Core / Extended Data Set

Schema

Research and Continuous Improvement Committee

September 11, 2026

SCHEMA

Three tiers

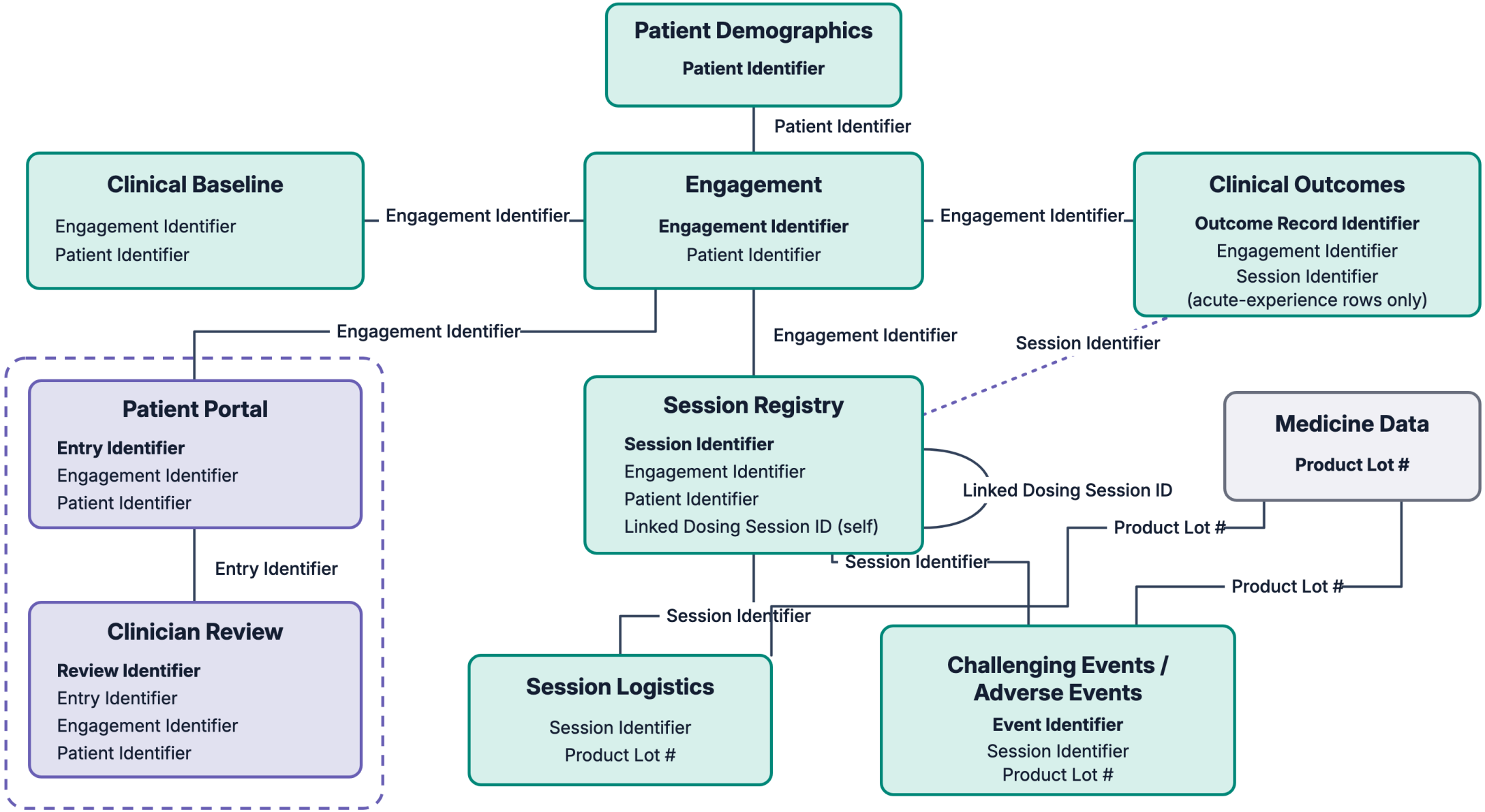
Core	The data set RACI recommends for every participant and every session. Compliance is the subset of Core the department requires.
Extended	Opt-in research data. Requires ongoing consent. Enriches analysis but not required for compliance.
Engagement	Platform/continuity-of-care features (portal, journaling, clinician review). Beyond regulatory minimums.

SCHEMA

Sections and counts

SECTION	FIELDS	CORE	EXTENDED	ENGAGEMENT
1 Patient Demographics	11	11	0	0
2 Clinical Baseline	14	13	1	0
3 Medicine Data (lot-level)	11	7	4	0
4 Engagement	7	7	0	0
5 Session Registry	11	9	1	1
6 Session Logistics	18	11	7	0
7 Challenging Events / Adverse Events	13	12	1	0
8 Clinical Outcomes	28	20	8	0
9 Patient Portal (Engagement layer)	9	1	0	8
10 Clinician Review + Feedback Loop	14	7	0	7
Total	**136**	**98**	**22**	**16**

How the records connect



bold = primary key; plain = foreign key; a child sits below or beside its parent.

Who enters what, and when

	Intake	Per lot, at testing	Engagement open	Each session	Dosing session	At event	Follow-up Baseline / 24hr / 4wk / 3mo / 6mo	Continuous	Each review
Patient	**Patient Demographics** 11 fields							**Patient Portal** 9 fields	
Medical Screener	**Clinical Baseline** 4 fields								
Licensed Grower		**Medicine Data** 8 fields							
Admin Clinician	**Clinical Baseline** 10 fields		**Engagement** 7 fields	**Session Registry** 11 fields	**Session Logistics** 17 fields	**Challenging Events / Adverse Events** 13 fields			
Integration Clinician							**Clinical Outcomes** 28 fields		**Clinician Review** 10 fields
Reviewer									**Clinician Review** 4 fields
Calculated		Max Theoretical Psilocin (MTP) Available Psilocin Fraction (AFP) Onset Category			Calculated MTP Dose				

SCHEMA

Identifiers

SECTION	PRIMARY KEY	FOREIGN KEYS
1 Patient Demographics	Patient Identifier	none
2 Clinical Baseline	none; keyed by foreign keys	Patient Identifier; Engagement Identifier
3 Medicine Data (lot-level)	Product Lot #	none
4 Engagement	Engagement Identifier	Patient Identifier
5 Session Registry	Session Identifier	Engagement Identifier; Patient Identifier; Linked Dosing Session ID
6 Session Logistics	none; keyed by foreign keys	Session Identifier; Product Lot #
7 Challenging Events / Adverse Events	Event Identifier	Session Identifier; Product Lot # (AE linkage)
8 Clinical Outcomes	Outcome Record Identifier	Engagement Identifier; Patient Identifier; Session Identifier (acute-experience rows only)
9 Patient Portal (Engagement layer)	Entry Identifier	Patient Identifier; Engagement Identifier
10 Clinician Review + Feedback Loop	Review Identifier	Patient Identifier; Engagement Identifier; Entry Identifier

SCHEMA

Roles

ROLE	FIELDS ENTERED	SECTIONS
Patient	20	1 Patient Demographics; 9 Patient Portal (Engagement layer)
Medical Screener	4	2 Clinical Baseline
Licensed Grower	8	3 Medicine Data (lot-level)
Admin Clinician	58	2 Clinical Baseline; 4 Engagement; 5 Session Registry; 6 Session Logistics; 7 Challenging Events / Adverse Events
Integration Clinician	38	8 Clinical Outcomes; 10 Clinician Review + Feedback Loop
Reviewer	4	10 Clinician Review + Feedback Loop
Calculated	4	3 Medicine Data (lot-level); 6 Session Logistics
Total	**136**	

Screening results enter through Medical readiness, imported from the screening system.

SCHEMA

Timepoints

TIMEPOINT	SECTIONS CAPTURED
Intake	1 Patient Demographics; 2 Clinical Baseline
Per lot, at testing	3 Medicine Data (lot-level)
Engagement open; updated on status change	4 Engagement
Each session	5 Session Registry
Dosing session	6 Session Logistics
Integration sessions	6 Session Logistics (Integration Methods / Practices Used)
At event; updated at follow-up	7 Challenging Events / Adverse Events
After dosing session	8 Clinical Outcomes (Mystical Experience, Challenging Experience, Ego Dissolution score and instrument fields)
Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	8 Clinical Outcomes
Continuous, participant-initiated	9 Patient Portal (Engagement layer)
Each review	10 Clinician Review + Feedback Loop

Every score is three fields

FIELD 1	**Depression Score**	Depression symptom severity score at baseline and follow-up
FIELD 2	**Depression instrument used**	Preferred: PHQ-9. Accepted: MADRS, QIDS-SR16, GRID-HAMD
FIELD 3	**Depression administration role**	Patient self-report, facilitator, licensed provider, integration clinician, trained rater

A site that cannot administer the preferred instrument reports with an accepted one. The score is still Core.

Every event is a tier and a class

TIER	HARM REDUCTION / QI TIER	REPORTING ACTION
Tier 1	Routine / No Incident	No individual incident report.
Tier 2	Challenging Experience Requiring Added Support	Facilitator log. Challenge flag in core data.
Tier 3	Adverse Event (Clinical Significance)	State registry within 5 business days.
Tier 4	Serious Adverse Event Requiring External Response or Formal Review	DOH within 24 to 48 hours. Formal investigation.

EVENT CLASS

Medical · Psychiatric · Safety and conduct

EVENT SUBTYPE

medical · psychiatric · behavioral · safety incident · conduct or ethics violation · medication or administration error · cultural or spiritual mismatch · product or lot safety signal

Tier says how it is reported. Class says what happened. Both on every event record.

Identity stays apart from outcome data

1. Direct identifiers held separately
2. Record identifiers carry every link
3. Re-identification authorized, two-key, logged
4. Least-privilege access
5. Free text masked. Quasi-identifiers controlled in output

SCHEMA

Compliance

The subset of Core the department requires. The department sets this subset; Core extends beyond it.

SECTION	FIELDS
1 Patient Demographics	Patient Identifier; Year of Birth; Sex at Birth; Gender Identity; Race / Ethnicity; Zip Code; State of Residence
2 Clinical Baseline	Primary Diagnosis
3 Medicine Data (lot-level)	Product Lot #
4 Engagement	Engagement Identifier; Engagement Status
5 Session Registry	Session Identifier; Session Type; Session Date; Provider ID
6 Session Logistics	Facilitator License; Dosage
7 Challenging Events / Adverse Events	Harm Reduction / QI Tier; Event class; Severity

20 fields. Identifiers are carried on every linked record.

APPENDIX / SECTION 1 OF 10

1. Patient Demographics (1 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Patient Identifier	Core	Patient	Intake	not stated	Anonymized unique ID.
Year of Birth	Core	Patient	Intake	YYYY	Age influences metabolism and cardiovascular risk.
Sex at Birth	Core	Patient	Intake	Male / Female / Intersex	Affects pharmacokinetics.
Gender Identity	Core	Patient	Intake	CDC SOGI	LGBTQ+ access equity.
Race / Ethnicity	Core	Patient	Intake	OMB	Equity tracking for Hispanic/Indigenous populations.
Tribal Affiliation	Core	Patient	Intake	not stated	Equity Fund utilization by Indigenous populations.
Household Income	Core	Patient	Intake	% FPL	Treatment Equity Fund subsidy eligibility.
Veteran Status	Core	Patient	Intake	not stated	PTSD outcome tracking in veterans.

1. Patient Demographics (2 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Diagnosed Disability	Core	Patient	Intake	No / Yes	ACLU compliance.
Zip Code	Core	Patient	Intake	not stated	Geographic access disparity (rural vs urban).
State of Residence	Core	Patient	Intake	not stated	Out-of-state jurisdictional reporting.

2. Clinical Baseline (1 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Patient Identifier	Core	Admin Clinician	Intake	not stated	Linked to Demographics.
Engagement Identifier	Core	Admin Clinician	Intake	not stated	Foreign key to Engagement. One baseline per engagement.
Medical readiness	Core	Medical Screener	Intake	Imported value	Medical readiness determination from the screening report. Imported from the screening system.
Primary Diagnosis	Core	Admin Clinician	Intake	ICD-10	e.g., F33.2 Major Depressive Disorder.
Diagnosis Duration	Core	Admin Clinician	Intake	not stated	Acute distress vs chronic condition.
Treatment History	Core	Admin Clinician	Intake	Count of failed meds	Verifies treatment-resistant status.
Baseline Severity	Core	Admin Clinician	Intake	Scores in Clinical Outcomes at Follow-up Interval = Baseline	Baseline scores are recorded in Clinical Outcomes with Follow-up Interval = Baseline, using the same instrument fields.
Screen-out decision	Core	Medical Screener	Intake	proceeded / deferred / excluded / referred elsewhere / patient declined	Outcome of screening. Rationale is recorded in Screen-out rationale.

2. Clinical Baseline (2 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Screen-out rationale	Core	Medical Screener	Intake	Coded reasons plus free text	Reason for a deferred, excluded, referred, or declined screening outcome. Coded reasons plus free text.
Referral From	Extended	Admin Clinician	Intake	not stated	Referral source (physician, self, etc.).
Health Assessment	Core	Admin Clinician	Intake	not stated	Medical clearance for treatment.
Current medications	Core	Medical Screener	Intake	RxNorm	All current medications at intake. Interaction and washout relevance. Captured again per session under Session Logistics.
Polysubstance / Supplement / Peptide Use	Core	Admin Clinician	Intake	Structured list plus Other with text. Categories include SSRIs, SNRIs, GLP-1s, supplements, peptides, recreational substances	[NEW] Recreational, supplement, and peptide use including GLP-1s. Interaction and safety screening.
Support Tier	Core	Admin Clinician	Intake	Tier 1 Standard Support / Tier 2 Enhanced Clinical Support / Tier 3 Specialist Supported Care / Tier 4 Not Appropriate for Participation at This Time	[NEW] Clinical Support Framework tier assigned at evaluation, per the Patient Qualification and Safety Committee.

3. Medicine Data (lot-level) (1 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Product Lot #	Core	Licensed Grower	Per lot, at testing	not stated	Traceability for recalls, contamination, dosage.
Psilocybin	Core	Licensed Grower	Per lot, at testing	mg/g	Measured per gram.
Psilocin	Core	Licensed Grower	Per lot, at testing	mg/g	Measured per gram.
Baeocystin	Core	Licensed Grower	Per lot, at testing	mg/g	Minor alkaloid; required NM panel.
Norbaeocystin	Core	Licensed Grower	Per lot, at testing	mg/g	Minor alkaloid; required NM panel.
Aeruginascin	Core	Licensed Grower	Per lot, at testing	mg/g	Antagonist activity; safety-relevant.
Max Theoretical Psilocin (MTP)	Extended	Calculated	Per lot, at testing	Calculated: MTP/g = Psilocin + (Psilocybin x 0.719)	MTP/g = Psilocin + (Psilocybin x 0.719). Normalizes potency.
Available Psilocin Fraction (AFP)	Extended	Calculated	Per lot, at testing	Calculated: AFP = Psilocin / MTP	AFP = Psilocin / MTP.

3. Medicine Data (lot-level) (2 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Onset Category	Extended	Calculated	Per lot, at testing	Calculated: Rapid (AFP >= 0.40), Balanced (0.21-0.39), Sustained (<= 0.20)	Rapid (AFP >= 0.40), Balanced (0.21-0.39), Sustained (<= 0.20).
Species / Cultivar	Extended	Licensed Grower	Per lot, at testing	not stated	Links batch to chemotype/lineage; dose-response by cultivar.
Drug Checking / Potency Source	Core	Licensed Grower	Per lot, at testing	Certificate of analysis property on the lot record	[NEW] Potency verification is a property of the lot record, from the laboratory certificate of analysis.

4. Engagement

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Engagement Identifier	Core	Admin Clinician	Engagement open; updated on status change	not stated	Parent key linking all sessions, entries, reviews.
Patient Identifier	Core	Admin Clinician	Engagement open; updated on status change	not stated	Linked to Demographics.
Engagement Open Date	Core	Admin Clinician	Engagement open; updated on status change	YYYY-MM-DD	Date initiated.
Engagement Status	Core	Admin Clinician	Engagement open; updated on status change	Active / Complete / Paused / Discontinued	
Discontinuation Reason	Core	Admin Clinician	Engagement open; updated on status change	not stated	Reason and responsible party if discontinued/paused.
Primary Prescriber ID	Core	Admin Clinician	Engagement open; updated on status change	not stated	License ID of prescriber who set dose range.
Planned dosage range	Core	Admin Clinician	Engagement open; updated on status change	MTP low - MTP high	Practitioner-recommended dosage range in the treatment plan (MTP low - MTP high).

5. Session Registry (1 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Session Identifier	Core	Admin Clinician	Each session	not stated	Primary key for session-linked data.
Engagement Identifier	Core	Admin Clinician	Each session	not stated	Foreign key to Engagement.
Patient Identifier	Core	Admin Clinician	Each session	not stated	Linked to Demographics.
Session Type	Core	Admin Clinician	Each session	Preparatory / Dosing / Integration / Check-in / Emergency	
Session Sequence	Core	Admin Clinician	Each session	Integer	Order within engagement.
Session Date	Core	Admin Clinician	Each session	YYYY-MM-DD	
Provider ID	Core	Admin Clinician	Each session	not stated	License ID of provider.
Provider Role	Core	Admin Clinician	Each session	Prescriber / Facilitator / Integration Therapist / Peer Support	

5. Session Registry (2 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Session Notes	Engagement	Admin Clinician	Each session	Free text	Free-text session notes.
Session outcome status	Core	Admin Clinician	Each session	routine / challenging experience / adverse event / serious adverse event / follow-up pending / unable to determine	Outcome classification of the session.
Linked Dosing Session ID	Extended	Admin Clinician	Each session	not stated	For prep/integration sessions, references the dosing session.

6. Session Logistics (1 of 3)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Session Identifier	Core	Admin Clinician	Dosing session	not stated	Foreign key to Session Registry.
Product Lot #	Core	Admin Clinician	Dosing session	not stated	Foreign key to Medicine Data. Lot administered in this session.
Facilitator License	Core	Admin Clinician	Dosing session	not stated	Links outcomes to provider for QI.
Concomitant Meds (incl. SSRIs/SNRIs)	Core	Admin Clinician	Dosing session	RxNorm	Per-session medications, including SSRIs and SNRIs.
Washout Compliance	Core	Admin Clinician	Dosing session	Yes / No / N/A	Pre-session washout protocol.
Dosage	Core	Admin Clinician	Dosing session	Number (grams)	Weight in grams administered.
Calculated MTP Dose	Core	Calculated	Dosing session	Calculated: Dosage weight x MTP/g	Dosage weight x MTP/g. Actual psilocin-equivalent.
Dosage Form	Extended	Admin Clinician	Dosing session	powder, whole, capsule, troche	Delivery efficacy.

6. Session Logistics (2 of 3)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Route of administration	Extended	Admin Clinician	Dosing session	Dropdown: chew / tea / lemon tek / other	Route of administration. Other is recorded in Route of administration, other.
Route of administration, other	Extended	Admin Clinician	Dosing session	Free text	Route of administration when not on the list.
Admin Mode	Core	Admin Clinician	Dosing session	Individual / Dyad / Group	Cost and safety.
Setting Type	Core	Admin Clinician	Dosing session	Clinic / Home / Retreat Center	Safety profile.
Prep Time	Extended	Admin Clinician	Dosing session	Minutes	Facilitator prep time.
Time of Admin	Core	Admin Clinician	Dosing session	HH:MM	Exact ingestion time.
Time of First Onset	Extended	Admin Clinician	Dosing session	HH:MM	First perceptual change.
Time of Peak	Extended	Admin Clinician	Dosing session	HH:MM	Maximum intensity.

6. Session Logistics (3 of 3)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Time of Resolution	Core	Admin Clinician	Dosing session	HH:MM	Return to functional baseline / discharge-ready.
Integration Methods / Practices Used	Extended	Admin Clinician	Integration sessions	Dropdown: fixed modality list, plus Other with short text	Integration modality used in the session. Fixed list maintained in committee guidance; Other with short text.

7. Challenging Events / Adverse Events (1 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Event Identifier	Core	Admin Clinician	At event; updated at follow-up	not stated	Primary key for the event record.
Session Identifier	Core	Admin Clinician	At event; updated at follow-up	not stated	Foreign key to Session Registry.
Product Lot # (AE linkage)	Core	Admin Clinician	At event; updated at follow-up	not stated	Product lot carried into the event record.
Harm Reduction / QI Tier	Core	Admin Clinician	At event; updated at follow-up	Tier 1 / Tier 2 / Tier 3 / Tier 4	Event tier per the Harm Reduction / QI Framework. Separate from CTCAE severity.
Event class	Core	Admin Clinician	At event; updated at follow-up	Medical / Psychiatric / Safety and conduct	Tier 4 subdivision from the framework, applied to every tier.
Event subtype	Core	Admin Clinician	At event; updated at follow-up	medical / psychiatric / behavioral / safety incident / conduct or ethics violation / medication or administration error / cultural or spiritual mismatch / product or lot safety signal	Finer classification of the event.
Participant direct report source	Core	Admin Clinician	At event; updated at follow-up	facilitator / DOH direct / portal / follow-up session / post-session survey / caregiver or third party	Channel through which the event was reported.
Event Description	Core	Admin Clinician	At event; updated at follow-up	Narrative	Narrative of the event.

7. Challenging Events / Adverse Events (2 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Severity	Core	Admin Clinician	At event; updated at follow-up	CTCAE v6.0 (Grades 1-5)	CTCAE v6.0 (Grades 1-5).
Intervention	Core	Admin Clinician	At event; updated at follow-up	Verbal / Rescue Meds / EMS	Service burden.
Suicidality	Core	Admin Clinician	At event; updated at follow-up	C-SSRS Score	Treatment-emergent risk.
Duration of AE	Core	Admin Clinician	At event; updated at follow-up	Minutes/Hours	Transient vs persistent.
AE Domain (Palitsky framework)	Extended	Admin Clinician	At event; updated at follow-up	not stated	[NEW] Map to Palitsky's 54-item framework: pharmacological, psycho-spiritual, psychotherapy-related, sociocultural. Referenced from the Palitsky framework.

8. Clinical Outcomes (1 of 4)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Outcome Record Identifier	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	not stated	Primary key for the outcome record.
Engagement Identifier	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	not stated	Foreign key to Engagement.
Patient Identifier	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	not stated	Linked to Demographics.
Session Identifier	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	not stated	Foreign key to Session Registry. Acute-experience rows only.
Date of Follow-up	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	YYYY-MM-DD	
Follow-up Interval	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	Baseline / 24hr / 4wk / 3mo / 6mo	
Setting Type	Extended	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	Clinic / Home / Retreat / Virtual	
Session Modality	Extended	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	not stated	Therapeutic approaches in follow-up integration.

8. Clinical Outcomes (2 of 4)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Mystical Experience Score	Extended	Integration Clinician	After dosing session	Score; instrument per Mystical Experience instrument used	Characterization of the acute session experience: meaningful/mystical experience (no baseline). Instrument recorded in Mystical Experience instrument used.
Mystical Experience instrument used	Extended	Integration Clinician	After dosing session	MEQ-30 / MEQ-4	Instrument used for the Mystical Experience Score. Preferred instrument MEQ-30; accepted alternative MEQ-4.
Challenging Experience Score	Extended	Integration Clinician	After dosing session	Score; instrument per Challenging Experience instrument used	Characterization of the acute session experience: challenging experience (no baseline). Instrument recorded in Challenging Experience instrument used.
Challenging Experience instrument used	Extended	Integration Clinician	After dosing session	CEQ-26 / CEQ-7	Instrument used for the Challenging Experience Score. Preferred instrument CEQ-26; accepted alternative CEQ-7.
Ego Dissolution Score	Extended	Integration Clinician	After dosing session	Score; instrument per Ego Dissolution instrument used	EDI. Instrument recorded in Ego Dissolution instrument used.
Ego Dissolution instrument used	Extended	Integration Clinician	After dosing session	EDI	Instrument used for the Ego Dissolution Score. Preferred instrument EDI; no accepted alternative listed.
Depression Score	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	Score; instrument per Depression instrument used	Depression symptom severity score at baseline and follow-up. Instrument recorded in Depression instrument used. Primary TRD endpoint.
Depression instrument used	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	PHQ-9 / MADRS / QIDS-SR16 / GRID-HAMD	Instrument used for the Depression Score. Preferred instrument PHQ-9; accepted alternatives MADRS, QIDS-SR16, GRID-HAMD.

8. Clinical Outcomes (3 of 4)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Depression administration role	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	patient self-report / facilitator / licensed provider / integration clinician / trained rater	Role of the person who administered the depression instrument.
PTSD Score	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	Score; instrument per PTSD instrument used	PTSD symptom severity score at baseline and follow-up (where PTSD is the qualifying condition). Instrument recorded in PTSD instrument used. Primary PTSD endpoint.
PTSD instrument used	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	PCL-5 / CAPS-5	Instrument used for the PTSD Score. Preferred instrument PCL-5; accepted alternative CAPS-5.
PTSD administration role	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	patient self-report / facilitator / licensed provider / integration clinician / trained rater	Role of the person who administered the PTSD instrument.
Anxiety Score	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	Score; instrument per Anxiety instrument used	Anxiety severity score at baseline and follow-up. Instrument recorded in Anxiety instrument used.
Anxiety instrument used	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	OASIS / GAD-7 / STAI	Instrument used for the Anxiety Score. Preferred instrument OASIS; accepted alternatives GAD-7, STAI.
Substance Use	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	Score; instrument per Substance Use instrument used	Substance use, risk, and protective recovery factors at treatment baseline and follow-up once accepted into the SUD pathway. Instrument recorded in Substance Use instrument used.
Substance Use instrument used	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	BAM / TLFB	Instrument used for Substance Use. Preferred instrument BAM (Brief Addiction Monitor); accepted alternative TLFB.

8. Clinical Outcomes (4 of 4)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Substance Use administration role	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	patient self-report / facilitator / licensed provider / integration clinician / trained rater	Role of the person who administered the substance use instrument.
Wellbeing Score	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	Score; instrument per Wellbeing instrument used	Positive wellbeing score at baseline and follow-up. Instrument recorded in Wellbeing instrument used.
Wellbeing instrument used	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	WHO-5 / SWLS	Instrument used for the Wellbeing Score. Preferred instrument WHO-5; accepted alternative SWLS.
Therapeutic Alliance (risk factor)	Core	Integration Clinician	Baseline / 24hr / 4wk / 3mo / 6mo per Follow-up Interval	WAI-SR, 12 items, 1 to 5 scale, patient and therapist versions	Therapeutic alliance rated at each follow-up interval as a risk factor. Preferred instrument WAI-SR.

9. Patient Portal (Engagement layer) (1 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Entry Identifier	Engagement	Patient	Continuous, participant-initiated	not stated	Primary key for the portal entry.
Patient Identifier	Engagement	Patient	Continuous, participant-initiated	not stated	Linked to Demographics.
Engagement Identifier	Engagement	Patient	Continuous, participant-initiated	not stated	Foreign key to Engagement.
Entry Timestamp	Engagement	Patient	Continuous, participant-initiated	YYYY-MM-DD HH:MM	
Entry Type	Engagement	Patient	Continuous, participant-initiated	Journal / Check-in Response	
Journal Text	Engagement	Patient	Continuous, participant-initiated	Free text	Free-text integration narrative.
Prompted Question	Engagement	Patient	Continuous, participant-initiated	not stated	Question the app sent.
Check-in Response Text	Engagement	Patient	Continuous, participant-initiated	not stated	Response to prompted check-in.

9. Patient Portal (Engagement layer) (2 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Distress Flag (self-reported)	Core	Patient	Continuous, participant-initiated	None / Mild / Moderate / Severe	Compliance-relevant trigger.

10. Clinician Review + Feedback Loop (1 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Review Identifier	Engagement	Integration Clinician	Each review	not stated	Unique ID for the review event.
Patient Identifier	Engagement	Integration Clinician	Each review	not stated	Linked to Demographics.
Engagement Identifier	Engagement	Integration Clinician	Each review	not stated	Foreign key to Engagement.
Entry Identifier	Engagement	Integration Clinician	Each review	not stated	Foreign key to the Patient Portal entry reviewed.
Review Timestamp	Engagement	Integration Clinician	Each review	Timestamp	When review completed.
Reviewing Clinician ID	Engagement	Integration Clinician	Each review	not stated	License/ID of reviewer.
Clinical Assessment	Core	Integration Clinician	Each review	No Concern / Monitor / Outreach Warranted / Escalate	
Action Taken	Core	Integration Clinician	Each review	No Action / Scheduled Follow-up / Outreach Call / Emergency Referral	

10. Clinician Review + Feedback Loop (2 of 2)

FIELD	TIER	ENTERED BY	TIMEPOINT	TYPE OR VALUE SET	DEFINITION
Review Notes	Engagement	Integration Clinician	Each review	Free text	Free-text observations/rationale.
Suicidality Flag	Core	Integration Clinician	Each review	Yes / No	Triggered C-SSRS/suicidality protocol?
Signal-to-Response Trigger	Core	Reviewer	Each review	Distress Flag = Severe / Suicidality Flag = Yes / Clinical Assessment = Escalate / Harm Reduction Tier = 3 or 4 / Session outcome status = adverse event or serious adverse event	[NEW] Which signal opened this review and made a response required. Recorded per review.
Review Cadence	Core	Reviewer	Each review	Prompt (Tier 4 within 24 to 48 hours; Tier 3 within 5 business days) / Routine monthly / Quarterly trend	[NEW] Review type. Prompt windows follow the Harm Reduction / QI Framework reporting timelines.
Response Owner	Core	Reviewer	Each review	Reviewing clinician / Facilitator / Prescriber / DOH	[NEW] Role that owns the response once a trigger fires. Recorded per review.
Response Protocol / Outcome	Core	Reviewer	Each review	Resolved / Ongoing / Referred out / No response needed; plus date closed	[NEW] Outcome of Action Taken and the date the review closed. Closes the loop.

SCHEMA

Value sets (1 of 4)

FIELD	VALUES
Sex at Birth	Male / Female / Intersex
Diagnosed Disability	No / Yes
Screen-out decision	proceeded / deferred / excluded / referred elsewhere / patient declined
Support Tier	Tier 1 Standard Support / Tier 2 Enhanced Clinical Support / Tier 3 Specialist Supported Care / Tier 4 Not Appropriate for Participation at This Time
Onset Category	Rapid (AFP >= 0.40), Balanced (0.21-0.39), Sustained (<= 0.20)
Engagement Status	Active / Complete / Paused / Discontinued
Session Type	Preparatory / Dosing / Integration / Check-in / Emergency
Provider Role	Prescriber / Facilitator / Integration Therapist / Peer Support
Session outcome status	routine / challenging experience / adverse event / serious adverse event / follow-up pending / unable to determine
Washout Compliance	Yes / No / N/A
Dosage Form	powder, whole, capsule, troche

SCHEMA

Value sets (2 of 4)

FIELD	VALUES
Route of administration	chew / tea / lemon tek / other
Admin Mode	Individual / Dyad / Group
Setting Type (Session Logistics)	Clinic / Home / Retreat Center
Harm Reduction / QI Tier	Tier 1 / Tier 2 / Tier 3 / Tier 4
Event class	Medical / Psychiatric / Safety and conduct
Event subtype	medical / psychiatric / behavioral / safety incident / conduct or ethics violation / medication or administration error / cultural or spiritual mismatch / product or lot safety signal
Participant direct report source	facilitator / DOH direct / portal / follow-up session / post-session survey / caregiver or third party
Intervention	Verbal / Rescue Meds / EMS
Duration of AE	Minutes/Hours

SCHEMA

Value sets (3 of 4)

FIELD	VALUES
Follow-up Interval	Baseline / 24hr / 4wk / 3mo / 6mo
Setting Type (Clinical Outcomes)	Clinic / Home / Retreat / Virtual
Mystical Experience instrument used	MEQ-30 / MEQ-4
Challenging Experience instrument used	CEQ-26 / CEQ-7
Ego Dissolution instrument used	EDI
Depression instrument used	PHQ-9 / MADRS / QIDS-SR16 / GRID-HAMD
Depression administration role	patient self-report / facilitator / licensed provider / integration clinician / trained rater
PTSD instrument used	PCL-5 / CAPS-5
PTSD administration role	patient self-report / facilitator / licensed provider / integration clinician / trained rater
Anxiety instrument used	OASIS / GAD-7 / STAI
Substance Use instrument used	BAM / TLFB

SCHEMA

Value sets (4 of 4)

FIELD	VALUES
Substance Use administration role	patient self-report / facilitator / licensed provider / integration clinician / trained rater
Wellbeing instrument used	WHO-5 / SWLS
Entry Type	Journal / Check-in Response
Distress Flag (self-reported)	None / Mild / Moderate / Severe
Clinical Assessment	No Concern / Monitor / Outreach Warranted / Escalate
Action Taken	No Action / Scheduled Follow-up / Outreach Call / Emergency Referral
Suicidality Flag	Yes / No
Signal-to-Response Trigger	Distress Flag = Severe / Suicidality Flag = Yes / Clinical Assessment = Escalate / Harm Reduction Tier = 3 or 4 / Session outcome status = adverse event or serious adverse event
Review Cadence	Prompt (Tier 4 within 24 to 48 hours; Tier 3 within 5 business days) / Routine monthly / Quarterly trend
Response Owner	Reviewing clinician / Facilitator / Prescriber / DOH
Response Protocol / Outcome	Resolved / Ongoing / Referred out / No response needed; plus date closed