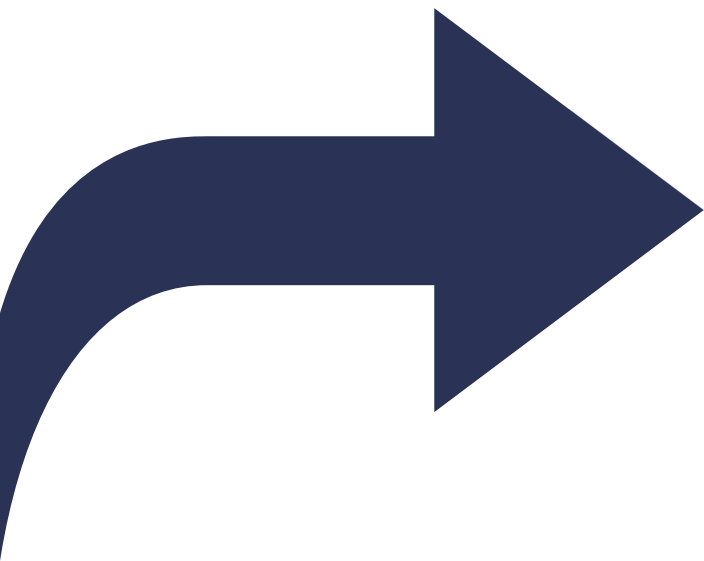


Introducción al modelo OMOP-CDM

Alberto Labarga – Febrero 2026





I am Alberto



alabarga



alabarga



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alberto.labarga@gmail.com

OMOP-CDM

El curso

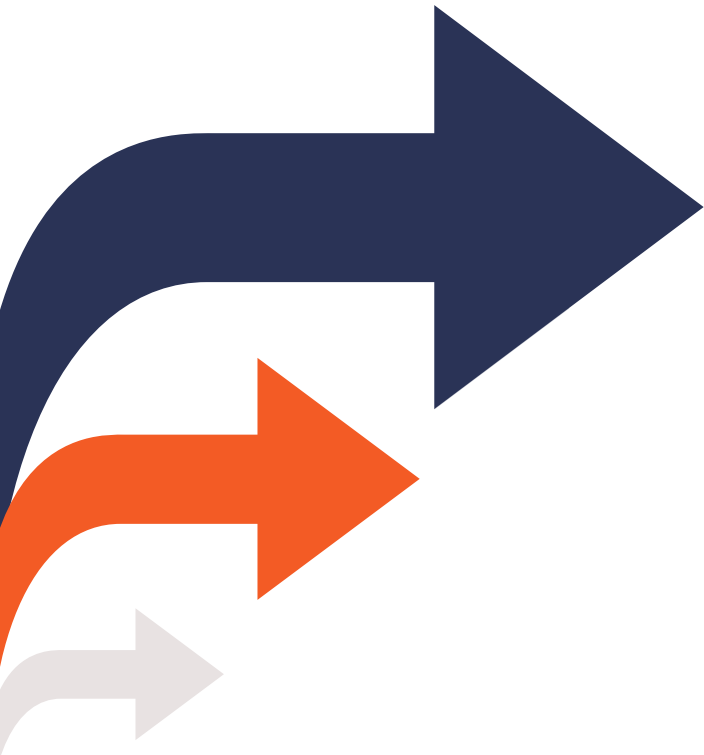
El curso tiene como objetivo proporcionar una comprensión profunda del modelo de datos

OMOP-CDM de la OHDSI, incluida su **estructura**, tablas clave y **vocabularios**.

Abordaremos también como **transformar** datos al modelo y explorar y analizar la **calidad** de los datos transformados.

L	M	X	J	V	S	D
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

Objetivos del curso



01

Introducción al modelo OMOP-CDM, a sus tablas y sus vocabularios

02

Transformación de datos al modelo OMOP-CDM utilizando la suite de herramientas de la OHDSI

03

Análisis de calidad y explotación de una base de datos OMOP-CDM

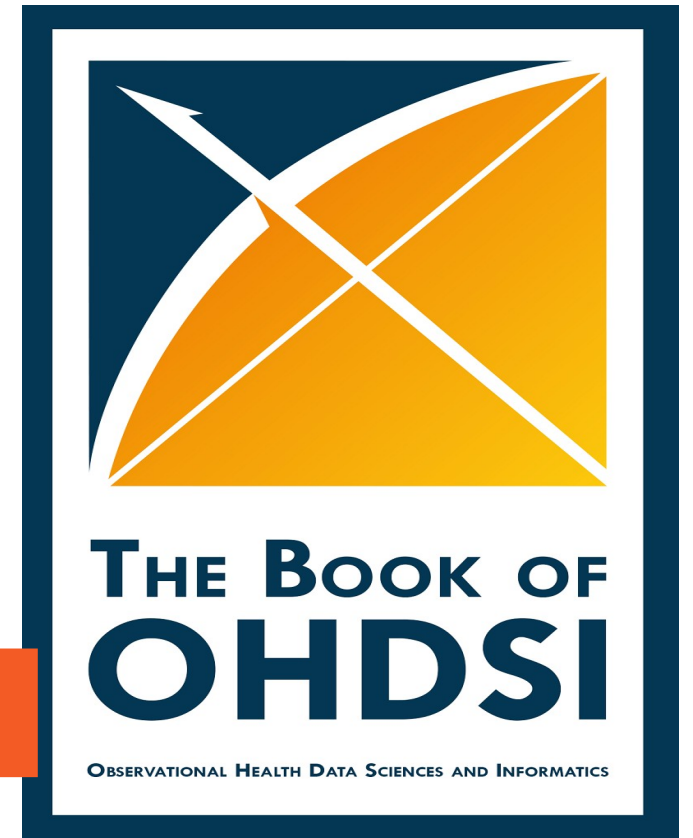
Recursos de aprendizaje



Sitio web: <https://github.com/alabarga/omop-cdm-course>

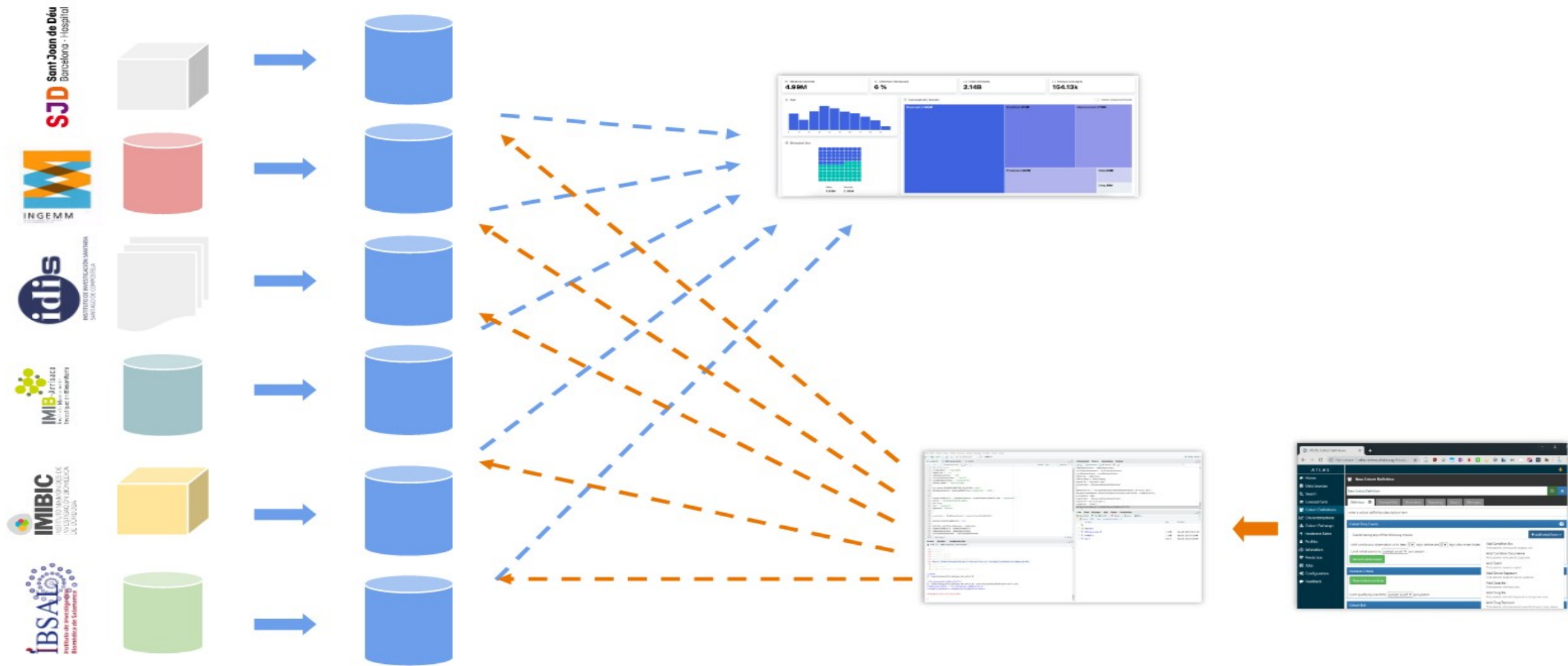


Libro <https://ohdsi.github.io/TheBookOfOhdsi/>



OMOP-CDM^{*}

VOCABULARIOS

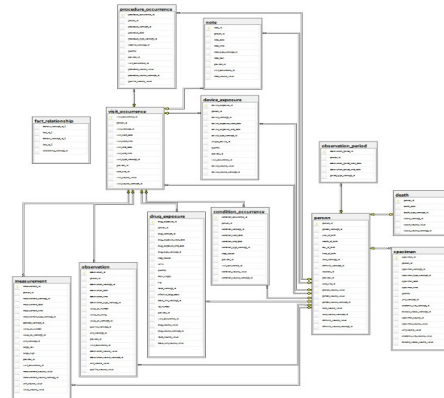


OMOP-CDM

Common Data Model

OMOP-CDM pretende servir como modelo de datos común para poder comprender los datos clínicos sin importar su origen. Este es un estándar de **licencia abierta** cuyo objetivo es estandarizar los datos y estructurarlos para permitir análisis y observaciones eficientes cuyos resultados sean fiables.

Propone **interoperabilidad sintáctica** (modelo de datos) e **interoperabilidad semántica** (vocabularios)



ATHENA

SEARCH BY KEYWORD: cancer

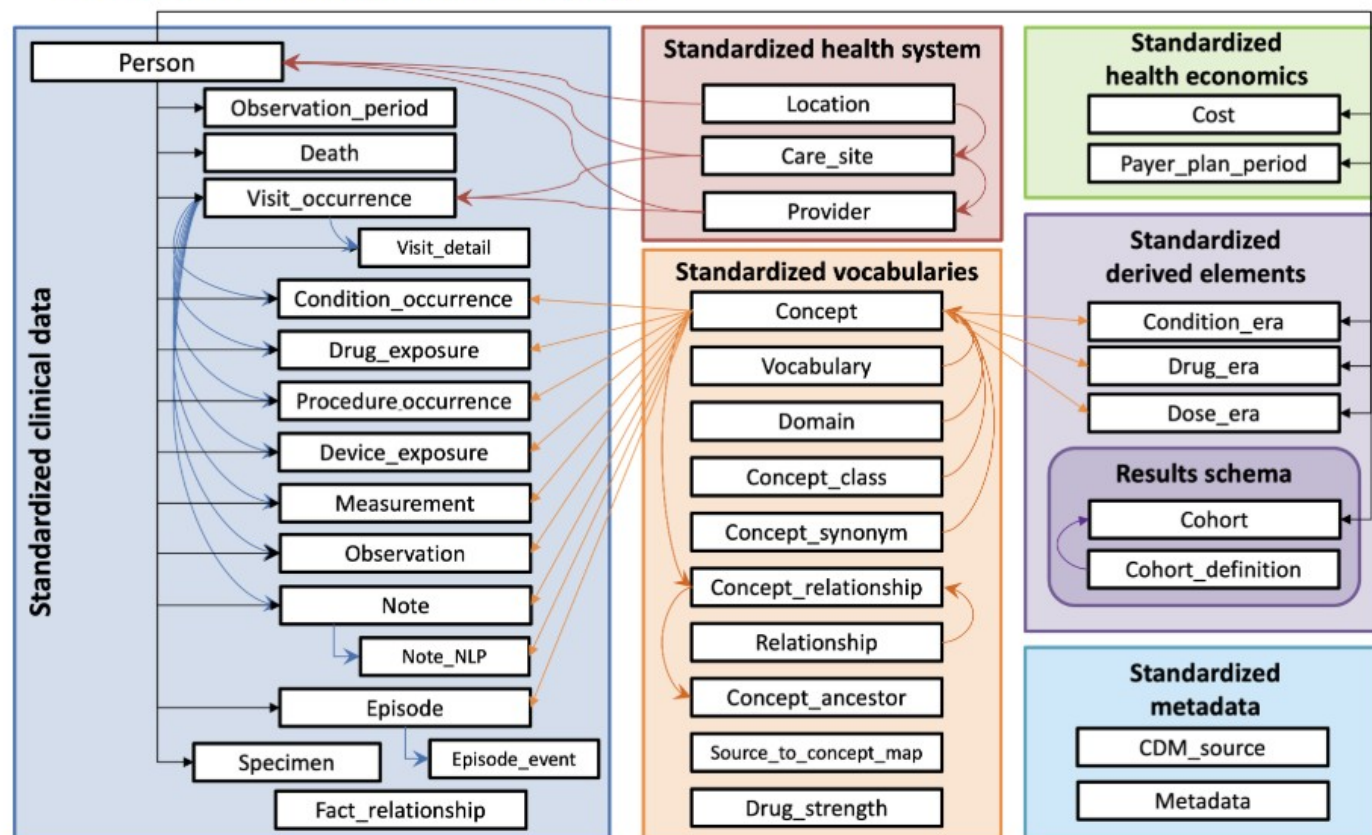
DOWNLOAD RESULTS

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ID	CODE	NAME	CLASS	CONCEPT	VALIDITY	DOMAIN	VOCAB
45877275	LA18524-9	Cancer	Answer	Standard	Valid	Meas Value	LOINC
1194405	39000000	Cancer confirmed	Control dependent	Standard	Valid	Condition	SNOMED
4299008	388001001	Cancer register	Source Context	Standard	Valid	Observation	SNOMED
1384533	CancerCardInfo_H3UCancer	Cancer Conditions: No Cancer	Answer	Standard	Valid	Observation	PR
4873814	343073306	Cancer education	Procedure	Standard	Valid	Procedure	SNOMED
44803809	722721000000100	Colorectal cancer	Qualifier Value	Standard	Valid	Observation	SNOMED
42157663	54520-7	Cancer	Survey	Standard	Valid	Observation	LOINC

The current CDM version is [CDM v5.4](#), depicted below. This CDM version was developed over the course of a year by considering requests that were sent via our [issues page](#). The list of proposed changes was then shared with the community in multiple ways: through discussions at the weekly OHDSI Community calls, discussions with the OHDSI Steering Committee, and discussions with all potentially affected workgroups. The [final changes](#) were then delivered to the Community through a new R package designed to dynamically generate the DDLs and documentation for all supported SQL dialects. Looking for an entity-relationship diagram? Click [here](#)!

- [Link to DDLs for CDM v5.4](#)
- [Link to ReadMe for instructions on how to use the R package](#)



[CommonDataModel](#) / [inst](#) / [ddl](#) / **5.4** / [🔗](#)

[clairblacketer](#) Removing codespell and older ddl folder for CRAN submission

Name

- ..
- bigquery
- duckdb
- hive
- impala
- netezza
- oracle
- pdw
- postgresql
- redshift
- snowflake
- spark
- sql_server
- sqlite
- sqlite_extended
- synapse

Show all



SHOW HISTORY

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<input type="checkbox"/>	ID (CDM V4.5)	CODE (CDM V5)	NAME	REQUIRED	LATEST UPDATE
<input checked="" type="checkbox"/>	1	SNOMED	Systematic Nomenclature of Medicine - Clinical Terms (IHTSDO)		01-Mar-2025
<input checked="" type="checkbox"/>	2	ICD9CM	International Classification of Diseases, Ninth Revision, Clinical Modification, Volume 1 and 2 (NCHS)		01-Oct-2014
<input checked="" type="checkbox"/>	3	ICD9Proc	International Classification of Diseases, Ninth Revision, Clinical Modification, Volume 3 (NCHS)		01-Oct-2014
<input checked="" type="checkbox"/>	4	CPT4	Current Procedural Terminology version 4 (AMA)	EULA required	05-May-2025
<input checked="" type="checkbox"/>	5	HCPCS	Healthcare Common Procedure Coding System (CMS)		01-Jul-2025
<input checked="" type="checkbox"/>	6	LOINC	Logical Observation Identifiers Names and Codes (Regenstrief Institute)		26-Feb-2025
<input type="checkbox"/>	7	NDFRT	National Drug File - Reference Terminology (VA)		06-Aug-2018
<input checked="" type="checkbox"/>	8	RxNorm	RxNorm (NLM)		02-Jun-2025
<input checked="" type="checkbox"/>	9	NDC	National Drug Code (FDA and manufacturers)		17-Aug-2025

Características de los vocabularios

- 01 Vocabularios estandarizados: se utilizan vocabularios estandarizados para estandarizar los registros, con el fin de que estos contengan todos los conceptos correspondientes.
- 02 Reutilización de vocabularios existentes: siempre que sea posible, el origen de los conceptos serán estándares industriales o nacionales, así como definiciones provenientes de organizaciones médicas.
- 03 Conservación de códigos de origen: todos los códigos están conectados a los vocabularios estandarizados, pero aún así OMOP almacena el código de origen con el fin de no perder información.
- 04 Cada concepto estándar tiene una asignación única de dominio que define en qué tabla se registran. Aunque la asignación de dominio correcta puede ser objeto de debate, la correspondencia estricta entre dominio-tabla-campo asegura una ubicación inequívoca para cualquier código o concepto.

CONCEPTOS

ESTANDARIZACIÓN SEMÁNTICA

En las tablas de datos del CDM, cada registro está representado por un conjunto de **conceptos normalizados**, que se almacenan en **tablas de eventos** con sus valores CONCEPT_ID, los cuales son claves foráneas a la tabla **CONCEPT**, que sirve como tabla de referencia general.

La tabla CONCEPT contiene información detallada sobre cada concepto, como su nombre, dominio y clase, entre otros.

Todas las instancias de CDM utilizan la misma tabla CONCEPT como referencia para los conceptos, lo que junto con el modelo de datos común es un mecanismo clave de interoperabilidad y la base de la red de investigación OHDSI.

concept		
concept_id	integer	NN
valid_start_date	date	NN
valid_end_date	date	NN
concept_name	text	NN
domain_id	text	NN
vocabulary_id	text	NN
concept_class_id	text	NN
concept_code	text	NN
standard_concept	text	
invalid_reason	text	

- Proporciona una visión estandarizada de los **conceptos clínicos** en distintos **dominios**
- Reutiliza **vocabularios existentes**
- Se actualiza constantemente
- NO es cerrado (**podemos añadir conceptos** usando concept_id > 2000000000)
- En caso de que no exista un concepto estándar o no se puede identificar, el valor del CONCEPT_ID se establece en **0, lo que representa un concepto inexistente, desconocido o no mapeable.**

concept		
concept_id	integer	NN
valid_start_date	date	NN
valid_end_date	date	NN
concept_name	text	NN
domain_id	text	NN
vocabulary_id	text	NN
concept_class_id	text	NN
concept_code	text	NN
standard_concept	text	
invalid_reason	text	

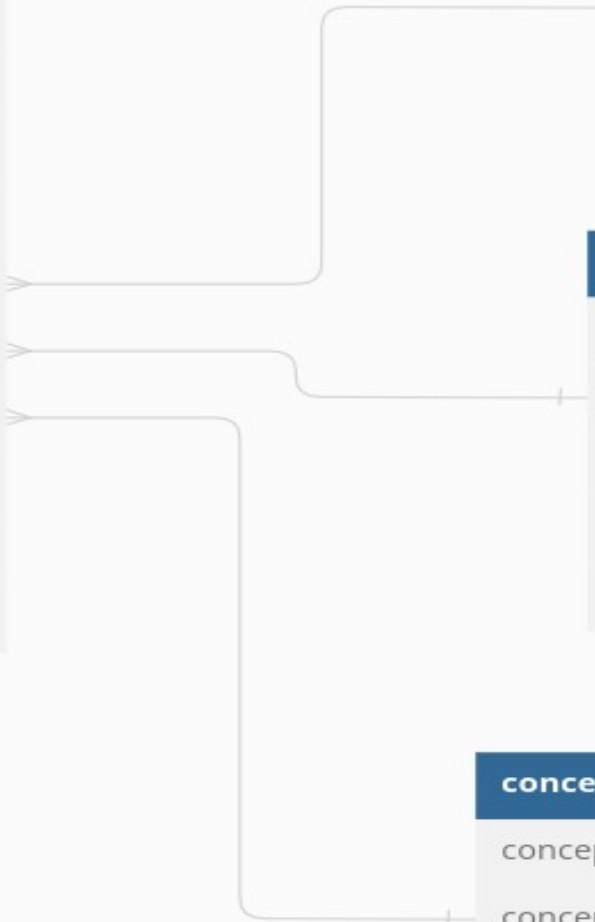
DETAILS		
Domain ID	Condition	
Concept Class ID	Clinical Finding	
Vocabulary ID	SNOMED	?
Concept ID	320128	
Concept code	59621000	
Validity	Valid	
Concept	Standard	
Synonyms	Essential hypertension (disorder) Idiopathic hypertension Primary hypertension Systemic primary arterial hypertension	
Valid start	31-Jan-2002	
Valid end	31-Dec-2099	

concept		
concept_id	integer	NN
valid_start_date	date	NN
valid_end_date	date	NN
concept_name	text	NN
domain_id	text	NN
vocabulary_id	text	NN
concept_class_id	text	NN
concept_code	text	NN
standard_concept	text	
invalid_reason	text	

domain		
domain_concept_id	integer	
domain_id	text	NN
domain_name	text	NN

vocabulary		
vocabulary_concept_id	integer	NN
vocabulary_id	text	NN
vocabulary_name	text	NN
vocabulary_reference	text	
vocabulary_version	text	

concept_class		
concept_class_concept_id	integer	NN
concept_class_id	text	NN
concept_class_name	text	NN

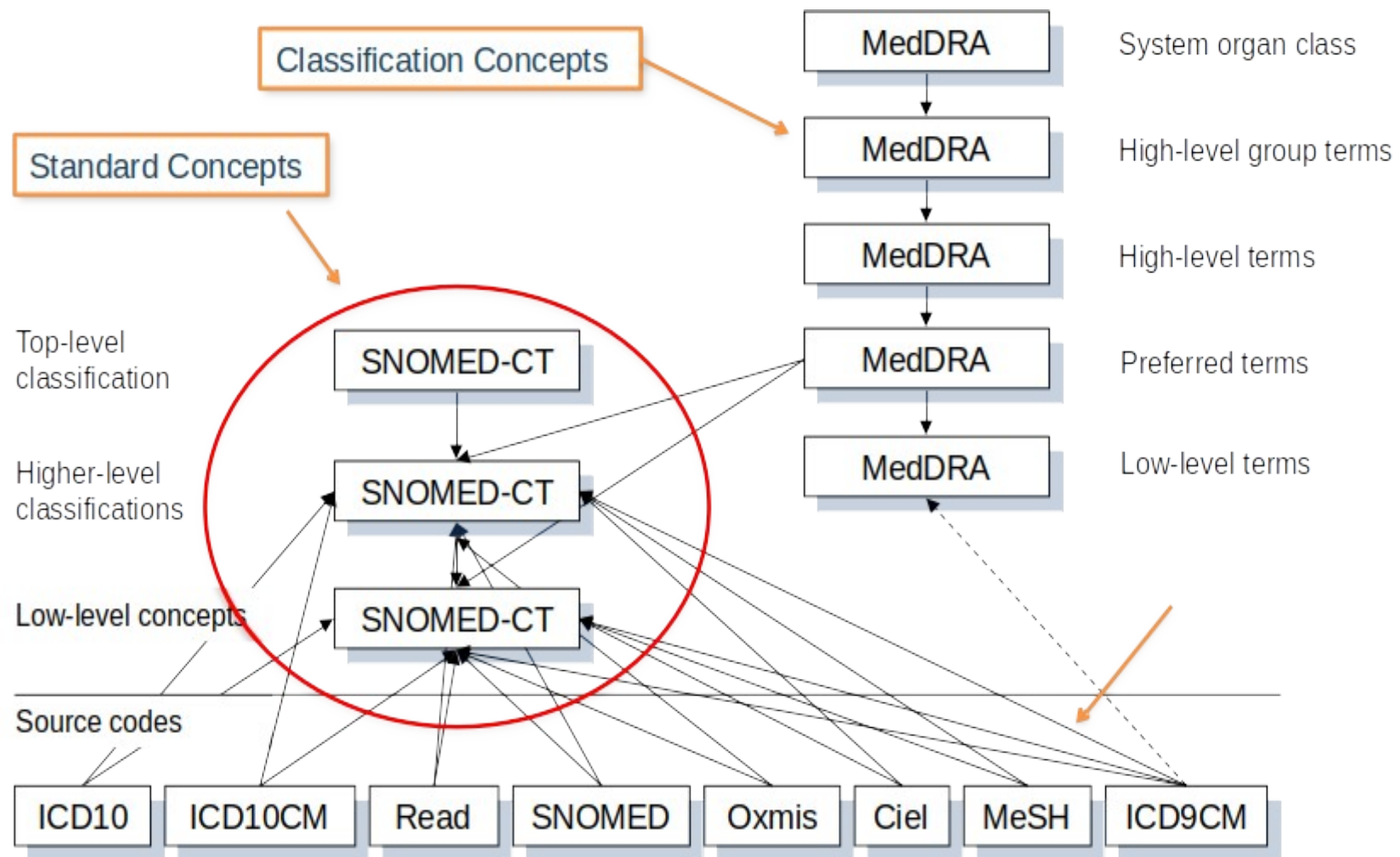


Concept Count	Domain ID	Concept Count	Domain ID
1731378	Drug	183	Route
477597	Device	180	Currency
257000	Procedure	158	Payer
163807	Condition	123	Visit
145898	Observation	51	Cost
89645	Measurement	50	Race
33759	Spec Anatomic Site	13	Plan Stop Reason
17302	Meas Value	11	Plan
1799	Specimen	6	Episode
1215	Provider Specialty	6	Sponsor
1046	Unit	5	Meas Value Operator
944	Metadata	3	Spec Disease Status
538	Revenue Code	2	Gender
336	Type Concept	2	Ethnicity
194	Relationship	1	Observation Type

```
select domain_id, count(*)
from concept
group by domain_id
```

concept		
concept_id	integer	NN
valid_start_date	date	NN
valid_end_date	date	NN
concept_name	text	NN
domain_id	text	NN
vocabulary_id	text	NN
concept_class_id	text	NN
concept_code	text	NN
standard_concept	text	
invalid_reason	text	

- Hay tres categorías de conceptos:
 - **Non-standard Concepts:** representaciones unívocas de un **código existente**
 - **Standard Concept:** Conceptos de un **vocabulario considerado estándar para un determinado dominio** para facilitar los análisis y estudios usando las herramientas de la OHDSI
 - **Classification Concepts:** No se utilizan directamente para codificar datos de origen sino que se utilizan para ejecutar **consultas jerárquicas** o definir un **concept set**



neoplasm ×

Clinical Finding ×

Condition ×

Standard ×

DOMAIN ▾

CONCEPT ▾

CLASS ▾

VOCAB ▲

filter

☐ Nebraska Lexicon (6)

☒ SNOMED (4275)

☐ SNOMED Veterinary (7)

☐ ABMS (0)

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1 2 3 4 5 ... 285 >

4290837	399956005	Melanocytic neoplasm	Clinical Finding	Standard	Valid	Condition	SNOMED
4294432	402877008	Rhabdomyomatous neoplasm	Clinical Finding	Standard	Valid	Condition	SNOMED
4344389	240204004	Synovial-like neoplasm	Clinical Finding	Standard	Valid	Condition	SNOMED
4129890	126871001	Neoplasm of omentum	Clinical Finding	Standard	Valid	Condition	SNOMED
4113639	286904004	Benign genital neoplasm	Clinical Finding	Standard	Valid	Condition	SNOMED
42537690	737223000	Dendritic cell neoplasm	Clinical Finding	Standard	Valid	Condition	SNOMED
443736	414653009	Mast cell neoplasm	Clinical Finding	Standard	Valid	Condition	SNOMED
4054416	126567006	Neoplasm of acromion	Clinical Finding	Standard	Valid	Condition	SNOMED
4129245	126639006	Neoplasm of axilla	Clinical Finding	Standard	Valid	Condition	SNOMED

neoplasm ×

Clinical Finding ×

Condition ×

Standard ×




DOMAIN ▾

CONCEPT ▾

CLASS ▾

VOCAB ▲

- filter
- ☐ Nebraska Lexicon (6)
- ☒ SNOMED (4275)
- ☐ SNOMED Veterinary (7)
- ☐ ABMS (0)

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4290837	399956005					Show all ▾	SHOW HISTORY	DOWNLOAD VOCABULARIES	
4294432	402877008	<input type="checkbox"/>	ID (CDM V4.5)	CODE (CDM V5)	NAME		REQUIRED	LATEST UPDATE	
4344389	240204004	<input checked="" type="checkbox"/>	1	SNOMED	Systematic Nomenclature of Medicine - Clinical Terms (IHTSDO)			28-Jan-2022	
4129890	126871001	<input checked="" type="checkbox"/>	2	ICD9CM	International Classification of Diseases, Ninth Revision, Clinical Modification, Volume 1 and 2 (NCHS)			01-Oct-2014	
4113639	286904004	<input checked="" type="checkbox"/>	3	ICD9Proc	International Classification of Diseases, Ninth Revision, Clinical Modification, Volume 3 (NCHS)			01-Oct-2014	
42537690	737223000	<input checked="" type="checkbox"/>	4	CPT4	Current Procedural Terminology version 4 (AMA)		EULA required	01-May-2023	
443736	414653009	<input checked="" type="checkbox"/>	5	HCPSC	Healthcare Common Procedure Coding System (CMS)			01-Jul-2023	
4054416	126567006	<input checked="" type="checkbox"/>	6	LOINC	Logical Observation Identifiers Names and Codes (Regenstrief Institute)			15-Aug-2023	
4129245	126639006	<input type="checkbox"/>	7	NDFRT	National Drug File - Reference Terminology (VA)			06-Aug-2018	
		<input checked="" type="checkbox"/>	8	RxNorm	RxNorm (NLM)			03-Jul-2023	
		<input checked="" type="checkbox"/>	9	NDC	National Drug Code (FDA and manufacturers)			27-Aug-2023	
			10	GPI	Medi-Span Generic Product Identifier (Wolters Kluwer Health)		 License required	14-Dec-2017	
		<input checked="" type="checkbox"/>	12	Gender	OMOP Gender				

neoplasm ✕

Clinical Finding ✕

Condition ✕

Standard ✕

DOMAIN ▾

CONCEPT ▾

CLASS ▾

VOCAB ▾

filter

☐ Nebraska Lexicon (6)

☒ SNOMED (4275)

☐ SNOMED Veterinary (7)

☐ ABMS (0)

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	ID (CDM V4.5)	CODE (CDM V5)	NAME	REQUIRED	LATEST UPDATE	
<input type="checkbox"/>	4290837	399956005				
<input checked="" type="checkbox"/>	4294432	402877008	1	SNOMED	Systematic Nomenclature of Medicine - Clinical Terms (IHTSDO)	28-Jan-2022
<input checked="" type="checkbox"/>	4344389	240204004	2	ICD9CM	International Classification of Diseases, Ninth Revision, Clinical Modification, Volume 1 and 2 (NCHS)	01-Oct-2014

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REFRESH

NOTIFICATIONS


BSC_OMOP_VOCABULARIES

> 09:56 AM | 13-FEB-2023

V5.0 23-JAN-23

ARCHIVED

RESTORE

<input checked="" type="checkbox"/>	8	RxNorm	RxNorm (NLM)	03-Jul-2023
<input checked="" type="checkbox"/>	9	NDC	National Drug Code (FDA and manufacturers)	27-Aug-2023
	10	GPI	Medi-Span Generic Product Identifier (Wolters Kluwer Health)	 License required 14-Dec-2017
<input checked="" type="checkbox"/>	12	Gender	OMOP Gender	

condition_occurrence	
condition_occurrence_id	bigint NN
person_id	bigint
provider_id	bigint
visit_occurrence_id	bigint
visit_detail_id	bigint
condition_start_datetime	timestamp
condition_end_datetime	timestamp
condition_concept_id	integer
condition_type_concept_id	integer
condition_status_concept_id	integer
condition_source_concept_id	integer
condition_start_date	date
condition_end_date	date
stop_reason	text
condition_source_value	text
condition_status_source_value	text

La tabla **CONDITION_OCCURRENCE** tiene como objetivo principal registrar las ocurrencias individuales de condiciones médicas, y diagnósticos, que han sido observadas o documentadas en pacientes en un contexto de atención médica.

El diagnóstico se recoge en el campo **condition_concept_id** usando SNOMED.

El campo **condition_status_concept_id** se utiliza para registrar el **contexto o la circunstancia** en la que se dio el diagnóstico de una condición médica en una visita médica específica. Esta información detalla las condiciones bajo las cuales se hizo el diagnóstico, como si se tratara de un diagnóstico de ingreso, un diagnóstico final, si se basó en hallazgos de laboratorio

CONCEPTOS

ESTANDARIZACIÓN SEMÁNTICA

[Event]_ID es una clave primaria de las tablas de eventos. Por ejemplo, el campo CONDITION_OCCURENCE_ID identifica a un diagnóstico concreto en la tabla CONDITION_OCCURENCE

[Event]_TYPE_CONCEPT_ID representa **el origen del dato** de forma estandarizada. Este campo declara el mecanismo de captura que creó el registro.

CONCEPTOS

EVENT TYPES

EHR: An Electronic Health (or Medical) Record. These are usually systems supporting hospitals or ambulatory healthcare providers

EHR administration record: A record in the EHR indicating the administration of a service, drug or treatment.

EHR discharge summary: A record in the EHR usually created by the discharging Provider upon discharge of a Person from the Provider's care (when a Person is discharged from inpatient hospitalization, discharged from a physical therapy series, discharged from counseling, etc.)

EHR note: Unspecified note recorded in the EHR

EHR Pathology report: Pathology Laboratory Report based on findings derived from examination of a specimen

EHR radiology report: Radiology Department Report based on findings derived from the analysis of imaging modalities

NLP: Information derived by Natural Language Processing

Survey: A survey in general

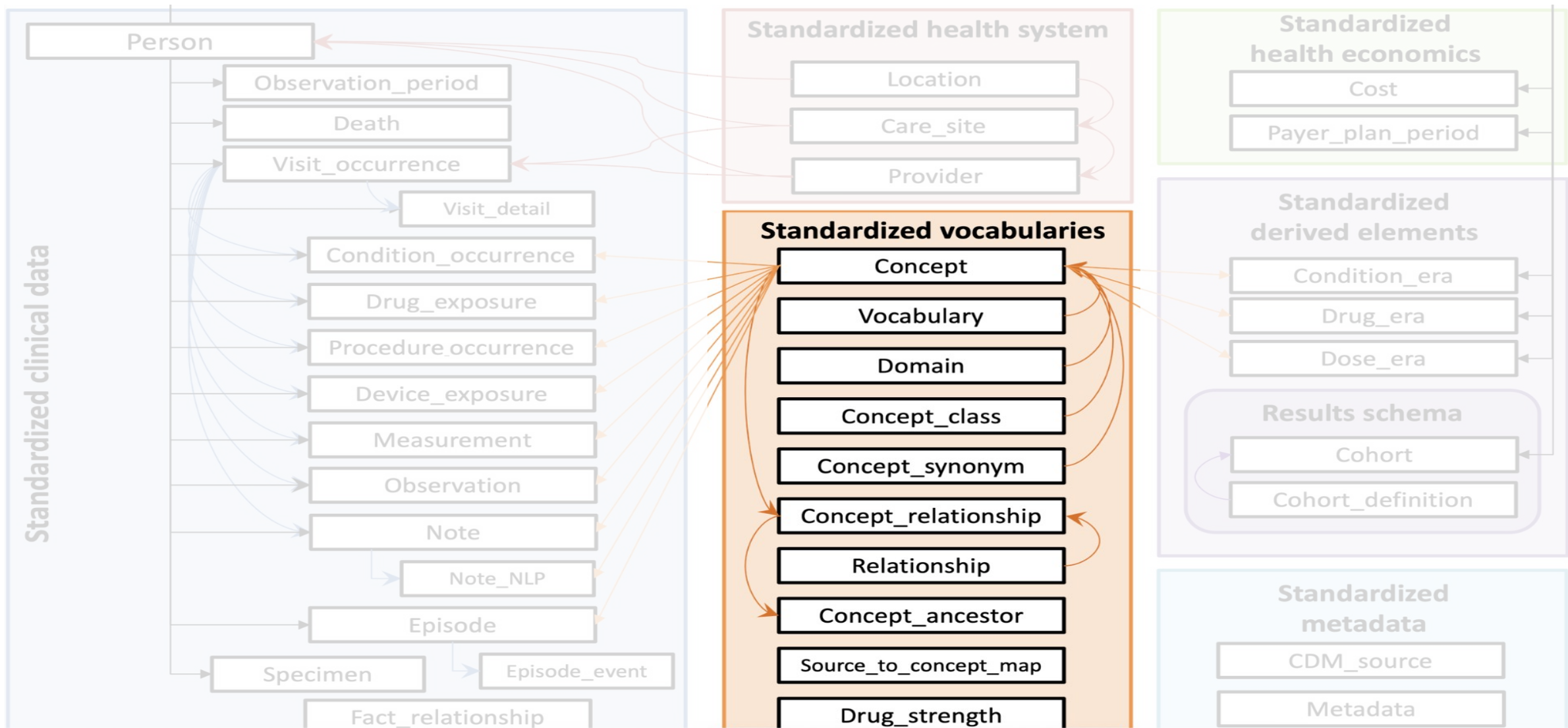
CONCEPTOS

EVENT CONCEPT

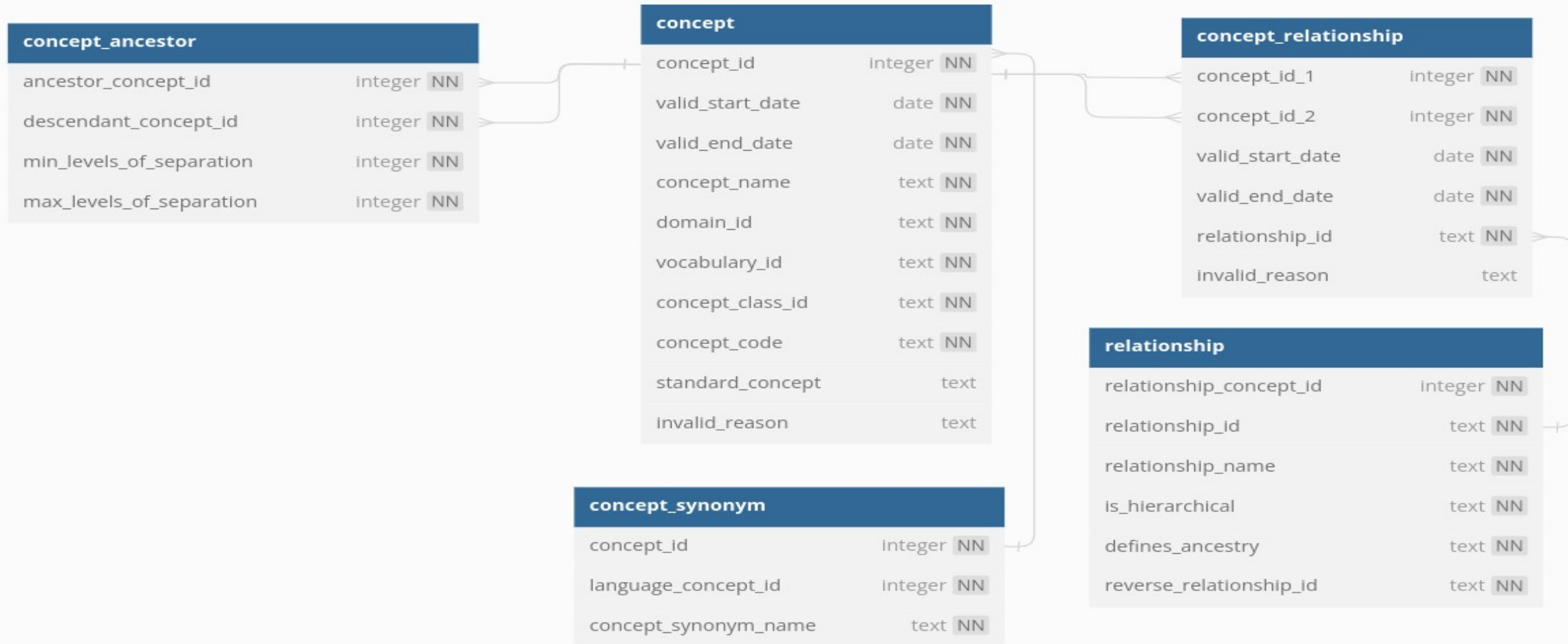
[Event]_CONCEPT_ID es el **concepto estándar** de la tabla CONCEPT, por ejemplo condition_occurrence_concept_id 8532 corresponde a 'Female'

[Event]_SOURCE_VALUE contiene la representación del **valor de origen**. Es importante tener en cuenta que este dato no se encuentra armonizado dentro del modelo de datos. Para el ejemplo de la Figura 3.6 el valor original es '72166-2'

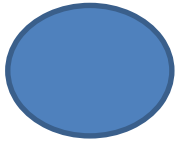
[Event]_SOURCE_CONCEPT_ID es otra clave foránea de la tabla CONCEPT, que contiene el concept_id del valor de origen en caso de que pertenezca a un vocabulario controlado. Siguiendo el ejemplo anterior, en la Figura 3.5 este campo tendría el valor '70070008', que es el valor del identificador de 'Torticollis' en el origen, y que se corresponde con el valor '440814' en el estándar SNOMED.



Jerarquía de conceptos



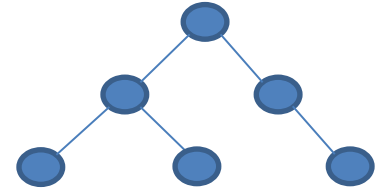
Jerarquía de conceptos



conceptos médicos en
concept



Relaciones directas entre conceptos
concept_relationship

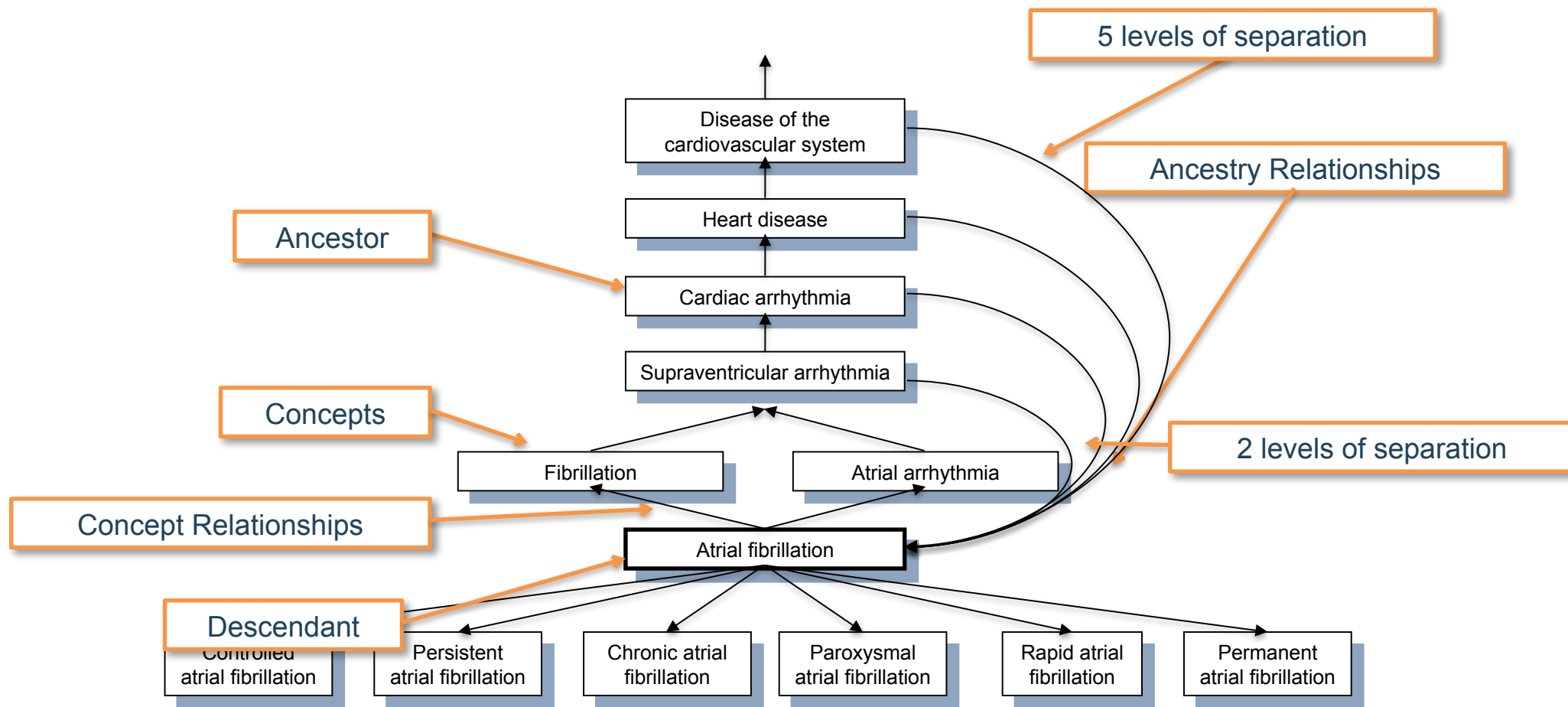


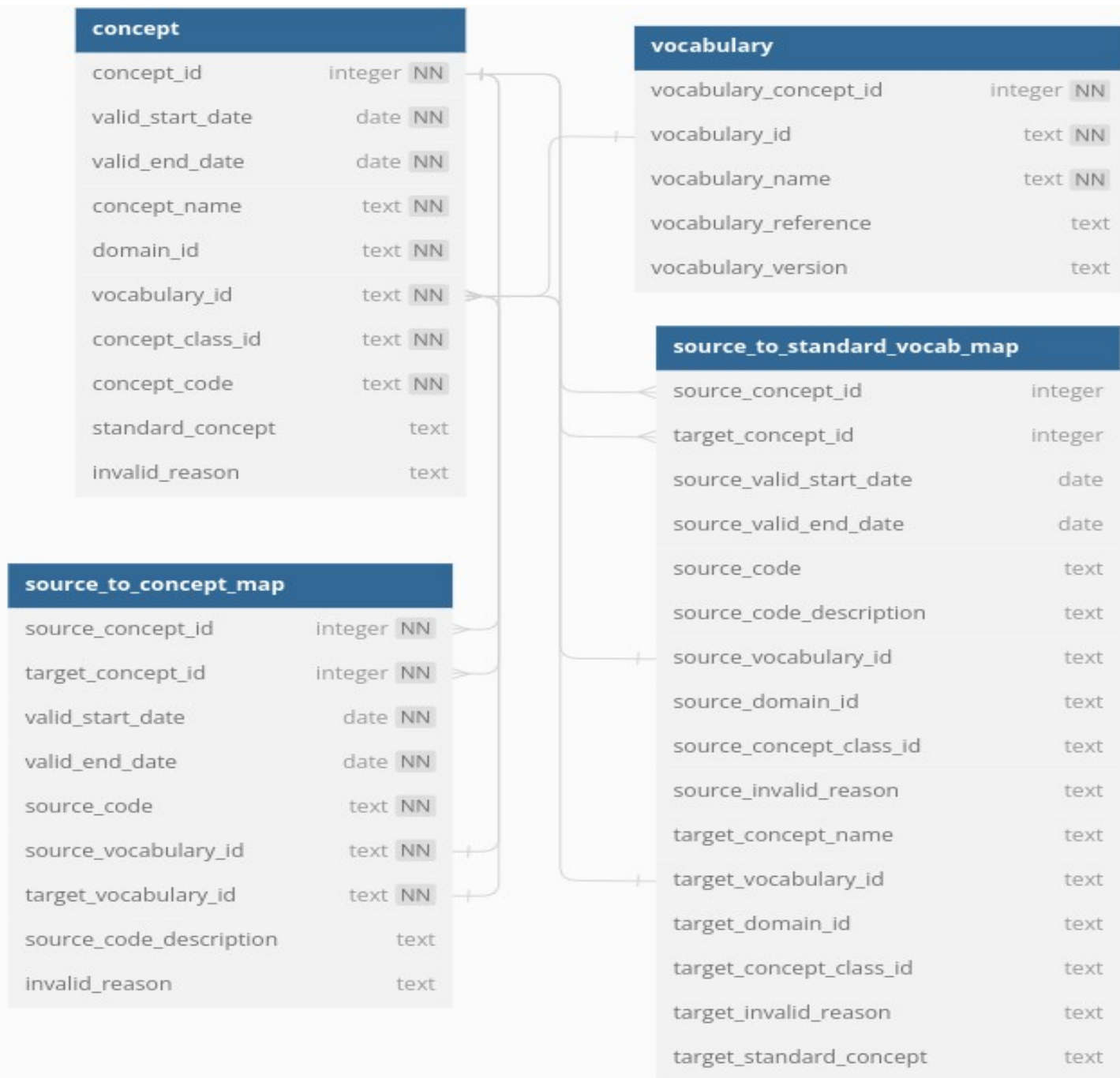
Relaciones jerárquicas
concept_ancestor

concept_ancestor

ancestor_concept_id	Integer	NN
descendant_concept_id	Integer	NN
min_levels_of_separation	Integer	NN
max_levels_of_separation	Integer	NN

```
WITH RECURSIVE related_concepts AS (  
    -- Base case  
    SELECT concept_id_1, concept_id_2  
    FROM concept_relationship  
    WHERE concept_relationship_id = 'is_a'  
  
    UNION ALL  
  
    -- Recursive step  
    SELECT rc.concept_id_1, cr.concept_id_2  
    FROM concept_relationship cr  
    JOIN related_concepts rc  
    ON cr.concept_id_1 = rc.concept_id_2  
    WHERE cr.concept_relationship_id = 'is_a'  
)  
  
SELECT DISTINCT concept_id_1, concept_id_2  
FROM related_concepts  
ORDER BY concept_id_1, concept_id_2;
```





Si los códigos utilizados en el EHR corresponden a un vocabulario existente en OMOP se pueden traducir a códigos standard

Por ejemplo:
ICD10 a SNOMED
ATC a RxNORM
Código nacional a SNOMED a RxNorm

Source to Source

```
SELECT c.concept_code AS SOURCE_CODE, c.concept_id AS SOURCE_CONCEPT_ID,
c.CONCEPT_NAME AS SOURCE_CODE_DESCRIPTION, c.vocabulary_id AS
SOURCE_VOCABULARY_ID, c.domain_id AS SOURCE_DOMAIN_ID, c.concept_class_id AS
SOURCE_CONCEPT_CLASS_ID, c.VALID_START_DATE AS SOURCE_VALID_START_DATE,
c.VALID_END_DATE AS SOURCE_VALID_END_DATE, c.invalid_reason AS
SOURCE_INVALID_REASON, c.concept_id as TARGET_CONCEPT_ID, c.concept_name AS
TARGET_CONCEPT_NAME, c.vocabulary_id AS TARGET_VOCABULARY_ID, c.domain_id AS
TARGET_DOMAIN_ID, c.concept_class_id AS TARGET_CONCEPT_CLASS_ID, c.INVALID_REASON
AS TARGET_INVALID_REASON, c.STANDARD_CONCEPT AS TARGET_STANDARD_CONCEPT
FROM CONCEPT c
UNION
SELECT source_code, SOURCE_CONCEPT_ID, SOURCE_CODE_DESCRIPTION,
source_vocabulary_id, c1.domain_id AS SOURCE_DOMAIN_ID, c2.CONCEPT_CLASS_ID AS
SOURCE_CONCEPT_CLASS_ID, c1.VALID_START_DATE AS SOURCE_VALID_START_DATE,
c1.VALID_END_DATE AS SOURCE_VALID_END_DATE, stcm.INVALID_REASON AS
SOURCE_INVALID_REASON, target_concept_id, c2.CONCEPT_NAME AS TARGET_CONCEPT_NAME,
target_vocabulary_id, c2.domain_id AS TARGET_DOMAIN_ID, c2.concept_class_id AS
TARGET_CONCEPT_CLASS_ID, c2.INVALID_REASON AS TARGET_INVALID_REASON,
c2.standard_concept AS TARGET_STANDARD_CONCEPT
FROM source_to_concept_map stcm
LEFT OUTER JOIN CONCEPT c1
ON c1.concept_id = stcm.source_concept_id
LEFT OUTER JOIN CONCEPT c2
ON c2.CONCEPT_ID = stcm.target_concept_id
WHERE stcm.INVALID_REASON IS NULL
```

Esta consulta genera una tabla con todos los códigos origen y sus correspondientes concept_id y se utiliza para rellenar los campos *_SOURCE_CONCEPT_ID

Source to Standard

```
SELECT c.concept_code AS SOURCE_CODE, c.concept_id AS SOURCE_CONCEPT_ID, c.concept_name AS
SOURCE_CODE_DESCRIPTION, c.vocabulary_id AS SOURCE_VOCABULARY_ID, c.domain_id AS SOURCE_DOMAIN_ID,
c.CONCEPT_CLASS_ID AS SOURCE_CONCEPT_CLASS_ID, c.VALID_START_DATE AS SOURCE_VALID_START_DATE,
c.VALID_END_DATE AS SOURCE_VALID_END_DATE, c.INVALID_REASON AS SOURCE_INVALID_REASON, c1.concept_id
AS TARGET_CONCEPT_ID, c1.concept_name AS TARGET_CONCEPT_NAME, c1.VOCABULARY_ID AS
TARGET_VOCABULARY_ID, c1.domain_id AS TARGET_DOMAIN_ID, c1.concept_class_id AS
TARGET_CONCEPT_CLASS_ID, c1.INVALID_REASON AS TARGET_INVALID_REASON, c1.standard_concept AS
TARGET_STANDARD_CONCEPT
FROM CONCEPT C
JOIN CONCEPT_RELATIONSHIP CR
ON C.CONCEPT_ID = CR.CONCEPT_ID_1
AND CR.invalid_reason IS NULL
AND lower(cr.relationship_id) = 'maps to'
JOIN CONCEPT C1
ON CR.CONCEPT_ID_2 = C1.CONCEPT_ID
AND C1.INVALID_REASON IS NULL
UNION
SELECT source_code, SOURCE_CONCEPT_ID, SOURCE_CODE_DESCRIPTION, source_vocabulary_id, c1.domain_id
AS SOURCE_DOMAIN_ID, c2.CONCEPT_CLASS_ID AS SOURCE_CONCEPT_CLASS_ID, c1.VALID_START_DATE AS
SOURCE_VALID_START_DATE, c1.VALID_END_DATE AS SOURCE_VALID_END_DATE, stcm.INVALID_REASON AS
SOURCE_INVALID_REASON, target_concept_id, c2.CONCEPT_NAME AS TARGET_CONCEPT_NAME,
target_vocabulary_id, c2.domain_id AS TARGET_DOMAIN_ID, c2.concept_class_id AS TARGET_CONCEPT_CLASS_ID,
c2.INVALID_REASON AS TARGET_INVALID_REASON, c2.standard_concept AS TARGET_STANDARD_CONCEPT
FROM source_to_concept_map stcm
LEFT OUTER JOIN CONCEPT c1
ON c1.concept_id = stcm.source_concept_id
LEFT OUTER JOIN CONCEPT c2
ON c2.CONCEPT_ID = stcm.target_concept_id
WHERE stcm.INVALID_REASON IS NULL
```

Esta consulta genera una tabla con todos los códigos origen y sus correspondientes concept_id estándar y se utiliza para rellenar los campos *_CONCEPT_ID

Preguntas?

GRACIAS POR VUESTRA ATENCIÓN

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