OHDSI CDM and Vocab WG

## FROM: OMOP Common Data Model V5.0.1

Initial Release: 1-Oct-2014, latest release 5-Apr-2016

Visit\_Occurrence Table

|  |  |  |  |
| --- | --- | --- | --- |
| visit\_type\_concept\_id | Yes | Integer | A foreign key to the predefined Concept identifier in the Standardized Vocabularies reflecting the type of source data from which the visit record is derived. |

Standard Visit Concepts are defined as **Inpatient Visit, Outpatient Visit, Emergency Room Visit and Long Term Care Visit**. Source Concepts from place of service vocabularies are mapped into these standard visit Concepts in the Standardized Vocabularies. Each Visit is standardized by assigning a corresponding Concept Identifier based on the type of facility visited and the type of services rendered.

1. FROM: PCORNet CDM v3.01

PCORNet Encounter Types

|  |  |  |
| --- | --- | --- |
| ENC\_TYPE  | AV=Ambulatory Visit ED=Emergency Department EI=Emergency Department Admit to Inpatient Hospital Stay (permissible substitution) IP=Inpatient Hospital Stay IS=Non-Acute Institutional Stay OA=Other Ambulatory Visit NI=No information UN=Unknown OT=Other  | Encounter type. **Details of categorical definitions:** **Ambulatory Visit**: Includes visits at outpatient clinics, physician offices, same day/ambulatory surgery centers, urgent care facilities, and other same-day ambulatory hospital encounters, but excludes emergency department encounters. **Emergency Department (ED):** Includes ED encounters that become inpatient stays (in which case inpatient stays would be a separate encounter). Excludes urgent care facility visits. ED claims should be pulled before hospitalization claims to ensure that ED with subsequent admission won't be rolled up in the hospital event. **Emergency Department Admit to Inpatient Hospital Stay**: Permissible substitution for preferred state of separate ED and IP records. Only for use with data sources where the individual records for ED and IP cannot be distinguished. **Inpatient Hospital Stay:** Includes all inpatient stays, including: same-day hospital discharges, hospital transfers, and acute hospital care where the discharge is after the admission date. Does not include observation stays (guidance added in v3.1). **Non-Acute Institutional Stay**: Includes hospice, skilled nursing facility (SNF), rehab center, nursing home, residential, overnight non-hospital dialysis, and other non-hospital stays. **Other Ambulatory Visit:** Includes other non-overnight AV encounters such as hospice visits, home health visits, skilled nursing visits, other non-hospital visits, as well as telemedicine, telephone and email consultations. May also include "lab only" visits (when a lab is ordered outside of a patient visit), "pharmacy only" (e.g., when a patient has a refill ordered without a face-to-face visit), "imaging only", etc.  |

1. Other information - PCORNet CDM List for Discharge Status- some of these are also places for ‘visits’

AF=Adult Foster Home – consider HOME

AL=Assisted Living Facility – consider HOME

~~AM=Against Medical Advice~~

~~AW=Absent without leave~~

~~EX=Expired~~

HH=Home Health

HO=Home / Self Care (???)

HS=Hospice

IP=Other Acute Inpatient Hospital

NH=Nursing Home (Includes ICF)

RH=Rehabilitation Facility

RS=Residential Facility

~~SH=Still In Hospital~~

SN=Skilled Nursing Facility

Suggested list of Standard Concepts for Visit\_Type

1. AV=Ambulatory Visit
2. ED=Emergency Department
3. EI=Emergency Department Admit to Inpatient Hospital Stay (permissible substitution)
4. IP=Inpatient Hospital Stay
5. OH = Observational Hospital Stay (NEW both PCORNet & OHDSI)
6. IS=Non-Acute Institutional Stay
	1. Skilled Nursing Facility
	2. Rehabilitation
	3.
7. Long-term Acute Care(LTAC)
8. OA=Other Ambulatory Visit
9. Hospice
10. Home Health
	1. RN
	2. PT
	3. OT
	4. Other- speech
11. Telehealth