

USCDIv2 Data Elements

The following USCDI V2 data classes and data elements are including in MX Products and Services, when received and properly coded and formatted according to USCDI standards:

USCDIv2	USCDIv2	Description		
Data Class	Data Element			
Allergies and Int	olerances: Harmful or unde	sired physiological responses associated with		
exposure to a sub	exposure to a substance.			
	Substance (Medication)	Pharmacologic agent believed to cause a		
		harmful or undesired physiologic response		
		following exposure.		
	Substance (Drug Class)	Pharmacologic category for an agent believed to		
		cause a harmful or undesired physiological		
		response following exposure.		
	Reaction	Harmful or undesired physiologic response		
		following exposure to a pharmacologic agent or		
		class of agents.		
Assessment and	I Plan of Treatment: Health	professional's conclusion and working		
assumption that w	vill guide treatment of the pat	tient.		
	Assessment and	Health professional's conclusions and working		
	Plan of Treatment	assumptions that will guide treatment of the		
		patient.		
	SDOH Assessment	Structured evaluation of risk (e.g., PRAPARE,		
		Hunger Vital Sign, AHC-HRSN screening tool)		
		for any Social Determinants of Health (SDOH)		
		domain such as food, housing, or transportation		
		security. SDOH data relate to conditions in		
		which people live, learn, work, and play and		
		their effects on health risks and outcomes.		



Care Team Members: Information on a person who participates or is expected to participate in				
the care of a patient.				
	Care Team Member	The first and last name of the care team		
	Name	member.		
	Care Team Member	Unique identifier for the care team member		
	Identifier	(e.g., NPI, NCSBN ID)		
	Care Team Member Role	Responsibility of an individual within the care		
		teams (e.g., primary care physician, caregiver,		
		etc.)		
	Care Team Member	The place where care is delivered by a care		
	Location	team member.		
	Care Team Member	The phone or email contact information for a		
	Telecom	care team member.		
Clinical Notes: Narrative patient data relevant to the context identified by note types.				
	Consultation Note	Response to request from a clinician for an		
		opinion, advice, or service from another		
		clinician.		
	Discharge Summary Note	Synopsis of a patient's admission and course in		
		a hospital or post-acute care setting. Usage		
		note: Must contain admission and discharge		
		dates and locations, discharge instructions, and		
		reason(s) for hospitalization.		
	History & Physical	Summary of current and past conditions and		
		observations used to inform an episode of care.		
		Examples include but are not limited to		
		admission, surgery, and other procedure.		
	Procedure Note	Synopsis of non-operative procedure. Examples		
		include but are not limited to interventional		
		cardiology, gastrointestinal endoscopy, and		
		osteopathic manipulation.		
	Progress Note	Summary of a patient's interval status during an		
		encounter.		



Clinical Tests: non-imaging and non-laboratory tests performed that result in structured or				
unstructured findings specific to the patient to facilitate the diagnosis and management of				
conditions.				
	Clinical Test	Non-imaging or non-laboratory test.		
	Clinical Test	Findings of clinical tests.		
	Result/Report			
Diagnostic Imag	ing: Tests that result in visua	l images requiring interpretation by a credentialed		
professional.				
	Diagnostic Imaging Test	Tests that generate visual images (e.g.,		
		radiographic, photographic, video) and require		
		interpretation by qualified professionals.		
	Diagnostic Imaging	Interpreted results of imaging tests. Includes		
	Report	structured and unstructured components.		
Encounter Information: Information related to interactions between healthcare providers and a				
patient.				
	Encounter Type	Category of health care service. (e.g., office		
		visit, telephone assessment, home visit).		
	Encounter Diagnosis	Coded diagnoses associated with an episode of		
		care.		
	Encounter Time	Date/times related to an encounter. (e.g.,		
		scheduled appointment time, check in time, start		
		and stop times).		
	Encounter Location	Place where a patient's care is delivered.		
	Encounter Disposition	Place or setting to which the patient left a		
		hospital or encounter.		
Goals: Desired st	tate to be achieved by a pation	ent.		
	Patient Goals	Desired outcomes of patient's care.		
	SDOH Goals	Desired future states (e.g., food security) for an		
		identified Social Determinants of Health-related		
		health concern, condition, or diagnosis. (e.g.,		
		food insecurity).		



Health Status Assessments: Assessments of a health-related matter of interest, importance, or worry to a patient, patient's family, or patient's healthcare provider that could identify a need, problem, or condition. Health Concerns Health-related issue or worry. (e.g., weight gain, cancer risk). Smoking Status Assessment of a patient's smoking behaviors. **Immunization**: Record of vaccine administration **Immunizations** Vaccine product administered, planned, or reported. Tests Analysis of specimens derived from humans which provide information for the diagnosis, prevention, treatment of disease, or assessment of health. Values/Results Documented findings of a tested specimen including structured and unstructured components. **Medications**: Pharmacological agents used in the diagnosis, cure, mitigation, treatment, or prevention of disease. Medications Pharmacologic agent used in the diagnosis, cure, mitigation, treatment, or prevention of disease. Patient Demographics: Data used to categorize individuals for identification, records matching, and other purposes. First Name Patient's first name. Last Name Patient's last name. Middle Name Patient's middle name. Suffix Name component following family name that may be used to describe a person's position in a family. Previous Name Patient's previous names. Date of Birth Patient's date of birth. Patient's race. Race



	Ethnicity	Patient's ethnicity.
	Sex	Documentation of a specific instance of sex
		and/or gender information.
	Sexual Orientation	Patient's identification of their emotional,
		romantic, sexual, or affectional attraction to
		another person.
	Gender Identity	Patient's internal sense of being a man, woman,
		both, or neither.
	Preferred Language	Patient's preferred language.
	Current Address	Patient's current address.
	Previous Address	Patient's previous address.
	Phone Number	Patient's phone number.
	Phone Number Type	Contact point when using a phone (e.g., home,
		work, mobile, etc.).
	Email Address	Patient's email address.
Problems: Condi	tions, diagnosis, or reason fo	or seeking medical attention.
	Problems	Condition, diagnosis, or reason for seeking
		medical attention.
	SDOH Problems/Heath	Social Determinants of Health-related health
	Concerns	concerns, conditions, or diagnoses. (e.g.,
		homelessness, food insecurity).
	Date of Diagnosis	Date of the diagnosis.
	Date of Resolution	Date of subsiding or termination of a symptom,
		problem, or condition.
Procedures: Acti	vity performed for or on a pa	tient as part of the provision of care.
	Procedures	Activity performed for or on a patient as part of
		the provision of care.
	SDOH Interventions	Actions or services to address an identified
		Social Determinants of Health-related health
		concern, condition, or diagnosis (e.g., education
		about food pantry program, referral to non-
		emergency medical transportation program).



Provenance: Metadata, or data that describes other data.				
	Author Time Stamp	Date and time of author action.		
	Author Organization	Organization associated with author.		
Unique Device Identifier(s) for a Patient's Implantable Device(s)				
	Unique Device	Unique identifier(s) for a patient's implantable		
	Identifier(s) for a Patient's	device(s).		
	Implantable Device(s)			
Vital Signs: Physiologic measurements of a patient.				
	Systolic Blood Pressure	Patient's systolic blood pressure.		
	Diastolic Blood Pressure	Patient's diastolic blood pressure.		
	Heart Rate	Number of heart beats per minute.		
	Respiratory Rate	Number of breaths per minute.		
	Body Temperature	Patient's body temperature.		
	Body Height	Patient's height.		
	Body Weight	Patient's weight.		
	Pulse Oximetry	Oxygen level of the blood.		
	Inhaled Oxygen	Percent of oxygen inhaled.		
	Concentration			
	BMI Percentile (2 – 20	Patient's body mass index.		
	Years)			
	Weight-for-length	Assessment of weight status (for children).		
	Percentile (Birth – 36			
	Months)			
	Head Occipital-frontal	Head circumference (for children).		
	Circumference Percentile			
	(Birth – 36 Months)			