**PEDSnet Common Data Model Version 1.0**

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The PEDSnet Common Data Model is an evolving specification, based in structure on the OMOP Common Data Model, but expanded to accommodate requirements of both the PCORnet Common Data Model and the primary research cohorts established in PEDSnet.

Version 1 of the PEDSnet CDM reflects the ETL processes developed during the first six months of network development. As such, it closely follows version 1 of the PCORnet CDM. We anticipate that the PEDSnet CDM will expand to include additional data domains such as medication usage, laboratory testing, and other types of clinical observations. However, in order to minimize discordance with the PCORnet CDM, specification of these domains has been deferred until the cognate portion of the PCORnet CDM is developed, or active research in one of the PEDSnet cohorts requires those data types.

This document provides the data model specification, including names, data types, and description of key semantic points, for the PEDSnet CDM. For ETL specification documents and reference code, please consult the PEDSnet GitHub site.

Comments on this specification, whether providing critique of the existing data elements or requesting additional data types, are welcome. Please send email to [pedsnet@email.chop.edu](mailto:pedsnet@email.chop.edu), or contact the PEDSnet project management office (details available via <http://www.pedsnet.info>).

**PEDSnet Data Standards and Interoperability Policies:**

1: The PEDSnet data network will store data using structures compatible with the PEDSnet Common Data Model (PCDM).

2: The PCDM will be based on the Observational Medical Outcomes Partnership (OMOP) data model. OMOP will be expanded to include the PCORnet and pediatric-specific data standards, as developed by PEDSnet.

3: A subset of data elements in the PCDM will be identified as principal data elements (PDEs). The PDEs will be used for population-level queries. Data elements which are NOT PDEs will be marked as “Optional” (ETL at site discretion) or “Non-PDE” (ETL required, but data need not be transmitted to DCC, and will not be used in queries without prior approval of site.

4: It is anticipated that PEDSnet institutions will make a good faith attempt to obtain as many of the data elements not marked as “Optional” as possible.

5: The data elements classified as PDEs and those included in the PCDM will be approved by the PEDSnet Leadership Council (comprised of each PEDSnet institution’s site principal investigator).

1. Concept IDs are taken from OMOP v4.5 vocabularies for PEDSnet CDM v1.
2. Regarding the nullibility of fields, the PEDSnet CDM will always require a valued to be inserted. In the presence of a missing value, one of the following values must be used:

|  |  |
| --- | --- |
| **Null Name** | **Definition of each field** |
| NULL | A data field is not present in the source system |
| NI = No Information | A data field is present in the source system, but the source value is null or blank |
| UN = Unknown | A data field is present in the source system, but the source value explicitly denotes an unknown value |
| OT = Other | A data field is present in the source system, but the source value cannot be mapped to the CDM |

**Please note: For all unique identifiers, please do not send actual cleartext identifiers from clinical source systems..**

The following tables are included in the CDM:

## PERSON

The person domain contains records that uniquely identify each patient in the source data who is time at-risk to have clinical observations recorded within the source systems. Each person record has associated demographic attributes, which are assumed to be constant for the patient throughout the course of their periods of observation. All other patient-related data domains have a foreign-key reference to the person domain.

| **Field** | **Required** | **Type** | **Description** | **PEDSnet Conventions** |
| --- | --- | --- | --- | --- |
| person\_id | Yes | integer | A unique identifier for each person This value will not be stored by the DCC nor used for reidentification or data update procedures. Note: This is not a value found in the EHR. |  |
| gender\_concept\_id | Yes | integer | A foreign key that refers to a standard concept identifier in the Vocabulary for the gender of the person. | Please include all valid concept ids (consistent with OMOP CDMv4). Predefined value set:  A = Ambiguous  F = Female  M = Male  NI = No Information  UN = Unknown  OT = Other |
| year\_of\_birth | Yes | integer | The year of birth of the person. For data sources with date of birth, the year is extracted. For data sources where the year of birth is not available, the approximate year of birth is derived based on any age group categorization available. | Please keep all accurate/real dates (No date shifting) |
| month\_of\_birth | No | integer | The month of birth of the person. For data sources that provide the precise date of birth, the month is extracted and stored in this field. | Please keep all accurate/real dates (No date shifting) |
| day\_of\_birth | No | integer | The day of the month of birth of the person. For data sources that provide the precise date of birth, the day is extracted and stored in this field. | Please keep all accurate/real dates (No date shifting) |
| pn\_time\_of\_birth | No | Time | The time of birth at the birth day (UTC). | Please keep all accurate/real dates (No date shifting) |
| race\_concept\_id | No | integer | A foreign key that refers to a standard concept identifier in the Vocabulary for the race of the person.  Details of categorical definitions:  **-American Indian or Alaska Native**: 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.  **-Asian**: 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.  **-Black or African American**: A person having origins in any of the black racial groups of Africa.  **-Native Hawaiian or Other Pacific Islander**: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.  **-White**: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. | Regarding patients with multiple races (i.e. biracial), race is considered a single concept, meaning there is only one race slot. If there are multiple races in the source system, concatenate all races into one source value, and code as ‘Multiple Race’.  Predefined values:  1=American Indian/Alaska Native  2=Asian  3=Black or African American  4=Native Hawaiian or Other Pacific Islander 5=White  6=Multiple Race  7=Refuse to answer  NI=No Information  UN=Unknown  OT=Other |
| ethnicity\_concept\_id | No | integer | A foreign key that refers to the standard concept identifier in the Vocabulary for the ethnicity of the person.  For PEDSnet, a person with Hispanic ethnicity is defined as “A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.” | Please include all valid concept ids (consistent with OMOP CDMv4). Predefined value set:  Y=Yes  N=No  NI=No Information  UN=Unknown  OT=Other |
| location\_id | No | integer | A foreign key to the place of residency (ZIP code) for the person in the location table, where the detailed address information is stored. |  |
| Provider\_id | No | Integer | Foreign key to the primary care provider – the person is seeing in the provider table. | Remove specialty values from provider table.  Specify convention about handling multiple providers? Care Teams? |
| care\_site\_id | Yes | integer | A foreign key to the site of primary care in the care\_site table, where the details of the care site are stored | Map care-site to the department level. For EPIC, Map care\_site\_id to Clarity Department.  Specify convention about handling encounters where patient is transferred from unit to unit? |
| pn\_gestational\_age | No | Number | The post-menstrual age in weeks of the person at birth, if known |  |
| person\_source\_value | No | varchar | A unique identifier for each person created and maintained by the site. We suggest a hash value created from some person identifier in the source data. The DCC will store this value and use it for reidentification and data update procedures, so sites must be able to link this value to source data and provide it across data updates in a repeatable fashion. No raw value with any medical, demographic, or identification significance should be placed here. |  |
| gender\_source\_value | No | varchar | The source code for the gender of the person as it appears in the source data. The person’s gender is mapped to a standard gender concept in the Vocabulary; the original value is stored here for reference. | MSCDM with modified field size and value set source: Administrative Sex (HL7) |
| race\_source\_value | No | varchar | The source code for the race of the person as it appears in the source data. The person race is mapped to a standard race concept in the Vocabulary and the original value is stored here for reference. | Regarding patients with multiple races (i.e. biracial), race is considered a single concept, meaning there is only one race slot. If there are multiple races in the source system, concatenate all races into one source value, and code as ‘Multiple Race’.  MSCDM with modified field size and value set. Original value set is based upon U.S. Office of Management and Budget (OMB) standard, and is compatible with the 2010 U.S. Census. |
| ethnicity\_source\_value | No | varchar | The source code for the ethnicity of the person as it appears in the source data. The person ethnicity is mapped to a standard ethnicity concept in the Vocabulary and the original code is, stored here for reference. | MSCDM with modified field size and value set; Compatible with "OMB Hispanic Ethnicity" (Hispanic or Latino, Not Hispanic or Latino) |

### Conventions

1. The person\_id will be discarded and replaced with one that is unique across PEDSnet by the DCC.
2. The person\_source\_value will be stored by the DCC and used for reidentification and data update procedures.
3. An individual may receive care at multiple contributing institutions, and therefore be represented more than once in the data.
4. One visit may involve multiple providers, in which case the ETL must specify how a single provider id is selected or leave the provider\_id field null.
5. One visit may involve multiple care sites, in which case the ETL must specify how a single care\_site id is selected or leave the care\_site\_id field null.

## DEATH

The death domain contains the clinical event for how and when a person dies. Living patients should not contain any information in the death table.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Field | Required | Type | Description | PEDSnet Conventions |
| person\_id | Yes | integer | A foreign key identifier to the deceased person. The demographic details of that person are stored in the person table. |  |
| death\_date | Yes | date | The date the person was deceased. If the precise date including day or month is not known or not allowed, December is used as the default month, and the last day of the month the default day. If no date available, use date recorded as deceased. | Please keep all accurate/real dates (No date shifting) |
| death\_type\_concept\_id | Yes | integer | A foreign key referring to the predefined concept identifier in the Vocabulary reflecting how the death was represented in the source data.  (vocabulary\_id = 45) |  |
| cause\_of\_death\_ct\_id | No | integer | A foreign referring to a standard concept identifier in the Vocabulary for conditions. |  |
| cause\_of\_death\_source\_value | No | varchar | The source code for the cause of death as it appears in thta. This code is mapped to a standard concept in the Vocabulary and the original code is, stored here for reference. |  |

### Conventions

* Each Person may have more than one record of death in the source data. It is the task of the ETL to pick the most plausible or most accurate records to be stored to this table.
* If the Death Date cannot be precisely determined from the data, the best approximation should be used.

## LOCATION

The Location table represents a generic way to capture physical location or address information. Locations are used to define the addresses for Persons and Care Sites.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field** | **Required** | **Type** | **Description** | **PEDnet Conventions** |
| location\_id | Yes | integer | A unique identifier for each geographic location. |  |
| state | No | varchar | The state field as it appears in the source data. |  |
| zip | No | varchar | The zip code. For US addresses, valid zip codes can be 3, 5 or 9 digits long, depending on the source data. |  |
| location\_source\_value | No | varchar | The verbatim information that is used to uniquely identify the location as it appears in the source data. |  |
| address\_1 | No | varchar | Optional - Do not transmit to DCC |  |
| address\_2 | No | varchar | Optional - Do not transmit to DCC |  |
| city | No | varchar | Optional - Do not transmit to DCC |  |
| county | No | varchar | Optional - Do not transmit to DCC |  |

### Conventions

* Each address or Location is unique and is present only once in the table

## CARE\_SITE

The Care Site table contains a list of uniquely identified physical or organizational units where healthcare delivery is practiced (offices, wards, hospitals, clinics, etc.).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Field | Required | Type | Description | PEDSnet Conventions |
| care\_site\_id | Yes | Integer | A unique identifier for each care site. A care site is the place where the provider delivered the healthcare to the person. | For PEDSnet, the care\_site\_id should be mapped to the department level. For example, in EPIC, care\_site\_id should be mapped to clarity\_dep. |
| place\_of\_service\_concept\_id | No | Integer | A foreign key that refers to a place of service concept identifier in the Vocabulary |  |
| location\_id | No | Integer | A foreign key to the geographic location of the care site in the location table, where the detailed address information is stored. |  |
| care\_site\_source\_value | Yes | varchar | The identifier for the care site in the source data. Must be consistent across data updates for use by the DCC. |  |
| place\_of\_service\_source\_value | No | varchar | The source code for the place of service as it appears in the source data, stored here for reference. |  |
| organization\_id | Yes | Integer | A foreign key to the organization record. |  |

### Conventions

* Care sites are primarily identified based on the specialty or type of care provided, and secondarily on physical location, if available (e.g. North Satellite Endocrinology Clinic)
* The Care Site Source Value typically contains the name of the Care Site.
* The Place of Service Concepts are based on a catalog maintained by the CMS

## ORGANIZATION

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Field | Required | Type | Description | PEDSnet Conventions |
| organization\_id | Yes | Integer | A unique identifier for each organization. Here, an organization is defined as a collection of one or more care sites that share a single EHR database. |  |
| place\_of\_service\_concept\_id | No | Integer | A foreign key that refers to a place of service concept identifier in the Vocabulary |  |
| location\_id | No | Integer | A foreign key to the geographic location of the administrative offices of the organization in the location table, where the detailed address information is stored. |  |
| organization\_source\_value | Yes | varchar | The identifier for the organization in the source data. Must be consistent across data updates for use by the DCC. |  |
| place\_of\_service\_source\_value | No | varchar | The source code for the place of service as it appears in the source data, stored here for reference. |  |

## PROVIDER

The Provider table contains a list of uniquely identified health care providers. These are typically physicians, nurses, etc.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Field** | **Required** | **Type** | **Description** | **PEDSnet Conventions** |
| provider\_id | Yes | Integer | A unique identifier for each provider. | Specify how to define providers |
| specialty\_concept\_id | No | Integer | A foreign key to a standard provider's specialty concept identifier in the Vocabulary.  (vocabulary\_id = 48) | Specify how to handle providers associated with multiple specialties |
| care\_site\_id | Yes | Integer | A foreign key to the main care site where the provider is practicing.. |  |
| NPI | No | varchar | OPTIONAL – DO NOT TRANSMIT TO DCC  The National Provider Identifier (NPI) of the provider. |  |
| DEA | No | varchar | OPTIONAL - DO NOT TRANSMIT TO DCC  The Drug Enforcement Administration (DEA) number of the provider. |  |
| year\_of\_birth | No | Integer | Optional | Please keep all accurate/real dates (No date shifting) |
| provider\_source\_value | Yes | varchar | A unique identifier for each provider created and maintained by the site. We suggest a hash value created from some identifier in the source data. Must be consistent across data updates for use by the DCC. |  |
| specialty\_source\_value | No | varchar | The source code for the provider specialty as it appears in the source data, stored here for reference. |  |

### Conventions

* Providers are not duplicated in the table.
* Valid Specialty Concepts are based on the CDC specialty classification.

## VISIT\_OCCURRENCE

The visit domain contains the spans of time a person continuously receives medical services from one or more providers at a care site in a given setting within the health care system. Visits are classified into 4 settings: outpatient care, inpatient confinement, emergency room, and long-term care

| **Field** | **Required** | **Type** | **Description** | **PEDSnet Conventions** |
| --- | --- | --- | --- | --- |
| visit\_occurrence\_id | Yes | integer | A unique identifier for each person’s visits or encounter at a healthcare provider. Sites can provide whatever integers (DCC will replace the value). |  |
| person\_id | Yes | integer | A foreign key identifier to the person for whom the visit is recorded. The demographic details of that person are stored in the person table. |  |
| visit\_start\_date | Yes | date | The start date of the visit. | Please keep all accurate/real dates (No date shifting) |
| visit\_end\_date | No | date | The end date of the visit. If this is a one-day visit the end date should match the start date. If the encounter is on-going at the time of ETL, this should be null. | For encounters that are multiple days, and are ongoing at the time of ETL: let the field be null.  Please keep all accurate/real dates (No date shifting) |
| place\_of\_service\_concept\_id | Yes | Integer | A foreign key to the predefined concept identifier in the Vocabulary reflecting the type of source data from which the visit record is derived. |  |
| provider\_id | No | integer | A foreign key to the provider in the provider table who was associated with the visit. |  |
| care\_site\_id | No | integer | A foreign key to the care site in the care site table that was visited. |  |
| place\_of\_service\_source\_value | No | varchar | The source data for the visit type. |  |

### Conventions

* A Visit Occurrence is recorded for each visit to a healthcare facility.
* Each Visit is standardized by assigning a corresponding Concept Identifier based on the type of facility visited and the type of services rendered.
* At any one day, there could be more than one visit.
* One visit may involve multiple providers, in which case the ETL must specify how a single provider id is selected or leave the provider\_id field null.
* One visit may involve multiple care sites, in which case the ETL must specify how a single care\_site id is selected or leave the care\_site\_id field null.

## CONDITION\_OCCURRENCE

The condition occurrence domain captures records of a disease or a medical condition based on diagnoses, signs and/or symptoms observed by a provider or reported by a patient.

Conditions are recorded in different sources and levels of standardization. For example:

* Medical claims data include ICD-9-CM diagnosis codes that are submitted as part of a claim for health services and procedures.
* EHRs may capture a person’s conditions in the form of diagnosis codes and symptoms as ICD-9-CM codes, but may not have a way to capture out-of-system conditions.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Field | Required | Type | Description | PEDSnet Conventions |
| condition\_occurrence\_id | Yes | integer | A unique identifier for each condition occurrence event. |  |
| person\_id | Yes | integer | A foreign key identifier to the person who is experiencing the condition. The demographic details of that person are stored in the person table. |  |
| condition\_concept\_id | Yes | integer | A foreign key that refers to a standard condition concept identifier in the Vocabulary.  (OMOP vocabulary\_id = 1) |  |
| condition\_start\_date | Yes | date | The date when the instance of the condition is recorded. | Please keep all accurate/real dates (No date shifting) |
| condition\_end\_date | No | date | The date when the instance of the condition is considered to have ended. If this information is not available, set to NULL. | Please keep all accurate/real dates (No date shifting) |
| condition\_type\_concept\_id | Yes | integer | A foreign key to the predefined concept identifier in the Vocabulary reflecting the source data from which the condition was recorded, the level of standardization, and the type of occurrence. For example, conditions may be defined as primary or secondary diagnoses, problem lists and person statuses.  (OMOP vocabulary\_id = 37) |  |
| stop\_reason | No | varchar | The reason, if available, that the condition was no longer recorded, as indicated in the source data. Valid values include discharged, resolved, etc. Note that a stop\_reason does not necessarily imply that the condition is no longer occurring. |  |
| associated\_provider\_id | No | integer | A foreign key to the provider in the provider table who was responsible for determining (diagnosing) the condition. | Specify convention clarifying how to handle conditions recorded by nurses, or as part of an electronic data transfer about |
| visit\_occurrence\_id | No | integer | A foreign key to the visit in the visit table during which the condition was determined (diagnosed). |  |
| condition\_source\_value | No | varchar | The source code for the condition as it appears in the source data. This code is mapped to a standard condition concept in the Vocabulary and the original code is, stored here for reference. Condition source codes are typically ICD-9-CM diagnosis codes from medical claims or discharge status/visit diagnosis codes from EHRs. |  |

### Conventions

* Standard Condition Concepts are based on SNOMED-CT.
* Condition records are inferred from diagnostic codes recorded in the source data by a clinician or abstractionist for a specific visit. In the current version of the CDM, problem list entries are not used, nor are diagnoses extracted from unstructured data, such as notes.
* Source code system, like ICD-9-CM, ICD-10-CM, etc., provide coverage of conditions. However, if the code does not define a condition, but rather an observation or a procedure, then such information is not stored in the CONDITION\_OCCURRENCE table, but in the respective tables instead.
* Source Condition identifiers are mapped to Standard Concepts for Conditions in the Vocabulary. When the source code cannot be translated into a Standard Concept, a CONDITION\_OCCURRENCE entry is stored with only the corresponding source\_value and a condition\_concept\_id of 0.
* Codes written in the process of establishing the diagnosis, such as "question of" of and "rule out", are not represented here.

## PROCEDURE\_OCCURRENCE

The procedure domain contains records of significant activities or processes ordered by and/or carried out by a healthcare provider on the patient to have a diagnostic and/or therapeutic purpose that are not fully captured in another table (e.g. drug\_exposure).

Procedures records are extracted from structured data in Electronic Health Records that capture CPT-4, ICD-9-CM (Procedures), HCPCS or OPCS-4 procedures as orders.

| **Field** | **Required** | **Type** | **Description** | **PEDSnet Conventions** |
| --- | --- | --- | --- | --- |
| procedure\_occurrence\_id | Yes | integer | A system-generated unique identifier for each procedure occurrence. Sites can use any integer- DCC will do a substitution. |  |
| person\_id | Yes | integer | A foreign key identifier to the person who is subjected to the procedure. The demographic details of that person are stored in the person table. |  |
| procedure\_concept\_id | Yes | integer | A foreign key that refers to a standard procedure concept identifier in the Vocabulary. | Specify which vocabulary to use/preferred? |
| procedure\_date | Yes | date | The date on which the procedure was performed. |  |
| procedure\_type\_concept\_id | Yes | integer | A foreign key to the predefined concept identifier in the Vocabulary reflecting the type of source data from which the procedure record is derived.  (OMOP vocabulary\_id = 38) |  |
| associated\_provider\_id | No | integer | A foreign key to the provider in the provider table who was responsible for carrying out the procedure. | Specify convention clarifying how to handle conditions recorded by nurses, or as part of an electronic data transfer about |
| visit\_occurrence\_id | No | integer | A foreign key to the visit in the visit table during which the procedure was carried out. |  |
| relevant\_condition\_concept\_id | No | integer | A foreign key to the predefined concept identifier in the vocabulary reflecting the condition that was the cause for initiation of the procedure. Note that this is not a direct reference to a specific condition record in the condition table, but rather a condition concept in the vocabulary.  (OMOP vocabulary\_id = 1) |  |
| procedure\_source\_value | No | varchar | The source code for the procedure as it appears in the source data. This code is mapped to a standard procedure concept in the Vocabulary and the original code is, stored here for reference. Procedure source codes are typically ICD-9-Proc, ICD-10-Proc, CPT-4, HCPCS or OPCS-4 codes. | Specify which vocabulary to use/preferred? |

### Conventions

* Procedure Concepts are based on a variety of vocabularies: SNOMED-CT, ICD-9-Proc, CPT-4, HCPCS and OPCS-4.
* Procedures could reflect the administration of a drug, in which case the procedure is recorded in the procedure table and simultaneously the administered drug in the drug table.
* The Visit during which the procedure was performed is recorded through a reference to the VISIT\_OCCURRENCE table. This information is not always available.
* The Provider carrying out the procedure is recorded through a reference to the PROVIDER table. This information is not always available.

## OBSERVATION

The observation domain captures clinical facts about a patient obtained in the context of examination, questioning or a procedure. For the PEDSnet CDM version 1, the following observations are extracted from source data:

* Height/length in cm (decimals are permissible, out to 3 decimals places)
* Height/length type
* Weight in kg (decimals are permissible, out to 3 decimals places)
* Body mass index in kg/m2 (extracted only if height and weight are not present)
* Systolic blood pressure in mmHg
  + Only populate if measure was taken on this date; If missing, leave blank;
  + Only report one reading per encounter - where multiple readings are present, chose the last if sequencing by time is possible, else choose the lowest.
* Diastolic blood pressure in mmHg
  + Only populate if measure was taken on this date; If missing, leave blank;
  + Only report one reading per encounter - where multiple readings are present, chose the last if sequencing by time is possible, else choose the lowest.

In addition, the following observations are derived via the DCC:

* Body mass index in kg/m2 if not directly extracted
* Height/length z score for age/sex using NHANES 2000 norms for measurements at which the person was <240 months of age. In the absence of a height/length type for the measurement, recumbent length is assumed for ages <24 months, and standing height thereafter.
* Weight z score for age/sex using NHANES 2000 norms for measurements at which the person was <240 months of age.
* BMI z score for age/sex using NHANES 2000 norms for visits at which the person was between 20 and 240 months of age.
* Systolic BP z score for age/sex/height using NHBPEP task force fourth report norms.
* Diastolic BP z score for age/sex/height using NHBPEP task force fourth report norms.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Field | Required | Type | Description | PEDSnet Conventions |
| observation\_id | Yes | integer | A unique identifier for each observation. |  |
| person\_id | Yes | integer | A foreign key identifier to the person about whom the observation was recorded. The demographic details of that person are stored in the person table. |  |
| observation\_concept\_id | Yes | integer | A foreign key to the standard observation concept identifier in the Vocabulary.  (OMOP vocabulary\_id = ?) | When determining the start/stop dates and any gap intervals for observation periods, please use the minimum and maximum for the observation period. |
| observation\_date | Yes | date | The date of the observation (UTC). | Please keep all accurate/real dates (No date shifting) |
| observation\_time | No | time | The time of the observation (UTC). | Please keep all accurate/real dates (No date shifting) |
| observation\_type\_concept\_id | Yes | integer | A foreign key to the predefined concept identifier in the Vocabulary reflecting the type of the observation.  (OMOP vocabulary\_id = 39) |  |
| value\_as\_number | No | float | The observation result stored as a number. This is applicable to observations where the result is expressed as a numeric value. |  |
| value\_as\_string | No | varchar | The observation result stored as a string. This is applicable to observations where the result is expressed as verbatim text. |  |
| value\_as\_concept\_id | No | Integer | A foreign key to an observation result stored as a concept identifier. This is applicable to observations where the result can be expressed as a standard concept from the Vocabulary (e.g., positive/negative, present/absent, low/high, etc.). |  |
| unit\_concept\_id | No | integer | A foreign key to a standard concept identifier of measurement units in the Vocabulary. |  |
| associated\_provider\_id | No | integer | A foreign key to the provider in the provider table who was responsible for making the observation. |  |
| visit\_occurrence\_id | No | integer | A foreign key to the visit in the visit table during which the observation was recorded. |  |
| relevant\_condition\_concept\_id | No | Integer | A foreign key to the condition concept related to this observation, if this relationship exists in the source data (*e.g.* indication for a diagnostic test). |  |
| observation\_source\_value | No | varchar | The observation code as it appears in the source data. This code is mapped to a standard concept in the Vocabulary and the original code is, stored here for reference. |  |
| units\_source\_value | No | varchar | The source code for the unit as it appears in the source data. This code is mapped to a standard unit concept in the Vocabulary and the original code is, stored here for reference. |  |
| range\_low | No | float | Optional  The lower limit of the normal range of the observation. It is not applicable if the observation results are non-numeric or categorical, and must be in the same units of measure as the observation value. |  |
| range\_high | No | float | Optional  The upper limit of the normal range of the observation. It is not applicable if the observation results are non-numeric or categorical, and must be in the same units of measure as the observation value. |  |

### Conventions

* Observations must have a value represented by one of a concept ID, a string, or a numeric value..
* The Visit during which the observation was made is recorded through a reference to the VISIT\_OCCURRENCE table. This information is not always available.
* The Provider making the observation is recorded through a reference to the PROVIDER table. This information is not always available.
* For vital signs, pull information from flowsheet rows.