Data dictionary example healthcare

For each of identification the data element name is italicized. It is not the intent to have documentation added at the time of abstraction to ensure the passing of a measure. The details include technical metadata such as name, data type, the owner (i.e., Registered By), and identifiers for version, registration, authority, etc. # A data dictionary stores metadata about database elements, including object names, data types, size, classification, and relationships. Save Your Seat To See Atlan in Action - Live Demo Series According to IBM's Computer Terminology Dictionary, a data dictionary is a "centralized repository of information about data such as meaning, relationships to other data, origin, usage, and format. It also contains metrics and data quality indicators such as minimum and maximum values and the unit of measure. "ONLY ACCEPTABLE SOURCES", "Priority Source", or "PHYSICIAN/APN/PA DOCUMENTATION ONLY". A vendor may include this information in data collection software. This allows users to discover assets using business terms through metadata-enriched querying and facilitates the creation of data products for self-service in a data marketplace. For example, if the patient had previously failed three or more trials of monotherapy and this information is available in the current chart being abstracted (e.g., a note made in the continuing care plan), this information should be used. While this is the expectation, it is recognized that in certain situations information may not be available (e.g., dates, times, codes, etc.). For example, if an ED record notes Lipid profile, and this is followed by a signature and/or a time, the abstractor should presume the test was performed. Data element information should be retrieved from the current medical record, covering the admission and discharge date, or reporting period for event measures being abstracted. If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select Unable to Determine (UTD) as the answer. Important Note: There are several data elements where abstraction of data from documentation dated/timed after discharge is restricted, and these exceptions are published on the respective data element pages of the data dictionary. Alphabetical List of All Data Elements Data Element Name Collection Notes Associated Measures ACEI Prescribed for LVSD in the Outpatient Setting ACHFOP-02 ARB Prescribed for LVSD in the Outpatient Setting ACHFOP-02 Activity Recommendation — Duration of Activity ACHFOP-03 Activity Recommendation — Intensity of Activity ACHFOP-05 Activity Recommendation — Type of Activity ACHFOP-05 Admission Date All Records ACHF, CSTK, HBIPS, PC, STK Admission to NICU PC-05 Admitting Diagnosis CSTK-04 Advance Directive Executed ACHF-05, ACHFOP-07 Aldosterone Receptor Antagonist Prescribed for LVSD in the Outpatient Setting ACHFOP-03 Antenatal Steroids Initiated PC-03 Anticoagulation Therapy Prescribed at Discharge STK-3 Antithrombotic Therapy Administered by End of Hospital Day 2 STK-5 Antithrombotic Therapy Prescribed at Discharge STK-2 Appropriate Justification for Multiple Antipsychotic Medications HBIPS-5 Arrival Date CSTK-01, CSTK-03, CSTK-05, CSTK-06, CSTK-07, CSTK-09, CSTK-11, STK-4, STK-5 Arrival Time CSTK-01, CSTK-03, CSTK-05, CSTK-06, CSTK-07, CSTK-09, CSTK-11, STK-4, STK-5 Arrival Time CSTK-01, CSTK-03, CSTK-05, CSTK-06, CSTK-07, CSTK-09, CSTK-11, STK-4, STK-5 Assessed for Rehabilitation Services STK-10 Atrial Fibrillation/Flutter STK-3 Birth Weight Risk Adjustment PC-04 Birthdate All Records ACHF, ACHFOP, CSTK, HBIPS, PC, STK Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Prescribed for LVSD in the Outpatient Setting ACHFOP-01 Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge ACHF-01 Bloodstream Infection Confirmed PC-04 Bloodstream Infection Present on Admission PC-04 Care Transition Record Transmitted ACHF-03 Care Transition Record-Discharge Medications ACHF-03 Care Transition Record-Follow-Up Treatment(s) and Service(s) Needed ACHF-03 Care Transition Record-Procedures Performed During Hospitalization ACHF-03 Care Transition Record-Reason for Hospitalization ACHF-03 Care Transition Record-Treatment(s)/Service(s) Provided ACHF-03 Clinical Trial ACHF-01, ACHF-04, ACHF-06, ACHFOP-01, ACHFOP-02, ACHFOP-03, ACHF-05, ACHFOP-05 CSTK Comfort Measures Only ACHF, CSTK-01, CSTK-03, CSTK-04, CSTK-06, STK-1, STK-10, STK-2, STK-3, STK-5, STK-6, STK-8 Date Last Known Well STK-4 Delayed Endovascular Rescue Procedure CSTK-09, CSTK-11 Direct Admission CSTK-01, CSTK-03 Discharge Date All Records ACHF, CSTK, HBIPS-1, HBIPS-5, PC, STK Discharge Disposition ACHF, CSTK-02, CSTK-10, HBIPS-5, PC-04, PC-05, STK-10, STK-2, STK-3, STK-6, STK-8 Discharge Time CSTK-01, CSTK-03, CSTK-06 Discussion of Advance Directives/Advance Care Planning ACHF-05, ACHFOP-06 E/M Code ACHFOP ED Patient CSTK-01, CSTK-03, STK-4 Education Addresses Activation of Emergency Medical System STK-8 Education Addresses Follow-up After Discharge STK-8 Education Addresses Medication Prescribed at Discharge STK-8 Education Addresses Risk Factors for Stroke STK-8 Education Addresses Warning Signs and Symptoms of Stroke STK-8 Elective Carotid Intervention CSTK-11, CSTK-12 First Pass Date CSTK-07 First Pass Time CSTK-07 First Pass of a Mechanical Reperfusion Device CSTK-07 Gestational Age PC-01, PC-02, PC-03 Health Care Organization Identifier All Records, Patient Population Data File, Hospital Clinical Data File HBIPS, PC, STK Highest NIHSS Score Documented Within 36 Hours Following IA t-PA or MER Initiation CSTK-05 Highest NIHSS Score Documented Within 36 Hours Following IV Thrombolytic Initiation CSTK-05 Highest NIHSS Score Documented Within 36 Hours Following IV Thrombolytic Initiation CSTK-05 Hispanic Ethnicity All Records ACHF, CSTK, HBIPS, PC, STK History of Stillbirth PC-01 IA Route of t-PA Administration CSTK-05, CSTK-07, CSTK-08, CSTK-09 IA Thrombolytic Initiation CSTK-05 IA Thrombolytic Initiation Time CSTK-07 IA Thrombolytic Initiation Date CSTK-05 IA t-PA or MER Initiation Date CSTK-05 IA t-PA or MER Initiation Time CSTK-05 ICD-10-CM Other Diagnosis Codes All Records CSTK-05, HBIPS-1, HBIPS-5, PC, STK ICD-10-CM Principal Diagnosis Code All Records ACHF, ACHFOP, CSTK, HBIPS-1, HBIPS-5, PC, STK ICD-10-PCS Other Procedure Codes All Records ACHF, ACHFOP, CSTK-01, CSTK-03, CSTK-05, CSTK-07, HBIPS, PC, STK ICD-10-PCS Other Procedure Dates All Records CSTK-01, CSTK-02, CSTK-03, CSTK-05, CSTK-07, HBIPS, PC, STK ICD-10-PCS Other Procedure Times CSTK-01, CSTK-03 INR Value > 1.4 CSTK-04 IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival STK-5 IV Thrombolytic Initiation CSTK-05, STK-4 IV Thrombolytic Initiation Date CSTK-05, STK-4 IV Thrombolytic Initiation Time CSTK-05, STK-4 IV Thrombolytic Therapy Prior to IA or Mechanical Reperfusion Therapy CSTK-05, CSTK-08, CSTK-10 Initial Blood Glucose Value at Hospital Arrival CSTK-05, CSTK-08, CSTK-10 Initial Blood Pressure at Hospital Arrival CSTK-05, CSTK-08, CSTK-10 Initial Hunt and Hess Scale Date CSTK-03 Initial Hunt and Hess Scale Performed CSTK-03 Initial Hunt and Hess Scale Time CSTK-03 Initial ICH Score Date CSTK-03 Initial ICH Score Performed CSTK-03 Initial ICH Score Time CSTK-03 Initial NIHSS Score Date CSTK-01 Initial NIHSS Score Performed CSTK-01 Initial NIHSS Score Time CSTK-01 Initial NIHSS Score at Hospital Arrival CSTK-05, CSTK-08, CSTK-10 Initial Platelet Count at Hospital Arrival CSTK-05, CSTK-08, CSTK-10 LVSD < 40% ACHF-01, ACHFOP-01, ACHFOP-02, ACHFOP-03 Labor PC-01 Last Known Well STK-4 Minutes of Physical Restraint HBIPS-2 Minutes of Seclusion HBIPS-3 Modified Rankin Score (mRS) CSTK-02, CSTK-10 Modified Rankin Score (mRS) Date CSTK-02, CSTK-10 NIHSS Score Documented Closest to IA t-PA or MER Initiation CSTK-05 NIHSS Score Documented Closest to IV Thrombolytic Initiation CSTK-05 New York Heart Association (NYHA) Classification ACHFOP-04 Nimodipine Administration CSTK-06 Nimodipine Administration Date CSTK-06 Nimodipine Administration Time CSTK-06 Number of Antipsychotic Medications Prescribed at Discharge HBIPS-5 Number of Previous Live Births PC-02 Outpatient Encounter Date ACHFOP Patient Status at Discharge HBIPS-5 Patient Strengths HBIPS-1 Payment Source All Records CSTK, HBIPS, PC, STK Positive Brain Image CSTK-05 Positive Brain Image Time CSTK-05 Post-Discharge Appointment Scheduled Within 7 Days ACHF-02 Post-Discharge Evaluation Conducted Within 72 Hours ACHF-06 Post-Treatment Thrombolysis in Cerebral Infarction (TICI) Reperfusion Grade CSTK-08, CSTK-11, CSTK-12 Post-Treatment Thrombolysis in Cerebral Infarction (TICI) Reperfusion Grade Time CSTK-11, CSTK-12 Prior Uterine Surgery Joint Commission Only PC-01 Procoagulant Reversal Agent Initiation CSTK-04 Proximal or Distal Occlusion CSTK-08 Psychiatric Care Setting All Records HBIPS-2, HBIPS-3, HBIPS-5 Psychiatric Inpatient Days - Medicare Only HBIPS-2, HBIPS-3 Psychiatric Inpatient Days-Non-Medicare Only HBIPS-2, HBIPS-3 Psychological Trauma History HBIPS-1 Race All Records ACHF, CSTK, HBIPS, PC, STK Reason for Extending the Initiation of IV Thrombolytic STK-4 Reason for No ACEI and No ARB Prescribed for LVSD in Outpatient Setting ACHFOP-02 Reason for No Activity Recommendations in the Outpatient Setting ACHFOP-05 Reason for No Aldosterone Receptor Antagonist Prescribed for LVSD in the Outpatient Setting ACHFOP-03 Reason for No Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Prescribed for LVSD in the Outpatient Setting ACHFOP-01 Reason for No Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge ACHF-01 Reason for No Post-Discharge Appointment Within 7 Days ACHF-02 Reason for No VTE Prophylaxis - Hospital Admission STK-1 Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2 STK-5 Reason for Not Administering Nimodipine Treatment CSTK-06 Reason for Not Administering a Procoagulant Reversal Agent CSTK-04 Reason for Not Initiating Antenatal Steroids PC-03 Reason for Not Initiating IV Thrombolytic STK-4 Reason for Not Prescribing Anticoagulation Therapy at Discharge STK-3 Reason for Not Prescribing Antithrombotic Therapy at Discharge STK-2 Reason for Not Prescribing Statin Medication at Discharge STK-6 Reason for Oral Factor Xa Inhibitor STK-1 Sex All Records ACHF, CSTK, HBIPS, PC, STK Site of Primary Vessel Occlusion CSTK-08, CSTK-11, CSTK-12 Skin Puncture CSTK-08, CSTK-11, CSTK-12 Skin Puncture Date CSTK-09, CSTK-12 Skin Puncture Time CSTK-09, CSTK-12 Statin Medication Prescribed at Discharge STK-6 Substance Use HBIPS-1 Term Newborn PC-05 Time Last Known Well STK-4 Total Leave Days - Medicare Only HBIPS-2, HBIPS-3 Total Leave Days-Non-Medicare Only HBIPS-2, HBIPS-3 VTE Prophylaxis STK-1 VTE Prophylaxis Date STK-1 Violence Risk to Others HBIPS-1 Violence Risk to Self HBIPS-1 Related Topics Table of Contents Transmission Alpha Data Dictionary Data Dictionary Introduction TJC Specifications Manual for Joint Commission National Quality Measures (v2017B2) Discharges 01-01-18 (1Q18) through 06-30-18 (2Q18) In this article, we have attempted to briefly explain various types of data collection instruments, and available techniques for checking the calibration, validity, and reliability of the data... Resident and intern notes should be considered physician documentation. Do you include the raw value for the numeric values, or did you calculate it using a formula? For the purposes of abstraction, telephone or verbal physician/APN/PA orders (TO/VO) in the medical record are considered physician/APN/PA documentation at the time they were written regardless of whether or not they were authenticated by the physician/APN/PA at the time of abstraction. Some common titles that represent the pharmacist role are: Doctor of Pharmacy (Pharm.D. or D.Ph.) Registered Pharmacist (R.Ph.) Medications: The approved medication tables contained in the dictionary may not be inclusive lists of all available therapeutic agents acceptable for a particular data element. Interpretation of Data Dictionary Terms Data elements fall into three broad categories in order to support a specific measure set. Example of a data dictionary # The data dictionary can be a simple table maintained using a spreadsheet, PDF, or a full-fledged web application. Diagnostic/Laboratory Tests Whether or not a diagnostic or laboratory test has been done is usually clear when using medical record sources such as diagnostic test reports, laboratory reports, or progress notes (where a physician might note test findings), but documentation can be more ambiguous in other sources, namely, physician orders and ED records. Note: Hospitals should use abbreviations according to their policy. # Data elements include object names, definitions, data types, sizes, valid values, relationships, and business rules for validation. That is the purpose of the data dictionary. The platform features AI-powered capabilities that suggest descriptions, generate READMEs, and assist with SQL queries, enhancing the usability and richness of the data dictionary. Think of it as a common language or a way to talk about the data consistently in an organization. Previous history information used in abstraction should be information that was part of the medical record during hospitalization, when care was being delivered. In the event that there are multiple ED visits within the inpatient medical record, for the same episode of care, it is recommended that the ED visit resulting in the admission to observation or inpatient status be utilized for the purposes of abstraction. Exclusions are unacceptable terms that should be abstracted as negative findings (e.g., No). business glossary A business glossary is a centralized repository of business terms, KPIs, metrics, and definitions. What tests or checks did you run to determine whether your data is trustworthy? The following Specification Manuals are available on Qualitynet.cms.gov: • Specifications Manual ... 1. Describe each component of the dataset # You should provide a complete definition for each component of the dataset. If a medication in the physician orders has been initialed and signed off with a time, do NOT presume that the medication was not administered. Table of contents # What is a data dictionary? Other documentation in the medical record supports the date of death as being accurate. Source: Atlan 3. Since the data dictionary displays descriptive statistics — minimum, maximum, count, frequency, mean, and median — spotting anomalies in data becomes easy. Most data dictionaries contain object names, data types, allowed values, default values, and data validation rules. This helps you avoid inaccuracies or inconsistencies in data. If, after reviewing the General Abstraction Guidelines, the data element definition, including the notes and guidelines for abstraction, an abstractor cannot clearly assign an allowable value, refer to the Resource section of this manual for additional contact information. How to choose a data dictionary tool? Where do data dictionaries fit in your stack? Medical student notes must be co-signed by a physician. Regardless of which measure sets are selected by a hospital, certain general data elements must be collected by the hospital and submitted for every patient that falls into any of the selected Initial Patient Populations. Hospitals must document the administration of each medication, as reported by the patient (or the patient's caregiver/support person where appropriate), in the patient's medical record [42CFR482.23(c)(6)]. You can click on each attribute to understand it further. Read the Magic Quadrant for D&A Governance What is an enterprise data dictionary? Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders if such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner responsible for the care of the patient [42CFR482.24(c)(3)]. Additionally, data catalogs also serve as the workspace for collaboration on data. Gartner's Inaugural Magic Quadrant for D&A Governance is Here # In a post-ChatGPT world where AI is reshaping businesses, data governance has become a cornerstone of success. Whether or not a medication has been administered to a patient is often clear when using medical record sources such as medication administration records, but documentation can be more ambiguous in other sources, namely, physician orders, ED records, and ambulance records. This should include: Creator or owner of the data dictionary Title Date of publishing The metrics or descriptive statistics The purpose of data collection Methodologies used or assumptions made while collecting data The Smithsonian recommends that you follow "the conventions of your discipline when choosing standardized terms or when structuring your data." This practice also comes in handy with compliance audits. data dictionary A data catalog helps users search, discover, understand, and trust data assets in an organization. Data integrity Editing Zero Values Verification mechanisms are necessary to assure that zero is the intended data value rather than an initialization value for those data elements which have an allowable value of zero (i.e., 0.0, 0000, 0). The PDS data dictionary is a web page with a search bar and a listing of all the entries, called attributes. We've got you covered with a 2-minute summary of the highlights of this article: A data dictionary includes technical metadata such as object names and definitions, properties, business rules for validation, reference data, missing data, and more. Pharmacist Documentation Pharmacist titles may vary. 2. Quick answer: Pressed for time? Gartner's Inaugural Magic Quadrant for D&A Governance is Here # In a post-ChatGPT world AI is reshaping businesses, data governance has become a cornerstone of success. The data elements Admission Date, Discharge Date and Birthdate require an actual date for submission of discharge measure information into the Joint Commission's Data Warehouse, and UTD cannot be selected as an allowable value. When the value documented is obviously in error (not a valid format/range or outside of the parameters for the data element) and no other documentation is found that provides this information, the abstractor should select UTD. Learn more → The Benefits of a data dictionary How to create a data dictionary? How did you measure it? What are the components of a data dictionary? # According to data governance coach Nicola Askham, you can have multiple data dictionaries as it has details of the systems hosting or holding data assets. How can I create a data dictionary? In some cases, it also covers specific business rules for defining a term. The list of exclusions should not be considered all-inclusive, unless otherwise specified in the data element. A Guide to Building a Business Case for a Data Catalog Download free ebook Components of a data dictionary # According to the USGS (US Geological Survey), a data dictionary can include: A listing of data objects (names and definitions) Detailed properties of data elements (data type, size, nullability, optionality, indexes) Entity-relationship (ER) and other system-level diagrams Reference data (classification and descriptive domains) Missing data and quality-indicator codes Business rules, such as for validation of a schema or data quality Additionally, the data dictionary should also include information on: Data source (data warehouse, data lakes, databases, applications) Date and time when the property was created or changed Descriptive statistics that go beyond missing values, such as min-max values and histogram distribution Owners and editors of data sets that contain these variables SQL queries attached to the data asset Social metadata associated with each data asset - stored as tags, notes, and chat transcripts Now, let's look at some examples of data dictionaries. Source: ORNL. What is it describing? All of the allowable values for a given data element are outlined, and notes and guidelines are often included with each data set. Data dictionary also provide the necessary direction for abstracting a data element. # Since several data dictionary tools (both enterprise and open-source) are available, we'll focus on the capabilities you should look for in a tool. Since the data dictionary usually should look to it as a tool. Since the data dictionary usually should look to it as a tool, do NOT presume that the test was done. According to a veteran technical business analyst, the enterprise data dictionary is "the key for any company looking to connect the dots for all users." Learn more → 6 types of metadata While exploring the concept of a data dictionary, you'll come across other terms such as data catalog, data glossary, and business glossary. The abstractor should first refer to the specific notes and guidelines under each data element. The next example is from NASA's PDS (Planetary Data System). For an ED or ambulance record, there is no need for documentation indicating that the medication was actually given. A data dictionary acts as a reference guide on a dataset. Think of it as a list along with a description of tables, fields, and columns. Any researcher can look up the terms they need using these in order to make sense of their planetary data. The glossary includes a more descriptive name and detailed description of each term, along with possible aliases. Some common titles that represent the advanced practice nurse role are: Nurse Practitioner (NP) Certified Registered Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Certified Nurse Midwife (CNM) When a physician/advanced practice nurse/physician assistant (physician/APN/PA) signs a form or report (e.g., ED sheet with triage and nursing information and a physician/APN/PA has signed somewhere on the form), information in that form/report should be abstracted as it was billed. Medical Record Documentation The intent of abstraction is to use only documentation that was part of the medical record during the hospitalization (is present upon discharge) and that is present at the time of abstraction. data dictionary: What's the difference? Missing and Invalid Data Each data element that is applicable per the algorithm for each of the measures within a topic must be touched by the abstractor. That's why the OSF (Center for Open Science) recommends that your data dictionary should contain: Name, definition, and description of each variable Synonyms and associated variables Measurement units A range of accepted values, along with minimum and maximum values 5 questions to ask your data team before building a data dictionary # To ensure that each variable contains the above information, you can ask your teams the following questions: What does each variable/element/field/attribute within a data set mean? The documentation MUST indicate that the test was actually done (e.g., accompanied by a word such as done). It includes metadata about the data's purpose, source, relationships, ownership, and usage characteristics. Suggested Data Sources are designed to provide guidance to the locations/sources where the information needed to abstract a data element will likely be found. Atlan supports collaboration by allowing users to save and share business-related queries and link terms for metric alignment, ensuring consistency in data definitions across the organization. Guidelines for Abstraction: Designed to assist abstractors in determining how a data element should be answered Note: Element specific notes and guidelines should take precedence over the General Abstraction Guidelines. Crawling all kinds of metadata also helps data catalogs visualize data flow and its lifecycle — the origins, transformations, and upstream and downstream dependencies. Each of these terms should be linked to tables/dashboards so that data teams can find the information they need faster. The data dictionary tool should also allow you to set up data definitions and descriptions as mentioned under the best practices listed above. General Abstraction Guidelines The General Abstraction Guidelines are a resource designed to assist abstractors in determining how a question should be answered. This information is intended to assist in processing patient level data elements for The Joint Commission's National Quality Measures. Who has interacted with your data, and what are the changes that they made? Frequently flow sheets or other documentation contain a "key or legend" that explains what the abbreviation or symbol stands for, especially if unique to that facility. Inclusions/Exclusions Inclusions are acceptable terms that should be abstracted as positive findings (e.g., Yes). # A data catalog handles the indexing, inventorying, and classification of data assets across multiple data sources in an organization. Can a data dictionary be automated? This late entry or addendum can be used, for abstraction purposes, as long as it has been added within 30 days of discharge, (Refer to the Medicare Conditions of Participation for Medical Records, 42CFR482.24(c)(2)(viii)), unless otherwise specified in the data element. Example: Patient expires on 02-12-20XX and documentation indicates the Event Date was 03-12-20XX. Unlike the data dictionary, there can only be one business glossary for an entire organization. This will ensure that the data are standardized and comparable across organizations. Hospitals may allow a patient (or his or her caregiver/support person where appropriate) to self-administer both hospital-issued medications and the patient's own medications brought into the hospital. Data catalog vs. Example of what constitutes a data dictionary. Prenatal forms which are available during the hospitalization and become a permanent part of the patient's medical record (electronic health record/EHR or paper) for the current hospitalization may be used for abstraction. Example from The Human Health Risk Assessment. The medical record must be abstracted as it was at some data dictionary examples. It is important to utilize the information found in the notes and guidelines when entering or selecting the most appropriate answer. Suggested Data Sources are listed by commonly used titles; however, information may be abstracted from any source that is equivalent to those listed. Files that contain any invalid and/or missing data will be rejected from the Joint Commission's Data Warehouse. Think of it as a platform that tells you the story of each data set. It is of primary importance that all health care organizations using The Joint Commission's National Quality Measures gather and utilize the data elements as defined in this section. Let's explore this in detail. Hospitals often format and reports with unique names or titles. Example: If the nursing admission assessment is listed as a suggested source, an acceptable alternative might be titled nurses initial assessment or nursing data base. Build transparency & enable self-serve within data teams # As mentioned earlier, the data dictionary democratizes everyone in your organization with a common repository for data definitions, standards, metrics, and more. Are they still the owners, or is it somebody else? Automated tools can generate a data dictionary from a database or data warehouse. Source: NASA's Planetary Data System. The goal is to define a common vocabulary of terms for an enterprise. This helps you validate each data set and make sure the information you have is reliable, which makes your decision-making more accurate. The versioning is automatic if you use a web-based file system (or wiki) like Git or ArcGIS. Additionally, modern data platforms such as a data catalog also let you visualize the overall data flow, making it easier to interpret your transformations' impact on upstream or downstream applications. If no other source provided is able to verify the handwritten documentation, only then is the abstractor to answer unable to determine from the medical record documentation, unless otherwise specified in the data element. Learn more → Data dictionary vs. What does a data dictionary include? How can you reach out to your data owners, admins, and editors? Read the Magic Quadrant for D&A Governance 4 Key benefits of a data dictionary # A data dictionary documents data assets with relevant context, making it easy to use, analyze, and discuss data across teams. Book your personalized demo today to find out how Atlan can be more than a robust and collaborative data dictionary solution for your organization. Image by Atlan. A simple, tabular data dictionary for specific data dictionary is the one used by ORNL (Oak Ridge National Laboratory). The medical record must be abstracted as documented (taken at face value). # A data dictionary is used by data administrators, analysts, and engineers to understand and trust data assets. It includes information necessary for defining and formatting the data elements, as well as the allowable values for each data element. These data elements include: Admission Date Birthdate Health Care Organization Identifier 2 Hispanic Ethnicity Ethnicity Measure Set 1,2 Performance Measure Identifier 1,2 Race Sample 1 Sex Vendor Tracking ID 1,2 Data elements that are general for every patient that fall into measures that are reported at time of discharge include: Discharge Date ICD-10-CM Other Diagnosis Codes ICD-10-PCS Other Procedure Codes (Optional for all HBIPS measures) ICD-10-PCS Other Procedure Dates (Optional for all HBIPS measures) ICD-10-CM Principal Diagnosis Code ICD-10-PCS Principal Procedure Code (Optional for all HBIPS measures) ICD-10-PCS Principal Procedure Date (Optional for all HBIPS measures) Payment Source Data elements that are general for every patient that falls into measures that are reported at the time of the event include: Event Date (HBIPS measures only) Event Type (HBIPS measures only) Psychiatric Care Setting (HBIPS measures only) Data elements that are general for every patient that falls into specific measures that are reported at the time of discharge include: 1 Transmission Data Element 2 These data elements are defined in the Transmission Data Dictionary within the Joint Commission National Quality Measures Data Transmission section of this manual Episode of Care An Episode of Care (EOC) is defined as the health care services given during a certain period of time, usually during a hospital stay (e.g., from the day of arrival or admission to the day of discharge). Read the Magic Quadrant for D&A Governance What is a data dictionary? Deviations from previous history (e.g., failed trials of monotherapy) AND determined to be part of the current hospital method may be used in abstraction. # The purpose of a dictionary is to help you avoid asking questions such as "what does this variable name mean?" or "what is the ideal value for this field?" How to create a data dictionary? We also explore the differences between a data dictionary, a business glossary, and a data catalog. After due diligence in reviewing all allowable data sources within the medical record, if the abstractor determines that a value is not documented, i.e. missing, or is unable to determine if a value is documented, the abstractor should select the UTD - Unable to Determine, value. Why is a data dictionary important? To make a determination using these sources, use the following criteria: For EHRs only accept documentation that reflects the actual administration of the medication in the context of the chart. These instructions should take precedence over the following General Abstraction Guidelines. The article looks into the components of a data dictionary, its benefits, usage process, and best practices. The PDS Data Dictionary. Grids Instructions for reading values recorded on grids: Measure from the midpoint of the symbol, number and letter. Data element specific notes and guidelines always take precedence over the following General Abstraction Guidelines. # A data dictionary maintains data consistency and ensures correct interpretation by clearly defining attributes, formats, and rules across users within an organization. However, documentation that is not timed, dated or authenticated may still be used for abstraction if not required by the specific data element. It helps in the creation of authentic, transparent, and consistent data throughout the organization. The goal of an enterprise data dictionary is to help business teams understand and use a data set easily. Next, offer a description that contains the following information: Component name, which could be the data label, column header, or filename A full "human readable" name of the element if the dataset uses codes or abbreviations Any units of measure and precision (if applicable) The format of the data element (if applicable) — integer, text, date, or time If the component is numeric, include what values are valid or allowed Any codes, symbols, or abbreviations used in the values themselves The source of the data element — sensor, observation, or another application Include data validation or quality control processes, wherever applicable 3. Handwritten, electronic signatures, facsimiles of original written or electronic signatures are acceptable. ORNL maintains this dictionary as a PDF and it resembles a detailed index at the end of a book. The documentation MUST indicate that the medication was actually given. If discharge medications are noted using only references such as continue current medications or continue present meds rather than lists of the discharge medications, the abstractor should include the medication in the count if the medication in question was listed as a medication on the day of discharge, unless documentation indicates it was to be discontinued at discharge or suggests otherwise If discharge medications are noted using general references such as continue home meds, continue previous medications, continue current meds, continue present meds, resume other meds, or continue meds, but a list of the names of the discharge medications also in the record gives conflicting information about what medications the patient was actually discharged on, the abstractor should consider the list most accurate and use only the list in determining whether or not a patient was discharged on a specific medication. To begin with, the data dictionary should define all technical terms from data tables or data models — for example, policy_expiration_date, and policy_id. The website allows you to filter your search results in an absolute sense. A data dictionary can be divided as a collection of metadata such as object name, data type, size, classification, and relationships with other data assets. Documents containing amendments, corrections, or delayed entries must employ the following widely accepted record keeping principles (CMS Medicare Program Integrity Manual Chapter 3, Section 3.3.2.4): Clearly and permanently identify any amendments, corrections or addenda; Clearly indicate the date and author of any amendments, corrections, or addenda; and Clearly identify all original content. Suggested Data Sources Suggested Data Sources are listed in alphabetical order, NOT priority order, unless otherwise specified in the data element. Since the Event Date is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select UTD. 80% of a data scientist's valuable time is spent simply finding, cleaning, and organizing data, leaving only 20% to perform analysis, according to HBR. The biggest benefits of using a data dictionary include: Detect anomalies quickly and avoid data inconsistencies Get more trustworthy data that's easy to analyze Establish consistent processes to collect, document, and use data Build transparency and enable self-serve within data teams 1. Release Notes: Data Dictionary Introduction TJC Version 2017B2 Table of Contents Introduction This section of the manual describes the data elements required to calculate category assignments and measurements for The Joint Commission's National Quality Measures. That's where a repository of all data assets — column descriptions, metrics, measurement units, and more — can help. FAQs about Data dictionary # 1. 4. Get more trustworthy data that's easy to analyze # As mentioned earlier, a data dictionary offers context by documenting metadata as well as data sources/origins, owners, creation dates, and so on. Who oversees the changes made to your data? This, in turn, simplifies regulatory compliance. How you collect each variable? Nursing Care Plans, Standing Orders and Protocols Per Medicare Conditions of Participation [42CFR482.23(b)(4)] hospitals have the option of having a stand-alone nursing care plan or a single interdisciplinary care plan that addresses nursing and other disciplines. This reduces dependencies, helps everyone use the data in the same way, and makes onboarding a breeze. All documentation in the medical record must be legible and must be timed, dated and authenticated. Physician/Advanced Practice Nurse/ Physician Assistant Documentation Advanced Practice Nurse (APN, APRN) titles may vary among state and clinical specialties. Some data elements also list excluded data sources that are unacceptable sources for abstraction. Discrepancies must be reported. If the value falls between two lines on the grid, abstract the earliest value. Authentication may include written signatures, initials, computer key, or other codes. Visualize the complete journey of your data asset from source to BI tools. Definition: A detailed explanation of the data element. See Appendix G (resource section) of this manual for contact information. So, let's look into the differences between these terms before delving into the components of a data dictionary. For data elements containing more than two categorical values and for numerical data elements (i.e., dates, times, etc.), a UTD option is included as an allowable value and is classified in the same category as not documented.

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