CCORP Data Specifications Version 7.1

#	Data Element	Valid Values	Definition
1	Medical Record Number	Alphanumeric	Indicate the patient's medical record number at the hospital where surgery occurred. This field should be collected in compliance with state/local privacy laws.
2	Type of CABG	1 = Isolated 3 = CABG + Valve 4= Other Non-isolated CABG	Indicate whether the surgery was considered an isolated CABG, CABG + Valve, or all other CABG. Other Non-isolated must include a CABG (not isolated valve). Exclusions from Isolated CABG: •Valve repairs or replacements •Operations on structures adjacent to heart valves (papillary muscle, chordae tendineae, traebeculae carneae cordis, annuloplasty, infundibulectomy) •Ventriculectomy when diagnosed preoperatively as a rupture, aneurysm or remodeling procedure. But not 1) sites intra-operatively diagnosed, 2) patch applications for site oozing discovered during surgery and 3) prophylactic patch applications to reduce chances of future rupture •Repair of atrial and ventricular septa, but not closure of patent foramen ovale •Excision of aneurysm of heart •Head and neck, intracranial endarterectomy •Other open heart surgeries, such as aortic arch repair, pulmonary endarterectomy •Endarterectomy of aorta •Thoracic endarterectomy (endarterectomy on an artery outside the heart) •Carotid endarterectomy •Heart transplantation •Repair of certain congenital cardiac anomalies, but not closure of patent foramen ovale (e.g., teratology of fallot, atrial septal defect (ASD), ventricular septal defect (VSD), valvular abnormality)

#	Data Element	Valid Values	Definition
			Exclusions from Isolated CABG (cont.): •Any aortic aneurysm repair (abdominal or thoracic) •Aorta-subclavian-carotid bypass •Aorta-renal bypass •Aorta-iliac-femoral bypass •Caval-pulmonary artery anastomosis •Extracranial-intracranial (EC-IC) vascular bypass •Coronary artery fistula •Resection of a lobe or segment of the lung (e.g., lobectomy or segmental resection of lung). But not simple biopsy of lung nodule in which surrounding lung is not resected, biopsy of a thoracic lymph node or excision or stapling of an emphysematous bleb. •Pleural decortication •Mastectomy for breast cancer (not simple breast biopsy) •Amputation of any extremity (e.g., foot or toe) •Resection of LV aneurysm
		1 = Isolated	•Ventricular Assist Device (VAD) as bridge to transplant
		3 = CABG + Valve	•Septal myectomy with hypertrophic obstructive cardiomyopathy
		4= Other Non-isolated	•Full open mazes
2	Type of CABG	CABG	•Repair of aortic dissection

#	Data Element	Valid Values	Definition
2	Type of CABG	1 = Isolated 3 = CABG + Valve 4= Other Non-isolated CABG	CABG + Valve includes all CABG cases with aortic valve replacement (AVR), mitral valve replacement (MVR), mitral valve repair (MVRepair) and AVR +MVR/MVRepair Exclusions from CABG + Valve: •Aortic Valve repair •Aortic Valve root replacement with valved conduit (Bentall) •Pulmonic Valve Procedure •Tricuspid Valve Procedure •Ventriculectomy when diagnosed preoperatively as a rupture, aneurysm or remodeling procedure. But not 1) sites intra-operatively diagnosed, 2) patch applications for site oozing discovered during surgery and 3) prophylactic patch applications to reduce chances of future rupture •Repair of atrial and ventricular septa, but not closure of patent foramen ovale •Excision of aneurysm of heart •Head and neck, intracranial endarterectomy •Other open heart surgeries, such as aortic arch repair, pulmonary endarterectomy •Endarterectomy of aorta •Thoracic endarterectomy (endarterectomy on an artery outside the heart) •Carotid endarterectomy •Heart transplantation •Repair of congenital cardiac anomalies, such as tetralogy of fallot, atrial septal defect (ASD), ventricular septal defect or other complex anomaly

#	Data Element	Valid Values	Definition
			Exclusions from CABG + Valve (cont.): •Any aortic aneurysm repair (abdominal or thoracic) •Repair of aortic dissection •Aorta-subclavian-carotid bypass •Aorta-renal bypass •Aorta-iliac-femoral bypass •Caval-pulmonary artery anastomosis •Extracranial-intracranial (EC-IC) vascular bypass •Coronary artery fistula •Resection of a lobe or segment of the lung (e.g., lobectomy or segmental resection of lung). But not simple biopsy of lung nodule in which surrounding lung is not resected, biopsy of a thoracic lymph node or excision or stapling of an emphysematous bleb. •Pleural decortication •Mastectomy for breast cancer (not simple breast biopsy) •Amputation of any extremity (e.g., foot or toe) •Resection of LV aneurysm •Ventricular Assist Device (VAD) as a bridge to transplant •Infundibulectomy •Septal myectomy with hypertrophic obstructive cardiomyopathy •Full Open MAZE for Aortic Valve cases only (epicardial MAZE procedures are not excluded and Full Open MAZE procedures are not excluded for Mitral Valve)
2	Type of CABG	1 = Isolated 3 = CABG + Valve 4= Other Non-isolated CABG	
2	Type of CABG	1 = Isolated 3 = CABG + Valve 4= Other Non-isolated CABG	Other Non-Isolated All other non-isolated CABGs must include a CABG (not isolated Valves)
3	Date of Surgery	Numeric: mmddyyyy	Indicate the date of index cardiac surgical procedure. Index cardiac surgical procedure is defined as the initial major cardiac surgical procedure of the hospitalization.
4	Date of Birth	Numeric: mmddyyyy	Indicate the patient's date of birth using 4-digit format for year. This field should be collected in compliance with state/local privacy laws.
5	Patient Age	Numeric	Indicate the patient's age in years, at time of surgery. This should be calculated from the date of birth and the date of surgery, according to the convention used in the USA (the number of birthdate anniversaries reached by the date of surgery). Do not submit CABG for patients <18 years old
6	Sex	1 = Male 2 = Female	Indicate the patient's sex at birth as either male or female.

#	Data Element	Valid Values	Definition
7	Race Documented	1 = Yes 2 = No 3 = Patient Declined to Disclose	Indicate whether race is documented.
8	Race - White	1 = Yes 2 = No	Indicate whether the patient's race, as determined by the patient or family, includes White. "White" refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicated their race(s) as "White" or reported entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.
9	Race - Black/African American	1 = Yes 2 = No	Indicate whether the patient's race, as determined by the patient or family, includes Black/African- American. "Black or African-American" refers to a person having origins in any of the black racial groups of Africa. It includes people who indicated their race(s) as “Black, African Am., or Negro” or reported entries such as African American, Kenyan, Nigerian, or Haitian.
10	Race - Asian	1 = Yes 2 = No	Indicate whether the patient's race, as determined by the patient or family, includes Asian. "Asian" refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes people who indicated their race(s) as "Asian" or reported entries such as "Asian Indian", "Chinese", "Filipino", "Korean", "Japanese", "Vietnamese", and "Other Asian" or provided other detailed Asian responses.
11	Race - American Indian/ Alaskan Native	1 = Yes 2 = No	Indicate whether the patient's race, as determined by the patient or family, includes American Indian/Alaskan Native. "American Indian or Alaska Native" refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. This category includes people who indicated their race(s) as "American Indian or Alaska Native" or reported their enrolled or principal tribe, such as Navajo, Blackfeet, Inupiat, Yup’ik, or Central American Indian groups or South American Indian groups.
12	Race - Native Hawaiian / Pacific Islander	1 = Yes 2 = No	Indicate whether the patient's race, as determined by the patient or family, includes Native Hawaiian / Pacific Islander. "Native Hawaiian or Other Pacific Islander" refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicated their race(s) as "Pacific Islander" or reported entries such as "Native Hawaiian", "Guamanian or Chamorro", "Samoan", and "Other Pacific Islander" or provided other detailed Pacific Islander responses.
13	Race - Other	1 = Yes 2 = No	Indicate whether the patient's race, as determined by the patient or family, includes any other race. "Some Other Race" includes all other responses not included in the White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander race categories described above.
14	Hispanic or Latino or Spanish Ethicity	1 = Yes 2 = No 3 = Not Documented	Indicate if the patient is of Hispanic, Latino or Spanish ethnicity as reported by the patient/family. "Hispanic, Latino or Spanish" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

#	Data Element	Valid Values	Definition
15	Date of Discharge	Numeric: mmddyyyy	Indicate the date the patient was discharged from the hospital (acute care) even if the patient is going to a rehab or hospice or similar extended care unit within the same physical facility. If the patient died in the hospital, the discharge date is the date of death.
16	Discharge/Mortality Status	2 = Died in Hospital; 3 = Discharged alive, last known status alive; 4 = Discharged alive, died after discharge	Indicate the discharge and current vital status of the patient.
17	Mortality Date	Numeric: mmddyyyy	Indicate the date the patient was declared dead.
18 a-c	Responsible Surgeon Name	18a. Surgeon Last Name 18b. Surgeon First Name 18c. Surgeon Middle Initial	Indicate the Surgeon's name.
19	Responsible Surgeon CA License Number		California physician license number of responsible surgeon assigned by the Medical Board of California of the Department of Consumer affairs.
20	Height(cm)	Usual Range: 122.0 – 213.0 Low/High: 20.0 – 251.0	Indicate the height of the patient in centimeters
21	Weight(kg)	Usual Range: 30.0 – 181.0 Low/High: 10.0 – 250.0	Indicate the weight of the patient in kilograms closest to the date of surgery.
22	Diabetes	1 = Yes 2 = No 3 = Unknown	History of diabetes diagnosed and/or treated by a healthcare provider. The American Diabetes Association criteria include documentation of the following: i. Hemoglobin A1c >=6.5%; or ii. Fasting plasma glucose >=126 mg/dL (7.0 mmol/l); or iii. 2-hour plasma glucose >=200 mg/dL (11.1 mmol/l) during an oral glucose tolerance test; or iv. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose >=200 mg/dL (11.1 mmol/l) This does not include gestational diabetes. 2013 ACCF/AHA Data Standards Cannon et al. JACC Vol. 61, No. 9, 2013

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23	Diabetes Control	1 = None 2 = Diet only 3 = Oral 4 = Insulin 5 = Other 6 = Other subcutaneous medication 7 = Unknown	Indicate the patient's diabetes control method as presented on admission. Patients placed on a preprocedure diabetic pathway of insulin drip at admission but whose diabetes was controlled by diet or oral methods are not coded as being treated with insulin. Choose the most aggressive therapy from the order below •Insulin: insulin treatment (includes any combination with insulin) •Other subcutaneous medications (e.g., GLP-1 agonist) •Oral: treatment with oral agent (includes oral agent with or without diet treatment) •Diet only: Treatment with diet only •None: no treatment for diabetes •Other: other adjunctive treatment, non-oral/insulin/diet •Unknown 2013 ACCF/AHA Data Standards Cannon et al. JACC Vol. 61, No. 9, 2013
24	Dialysis	1 = Yes 2 = No 3 = Unknown	Indicate whether the patient is currently (prior to surgery) undergoing dialysis.
25	Hypertension	1 = Yes 2 = No 3 = Unknown	Indicate if the patient has a current diagnosis of hypertension defined by any 1 of the following: i. History of hypertension diagnosed and treated with medication, diet, and/or exercise; ii. Prior documentation of blood pressure >140 mmHg systolic and/or 90 mmHg diastolic for patients without diabetes or chronic kidney disease, or prior documentation of blood pressure >130 mmHg systolic or 80 mmHg diastolic on at least 2 occasions for patients with diabetes or chronic kidney disease; iii. Currently undergoing pharmacological therapy for treatment of hypertension.
26	Endocarditis	1 = Yes 2 = No	Indicate whether the patient has a history of endocarditis. Endocarditis must meet the current CDC definition). Choose "Yes" for patients with pre-operative endocarditis who begin antibiotics post-op. Code "Yes" for patients who are diagnosed intraoperatively.
27	Infectious Endocraditis Type	1 = Treated 2 = Active	Indicate the type of endocarditis the patient has. If the patient is currently being treated for endocarditis, the disease is considered active. If no antibiotic medication (other than prophylactic medication) is being given at the time of surgery and the cultures are negative, then the infection is considered treated.

#	Data Element	Valid Values	Definition
28	Chronic Lung Disease	1 = No 2 = Mild 3 = Moderate 4 = Severe 5 = Lung disease documented, severity unknown 6 = Unknown	Indicate whether the patient has chronic lung disease, and the severity level according to the following classification: No; Mild: FEV1 60% to 75% of predicted, and/or on chronic inhaled or oral bronchodilator therapy. Moderate: FEV1 50% to 59% of predicted, and/or on chronic oral/systemic steroid therapy aimed at lung disease. Severe: FEV1 < 50% and/or Room Air pO2 < 60 or pCO2 > 50. CLD present, severity not documented. Unknown A history of chronic inhalation reactive disease (asbestosis, mesothelioma, black lung disease or pneumoconiosis) may qualify as chronic lung disease. Radiation induced pneumonitis or radiation fibrosis also qualifies as chronic lung disease. (if above criteria is met) A history of atelectasis is a transient condition and does not qualify. Chronic lung disease can include patients with chronic obstructive pulmonary disease, chronic bronchitis, or emphysema. It can also include a patient who is currently being chronically treated with inhaled or oral pharmacological therapy (e.g., beta-adrenergic agonist, anti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patients with asthma or seasonal allergies are not considered to have chronic lung disease.
29	Liver Disease	1 = Yes 2 = No 3 = Unknown	Indicate whether the patient has a history of hepatitis B, hepatitis C, cirrhosis, portal hypertension, esophageal varices, chronic alcohol abuse or congestive hepatopathy. Exclude NASH in the absence of cirrhosis. if Liver disease is present, Creatinine, Bilirubin and INR are expected.
30	Immunocompromise	1 = Yes 2 = No 3= Unknown	Indicate whether immunocompromise is present due to immunosuppressive medication therapy within 30 days preceding the operative procedure or existing medical condition. This includes, but is not limited to systemic steroid therapy, anti-rejection medications and chemotherapy. This does not include topical steroid applications, one time systemic therapy, inhaled steroid therapy or preprocedure steroid protocol.
31	Peripheral Arterial Disease (PVD)	1 = Yes 2 = No 3= Unknown	Indicate whether the patient has a history of peripheral arterial disease (includes upper and lower extremity, renal, mesenteric, and abdominal aortic systems). This can include: 1. Claudication , either with exertion or at rest, 2. Amputation for arterial vascular insufficiency, 3. Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities (excluding dialysis fistulas and vein stripping), 4. Documented abdominal aortic aneurysm with or without repair, 5. Positive noninvasive test (e.g., ankle brachial index =< 0.9, ultrasound, magnetic resonance or computed tomography imaging of > 50% diameter stenosis in any peripheral artery, i.e., renal, subclavian, femoral, iliac) or angiographic imaging. Peripheral arterial disease excludes disease in the carotid, cerebrovascular arteries or thoracic aorta. PVD does not include DVT.

#	Data Element	Valid Values	Definition
32	CVD	1 = Yes 2 = No 3= Unknown	Indicate whether the patient has a current or previous history of any of the following: i. Stroke: is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction, where the neurological dysfunction lasts for greater than 24 hours. ii. TIA: is defined as a transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia, without acute infarction, where the neurological dysfunction resolves within 24 hours. iii. Noninvasive or invasive arterial imaging test demonstrating >=50% stenosis of any of the major extracranial or intracranial vessels to the brain iv. Previous cervical or cerebral artery revascularization surgery or percutaneous intervention. This does not include chronic (nonvascular) neurological diseases or other acute neurological insults such as metabolic and anoxic ischemic encephalopathy
33	Prior CVA	1 = Yes 2 = No 3= Unknown	Indicate whether the patient has a history of stroke. Stroke is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction, where the neurological dysfunction lasts for greater than 24 hours
34	Prior CVA When	3 = Recent <= 30 days 4 = Remote > 30 days	Indicate when the CVA events occurred. Those events occurring within 30 days prior to the surgical procedure are considered recent, while all others are considered remote.
35	CVD TIA	1 = Yes 2 = No 3 = Unknown	Indicate whether the patient has a history of a Transient Ischemic Attack (TIA). Transient ischemic attack (TIA) is defined as a transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia, without acute infarction, where the neurological dysfunction resolves within 24 hours.
36	CVD - Carotid Stenosis	1 = None 2 = Right 3 = Left 4 = Both 5 = Not Documented	Indicate which carotid artery was determined from any diagnostic test to be >= 50% stenotic.
37	CVD Carotid Stenosis -Right	1 = 80-99% 2 = 100% 3 = 50-79% 4 = Not Documented	Indicate the severity of stenosis reported on the right carotid artery.

#	Data Element	Valid Values	Definition
38	CVD Carotid Stenosis - Left	1 = 80-99% 2 = 100% 3 = 50-79% 4 = Not Documented	Indicate the severity of stenosis reported on the left carotid artery.
39	CVD Prior Carotid Surgery	1 = Yes 2 = No	Indicate whether the patient has a history of previous carotid artery surgery and/or stenting.
40	Last Creatinine Level	Usual Range: 0.10 – 12.00 Low/ High: 0.10 – 30.00	Indicate the creatinine level closest to the date and time prior surgery but prior to anesthetic management (induction area or operating room). A creatinine level should be collected on all patients, even if they have no prior history of renal disease. A creatinine value is a high predictor of a patient's outcome and is used in the predicted risk models. if Liver disease is present, Creatinine, Bilirubin and INR are expected.
41	Total Albumin	Usual range: 3.50 - 5.00 Low/High: 1.00 - 10.00 (mg/dL)	Indicate the total albumin closest to the date and time prior to surgery but prior to anesthetic management (induction area or operating room).
42	Total Bilirubin	Usual range: 0.20 - 1.30 Low/High: 0.10 - 50.00 (mg/dL)	Indicate the total Bilirubin closest to the date and time prior to surgery but prior to anesthetic management (induction area or operating room). if Liver disease is present, Creatinine, Bilirubin and INR are expected
43	INR	Usual range 0.90 - 1.30 Low/High: 0.50 - 30.00	Indicate the International Normalized Ratio (INR) closest to the date and time prior to surgery but prior to anesthetic management (induction area or operating room). if Liver disease is present, Creatinine, Bilirubin and INR are expected.
44	Previous CABG	1 = Yes 2 = No	Indicate whether the patient had a previous Coronary Bypass Graft prior to the current admission.
45	Previous Valve	1 = Yes 2 = No	Indicate whether the patient had a previous surgical replacement and/or surgical repair of a cardiac valve. This may also include percutaneous valve procedures.
46	Previous PCI	1 = Yes 2 = No	Indicate whether a previous Percutaneous Coronary Intervention (PCI) was performed any time prior to this surgical procedure. Percutaneous coronary intervention (PCI) is the placement of an angioplasty guide wire, balloon, or other device (e.g. stent, atherectomy, brachytherapy, or thrombectomy catheter) into a native coronary artery or coronary artery bypass graft for the purpose of mechanical coronary revascularization.
47	Previous PCI Interval	1 = ≤ 6 Hours 2 = > 6 Hours	Indicate the interval of time between the previous PCI procedure and the current surgical procedure.

#	Data Element	Valid Values	Definition
48	Prior MI	1 = Yes 2 = No 3 = Unknown	Indicate if the patient has had at least one documented previous myocardial infarction at any time prior to this surgery.
49	MI When	1 = ≤ 6 Hrs 2 = > 6 Hrs but < 24 Hrs 3 = 1 to 7 Days 4 = 8 to 21 Days 5 = > 21 Days	Indicate the time period between the last documented myocardial infarction and surgery.
50	Heart Failure	1 = Yes 2 = No 3 = Unknown	Indicate whether there is physician documentation or report that the patient has been in a state of heart failure.
51	Heart Failure Timing	1 = Acute 2 = Chronic 3 =Both	Indicate whether heart failure is acute, chronic or both (acute on chronic). Acute is new onset/ worsening heart failure within 2 weeks prior to procedure. Chronic is greater than 2 weeks prior to this procedure. Both are worsening heart failure within 2 weeks in a patient with a known history of heart failure.
52	Classification - NYHA	1 = Class I 2 = Class II 3 = Class III 4 = Class IV 5 = Not Documented	Indicate the patient's worst dyspnea or functional class, coded as the New York Heart Association (NYHA) classification within the past 2 weeks. This is to be used for heart failure only, is not intended to classify angina.
53	Cardiogenic Shock	2 = No 3 = Yes, at the time of procedure 4 = Yes, not at the time of procedure, but within prior 24 hours	Indicate if the patient developed cardiogenic shock. Cardiogenic shock is defined as a sustained (>30 min) episode of hypoperfusion evidenced by systolic blood pressure <90 mm Hg and/or, if available, cardiac index <2.2 L/min per square meter determined to be secondary to cardiac dysfunction and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, VADs) to maintain blood pressure and cardiac index above those specified levels
54	Resuscitation	2 = No 3 = Yes, within 1 hour of start of the procedure 4 = Yes, > 1 hour before, but < 24 hours of the start of the procedure	Indicate whether the patient required cardiopulmonary resuscitation before the start of the operative procedure which includes the institution of anesthetic management. Capture resuscitation timeframe: within 1 hour or 1-24 hours pre-op.

#	Data Element	Valid Values	Definition
55	Cardiac Arrythmia	1 = Yes 2 = No	Indicate whether the patient has a history of a cardiac rhythm disturbance before the start of the operative procedure which includes the institution of anesthetic management.
56	Cardiac Arrythmia - Vtach/Vfib	1 = None 2 = Remote (> 30 days) 3 = Recent (≤ 30 days)	Indicate whether arrhythmia was VTach or VFib.
57	Cardiac Arrhythmia – Aflutter	1 = None 2 = Remote (> 30 days) 3 = Recent (≤ 30 days)	Indicate whether arrhythmia was atrial flutter.
58	Cardiac Arrhythmia – Third Degree Heart Block	1 = None 2 = Remote (> 30 days) 3 = Recent (≤ 30 days)	Indicate whether arrhythmia was third degree heart block.
59	Cardiac Arrhythmia – Atrial Fibrillation	1 = None 2 = Remote (> 30 days) 3 = Recent (≤ 30 days)	Indicate whether arrhythmia was atrial fibrillation.
60	Cardiac Arrhythmia- Atrial Fibrillation- Type	2 = Paroxysmal 4 = Persistent 5 = Longstanding Persistent 6 = Permanent	Indicate whether arrhythmia was atrial fibrillation and if so, which type.
61	Warfarin Use (within 5 days)	1 = Yes 2 = No 3 = Unknown	Indicate whether the patient received Warfarin (Coumadin) within 5 days preceding surgery
62	Coronary Anatomy/ Disease Known	1 = Yes 2 = No	Indicate whether coronary artery anatomy and/or disease is documented and available prior to surgery.
63	Number of Diseased Vessels	1 = None 2 = One 3 = Two 4 = Three	Indicate the number of diseased major native coronary vessel systems: LAD system, Circumflex system, and/or Right system with >= 50% narrowing of any vessel preoperatively. NOTE: Left main disease (>=50%) is counted as TWO vessels (LAD and Circumflex, which may include a Ramus Intermedius). For example, left main and RCA would count as three total. A vessel that has ever been considered diseased, should always be considered diseased.

#	Data Element	Valid Values	Definition
64	Percent Native Artery Stenosis Known	1 = Yes 2 = No	Indicate whether the percent stenosis of native coronary stenosis is known
65	Percent Stenosis left main	Usual Range: 0 – 100 Low/ High: 0 – 100	Indicate the highest percent stenosis in this vessel at the time of this surgery.
66	Ejection Fraction Done	1 = Yes 2 = No	Indicate whether the Ejection Fraction was measured prior to the induction of anesthesia.
67	Ejection Freaction (%)	Usual Range: 5.0 – 90.0 Low/ High: 1.0 – 99.0	Indicate the percentage of the blood emptied from the left ventricle at the end of the contraction. Use the most recent determination prior to the surgical intervention documented on a diagnostic report. Enter a percentage in the range of 1 - 99. If a percentage range is reported, report a whole number using the "mean" (i.e., 50-55% is reported as 53%). ● Hyperdynamic: >70% (code 71%) ● Normal: 50%–70% (midpoint 60%) ● Mild dysfunction: 40%–49% (midpoint 45%) ● Moderate dysfunction: 30%–39% (midpoint 35%) ● Severe dysfunction: <30% (code 29%) Note: If no diagnostic report is in the medical record, a value documented in the medical record is acceptable. ACCF/AHA 2013
68	PA Systolic Pressure Measured	1 = Yes 2 = No	Indicate whether the PA systolic pressure was measured prior to induction.
69	PA Systolic Pressure	Usual Range: 15.0 – 40.0 Low/High: 10.0 – 150.0	Capture highest PA systolic pressure recorded prior to induction
70	Insufficiency - Mitral	0 = None 1 = Trivial/Trace 2 = Mild 3 = Moderate 4 = Severe 5 = Not Documented	Indicate whether there is evidence of Mitral valve insufficiency/regurgitation. Enter the degree of insufficiency reported closest to incision and no more than 6 months prior to surgery.

#	Data Element	Valid Values	Definition
71	Incidence	1 = First cardiovascular surgery 2 = First re-op cardiovascular surgery 3 = Second re-op cardiovascular surgery 4 = Third re-op cardiovascular surgery 5 = Fourth or more re-op cardiovascular surgery	Indicate if this is the patient's: -First surgery -First re-op surgery -Second re-op surgery -Third re-op surgery -Fourth or more re-op surgery
72	Status	1 = Elective 2 = Urgent 3 = Emergent 4 = Emergent Salvage	Indicate the clinical status of the patient prior to entering the operating room.

#	Data Element	Valid Values	Definition
73	Urgent or Emergent	1 = AMI 2 = Anatomy 3 = Aortic Aneurysm 4 = Aortic Dissection 5 = CHF 6 = Device Failure 7 = Diagnostic/ Interventional Procedure Complication 8 = Endocarditis Therapy 10 = IABP 11 = Infected Device 12 = Intracardiac mass or thrombus 13 = Ongoing Ischemia 14 = PCI Incomplete without clinical deterioration 15 = PCI or attempted PCI with Clinical Deterioration 16 = Pulmonary Edema	Choose one reason from the list below that best describes why this operation was considered urgent or emergent.

#	Data Element	Valid Values	Definition
73	Urgent or Emergent	17 = Pulmonary Embolus 18 = Rest Angina 19 = Shock Circulatory Support 20 = Shock No Circulatory Support 21 = Syncope 22 = Transplant 23 = Trauma 24 = USA 25 = Valve Dysfunction 26 = Worsening CP 27 = Other 28 = Failed Transcatheter Valve Therapy- Acute Annular Disruption 29 = Failed Transcatheter Valve Therapy- Acute Device Malposition 30 = Failed Transcatheter Valve Therapy – Subacute Device Dysfunction	Choose one reason from the list below that best describes why this operation was considered urgent or emergent.
74	CPB Utilization	1 = None 2 = Combination 3 = Full	Indicate the level of CPB or coronary perfusion used during the procedure.
75	CPB Utilization - Combination Plan	1 = Planned 2 = Unplanned	Indicate whether the combination procedure from off-pump to on-pump was a planned or an unplanned conversion.
76	IMA Used	1 = Yes 2 = No	Indicate whether an internal mammary artery conduit was used

#	Data Element	Valid Values	Definition
77	Reasons for no IMA	2 = Subclavian stenosis 3 = Previous cardiac or thoracic surgery 4 = Previous mediastinal radiation 5 = Emergent or salvage procedure 6 = No (bypassable) LAD disease 7 = Other	Indicate PRIMARY reason Internal Mammary artery was not used as documented in medical record.
78	Valve	1 = Yes 2 = No	Indicate whether a surgical procedure was done on the Aortic, Mitral, Tricuspid or Pulmonic valves
79	Aortic Valve	2 = No 3 = Yes, planned 4 = Yes, unplanned due to surgical complication 5 = Yes, unplanned due to unsuspected disease or anatomy	Indicate whether an aortic valve procedure was performed
80	Aortic Valve Procedure	1 = Replacement 2 = Repair/ Reconstruction	Indicate the type of procedure that was performed on the aortic valve and/or ascending aorta.
81	Mitral Valve	2 = No 3 = Yes, planned 4 = Yes, unplanned due to surgical complication 5 = Yes, unplanned due to unsuspected disease or anatomy	Indicate whether a mitral valve procedure was performed.
82	Mitral Valve Procedure	1 = Repair 2 = Replacement	Indicate the type of procedure that was performed on the mitral valve.

#	Data Element	Valid Values	Definition
83	Tricuspid Valve	2 = No 3 = Yes, planned 4 = Yes, unplanned due to surgical complication 5 = Yes, unplanned due to unsuspected disease or anatomy	Indicate whether a tricuspid valve procedure was performed.
84	Pulmonic Valve	2 = No 3 = Yes, planned 4 = Yes, unplanned due to surgical complication 5 = Yes, unplanned due to unsuspected disease or anatomy	Indicate whether a pulmonic valve procedure was performed.
85	Reoperation for Bleed	1 = Yes 2 = No	Indicate whether the patient was re-explored for mediastinal bleeding with or without tamponade either in the ICU or returned to the operating room.
86	Reintervention - Myocardial Ischemia	1 = Yes 2 = No	Indicate whether the patient required postoperative reintervention for Myocardial Ischemia.
87	Reintervention – Myocardial Ischemia- Vessel	1 = Native Coronary 2 = Graft 3 = Both	Indicate the type of vessels that required postoperative reintervention for Myocardial Ischemia.
88	Deep Sternal Infection/ Mediastinitis	2 = No 3 = Yes, within 30 days of procedure 4 = Yes, >30 days after procedure, but during hospitalization for surgery	Indicate whether a deep sternal wound infection or mediastinitis was diagnosed within 30 days of the procedure or any time during the hospitalization for surgery.
89	Neuro - Stroke Permanent	2 = No 3 = Yes, hemorrhagic 4 = Yes, ischemic 5 = Yes, undetermined type	Indicate whether the patient has a postoperative stroke and the type of stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in blood supply to the brain) that did not resolve within 24 hours.

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90	Pulm- Ventilation Prolonged	1 = Yes 2 = No	Indicate whether the patient had prolonged post-operative pulmonary ventilation > 24.0 hours. The hours of postoperative ventilation time include OR exit until extubation, plus any additional hours following reintubation. Include (but not limited to) causes such as ARDS, pulmonary edema, and/or any patient requiring mechanical ventilation > 24 hours postoperatively.
91	Renal - Renal Failure	1 = Yes 2 = No	Indicate whether the patient had acute renal failure or worsening renal function resulting in ONE OR BOTH of the following: A) Increase in serum creatinine level 3.0 x greater than baseline, or serum creatinine level ≥4 mg/dL, Acute rise must be at least 0.5 mg/dl B) A new requirement for dialysis postoperatively.
92	Renal - Dialysis Requiement	1 = Yes 2 = No	Indicate whether the patient had a new requirement for dialysis postoperatively, which may include hemodialysis, peritoneal dialysis.
93	Other - A Fib	1 = Yes 2 = No	Indicate whether the patient experienced atrial fibrillation/flutter (AF) requiring treatment. Exclude patients who were in A Fib at the start of surgery.
94	Facility Identification Number		The six-digit facility identification number assigned to a hospital by the Office of Statewide Health Planning and Development (OSHPD), as defined in Section 97170.