admission indicator.	problem_list.is_present_on_adm_c, hsp_acct_dx_list.final_dx_poa_c, hsp_acct_extinj_cd.ecode_dx_poa_c

	4-Clinically Undetermined 5-Exempt from POA reporting		
PRESENT_ON_ADM	See above	Present on admission.	zc_dx_poa.name
SOURCE	1 -> pat_enc_dx 2 -> problem_list 5 -> hsp_acct_dx_list 7 -> arpb_transactions 9 -> hsp_acct_extinj_cd 10 -> hsp_acct_admit_dx 11 -> hsp_admit_diag	Source clarity table	Null for historical HL7 codes.
DATA_SOURCE	CLARITY_SHC, CLARITY_LPCH, HL7_LPCH, HL7_SHC	Source of the row in table.	

5.4 PROCEDURE_BILLING_CODES

PROCEDURE_BILLING_CODES contains reimbursement codes that indicate surgical, medical treatment or diagnostic interventions. It aggregates data from these Clarity billing tables: HSP_ACCT_PX_LIST. ARPB_TRANSACTIONS, HSP_ACCT_CPT_CODES, and HSP_TRANSACTIONS.

Field Name	List of values	Definition	Source
{Prefix}_PAT_CODED_ID		Unique coded identifier for the patient. This is a foreign key reference to DEMOGRAPHICS.PAT_ID_ CODED	{Prefix}: Used for tracking the data download source. For example, if Prefix=SP, the 'S' in the 'SP' prefix stands for STARR and the 'P' is for PHS. The codebook maintaining the mapping from this study ID back to the patient's real identity is maintained in STARR.
LINE		Line number of the procedure code in case of multiple procedures.	visit_eav_coded_value.sequence_number, arpb_transactions.line, hsp_acct_cpt_codes.line, hsp_acct_px_list.line
PAT_ENC_CSN_ID_CODE D		Unique serial number for the encounter.	Mapped to arpb_transactions.pat_enc_csn_id, hsp_account. prim_enc_csn_id
PX_ID		Unique ID of the procedure.	hsp_acct_px_list. final_icd_px_id
CODE		Procedure code.	arpb_transactions.cpt_code, hsp_acct_cpt_codes.cpt_code, cl_icd_px.ref_bill_code
DESCRIPTION		Procedure code description	Either clarity_eap.bill_desc(preferred) or clarity_eap.proc_name
CODE_TYPE		Type of the procedure code.	ICD9CM, ICD10PCS, CPT
START_DATE_JITTERED		Date when the procedure was performed.	arpb_transactions.service_date, hsp_acct_cpt_codes.cpt_code_date, hsp_account.adm_date_time, hsp_acct_px_list.proc_date
PROC_DATE_JITTERED		Date associated with a procedure.	hsp_acct_px_list.proc_date
ADM_DATE_TIME_JITTE RED		Admission date and time.	Hsp_account.adm_date_time
END_DATE_JITTERED		Date when the procedure ended.	visit.activity_time
PERF_PROV_MAP_ID		Performing provider.	arpb_transactions.serv_provider_id, hsp_acct_cpt_codes.cpt_perf_prov_id, hsp_acct_px_list.proc_perf_prov_id, visit_eav_participation(value_type_id=1981 471/'Physician' or 4750253/'Performed By Physician')
BILLING_PROV_MAP_ID		Billing provider.	arpb_transactions. billing_prov_id, visit_eav_participation(value_type_id=

			4014621/'Referring Physician', 4173407/'Primary Care Physician'). Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
ENTRY_PROV_MAP_ID		Unique ID of he user that last edited the record.	hsp_account. coding_sts_user_id, arpb_transactions.user_id, visit_eav_participation(value_type_id= 2016247/'Healthcare professional',4014534/'Admitting Physician'). Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
DEPT_ID		The ID of the department.	arpb_transactions.department_id, hsp_account.disch_dept_id
DATA_SOURCE	CLARITY_SHC, CLARITY_LPCH, HL7_LPCH, HL7_SHC	Source of the row in table.	
SOURCE	6 -> hsp_acct_px_list 7 -> arpb_transactions 8 -> hsp_acct_cpt_codes 12 -> hsp_transactions	Source clarity table.	Null for historical HL7 codes.

5.5 LAB_RESULTS

LAB_RESULTS contains actual results along with ordering information on blood and other biospecimen samples.

Field Name	List of values	Definition	Source
{Prefix}_PAT_ID_CODED		Unique coded identifier for the patient. This is a foreign key reference to DEMOGRAPHICS.PAT_ID_CODED	{Prefix}: Used for tracking the data download source. For example, if Prefix=SP, the 'S' in the 'SP' prefix stands for STARR and the 'P' is for PHS. The codebook maintaining the mapping from this study ID back to the patient's real identity is maintained in STARR.
PAT_ENC_CSN_ID_CODED		A coded unique serial number for this encounter. This is a foreign key reference to ENCOUNTERS.PAT_ENC_CSN_ID_CODED	Mapped as follows: HL7 → visit.visit_id PAT_ENC_CSN_ID is null for HL7 CLARITY → pat_enc.pat_enc_csn_id
ORDER_TIME_JITTERED		The jittered date and time when the procedure order was placed.	HL7 → lab.effective_time CLARITY →order_proc.order_time
TAKEN_TIME_JITTERED		The jittered date the specimen was taken.	HL7 → null CLARITY → order_proc_2.specimn_taken_time
RESULT_TIME_JITTERED		The jittered date and time the technician ran the tests for each order in calendar format.	HL7 → lab.effective_time CLARITY → order_results.result_time
COMPONENT_ID		Unique identifier for a component in a group lab name for a patient	HL7 → lab_eav_number.lab_eav_id, lab_eav_text.lab_eav_id CLARITY → order_results.component_id
LINE		The line number of each result component within each ordered procedure.	HL7 → lab_eav_number.sequence_number, lab_eav_text.sequence_number CLARITY → order_results.line
ORDER_TYPE		The name corresponding to the order type category number for the procedure order.	HL7 → null CLARITY → zc_order_type.name corresponding to order_proc.order_type_c
PROC_CODE		The procedure code associated with this order. Corresponding name is group_lab_name.	HL7 → concept.code corresponding to lab.code CLARITY → order_proc.proc_code

GROUP_LAB_NAME		The name of the order as it appears in the patient's record or a brief summary of the procedure order.	HL7 → concept.preferred_text corresponding to lab.code CLARITY → order_proc.display_name or order_proc.description, whichever is not null
LAB_NAME		The external name or alias of the result component name.	HL7 → concept.preferred_text corresponding to lab_eav_number.value_type_id or concept.preferred_text corresponding to lab_eav_text.value_type_id CLARITY → clarity_component.external_name
BASE_NAME		The name used by clinical system's Best Practice Alerts to group related components.	HL7 → null CLARITY → clarity_component.base_name
ORD_VALUE		The value returned for each result component, in short free text format.	HL7 → lab_eav_number.labvalue for number results or lab_eav_text.cvalue for text results CLARITY → order_results.ord_value
ORD_NUM_VALUE		A numeric representation of the value returned for each component where applicable.	HL7 → lab_eav_number.labvalue for number results or null for text results CLARITY → order_results.ord_num_value
REFERENCE_LOW		The lowest acceptable value for each result component.	HL7 → lower limit part of lab_eav_number.reference_range for number results or null for text results CLARITY →order_results.reference_low
REFERENCE_HIGH		The highest acceptable value for each result component.	HL7 → higher limit part of lab_eav_number.reference_range for number results or null for text results CLARITY → order_results.reference_high
REFERENCE_UNIT		The units for each result component value.	HL7 → lab_eav_number.units for number results or lab_eav_text.cvalue for value_type_id = 'OBSERVATION_UNITS' CLARITY → order_results.reference_unit
RESULT_IN_RANGE_YN	Y N	A Yes/No category value to indicate whether a result has been verified to be within its reference range. This item is set by the interface when the result is sent. A null value is equivalent to a "no" value.	HL7 → an indication of whether lab_eav_number.labvalue is between the lower and higher limits in lab_eav_number.reference_range or null for text results CLARITY → order_results.result_in_range_yn

RESULT_FLAG	(NONE) Abnormal Panic Low High Low Panic High Panic Low Off-Scale High Off-Scale Sig Change Up Sig Change Down Better Worse Sensitive Resistant Intermediate Moderately Sensitive Very Sensitive	The category value associated with a standard HL7 flag code to mark each component result as abnormal. Any value in this field not equal to 1 is considered abnormal.	HL7 → null CLARITY → zc_result_flag.name corresponding to order_results.result_flag_c
AUTH_PROV_MAP_ID		The unique ID of the provider prescribing or authorizing the order.	Derived by joining these to PROV_MAP: HL7 → null CLARITY → order_proc.authrzing_prov_id Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
ORDERING_MODE	Outpatient Inpatient	The ordering mode category number for the order.	HL7 → null CLARITY → zc_ordering_mode.name corresponding to order_proc_3.ordering_mode_c or order_proc.ordering_mode (now deprecated)
EXTENDED_VALUE_COMMENT			HL7 → null CLARITY → order_res_comp_cmt.results_comp_cmt sorted by order_res_comp_cmt.line_comment
EXTENDED_COMP_COMMENT			HL7 → null CLARITY → order_res_comment.results_cmt sorted based on comment.line_comment
DATA_SOURCE	CLARITY_SHC CLARITY_LPCH HL7_LPCH	Indicates whether the record came from CLARITY / HL7 and SHC/LPCH.	This is a hard coded value. CLARITY_SHC records also include HL7 historic records from SHC since they were merged.

5.6 PATHOLOGY_REPORTS

This table contains metadata on pathology reports that document the findings from examining cells and tissues under a microscope. Pathology reports are generally considered the gold standard for determining a diagnosis.

The actual text for these reports are available, but since full text anonymization techniques are not 100% reliable we deem that they may contain PHI. Accordingly we require that you document the risk of possible incidental exposure to PHI prior to supplying you with the full text of the actual pathology reports, even when supplying you with reports that have been anonymized.

Field Name	List of values	Definition	Source
{Prefix}_PAT_ID_CODED		Unique coded identifier for the patient. This is a foreign key reference to DEMOGRAPHICS.PAT_ID_CODED	{Prefix}: Used for tracking the data download source. For example, if Prefix=SP, the 'S' in the 'SP' prefix stands for STARR and the 'P' is for PHS. The codebook maintaining the mapping from this study ID back to the patient's real identity is maintained in STARR.
PAT_ENC_CSN_ID_CODED		A coded unique serial number for this encounter. This is a foreign key reference to ENCOUNTERS.PAT_ENC_CSN_ID_CODED	Mapped to order_proc.pat_enc_csn_id
PROC_CODE		Procedure code.	order_proc.proc_code, concept.code
DESCRIPTION		Procedure code description.	order_proc.description, concept.preferred_text
ORDERING_DATE_JITTERED		Jittered date when the procedure was ordered.	order_proc.ordering_date, pathology.effective_time
CONTACT_DATE_JITTERED		Jittered date when the procedure was ordered.	order_proc.ordering_date, pathology.effective_time
PROC_END_TIME_JITTERED		The jittered date and time when the exam for the procedure order has ended.	order_proc.proc_end_time
RESULT_TIME_JITTERED		The most recent jittered date and time when the procedure order was resulted.	order_proc.result_time, pathology. observation_date
ACCESSION_NUMBER *		Accession number associated with an order.	order_rad_acc_num. acc_num, pathology. filler_order_number
AUTHRZING_PROV_MAP_ID		Provider prescribing or authorizing the order.	order_proc. authrzing_prov_id, path_Eav_participation(value_type_id=4014589/'Ordering Physician'). Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.

BILLING_PROV_MAP_ID		Provider under whose name this order should be billed.	order_proc. billing_prov_id. Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
REFERRING_PROV_MAP_ID		Provider who has referred this order.	order_proc.referring_prov_id. Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
PROC_PERF_PROV_MAP_ID		Provider who will be performing the procedure.	order_proc.proc_perf_prov_id. Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
LAB_STATUS_C	1-In process 2-Preliminary result 3-Final result 4-Edited 5-Edited Result-FINA	Status of results for an order	order_proc.lab_status_c
LAB_STATUS		Name of the result Status for an order.	zc_lab_status.name
ORDER_STATUS_C	1-Pending 2-Sent 3-Resulted 4-Canceled 5-Completed 6-Holding for Referral 7-Denied Approval 8-Suspend 9-Discontinued 10-Verified 11-Dispensed 12-Pending Verify	Status of the order.	order_proc.order_status_c
ORDER_STATUS		Name of the order status.	zc_order_status.name
REPORT *			pathology.txt, lines of text from order_impression.impression, order_narrative.narrative and multiple order_rad_acc_num.acc_num separated by carriage return.
DATA_SOURCE	CLARITY_SHC, CLARITY_LPCH, HL7_LPCH	Source of the row in table.	

5.7 IMAGING_REPORTS

IMAGING_REPORTS contains the radiologist's interpretation and impression of the diagnostic images collected using imaging techniques such X-ray, ultrasound, computed tomography (CT) etc.

As with pathology reports, the actual text for radiology reports are available, but since full text anonymization techniques are not 100% reliable we deem that they may contain PHI. Accordingly we require that you document the risk of possible incidental exposure to PHI prior to supplying you with the full text of the actual pathology reports, even when supplying you with reports that have been anonymized.

Field Name	List of values	Definition	Source
{Prefix}_PAT_ID_CODED		Unique coded identifier for the patient. This is a foreign key reference to DEMOGRAPHICS.PAT_ID_CODED	{Prefix}: Used for tracking the data download source. For example, if Prefix=SP, the 'S' in the 'SP' prefix stands for STARR and the 'P' is for PHS. The codebook maintaining the mapping from this study ID back to the patient's real identity is maintained in STARR.
PAT_ENC_CSN_ID_CODED		A coded unique serial number for this encounter. This is a foreign key reference to ENCOUNTERS.PAT_ENC_CSN_ID_CODED	Mapped to order_proc.pat_enc_csn_id
PROC_CODE		Procedure code.	order_proc.proc_code, concept.code
CODE	XR-X-Ray US-Ultrasound UL-Ultrasound MA-Mammogram MR-Magnetic Resonance Imaging PT-Positron emission tomography CT-Computed Tomography MT-MRT PR-Presentation State NU-Nuclear Medicine NM-Nuclear Medicine NT-Nuclear Medicine Therapy AN-Angiography FL-Fluoroscopy Other	Modality of the radiology order.	Based on substring of order_proc.description or radiology_modality or substring of concept.code matched on radiology.code.
DESCRIPTION		Procedure code description.	order_proc.description, concept.preferred_text

ORDERING_DATE_JITTERED		Date when the procedure was ordered.	order_proc.ordering_date, radiology.effective_time
PROC_START_TIME_JITTERED		Date and time when the exam for procedure was started.	order_rad_audit.proc_start_time
RPT_PRELIM_DTTM_JITTERED		Date and time of the preliminary report	order_rad_audit.audit_dttm(AUDIT_ORDER_STAT_C=70)
RPT_FINAL_DTTM_JITTERED		Date and time of the final report	order_rad_audit.audit_dttm(AUDIT_ORDER_STAT_C=90)
PROC_END_TIME_JITTERED		The date and time when the exam for the procedure order has ended.	order_proc.proc_end_time, radiology.report_change_date
RESULT_TIME_JITTERED		The most recent date and time when the procedure order was resulted.	order_proc.result_time
ACCESSION_NUMBER_CODED		Coded study identifier corresponding to the accession number associated with an order.	order_rad_acc_num. acc_num, radiology.filler_order_number The codebook maintaining the mapping from this study ID back to the actual accession number is maintained in STARR
AUTHRZING_PROV_MAP_ID		Provider prescribing or authorizing the order.	order_proc.authrzing_prov_id, rad_eav_participation(value_type_id= 4318304/'Primary Activity Provider'). Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
RPT_PRELIM_PROV_MAP_ID		Preliminary report author	order_rad_audit.user_id(AUDIT_ORDER_STAT_C=70)
RPT_FINAL_PROV_MAP_ID		Final report author	order_rad_audit.user_id(AUDIT_ORDER_STAT_C=90)
BILLING_PROV_MAP_ID		Provider under whose name this order should be billed.	order_proc. billing_prov_id, rad_eav_participation(value_type_id= 4244185/'Autheticator'). Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
REFERRING_PROV_MAP_ID		Provider who has referred this order.	order_proc.referring_prov_id,rad_eav_participation(value_type_id= 4244180/'Originator'). Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
PROC_PERF_PROV_MAP_ID		Provider who will be performing the procedure.	order_proc.proc_perf_prov_id. Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
LAB_STATUS_C	1-In process 2-Preliminary result 3-Final result	Status of results for an order.	order_proc.lab_status_c

	4-Edited 5-Edited Result-FINA		
LAB_STATUS		Name of the status of order results.	zc_lab_status.name
ORDER_STATUS_C	1-Pending 2-Sent 3-Resulted 4-Canceled 5-Completed 6-Holding for Referral 7-Denied Approval 8-Suspend 9-Discontinued 10-Verified 11-Dispensed 12-Pending Verify	Coded status of the order, e.g. 5. 90% of the reports are coded as 5-Completed, but ~10% have no status code. Fewer than 25 are coded as either 3-Resulted or 2-Sent.	order_proc.order_status_c
ORDER_STATUS	2-Sent 3-Resulted 5-Completed	Descriptive text corresponding to the code in order_status_c, e.g. Completed.	zc_order_status.name
DATA_SOURCE	CLARITY_SHC, CLARITY_LPCH, HL7_LPCH	Source of the row in table.	

5.8 CLINICAL_DOCUMENTATION

This data table contains clinical documentation created by providers during a hospital stay or outpatient care. Examples of clinical documents are progress notes, history and physical exam notes, operative/procedure reports and discharge summaries. It also includes interpretive impression reports for tests such as EKG, EEG etc. that are neither pathology nor imaging related.

Field Name	List of values	Definition	Source
{Prefix}_PAT_ID_CODED		Unique coded identifier for the patient. This is a foreign key reference to DEMOGRAPHICS.PAT_ID_CODED	{Prefix}: Used for tracking the data download source. For example, if Prefix=SP, the 'S' in the 'SP' prefix stands for STARR and the 'P' is for PHS. The codebook maintaining the mapping from this study ID back to the patient's real identity is maintained in STARR.
PAT_ENC_CSN_ID_CODED		A coded unique serial number for this encounter. This is a foreign key reference to ENCOUNTERS.PAT_ENC_CSN_ID_CODED	Mapped to hno_info.pat_enc_csn_id
FILING_DATE_JITTERED		Jittered date when the note was filed.	note_enc_info.not_filetm_loc_dttm
NOTE_DATE_JITTERED		Jittered date when the note was specified.	note_enc_info.spec_time_loc_dttm
ACTIVITY_DATE_JITTERED		Jittered activity date and time of the partial dictation/transcription.	note_enc_info.activity_dttm
AUTHOR_PROV_MAP_ID		Author of the note.	note_enc_info.author_user_id, trans_eav_participation(value_type_id= 4244185/'Autheticator'). Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
EFFECTIVE_DEPT_ID		Foreign key reference to DEPARTMENT_REFERENCE.DEPARTMENT_ID	
NOTE_STATUS_C	1-Incomplete 2-Signed 3-Addendum 4-Deleted 5-Revised 6-Cosigned 7-Finalized 8-Unsigned 9-Cosign Needed 10-Incomplete Revision	Status of the note.	note_enc_info.note_status_c

	11-Cosign Needed Addendum 12-Shared		
NOTE_STATUS		Name of the note status.	zc_lab_status.name
AMBULATORY	Y-Yes N-No	Is this an ambulatory note?	hno_info.amb_note_yn
LTR_STATUS_C	1-Pending 2-Sent 3-Resulted 4-Canceled 5-Completed 6-Holding for Referral 7-Denied Approval 8-Suspend 9-Discontinued 10-Verified 11-Dispensed 12-Pending Verify	Status of the letter.	pat_enc_letters.ltr_status_c
LETTER_STATUS		Name of the letter status.	zc_ltr_status.name
NOTE_TYPE		Type of the note.	clinical_document_type.description or 'Other Note'
NOTE_TYPE_DESC		Note type description.	clinical_note_type_mapping.notetypedesc
EFFECTIVE_TIME_JITTERED		The date of the encounter.	transcription.effective_time, pat_enc.effective_date_dt
AUTH_LNKED_PROV_MAP_ID		Provider id of the note's author.	note_enc_info.auth_lnked_prov_id. Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
COSIGN_PROV_MAP_ID		Provider who cosigned this note.	note_enc_info.cosignuser_id. Join with PROV_MAP.PROV_MAP_ID for prov_id, entity_id or other provider details.
DATA_SOURCE	CLARITY_SHC, CLARITY_LPCH, HL7_LPCH	Source of the row in table.	

5.9 PHARMACY_ORDERS

PHARMACY_ORDERS contains information on medication orders, which may or may not correspond to the patient actually taking the ordered drug. Actual drug administration is recorded in the Medication Administration Record or MAR, available upon request.

Field Name	List of values	Definition	Source
{Prefix}_PAT_ID_CODED		Unique coded identifier for the patient. This is a foreign key reference to DEMOGRAPHICS.PAT_ID_CODED	{Prefix}: Used for tracking the data download source. For example, if Prefix=SP, the 'S' in the 'SP' prefix stands for STARR and the 'P' is for PHS. The codebook maintaining the mapping from this study ID back to the patient's real identity is maintained in STARR.
PAT_ENC_CSN_ID_CODED		A coded unique serial number for this encounter. This is a foreign key reference to ENCOUNTERS.PAT_ENC_CSN_ID_CODED	
MEDICATION_ORDERID_CODED		A coded unique identifier for this medication order. Used as a primary key for joins with the MAR	
ORDER_TIME_JITTERED		Jittered date when the medication was ordered.	
START_TIME_JITTERED		Jittered date and time when the medication should be started.	
END_TIME_JITTERED		Jittered date and time when the medication should end.	
EXTERNAL_MED_ID		Unique ID of the medication.	SHC Epic: order_med.medication_id or order_medinfo.dispensable_med_id SHC HL7: rx_order.code (9/1/2005 – 4/1/2008) LPCH Epic: order_med.medication_id or order_medinfo.dispensable_med_id LPCH HL7: rx_order.code (9/1/2005 – 5/1/2016)
MED_DESCRIPTION		The description of the order.	
ORDER_CLASS	Normal Point of Care Historical Med Lab Collect OTC Sample …	The category number for the order class. This defines how the clinical system processed the order.	The category number for the order class. This defines how the clinical system processed the order.

ORDERING_MODE	Outpatient Inpatient	Whether the order was done inpatient or outpatient.	
ROUTE	Oral Intravenous Subcutaneous Inhalation Topical Intramuscular Rectal Injection Nasal Transdermal Both Eyes Right Eye Left Eye Feeding Tube Sublingual Other Epidural Intravenous Intramuscular Vaginal G Tube In Vitro ….	The route of administration of a medication.	
ORDER_STATUS			
SIG		Patient instructions for the prescription as entered by the user in the orders activity.	
QUANTITY		The quantity of the prescription being dispensed as entered by the user in the orders activity.	.
REFILLS		The number of refills allowed for this prescription.	
AUTHR_PROV_MAP_ID		Authorizing provider.	
PRESC_PROV_MAP_ID		Prescribing provider.	
DISCON_TIME		Discontinue time.	
FREQ_NAME		Frequency name.	Ip_frequence.hv_discr_freq_id
NUMBER_OF_TIMES		This determines how often a task is to be scheduled.	

DOSE_UNIT		The dosage unit of the medication.	
IS_ADMINISTERED		Whether the medication was administered as inpatient.	
PHARM_CLASS_NAME		Pharmaceutical class name.	
THERA_CLASS_NAME			
DATA_SOURCE			

5.10 PHARMACY_MAR

PHARMACY_MAR contains records on medications administered to patients at the hospital. MAR stands for Medication Administration Record.

The records in this table join to records in PHARMACY through the "medication_orderid_coded" join key.

Note that most of the records in PHARMACY do not have counterpart records in the MAR, so take care when joining these tables lest you inadvertently filter out orders for which no corresponding in-hospital administration was recorded. For example in the sample data set the healthiest of the three sample patients has 11 medication orders but only 6 corresponding MAR records.

Field Name	List of values	Definition	Source
{Prefix}_PAT_ID_CODED		Unique coded identifier for the patient. This is a foreign key reference to DEMOGRAPHICS.PAT_ID_CODED	{Prefix}: Used for tracking the data download source. For example, if Prefix=SP, the 'S' in the 'SP' prefix stands for STARR and the 'P' is for PHS. The codebook maintaining the mapping from this study ID back to the patient's real identity is maintained in STARR.
PAT_ENC_CSN_ID_CODED		A coded unique serial number for this encounter. This is a foreign key reference to ENCOUNTERS.PAT_ENC_CSN_ID_CODED	
MEDICATION_ORDERID_CODED		A coded unique identifier for this medication order. Used as a foreign key to join with the originating pharmacy order	
TAKEN_TIME_JITTERED		The jittered time that the action took place.	CLARITY → mar_admin_info.taken_time
SCHEDULED_TIME_JITTERED		The scheduled time on the MAR.	CLARITY → mar_admin_info.scheduled_time
MAR_TIME_SOURCE_C	1 - After Signing 2 - MAR 3 - After Verification 4 - After Adjust Times 5 - End of Day Rescheduling 6 - Edit Infusion Rate on Live Order	The action source category number for the administration.	CLARITY → mar_admin_info.mar_time_source_c

	7 - Edit Ending Information on a Live Order 8 - Scheduled from Triggered Fills 9 - Anesthesia 10 - Nursing Narrator 11 - Medication Data Validate 12 - Surgery Intra-op Navigator 13 - Invasive Labs Narrator 14 - Schedule Reset After Modify 15 - Stop Infusion From Narrator 16 - Orthopaedic 17 - Leave of Absence Auto-hold		
MAR_ACTION_C	1 - Given 2 - Missed 3 - Refused 4 - Canceled Entry 5 - Held 6 - New Bag 7 - Restarted 8 - Stopped 9 - Rate Change 10 - MAR Hold 11 - MAR Unhold 12 - Bolus 13 - Push 14 - Rate Verify 15 - See Alternative 16 - Paused 98 - Pending 99 - Automatically Held 100 - Due	The MAR action category number associated with this administration.	CLARITY → mar_admin_info.mar_action_c
MAR_ACTION		Name associated with the MAR action category number associated with this administration.	CLARITY → zc_mar_rslt.name for mar_admin_info.mar_action_c
SIG		The dose value of the administration.	CLARITY → mar_admin_info.sig

ROUTE_C		The route category number associated with this administration.	CLARITY → mar_admin_info.route_c
ROUTE		Name associated with the route category number associated with this administration.	CLARITY → zc_admin_route.name for mar_admin_info.route_c
REASON_C		The reason category number associated with the use of a specific action. A reason is generally required for the actions of Missed and MAR Hold, but can be configured for any action.	CLARITY → mar_admin_info.reason_c
REASON		Name associated with the reason category number associated with the use of a specific action. A reason is generally required for the actions of Missed and MAR Hold, but can be configured for any action.	CLARITY → zc_mar_rsn.name for mar_admin_info.reason_c
SITE_C		The site category number used for the administration.	CLARITY → mar_admin_info.site_c
SITE		Name associated with the site category number used for the administration.	CLARITY → zc_mar_site.name for mar_admin_info.site_c
INFUSION_RATE		The rate at which the medication was infused.	CLARITY → mar_admin_info.infusion_rate
MAR_INF_RATE_UNIT_C	1 - mL 2 - L 3 - mg 4 - g 5 - Units 6 - mmol 7 - mEq 8 - mcg 9 - % 10 - Int'l Units … and so on	The unit category number associated with the infusion rate of the administration.	CLARITY → mar_admin_info.mar_inf_rate_unit_c

MAR_INF_RATE_UNIT		Name associated with the unit category number associated with the infusion rate of the administration.	CLARITY → zc_med_unit.name for mar_admin_info.mar_inf_rate_unit_c
DOSE_UNIT_C		The unit category number associated with the dose of the administration.	CLARITY → mar_admin_info.dose_unit_c
DOSE_UNIT		Name associated with the unit category number associated with the dose of the administration.	CLARITY → zc_med_unit.name for mar_admin_info.dose_unit_c
MAR_DURATION		The length of time the administration took to complete or infuse.	CLARITY → mar_admin_info.mar_duration
MAR_DURATION_UNIT_C		The duration unit category number associated with the administration.	CLARITY → mar_admin_info.mar_duration_unit_c
MAR_DURATION_UNIT		Name associated with the duration unit category number associated with the administration.	CLARITY → zc_med_duration_un.name for mar_admin_info.mar_duration_unit_c
DATA_SOURCE	CLARITY_SHC CLARITY_LPCH	Indicates whether the record came from CLARITY and SHC/LPCH.	This is a hard coded value

5.11 FLOWSHEET_MEASURES

FLOWSHEET_MEASURES contains nurse-entered vital signs and other frequently collected patient care metrics. The companion data file FLOWSHEET_MEASURE_FREQ documents the frequency of occurrence of the ROW_DISP_NAME variable.

Note that the volume of data contained in flowsheets is such that these data can be difficult to work with. We highly recommend that you consult FLOWSHEET_MEASURE_FREQ to identify which flowsheet values are of interest to your study prior to making a request for flowsheet measure data on your patient population.

Field Name	List of values	Definition	Source
{Prefix}: PAT_ID_CODED		Unique coded identifier for the patient. This is a foreign key reference to DEMOGRAPHICS.PAT_ID_CODED	{Prefix}: Used for tracking download source. If Prefix=SP, the 'S' in the 'SP' prefix stands for STARR and the 'P' is for PHS. The codebook maintaining the mapping from this study ID back to the patient's real identity is maintained in STARR.
PAT_ENC_CSN_ID_CODED		A coded unique serial number for this encounter. This is a foreign key reference to ENCOUNTERS.PAT_ENC_CSN_ID_CODED	
RECORDED_TIME_JITTERED		The jittered day and time the reading was taken. Note that time of day is preserved by date jittering	CLARITY → ip_flwsht_meas.recorded_time
INPATIENT_DATAID_CODED		A coded ID mapped to the inpatient record identifier associated with this flowsheet reading.	CLARITY → ip_flwsht_rec.inpatient_data_id
FSDID_CODED		A coded ID mapped to the unique ID for the flowsheet data record.	CLARITY → ip_flwsht_rec.fsd_id
TEMPLATE_ID		The unique ID for the flowsheet template.	CLARITY → ip_flt_data.template_id
TEMPLATE		The display name associated with this template. An example of a template name is " Pre DIAL Assess I ". Templates are groupers for a set of related measures.	CLARITY → ip_flt_data.display_name

GRP_FLO_MEAS_ID		The unique ID of the flowsheet group/row.	CLARITY → ip_flo_gp_data.flo_meas_id for ip_flt_comps.flo_meas_id = ip_flo_gp_data.flo_meas_id
GRP_DISP_NAME		The display name given to the flowsheet group/row.	CLARITY → ip_flo_gp_data.disp_name for ip_flt_comps.flo_meas_id = ip_flo_gp_data.flo_meas_id
GRP_ROW_TYP_C		This determines the purpose of the record (i.e. data, group, custom formula).	CLARITY → ip_flo_gp_data.row_typ_c for ip_flt_comps.flo_meas_id = ip_flo_gp_data.flo_meas_id
LINE		The line number of the flowsheet group/row.	CLARITY → ip_flwsht_meas.line
ROW_DISP_NAME		The display name given to the flowsheet group/row.	CLARITY → ip_flo_gp_data.disp_name for ip_flo_measuremnts.measurement_id = ip_flo_gp_data.flo_meas_id
ROW_TYP_C		This determines the purpose of the record (i.e. data, group, custom formula).	CLARITY → ip_flo_gp_data.row_typ_c for ip_flo_measuremnts.measurement_id = ip_flo_gp_data.flo_meas_id
VAL_TYPE_C		This determines the type of data in the record (i.e. numeric, string, temperature, etc).	CLARITY → ip_flo_gp_data.val_type_c
MEAS_VALUE		The actual value of the flowsheet reading.	CLARITY → ip_flwsht_meas.meas_value
UNITS		This determines the units that will display with the value in the additional information window.	CLARITY → ip_flo_gp_data.units
OCCURANCE		If the flowsheet group/row appears multiple times, this will distinguish the occurrence.	CLARITY → ip_flwsht_meas.occurance

LDA_PLACEMENT_INSTANT_JITTERED		This item stores the placement instant of the record.	CLARITY → ip_lda_noaddsingle.placement_instant
PROPERTIES_DISPLAY		Stores the properties display string to be displayed in Doc Flowsheets and Reports.	CLARITY → ip_lda_noaddsingle.properties_display
SITE		This item stores site information for the inserted LDA.	CLARITY → ip_lda_noaddsingle.site
ENTRY_USER_ID		The unique ID of the user entering the readings.	CLARITY → ip_flwsht_meas.entry_user_id
UPDATE_DATE_JITTERED		The jittered date and time this row was last updated (the last time it was extracted or this column was backfilled).	CLARITY → ip_flwsht_meas.update_date
DATA_SOURCE	CLARITY_SHC CLARITY_LPCH	Indicates whether the record came from CLARITY and SHC/LPCH.	This is a hard coded value

5.12 PROV_MAP (Provider reference data)

Field Name	List of values	Definition	Source
PROV_MAP_ID		Unique identifier (primary key) for the provider.	'S' || SHC_PROV_ID or 'L' || LPCH_PROV_ID if SHC_PROV_ID is null
PROV_YEAR_OF_BIRTH		Year of birth of the provider.	CLARITY → year component of clarity_ser.birth_date for adult and pediatric hospital providers
PROV_TYPE		The provider type for the provider or resource.	CLARITY → clarity_ser.prov_type
CLINICIAN_TITLE		The clinician title for the provider.	CLARITY → clarity_ser.clinician_title
ACTIVE_STATUS		Indicates the current status with regard to scheduling appointments for this provider.	CLARITY → clarity_ser.active_status
SEX		Gender of the provider.	CLARITY → clarity_ser.sex
STATE		State of the provider	CLARITY → zc_state.title corresponding to clarity_ser_addr.state_c
DEPT_ID		The unique ID of the department in which the provider can be scheduled, provided that the provider is active for scheduling in the department.	CLARITY → clarity_ser_dept.dept_id
DEPT_NAME		Department name for the provider.	CLARITY → clarity_ser_dept.dept_name
DEPT_SPECIALTY		The name of the medical specialty practiced in this department.	CLARITY → clarity_dept.specialty

PROV_SPECIALTY_1		A provider can have multiple specialties. This is the provider's first specialty.	CLARITY → zc_specialty.title corresponding to clarity_ser_spec.line = 1
PROV_SPECIALTY_2		A provider can have multiple specialties. This is the provider's second specialty.	CLARITY → zc_specialty.title corresponding to clarity_ser_spec.line = 2
PROV_SPECIALTY_3		A provider can have multiple specialties. This is the provider's third specialty.	CLARITY → zc_specialty.title corresponding to clarity_ser_spec.line = 3
SPECIALTY_OR_DEPT		Provider's specialty.	Coalesce (prov_specialty_1, dept_specialty)

5.13 DEP_MAP (Department reference data)

Department details are stored in the DEP_MAP table that gets refreshed from both clarity databases every night. DEPARTMENT_ID is a unique identifier in this table.

Field Name	List of values	Definition	Source
DEPARTMENT_ID		Unique ID assigned to this department.	Clarity_dep_department_id
DEPARTMENT_NAME		The name of the department.	Clarity_dep.department_name
DEPT_ABBREVIATION		Abbreviation of the department name.	Clarity_dep.dept_abbreviation
SPECIALTY		Name of the medical specialty practiced in this department.	Clarity_dep.specialty
SPECIALTY_DEP_C		Category number of the medical specialty practiced in this department.	Clarity_dep.specialty_dep_c
DATA_SOURCE	CLARITY_SHC, CLARITY_LPCH, HL7_LPCH, HL7_SHC	Source of the row in table.	