Working Group Issues for OMOP PCORnet v3.

Here are the items from last week’s meeting that we need to take a look at and prioritize for the group.

1.       Medications (done)

a.       Prescribing

b.      Dispensing

2.       Death including Death Condition

Death

*Reported mortality information for patients.*

Additional Notes:

* The DEATH table contains one record per unique combination of PATID, DEATH\_DATE, and DEATH\_SOURCE
* One patient may potentially have multiple records in this table because their death may be reported by different sources.
* Deaths represented in the ENCOUNTER.DISCHARGE\_DISPOSITION and ENCOUNTER.DISCHARGE\_STATUS would generally be expected to be present in this table (see guidance for DEATH\_SOURCE).

Death Condition

*The individual causes associated with a reported death.*

Additional Notes:

* The DEATH\_CAUSE table contains one record per unique combination of PATID, DEATH\_CAUSE, DEATH\_CAUSE\_CODE, DEATH\_CAUSE\_TYPE, and DEATH\_CAUSE\_SOURCE.
* When legacy data have conflicting reports, please make a local determination as to which to use. There is typically a 1-2 year lag in death registry data.

3.       Conditions (done)

Diagnosis vs Condition (PCORnet view of the world)

Diagnosis

*Encounters are interactions between patients and providers within the context of healthcare delivery.*

Additional Notes:

* This table should capture all uniquely recorded diagnoses for all encounters.
* Diagnoses from problem lists will be captured in the separate CONDITION table.
* If a patient has multiple diagnoses associated with one encounter, then there would be one record in this table for each diagnosis.
* ENCOUNTERID is not optional for DIAGNOSIS and PROCEDURES. The definitions of the DIAGNOSIS and PROCEDURES tables are dependent upon a healthcare context; therefore, the ENCOUNTER basis is necessary.
* Data in this table are expected to be from healthcare-mediated processes and reimbursement drivers. This can include both technical/facility billing and professional billing.
* We recognize that, in many cases, these diagnoses may only be related to the **treatment** of the patient during the specific encounter. For example, chronic conditions may not be pertinent to the treatment of a specific encounter, and would not be expected to be present.
* If a local ontology is used, but cannot be mapped to a standard ontology such as ICD-9-CM, DX\_TYPE should be populated as “Other”.

Condition

*A condition represents a patient’s diagnosed and self-reported health conditions and diseases. The patient’s medical history and current state may both be represented.*

Additional Notes:

* This table includes both healthcare and non-healthcare settings.
* Rollback or voided transactions and other adjustments should be processed before populating this table.

OMOP Condition Type Concepts (can we partition these types into PCORnet view)

* EHR Chief Complaint
* EHR Episode Entry
* EHR problem list entry
* First Position Condition
* Inpatient header - primary
* Primary Condition
* Referral record
* Secondary Condition

4.       Pro-CM (Patient reported)

5.       Labs (Parking lot issues)