

OMOP Data Tables for Research Data Requests

OMOP data tables and elements are available as a HIPAA Limited Data Set or Fully De-Identified (Non-human) data set

Reference "All OMOP Tables" in the Data collection section of your IRB submission

For more information on OMOP or the OMOP Common Data Model see: <https://www.ohdsi.org/data-standardization/>

For questions about UF OMOP data and data release process, please email: IRBDataRequest@ahc.ufl.edu

LIST OF TABLES (see following pages for data details within tables)

- 1 **PERSON TABLE:** This table serves as the central identity management for all Persons in the database. It contains records that uniquely identify each person or patient, and some demographic information.
- 2 **DEATH TABLE:** contains the death date for each patient that is known to be deceased
- 3 **VISIT_OCCURRENCE TABLE:** contains events where Persons engage with the healthcare system for a duration of time. They are often also called "Encounters".
- 4 **OBSERVATION TABLE:** contains observations collected during all encounters. Observations include (but not limited to) smoking history, zip codes, and insurance type. Observations differ from Measurements in that they do not require a standardized test or some other activity to generate clinical fact.
- 5 **OBSERVATION_PERIOD TABLE:** provides start and end dates for available encounter records
- 6 **CONDITION_OCCURRENCE TABLE:** contains records of Events of a Person suggesting the presence of a disease or medical condition stated as a diagnosis, a sign, or a symptom, which is either observed by a Provider or reported by the patient.
- 7 **PROCEDURE_OCCURRENCE TABLE:** contains records of activities or processes ordered or carried out by a healthcare Provider on the patient with a diagnostic
- 8 **DRUG_EXPOSURE TABLE:** contains information about medications prescribed for outpatient use and administrations documented on the MAR during hospital
- 9 **MEASUREMENT TABLE:** information on measurements collected during encounters. Measurements include lab results, vitals, and assessment scales.
- 10 **DEVICE_EXPOSURE TABLE:** information about devices used during any encounter. It is generated based on procedure CPT and ICD codes that map to an
- 11 **PROVIDER TABLE:** information about providers (de-identified; no information will be provided that will allow identification of actual provider)
- 12 **LOCATION TABLE:** represents a generic way to capture physical location or address information of Persons and Care Sites. Locations do not contain names,
- 13 **CARE_SITE TABLE:** contains a list of uniquely identified institutional (physical or organizational) units where healthcare delivery is practiced (offices, wards, hos

PERSON TABLE: This table serves as the central identity management for all Persons in the database. It contains records that uniquely identify each person or patient, and some demographic information.

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset	Fully De-Identified Dataset
person_id	Unique key for each unique patient	Unique number providing a way to link patient data while maintaining confidentiality	Y	De-identified	De-identified
gender_concept_id	OMOP standard concept ID for gender of the patient		N	Raw value provided	Raw value provided
year_of_birth	Year part of birth_datetime		N	Raw value provided	Raw value provided
month_of_birth	Month part of birth_datetime		N	Raw value provided	Raw value provided
day_of_birth	Day part of birth_datetime		Y	Raw value provided	Date Shifted
birth_datetime	Time of birth	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
race_concept_id	OMOP standard concept for specific race		N	Raw value provided	Raw value provided
ethnicity_concept_id	OMOP standard concept_id for specific ethnicity		N	Raw value provided	Raw value provided
location_id	A unique identifier for physical address of the person	Unique number providing a way to link patient location data while maintaining confidentiality	Y	De-identified	De-identified
provider_id	ID number for last known primary care provider	Unique number that links to patient's primary care provider in PROVIDER table	Y	De-identified	De-identified
care_site_id	The Care Site refers to where the Provider typically provides the primary care	Unique number that links to patient's primary care provider location	Y	De-identified	De-identified
person_source_value	Original source code or identifier for a person as it appears in the source data. We use patient key for this column.	Links directly back to patient in source data.	Y	De-identified	De-identified
gender_source_value	Sex as reported at birth		N	Raw value provided	Raw value provided
gender_source_concept_id	OMOP standard concept ID for gender source	Always zero. Use gender_source_value to determine birth sex	N	Raw value provided	Raw value provided
race_source_value	Most recent race recorded in EHR as reported by patient		N	Raw value provided	Raw value provided
race_source_concept_id	OMOP standard concept ID for race source	Always zero. Use race_source_value to determine race	N	Raw value provided	Raw value provided
ethnicity_source_value	Most recent ethnicity recorded in EHR as reported by patient		N	Raw value provided	Raw value provided
ethnicity_source_concept_id	OMOP standard concept ID for ethnicity source	Always zero. Use ethnicity_source_value to determine ethnicity	N	Raw value provided	Raw value provided

DEATH TABLE: contains the death date for each patient that is known to be deceased.

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
person_id	Unique key for each unique patient	Unique number providing a way to link patient data while maintaining confidentiality	Y	De-identified	De-identified
death_date	Date of death		Y	Raw value provided	Date Shifted
death_datetime	Time of death	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
death_type_concept_id	OMOP ID denoting source of information. Declares the capture mechanism that created this record	Either Epic EHR or SSDI	N	Raw value provided	Raw value provided
cause_concept_id	Not populated in source data		N/A	N/A	N/A
cause_source_value	Not populated in source data		N/A	N/A	N/A
cause_source_concept_id	Not populated in source data		N/A	N/A	N/A

VISIT_OCCURRENCE TABLE: contains events where Persons engage with the healthcare system for a duration of time. They are often also called “Encounters”.

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
visit_occurrence_id	Unique key for each unique interaction between a person and the healthcare system where the person receives a medical good or service	Unique number that links to individual patient encounters (visits)	Y	De-identified	De-identified
person_id	Unique key for each unique patient	Unique number providing a way to link patient data while maintaining confidentiality	Y	De-identified	De-identified
visit_concept_id	OMOP standard concept_id representing the kind of visit, like inpatient or outpatient	Derived from visit_source_value	N	Raw value provided	Raw value provided
visit_start_date	Start date of encounter	For inpatient visits, the start date is typically the admission date. For outpatient visits the start date and end date will be the same.	Y	Raw value provided	Date Shifted
visit_start_datetime	Start time of encounter	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
visit_end_date	End date of encounter	Discharge date for hospital visit or Appointment date for clinic visit	Y	Raw value provided	Date Shifted
visit_end_datetime	End time of encounter	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
visit_type_concept_id	OMOP ID denoting source of information. Declares the capture mechanism that created this record.	All results currently set to EHR concept ID (32817)	N	Raw value provided	Raw value provided
provider_id	The main provider for the encounter. It is attending provider for inpatient encounters and visit provider for outpatient providers	Unique number that links to encounter provider. There will only be one provider per visit record	Y	De-identified	De-identified
care_site_id	The Care Site where the encounter (visit) took place	Unique de-identified number that links to encounter location	Y	De-identified	De-identified
visit_source_value	Value from the source data representing the kind of visit that took place (inpatient, outpatient, emergency, etc)		N	Raw value provided	Raw value provided
visit_source_concept_id	Same as visit_concept_id		N	Raw value provided	Raw value provided
admitting_source_concept_id	OMOP standard concept_id for specific admitting source	Derived from admitting_source_value	N	Raw value provided	Raw value provided
admitting_source_value	Where the patient was admitted from (e.g., referral, emergency room, from another hospital)		N	Raw value provided	Raw value provided
discharge_to_concept_id	OMOP standard concept_id for specific discharge location	Derived from discharge_to_source_value	N	Raw value provided	Raw value provided
discharge_to_source_value	Where the patient was discharged following the visit (e.g., home, alternate health care facility)		N	Raw value provided	Raw value provided
preceding_visit_occurrence_id	Not populated in source data		N/A	N/A	N/A

OBSERVATION TABLE: contains observations collected during all encounters. Observations include (but not limited to) smoking history, zip codes, and insurance type. Observations differ from Measurements in that they do not require a standardized test or some other

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
observation_id	Unique key given to each observation present in the source data	Each instance of a observation present in the source data	N	Raw value provided	Raw value provided
person_id	Unique key for each unique patient	Unique number providing a way to link patient data while maintaining confidentiality	Y	De-identified	De-identified
observation_concept_id	OMOP standard concept_id for specific observation	Derived based on observation_source_value	N	Raw value provided	Raw value provided
observation_date	Date of observation		Y	Raw value provided	Date Shifted
observation_datetime	Time of observation	If time is unknown, it is set to midnight	Y	Raw value provided	Raw value provided
observation_type_concept_id	OMOP ID denoting source of information. Declares the capture mechanism that created this record.	All results currently set to EHR concept ID (32817)	N	Raw value provided	Raw value provided
value_as_number	Numerical value of the Result of the Observation, if applicable and available		N (Y for Zips)	Raw value provided	3 digit zip only (masked for low population zip codes)
value_as_string	Categorical value of the Result of the Observation, if applicable and available.		N (Y for Zips)	Raw value provided	3 digit zip only (masked for low population zip codes)
value_as_concept_id	Not populated in source data		N/A	N/A	N/A
qualifier_concept_id	Not populated in source data		N/A	N/A	N/A
unit_concept_id	OMOP standard concept_id for specific unit. Not populated for all observation concepts.	Derived based on unit_source_value	N	Raw value provided	Raw value provided
provider_id	Unique key for the provider associated with the observation record	Frequently the same provider associated with the encounter (visit)	Y	De-identified	De-identified
visit_occurrence_id	Unique key for each unique interaction between a person and the healthcare system where the person receives a medical good or service	Unique number that links to individual patient encounters (visits)	Y	De-identified	De-identified
visit_detail_id	Unique key to identify unique interactions between a person and the healthcare system.	Used to link events with a visit detail	Y	De-identified	De-identified
observation_source_value	Verbatim value from the source data representing the Observation that occurred.	Examples include "Payer"; "Smoking Status", "Zipcode", "Marital Status", etc	N (Y for Zips)	Raw value provided	3 digit zip only (masked for low population zip codes)
observation_source_concept_id	OMOP concept_id for specific observation; not necessarily standard concept_id	Derived based on observation_source_value	N	Raw value provided	Raw value provided
unit_source_value	Value from the source data representing the unit of the Observation that occurred.	Mapped to a Standard Condition Concept in the Standardized Vocabularies and the original code is stored here for reference.	N	Raw value provided	Raw value provided
qualifier_source_value	Not populated in source data		N/A	N/A	N/A
value_source_value	Verbatim result value of the Observation from the source data.		N (Y for Zips)	Raw value provided	3 digit zip only (masked for low population zip codes)
observation_event_id	Not populated in source data		N/A	N/A	N/A
obs_event_field_concept_id	Not populated in source data		N/A	N/A	N/A

OBSERVATION_PERIOD TABLE: provides start and end dates for available encounter records

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
observation_period_id	Unique key given to each discrete Observation Period for a person	A Person can have multiple discrete Observation Periods which are identified by the Observation_Period_Id	N	Raw value provided	Raw value provided
person_id	Unique key for each unique patient	Unique number providing a way to link patient data while maintaining confidentiality	Y	De-identified	De-identified
observation_period_start_date	The earliest visit_start_date in visit_occurrence table for the patient		Y	Raw value provided	Date Shifted
observation_period_end_date	The latest visit_end_date in visit_occurrence table for the patient		Y	Raw value provided	Date Shifted
period_type_concept_id	OMOP ID denoting source of information. Declares the capture mechanism that created this record.	All results currently set to EHR concept ID (32817)	N	Raw value provided	Raw value provided

CONDITION_OCCURRENCE TABLE: :contains records of Events of a Person suggesting the presence of a disease or medical condition stated as a diagnosis, a sign, or a symptom, which is either observed by a Provider or reported by the patient.

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
condition_occurrence_id	Unique key given to a condition record for a person	Each instance of a condition present in the source data	N	Raw value provided	Raw value provided
person_id	Unique key for each unique patient	Unique number providing a way to link patient data while maintaining confidentiality	Y	De-identified	De-identified
condition_concept_id	OMOP standard concept mapped from the source value which represents a condition	Derived based on condition_source_value	N	Raw value provided	Raw value provided
condition_start_date	Date the condition is noted in the data source (e.g., EHR). This is not necessarily the first time the patient has had the condition in their life.		Y	Raw value provided	Date Shifted
condition_start_datetime	Time the condition is noted in the data source (e.g., EHR).	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
condition_end_date	End date of the condition if available		Y	Raw value provided	Date Shifted
condition_end_datetime	Ttime of the condition if available	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
condition_type_concept_id	OMOP ID denoting source of information. Declares the capture mechanism that created this record.	Currently set to EHR	N	Raw value provided	Raw value provided
condition_status_concept_id	OMOP standard concept_id that represents the point during the visit the diagnosis was given (admitting diagnosis, final diagnosis)	Derived based on condition_status_source_value	N	Raw value provided	Raw value provided
stop_reason	Not populated in source data		N/A	N/A	N/A
provider_id	Unique key for the provider associated with the observation record	Frequently the same provider associated with the encounter (visit)	Y	De-identified	De-identified
visit_occurrence_id	Unique key for the visit during which the condition was recorded.	Uniqe number that links to individual patient encounters (visits)	Y	De-identified	De-identified
visit_detail_id	Unique key to identify unique interactions between a person and the healthcare system.	Used to link events with a visit detail	Y	De-identified	De-identified
condition_source_value	This field houses the verbatim value from the source data representing the condition that occurred.	ICD-9 (prior to Oct 2015) or ICD-10 (after Oct 2015) value	N	Raw value provided	Raw value provided
condition_source_concept_id	OMOP concept_id for specific condition; not necessarily standard concept_id	Discouraged from use in analysis because it is not required to contain Standard Concepts that are used across the OHDSI community, and should only be used when Standard Concepts do not adequately represent the source detail for the Condition necessary for a given analytic use case.	N	Raw value provided	Raw value provided
condition_status_source_value	Source of the condition. Verbatim code or free text string reflecting how this Event was represented in the source data.	Admit, Principal, POA diagnosis	N	Raw value provided	Raw value provided

PROCEDURE_OCCURRENCE TABLE: contains records of activities or processes ordered or carried out by a healthcare Provider on the patient with a diagnostic or therapeutic purpose

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
procedure_occurrence_id	Unique key given to a procedure record for a person.	Each instance of a procedure present in the source data	N	Raw value provided	Raw value provided
person_id	Unique key for each unique patient	Unique number providing a way to link patient data while maintaining confidentiality	Y	De-identified	De-identified
procedure_concept_id	OMOP standard concept for specific procedure recommended for primary use in analyses, and must be used for network studies.	Maps to a corresponding SNOMED ID procedure code	N	Raw value provided	Raw value provided
procedure_date	Start date of procedure		Y	Raw value provided	Date Shifted
procedure_datetime	Start time of procedure	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
procedure_end_date	End date of the procedure if available		Y	Raw value provided	Date Shifted
procedure_end_datetime	End time of the procedure if available	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
procedure_type_concept_id	OMOP ID denoting source of information. Declares the capture mechanism that created this record.	Provides information about the provenance of the procedure record, i.e. does it come from the EHR order, administrative claim, etc	N	Raw value provided	Raw value provided
modifier_concept_id	Intended to give additional information about the procedure	Not used. All values currently set to "0"	N	Raw value provided	Raw value provided
quantity	If the quantity value is omitted, a single procedure is assumed	Not used. All values currently set to "1"	N	Raw value provided	Raw value provided
provider_id	The OMOP provider ID associated with the procedure record, e.g. the provider who performed the Procedure.		Y	De-identified	De-identified
visit_occurrence_id	A unique identifier for each unique interaction between a person and the healthcare system where the person receives a medical good or service		Y	De-identified	De-identified
visit_detail_id	Unique key to identify unique interactions between a person and the healthcare system.	Used to link events with a visit detail	Y	De-identified	De-identified
procedure_source_value	Verbatim value from the source data representing the procedure that occurred.	The code or information for the procedure as it appears in the source data. Frequently the CPT value.	N	Raw value provided	Raw value provided
procedure_source_concept_id	OMOP concept_id for specific procedure; not necessarily standard concept_id	Discouraged from use in analysis because it is not required to contain Standard Concepts that are used across the OHDSI community, and should only be used when Standard Concepts do not adequately represent the source detail for the Procedure necessary for a given analytic use case.	N	Raw value provided	Raw value provided
modifier_source_value	Not populated in source data		N/A	N/A	N/A

DRUG_EXPOSURE TABLE: contains information about medications prescribed for outpatient use and administrations documented on the MAR during hospital encounters.

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
drug_exposure_id	Unique key given to records of drug orders or administrations for a person	Each instance of a drug order or administration present in the source data	N	Raw value provided	Raw value provided
person_id	Unique key for each unique patient	Unique number providing a way to link patient data while maintaining confidentiality	Y	De-identified	De-identified
drug_concept_id	OMOP standard concept for standard concept mapped from the drug source concept id which represents a drug product	Maps to specific drug	N	Raw value provided	Raw value provided
drug_exposure_start_date	Start date for taking medication	If start date is not recorded in EHR, order date is used	Y	Raw value provided	Date Shifted
drug_exposure_start_datetime	Start time for taking medication	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
drug_exposure_end_date	End date for taking medication	If end date is not recorded in EHR, it is set to start date	Y	Raw value provided	Date Shifted
drug_exposure_end_datetime	End time for taking medication	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
verbatim_end_date	End date for taking medication as recorded in EHR	If end date is not recorded in EHR, this column remains blank	Y	Raw value provided	Date Shifted
drug_type_concept_id	OMOP ID denoting source of information. Declares the capture mechanism that created this record.	Provides information about the provenance of the record, e.g. whether it came from a record of a prescription written or physician administered drug	N	Raw value provided	Raw value provided
stop_reason	Not populated in source data		N/A	N/A	N/A
refills	The number of refills indicated at the time of the prescription		N	Raw value provided	Raw value provided
quantity	The drug quantity as recorded in the original prescription or dispensing record		N	Raw value provided	Raw value provided
days_supply	Not populated in source data		N/A	N/A	N/A
sig	The directions on the drug prescription as recorded in the original prescription (and printed on the container) or dispensing record		N	Raw value provided	Raw value provided
route_concept_id	Not populated in source data		N/A	N/A	N/A
lot_number	Not populated in source data		N/A	N/A	N/A
provider_id	The OMOP provider ID associated with drug record		Y	De-identified	De-identified
visit_occurrence_id	A unique identifier for each unique interaction between a person and the healthcare system in which the drug was prescribed, administered or dispensed.		Y	De-identified	De-identified
visit_detail_id	Unique key to identify unique interactions between a person and the healthcare system.	Used to link events with a visit detail	Y	De-identified	De-identified
drug_source_value	RxNorm	Source code for the drug as it appears in the source data	N	Raw value provided	Raw value provided
drug_source_concept_id	OMOP concept_id for specific medication; frequently matches drug_concept_id but not always	Another OMOP standard concept that maps to specific drug	N	Raw value provided	Raw value provided
route_source_value	Med route as specified in the EHR (e.g., oral, intravenous, inhalation, topical, etc.)		N	Raw value provided	Raw value provided
dose_unit_source_value	Dose unit as specified in the EHR (e.g., mg, mcg/kg/minute, capsule etc.)		N	Raw value provided	Raw value provided

MEASUREMENT TABLE: information on measurements collected during encounters. Measurements include lab results, vitals, and assessment scales.

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
measurement_id	Unique OMOP key given to a Measurement record for a Person	Each instance of a measurement present in the source data	N	Raw value provided	Raw value provided
person_id	Unique key for each unique patient	Unique number providing a way to link patient data while maintaining confidentiality	Y	De-identified	De-identified
measurement_concept_id	OMOP standard concept for specific measurement	Derived based on measurement_source_value	N	Raw value provided	Raw value provided
measurement_date	Date of measurement		Y	Raw value provided	Date Shifted
measurement_datetime	Time of measurement	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
measurement_time	Time part of measurement_datetime	If time is unknown, the field is set to NULL	N	Raw value provided	Raw value provided
measurement_type_concept_id	OMOP concept_ID for source of information	Provides information about the provenance of the measurement record, e.g. EHR, billing claim, etc	N	Raw value provided	Raw value provided
operator_concept_id	OMOP concept_ID for measurement operators (greater than, less than, etc)	Only applicable to numeric values in which the result is represented with an operator.	N	Raw value provided	Raw value provided
value_as_number	Result of measurement if the result is numeric		N	Raw value provided	Raw value provided
value_as_concept_id	OMOP standard concept_ID for specific measurement value	Derived based on value_source_value when populated. Only populated for a subset of measurements.	N	Raw value provided	Raw value provided
unit_concept_id	OMOP ID denoting source of information. Declares the capture mechanism that created this record.	Derived based on unit_source_value	N	Raw value provided	Raw value provided
range_low	The lower bound of normal range of the measurement	Only populated for a subset of labs	N	Raw value provided	Raw value provided
range_high	The upper bound of normal range of the measurement	Only populated for a subset of labs	N	Raw value provided	Raw value provided
provider_id	OMOP Provider ID associated with the measurement record	Provider who ordered the test	Y	De-identified	De-identified
visit_occurrence_id	A unique identifier for the visit during which the Measurement occurred		Y	De-identified	De-identified
visit_detail_id	Unique key to identify unique interactions between a person and the healthcare system.	Used to link events with a visit detail	Y	De-identified	De-identified
measurement_source_value	Exact value from the source data that represents the measurement that occurred.	Includes Vitals, Assessments, Measurement Scales, and Labs.	N	Raw value provided	Raw value provided
measurement_source_concept_id	OMOP concept_id for specific measurement; not necessarily standard concept_id	Derived based on measurement_source_value	N	Raw value provided	Raw value provided
unit_source_value	Exact value from the source data that represents the unit of measurement used.		N	Raw value provided	Raw value provided
unit_source_concept_id	OMOP concept_id for specific unit; not necessarily standard concept_id		N	Raw value provided	Raw value provided
value_source_value	Verbatim result value of the Measurement from the source data .		N	Raw value provided	Raw value provided
measurement_event_id	Not populated in source data		N/A	N/A	N/A
meas_event_field_concept_id	Not populated in source data		N/A	N/A	N/A
modifier_of_event_id	Not populated in source data		N/A	N/A	N/A
modifier_of_field_concept_id	Not populated in source data		N/A	N/A	N/A

DEVICE_EXPOSURE TABLE: information about devices used during any encounter. It is generated based on procedure CPT and ICD codes that map to an OMOP concept in the device domain.

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
device_exposure_id	Unique OMOP key given to records a person's exposure to a foreign physical object or instrument.	Each instance of an exposure to a foreign object or device present in the source data	N	Raw value provided	Raw value provided
person_id	Unique key for each unique patient	Unique number providing a way to link patient data while maintaining confidentiality	Y	De-identified	De-identified
device_concept_id	OMOP standard concept mapped from the source_concept_id which represents a foreign object or instrument the person was exposed to.	The CONCEPT_ID that the DEVICE_SOURCE_VALUE maps to.	N	Raw value provided	Raw value provided
device_exposure_start_date	Start date of device exposure		Y	Raw value provided	Date Shifted
device_exposure_start_datetime	Start time of device exposure	If time is unknown, it is set to midnight	N	Raw value provided	Raw value provided
device_exposure_end_date	Not populated in source data		N/A	N/A	N/A
device_exposure_end_datetime	Not populated in source data		N/A	N/A	N/A
device_type_concept_id	OMOP ID denoting source of information. Declares the capture mechanism that created this record.	All results currently set to EHR concept ID (32817)	N	Raw value provided	Raw value provided
unique_device_id	Not populated in source data		N/A	N/A	N/A
production_id	Not populated in source data		N/A	N/A	N/A
quantity	Not populated in source data		N/A	N/A	N/A
provider_id	OMOP Provider ID associated with device record, e.g. the provider who wrote the prescription or the provider who implanted the device.		Y	De-identified	De-identified
visit_occurrence_id	A unique identifier for the visit during which the device was prescribed or given.		Y	De-identified	De-identified
visit_detail_id	Unique key to identify unique interactions between a person and the healthcare system.	Used to link events with a visit detail	Y	De-identified	De-identified
device_source_value	Value from the source data representing the device exposure that occurred.	This code is mapped to a Standard Device Concept in the Standardized Vocabularies and the original code is stored here for reference.	N	Raw value provided	Raw value provided
device_concept_source_id	OMOP concept_id for specific device; not necessarily standard concept_id	Derived based on device_source_value	N	Raw value provided	Raw value provided
unit_concept_id	Not populated in source data		N/A	N/A	N/A
unit_source_value	Not populated in source data		N/A	N/A	N/A
unit_source_concept_id	Not populated in source data		N/A	N/A	N/A

PROVIDER TABLE: information about providers (de-identified; no information will be provided that will allow identification of actual provider).

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
provider_id	A unique OMOP key for individual provider	Each individual provider will have his/her own unique provider_id	Y	De-identified	De-identified
provider_name	Provider real name		Y	Suppressed	Suppressed
npi	Provider's National Provider Number		Y	Suppressed	Suppressed
dea	Provider's DEA number		Y	Suppressed	Suppressed
specialty_concept_id	OMOP standard concept_id for provider specialty	Derived based on specialty_source_value	N	Raw value provided	Raw value provided
care_site_id	Not populated in source data		N/A	N/A	N/A
year_of_birth	Recorded year of birth of the provider in the source data		N	Raw value provided	Raw value provided
gender_concept_id	OMOP ID representing recorded gender of the provider in the source data		N	Raw value provided	Raw value provided
provider_source_value	Field to link back to providers in the source data.		Y	Suppressed	Suppressed
specialty_source_value	Specific type of healthcare provider or field of expertise listed in the source data		N	Raw value provided	Raw value provided
specialty_source_concept_id	Not populated in source data		N/A	N/A	N/A
gender_source_value	Providers gender as it appears in source data	Male, Female, etc	N	Raw value provided	Raw value provided
gender_source_concept_id	Not populated in source data		N/A	N/A	N/A

LOCATION TABLE: represents a generic way to capture physical location or address information of Persons and Care Sites. Locations do not contain names, such as the name of a hospital.

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
location_id	Unique OMOP key given to a unique Location	Each individual location will have its own unique location_id. Not linked to any patient in the context of this table.	N	Raw value provided	Raw value provided
address_1	Patients most recent street address		Y	Suppressed	Suppressed
address_2	Additional details for address (apartment #, etc)		Y	Suppressed	Suppressed
city	Most recent city		Y	Suppressed	Suppressed
state	Most recent state		N	Suppressed	Suppressed
zip	Most recent zip code	Changed to "000" when population less than 20,000	Y	Raw value provided	3 digit zip only (masked for low population zip codes)
county	Most recent county		Y	Suppressed	Suppressed
location_source_value	A unique internal identifier for the table	Our internal identification number associated with the location in the source value	Y	Suppressed	Suppressed
country_concept_id	Not populated in source data		N/A	N/A	N/A
country_source_value	Not populated in source data		N/A	N/A	N/A
latitude	Most recent address latitude		Y	Suppressed	Suppressed
longitude	Most recent address longitude		Y	Suppressed	Suppressed

CARE_SITE TABLE: contains a list of uniquely identified institutional (physical or organizational) units where healthcare delivery is practiced (offices, wards, hospitals, clinics, etc.).

Column Name	Description	Notes	PHI?	HIPAA Limited Dataset notes	Fully De-Identified Dataset notes
care_site_id	Unique OMOP key that represents the unique combination of location_id and nature of the site	Nature of the site could be the place of service, name, or another characteristic in the source data	N	Raw value provided	Raw value provided
care_site_name	Name of the care_site as it appears in the source data		Y	Suppressed	Suppressed
place_of_service_concept_id	Not populated in source data		N/A	N/A	N/A
location_id	The location_id from the LOCATION table representing the physical location of the care_site		N	Raw value provided	Raw value provided
care_site_source_value	Identifier of the care_site as it appears in the source data.		Y	Suppressed	Suppressed
place_of_service_source_value	Place of service of the care_site as it appears in the source data	General description of care site (office, hospital, etc). No specific location	N	Raw value provided	Raw value provided