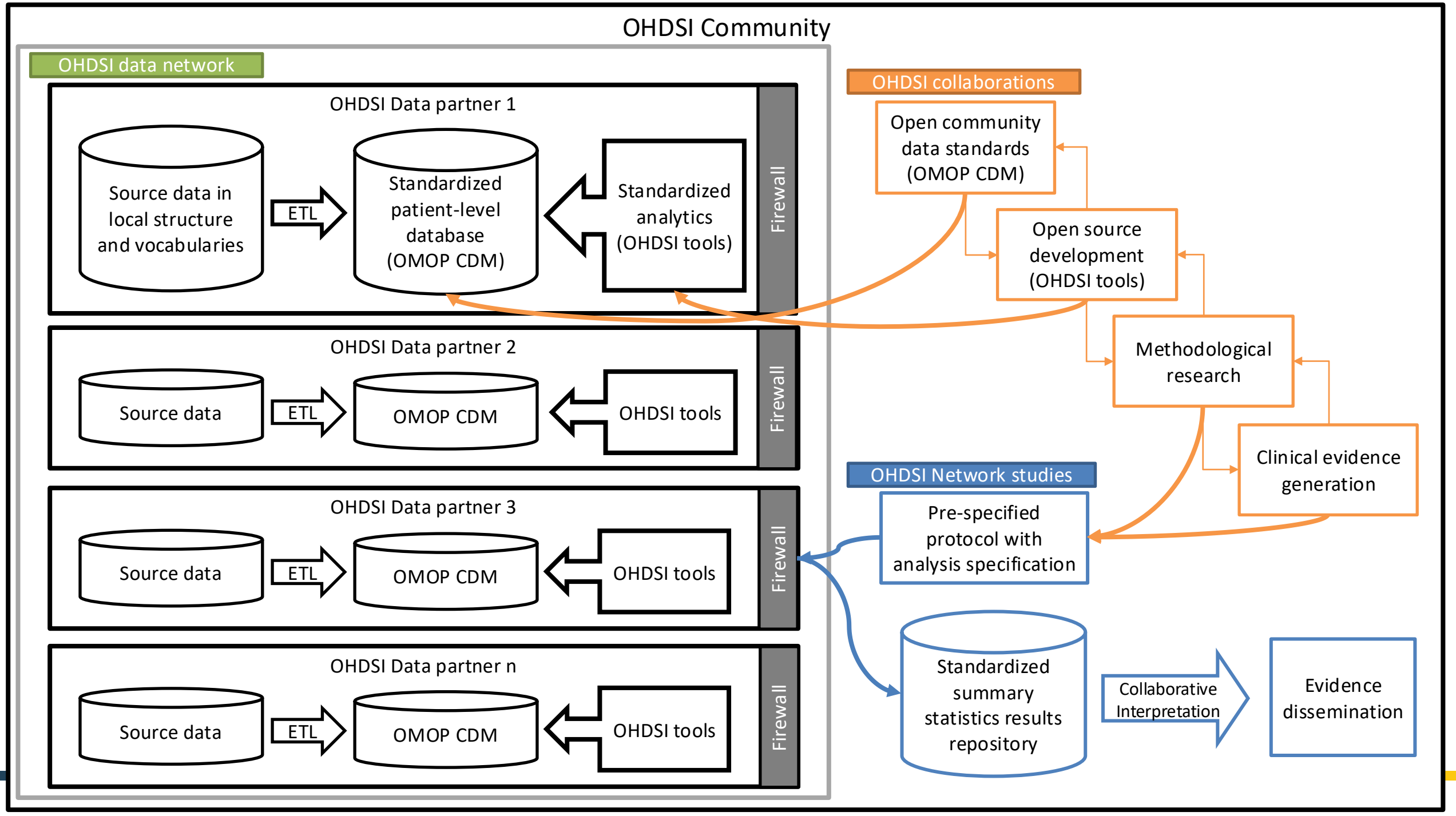
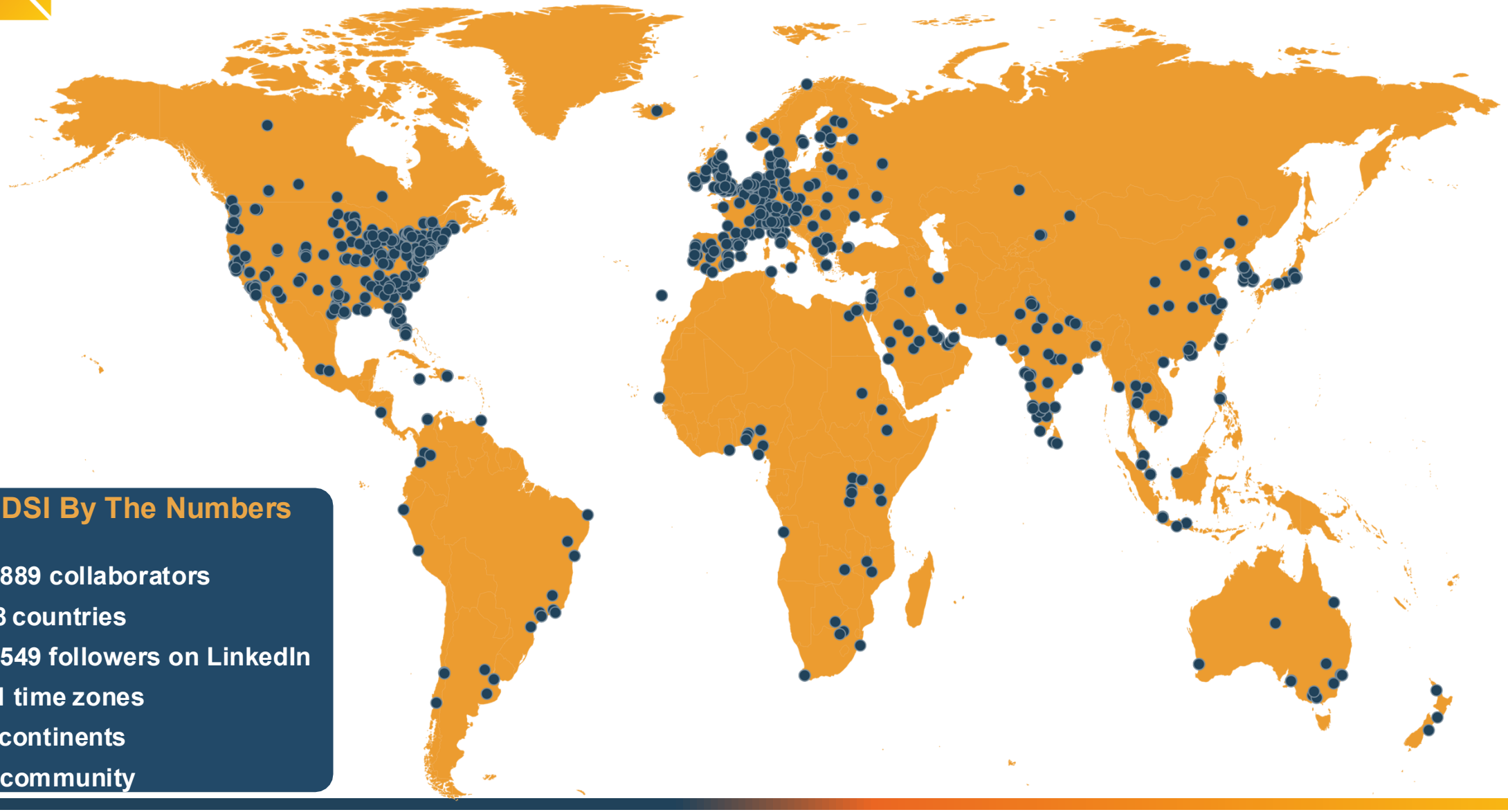
OHDSI in 2026:
Where can we go together?

OHDSI's mission

To improve health by empowering a community to collaboratively generate the evidence that promotes better health decisions and better care


OHDSI Community
OHDSI data network
OHDSI Data partner 1
Source data in local structure and vocabularies
ETL
Standardized patient-level database (OMOP CDM)
Standardized analytics (OHDSI tools)
Firewall
OHDSI Data partner 2
Source data
ETL
OMOP CDM
OHDSI tools
Firewall
OHDSI Data partner 3
Source data
ETL
OMOP CDM
OHDSI tools
Firewall
OHDSI Data partner n
Source data
ETL
OMOP CDM
OHDSI tools
Firewall
OHDSI collaborations
Open community data standards (OMOP CDM)
Open source development (OHDSI tools)
Methodological research
Clinical evidence generation
OHDSI Network studies
Pre-specified protocol with analysis specification
Standardized summary statistics results repository
Collaborative Interpretation
Evidence dissemination

OHDSI collaborators

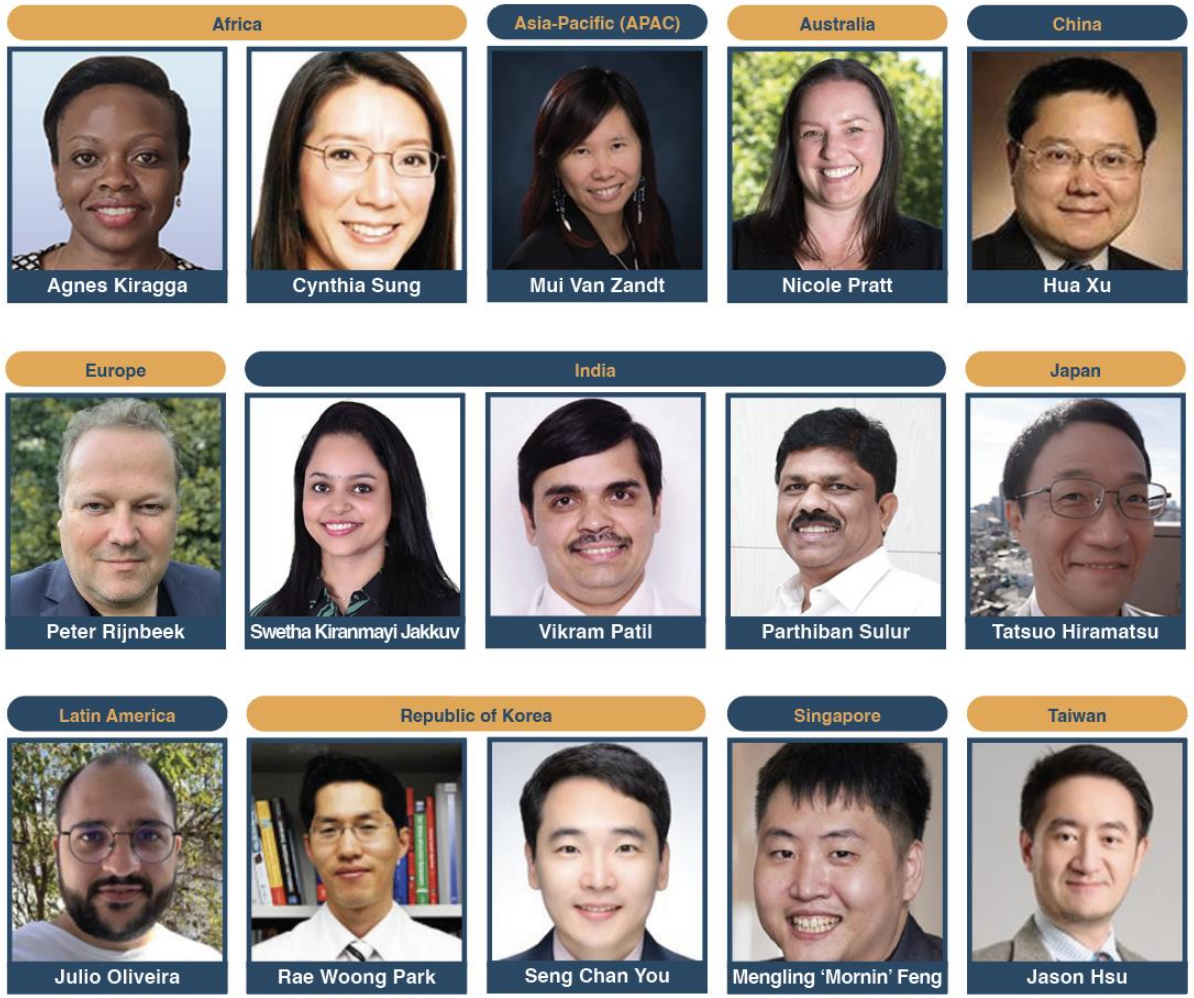


OHDSI By The Numbers

- 4,889 collaborators
- 88 countries
- 9,549 followers on LinkedIn
- 21 time zones
- 6 continents
- 1 community

Join the Journey at https://ohdsi.org/

Regional chapters and national nodes



Node	Lead(s)
Belgium	Liesbet Peeters, Annelies Verbiest, Ilse Vermeulen
Denmark	Ismail Gögenur, Martin Høyer Rose, Andreas Weinberger Rosen
Estonia	Raivo Kolde, Sulev Reisberg
Finland	Eric Fey, Gustav Klingstedt
Germany	Ines Reinecke, Michele Zoch
Greece	Anastasia Farmaki, Pantelis Natsiavas,Grigoris Papapostolou
Hungary	Zsolt Bagyura, Ágota Mészáros
Ireland	Aedin Culhane, Mark Lawler, Catherine Mahoney
Israel	Chen Yanover
Italy	Lucia Sacchi, Matteo Gabetta
Luxembourg	Claudine Backes, Andreas Kremer, Maria Quaranta
Netherlands	Renske Los, Aniek Markus
Norway	Espen Enerly, Siri Larønningen
Portugal	Patricia Couceiro, Carmen Nogueira
Spain	Miguel Angel Mayer, Talita Duarte Salles
Switzerland	Olga Endrich, Karen Triep
United Kingdom	Dani Prieto-Alhambra
coming soon	*Austria, Sweden*

Workgroups led by community

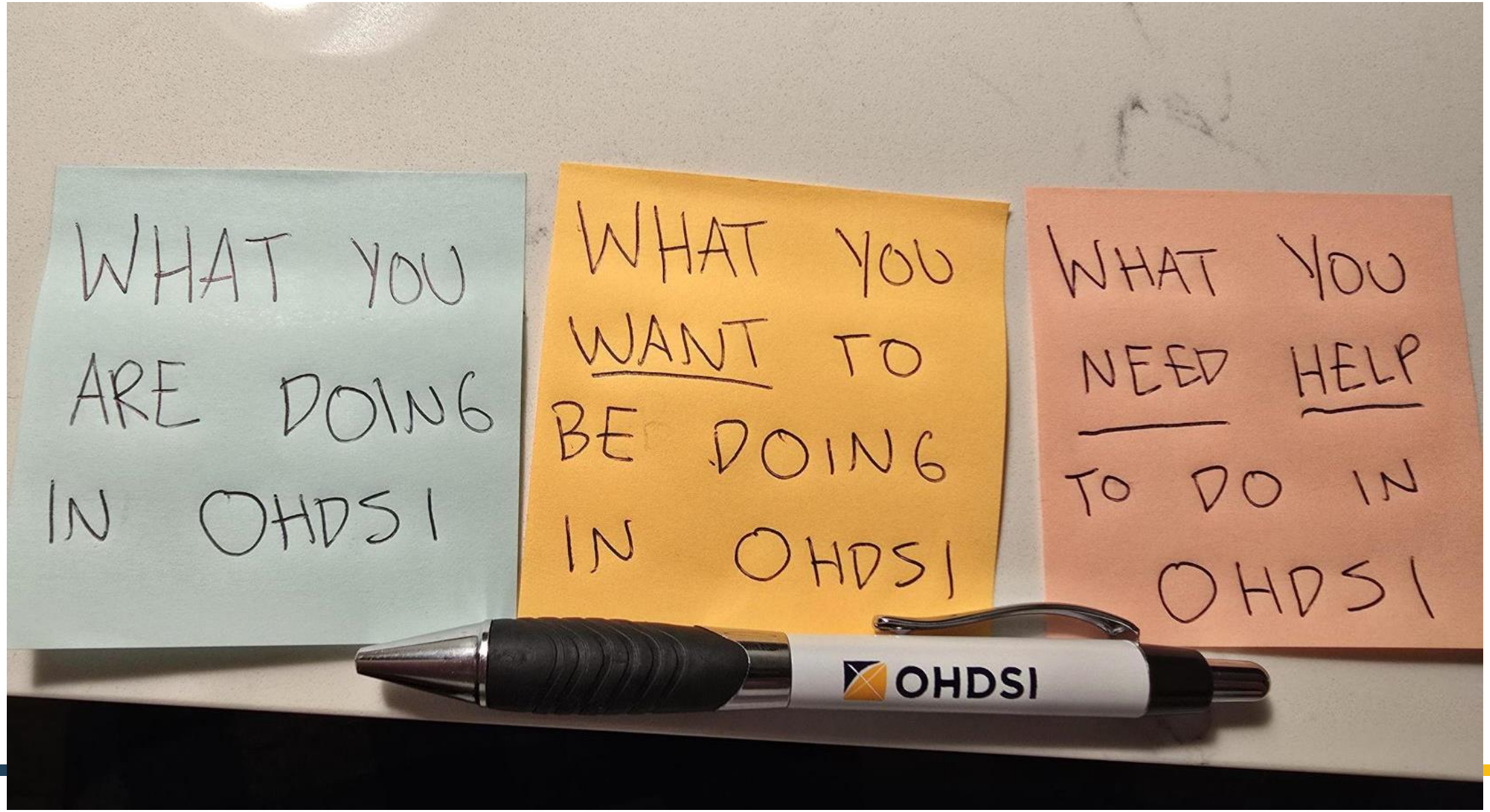
When poll is active respond at **PollEv.com/patrickryan800**

What do you want to accomplish together in 2026?

Nobody has responded yet.

Hang tight! Responses are coming in.

2025 OHDSI Global Symposium post-it exercise



Themes from 2025 OHDSI Global Symposium post-its

What people are *currently doing*

- OMOP conversions + early network studies
- Methods development
- Domain-specific analyses
- Teaching or learning OHDSI foundational skills

What people *WANT to be doing*

- Advanced analytics (AI/ML, causal inference, trajectories)
- Larger network studies
- Contributing phenotypes and methods
- Engaging in international collaboration
- Establishing local OHDSI hubs

Where people *NEED HELP*

- Vocabularies + concept sets
- ETL and data quality
- Study execution (ATLAS/HADES)
- Methods mentoring
- Concrete examples and reproducible code

2025 Workgroup leader year-in-review summary: What's Needed

A. Strategic Direction & Prioritization

- Clearer global OHDSI priorities
- A shared roadmap that aligns workgroups
- Guidance on where to focus limited resources

Groups **want top-down direction—not to constrain them, but to empower them**.

B. Help with Participation, Recruitment, and Visibility

- Publicizing workgroup activities
- Helping attract contributors with needed skills
- Coordinated onboarding pathways for new members

The community needs **better talent matching** and **pipeline building**.

C. Support for Cross-Group Coordination

- Mechanisms to align with related groups
- Shared communication channels for dependencies
- Avoiding duplicated or conflicting work

There is a strong desire for OHDSI to function more as an **integrated ecosystem**.

D. More Dedicated Technical / Engineering Support

- Developer time
- Data engineering support
- Hands-on help for code review, pipeline building, vocab work, etc.

This echoes the earlier theme **of technical workforce constraints**.

OHDSI Central Coordinating Center responsibilities

Steward open community data standards

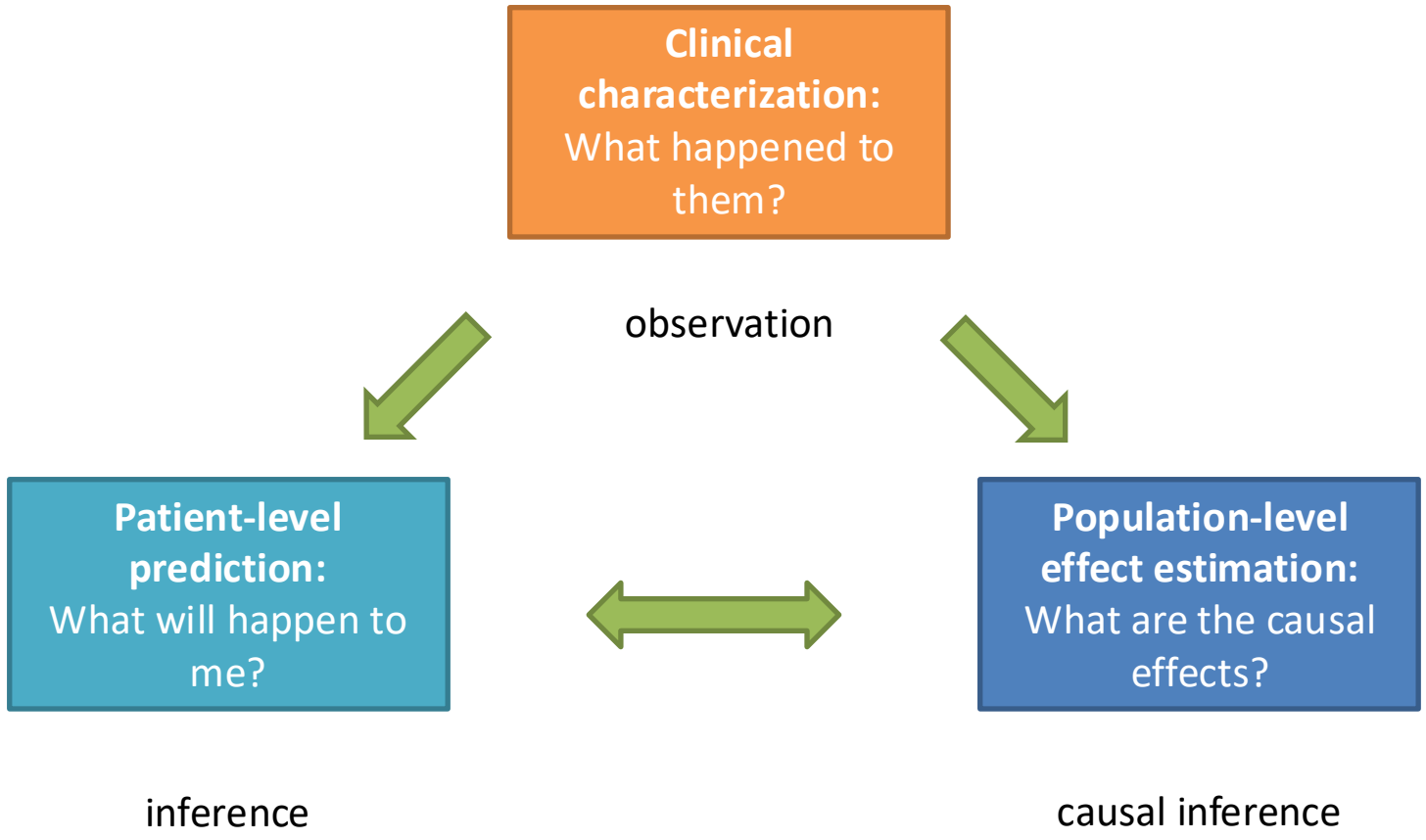
Enable open source development

Facilitate methods research and clinical applications

Encourage open sharing and evidence dissemination

Foster collaborations and empower community

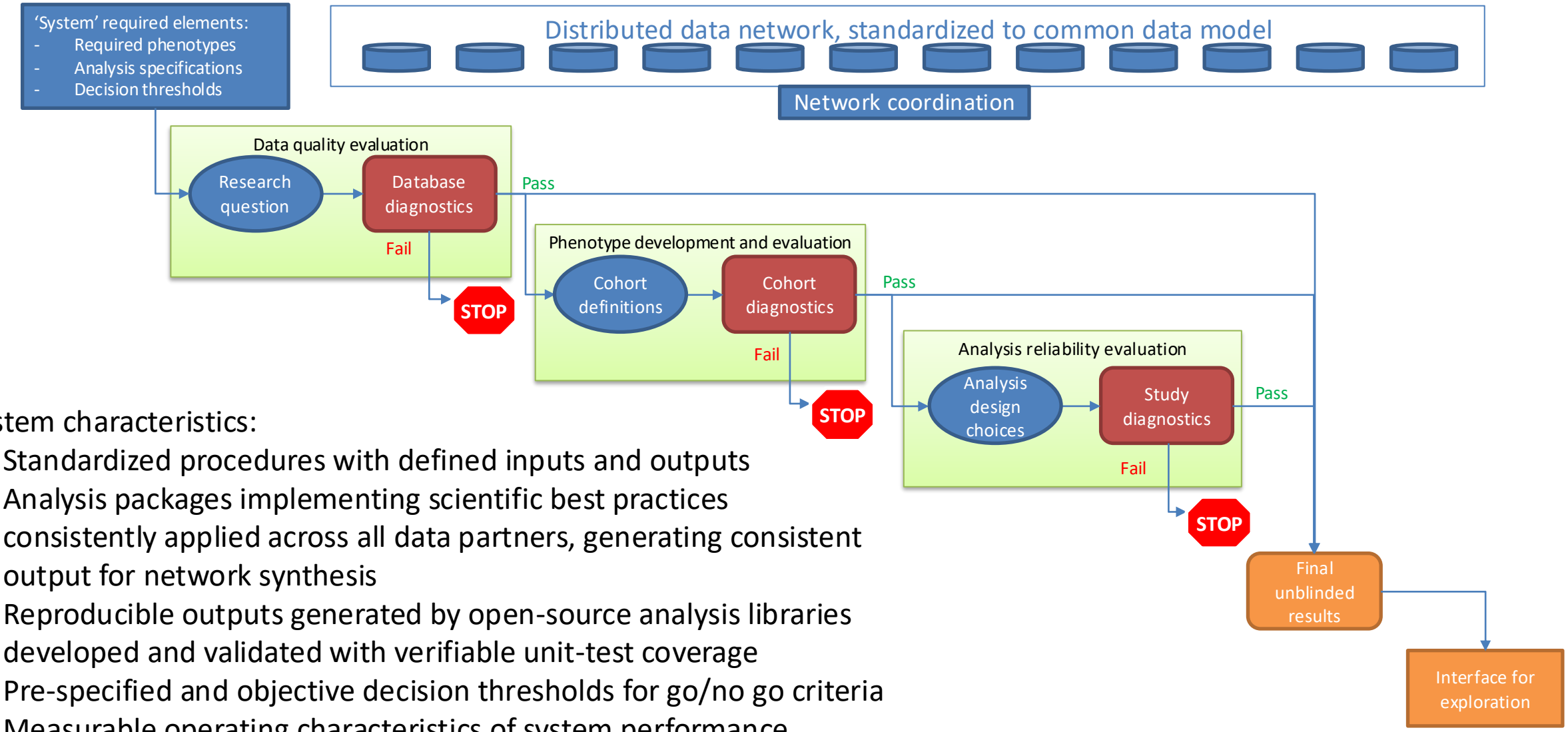
Complementary evidence to inform the patient journey



Standardizing the question makes it possible to standardize the evidence

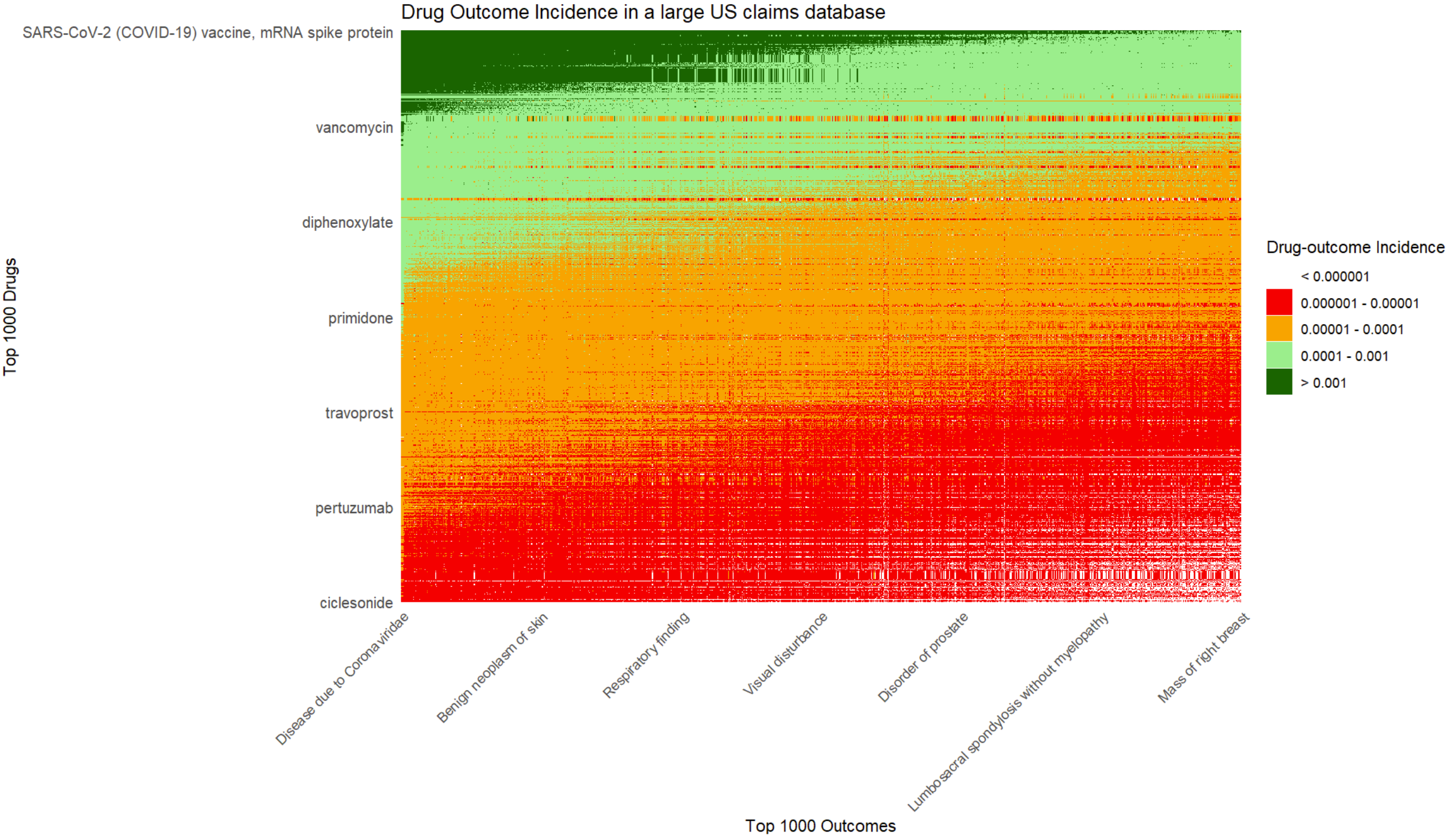
Analytic use case	Type	Structure
Clinical characterization	**Disease Natural History**	Amongst patients who are diagnosed with <insert disease of interest>, what are the patient's characteristics from their medical history?
	Treatment utilization	Amongst patients who have <insert disease of interest>, which treatments were patients exposed to amongst <list of treatments for disease> and in which sequence?
	Outcome incidence	Amongst patients who are new users of <insert drug of interest> among the population with <insert indication of interest>, how many patients experienced <insert outcome of interest> within <time horizon following exposure start>?
Population-level effect estimation	**Safety surveillance**	Does exposure to <insert drug of interest> increase the risk of experiencing <insert an adverse event> within <time horizon following exposure start>, among the population with <insert indication of interest>?
	Comparative effectiveness	Does exposure to <insert drug of interest> have a different risk of experiencing <insert any outcome (safety or benefit) > within <time horizon following exposure start>, relative to <insert comparator treatment>, among the population with <insert indication of interest>?
Patient level prediction	**Disease onset and progression**	For a given patient who is diagnosed with <insert your favorite disease>, what is the probability that they will go on to have <another disease or related complication> within <time horizon from diagnosis>?
	Treatment response	For a given patient who is a new user of <insert drug of interest> for <insert indication of interest>, what is the probability that they will <insert desired effect> in <time window>?
	Treatment safety	For a given patient who is a new user of <insert drug of interest> for <insert indication of interest>, what is the probability that they will experience <insert adverse event> within <time horizon following exposure>?

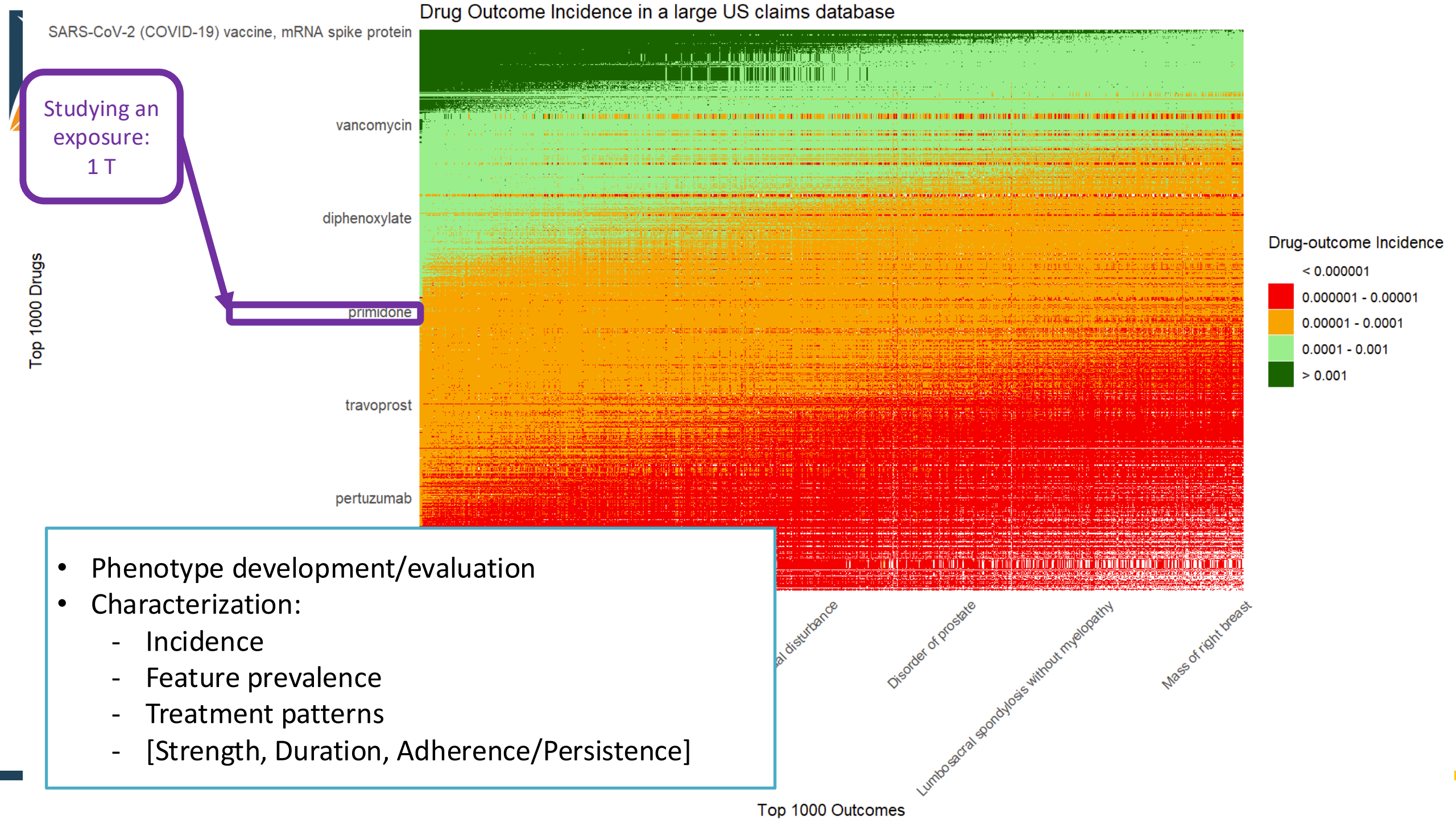
Engineering open science systems that build trust into the real-world evidence generation and dissemination process



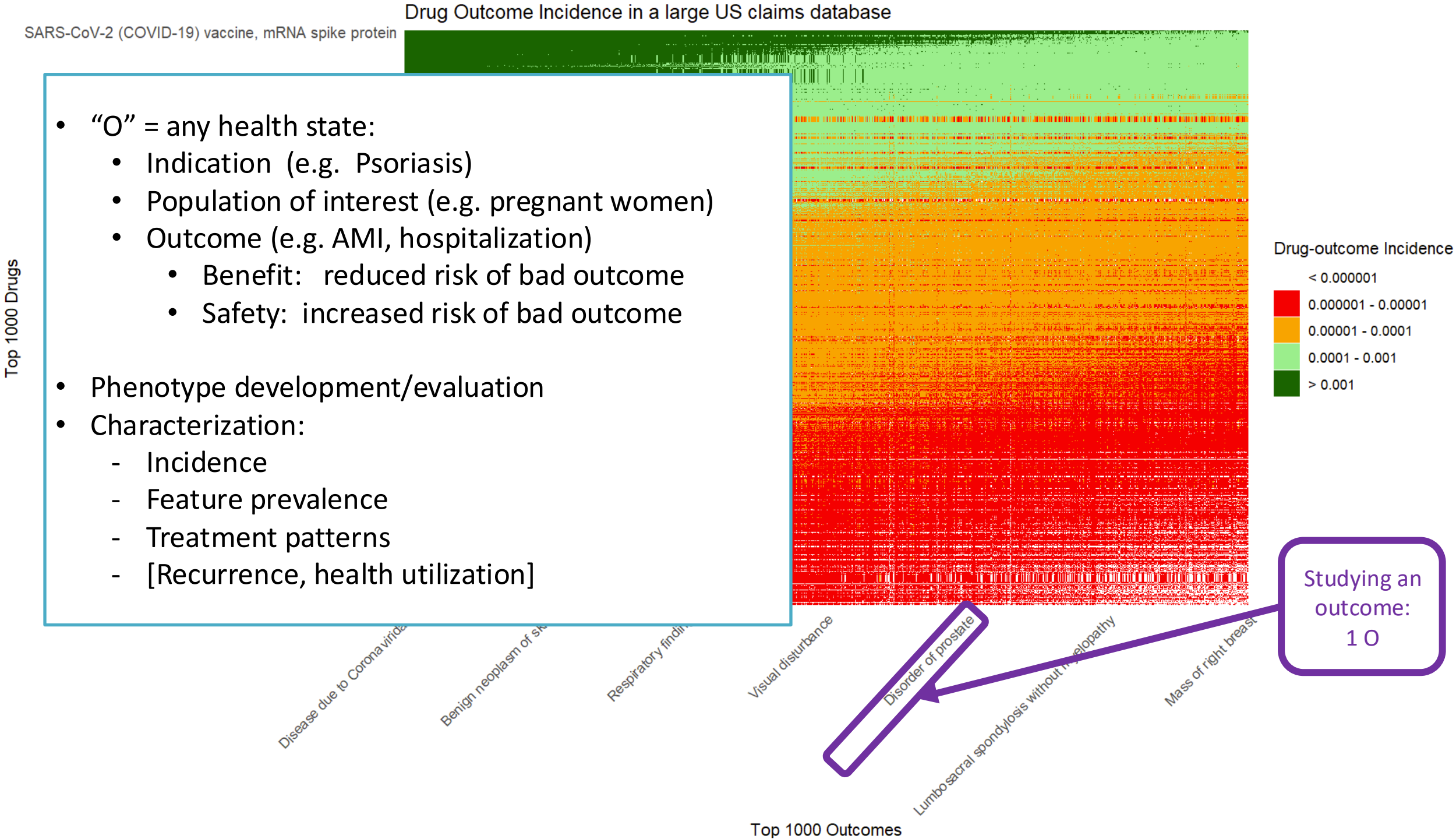
System characteristics:

- Standardized procedures with defined inputs and outputs
- Analysis packages implementing scientific best practices consistently applied across all data partners, generating consistent output for network synthesis
- Reproducible outputs generated by open-source analysis libraries developed and validated with verifiable unit-test coverage
- Pre-specified and objective decision thresholds for go/no go criteria
- Measurable operating characteristics of system performance


Drug Outcome Incidence in a large US claims database
SARS-CoV-2 (COVID-19) vaccine, mRNA spike protein
Top 1000 Drugs
vancomycin
diphenoxylate
primidone
travoprost
pertuzumab
ciclesonide
Disease due to Coronaviridae
Benign neoplasm of skin
Respiratory finding
Visual disturbance
Disorder of prostate
Lumbosacral spondylosis without myelopathy
Mass of right breast
Top 1000 Outcomes
Drug-outcome Incidence
< 0.000001
0.000001 - 0.00001
0.00001 - 0.0001
0.0001 - 0.001
> 0.001

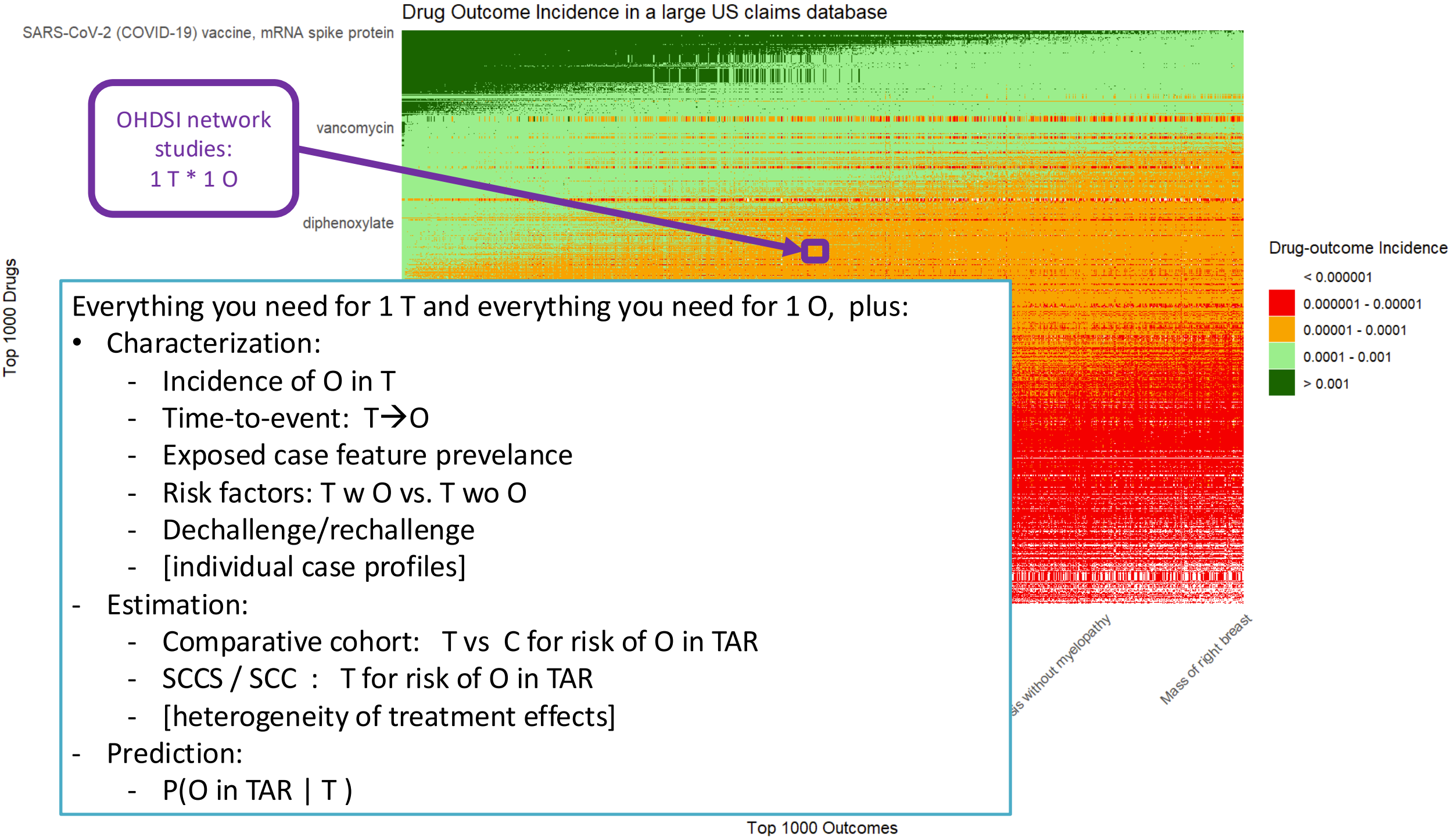


- Phenotype development/evaluation
- Characterization:
  - Incidence
  - Feature prevalence
  - Treatment patterns
  - [Strength, Duration, Adherence/Persistence]



- "O" = any health state:
  - Indication (e.g. Psoriasis)
  - Population of interest (e.g. pregnant women)
  - Outcome (e.g. AMI, hospitalization)
    - Benefit: reduced risk of bad outcome
    - Safety: increased risk of bad outcome

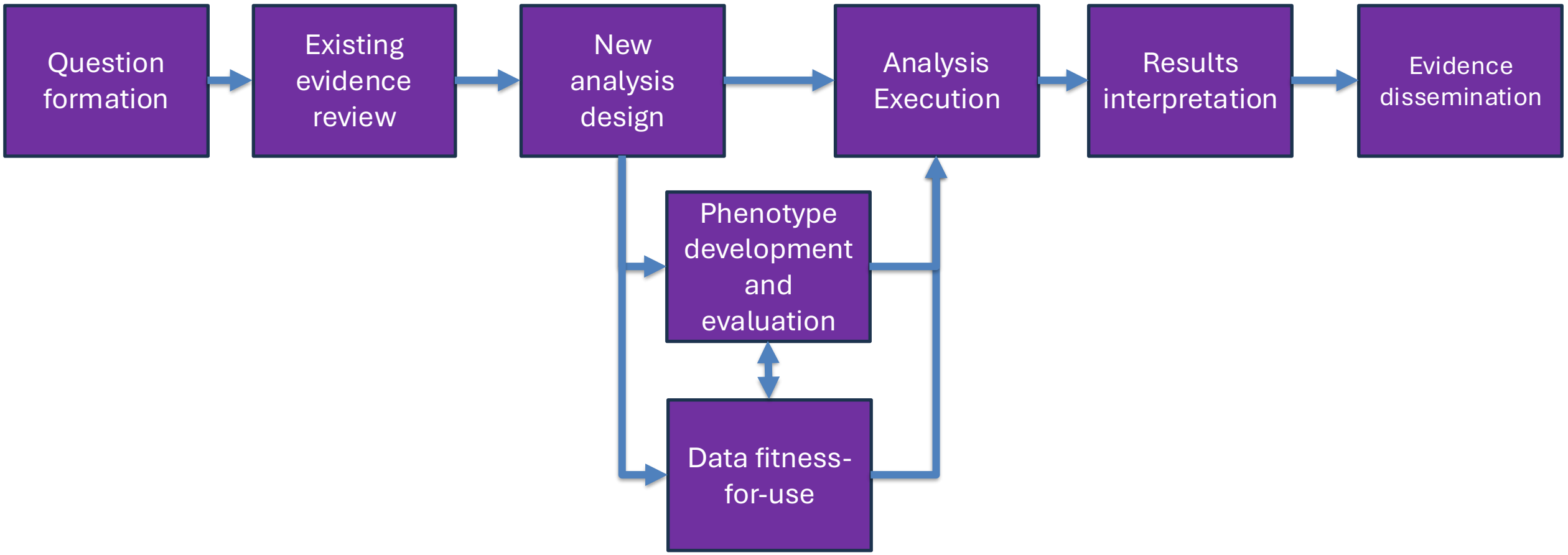
- Phenotype development/evaluation
- Characterization:
  - Incidence
  - Feature prevalence
  - Treatment patterns
  - [Recurrence, health utilization]

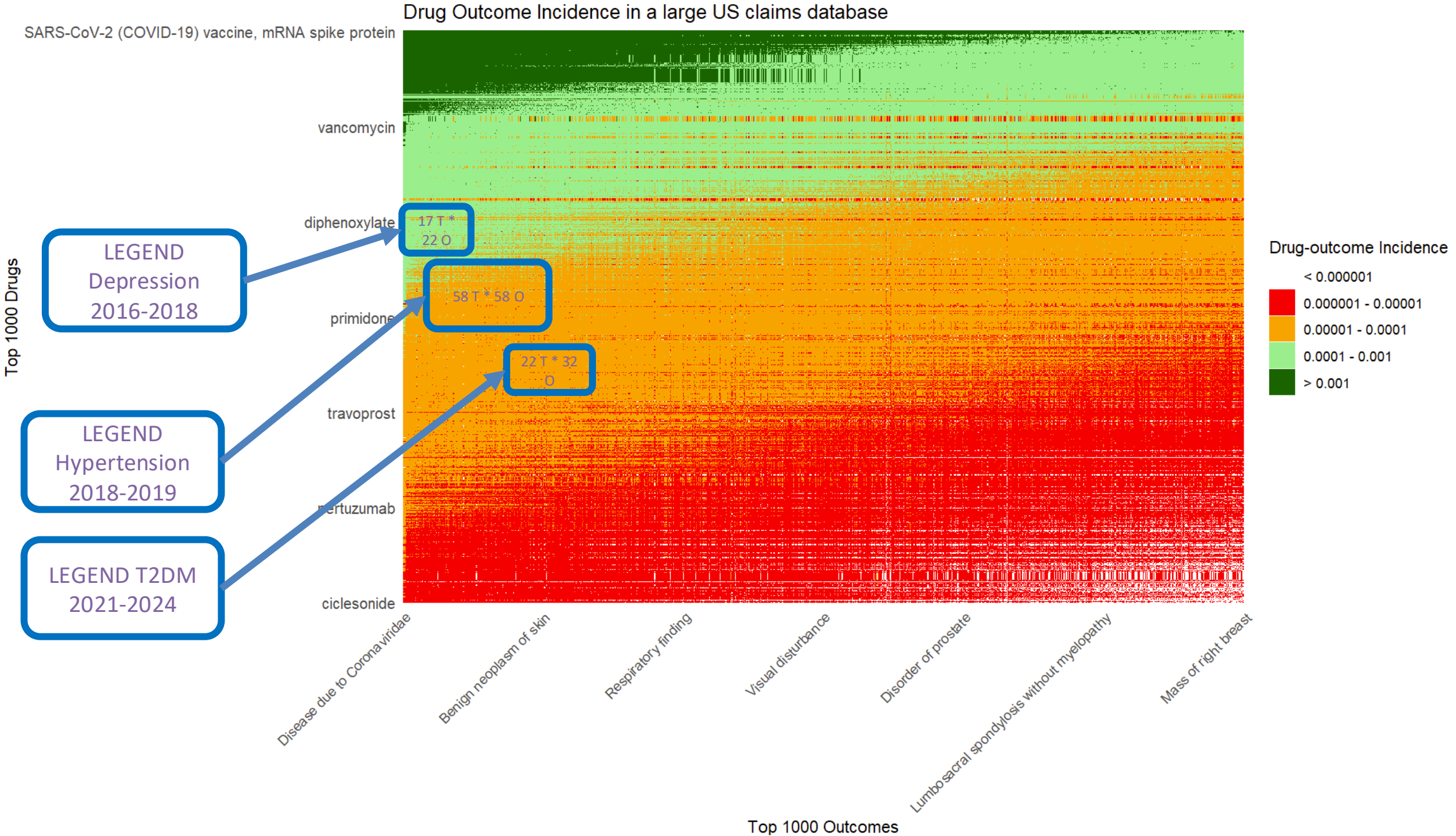


Everything you need for 1 T and everything you need for 1 O, plus:

- Characterization:
  - Incidence of O in T
  - Time-to-event: T→O
  - Exposed case feature prevelance
  - Risk factors: T w O vs. T wo O
  - Dechallenge/rechallenge
  - [individual case profiles]
- Estimation:
  - Comparative cohort: T vs C for risk of O in TAR
  - SCCS / SCC : T for risk of O in TAR
  - [heterogeneity of treatment effects]
- Prediction:
  - P(O in TAR | T)

Where along the evidence generation process can we improve reliability and increase efficiency?




Drug Outcome Incidence in a large US claims database
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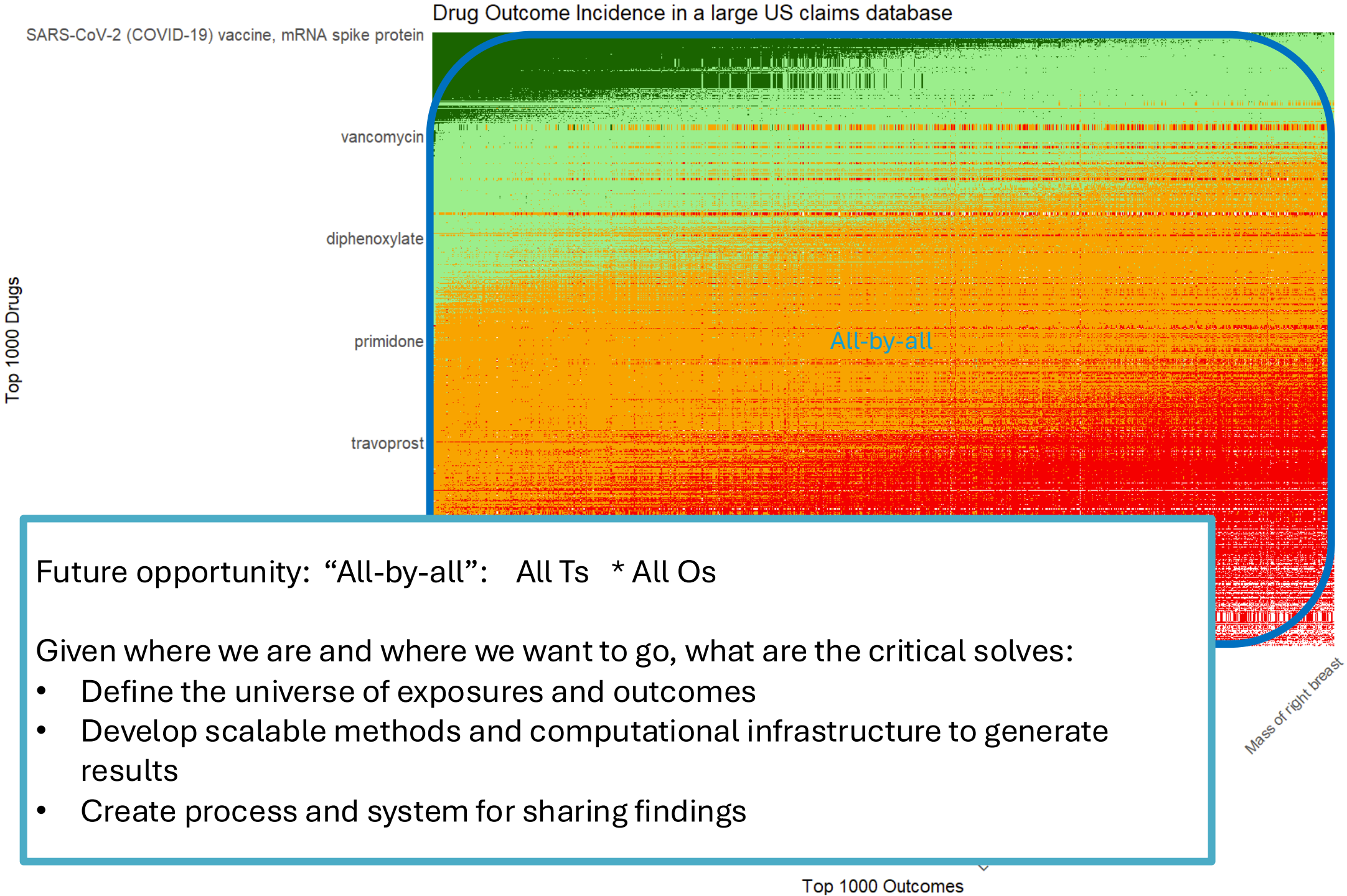
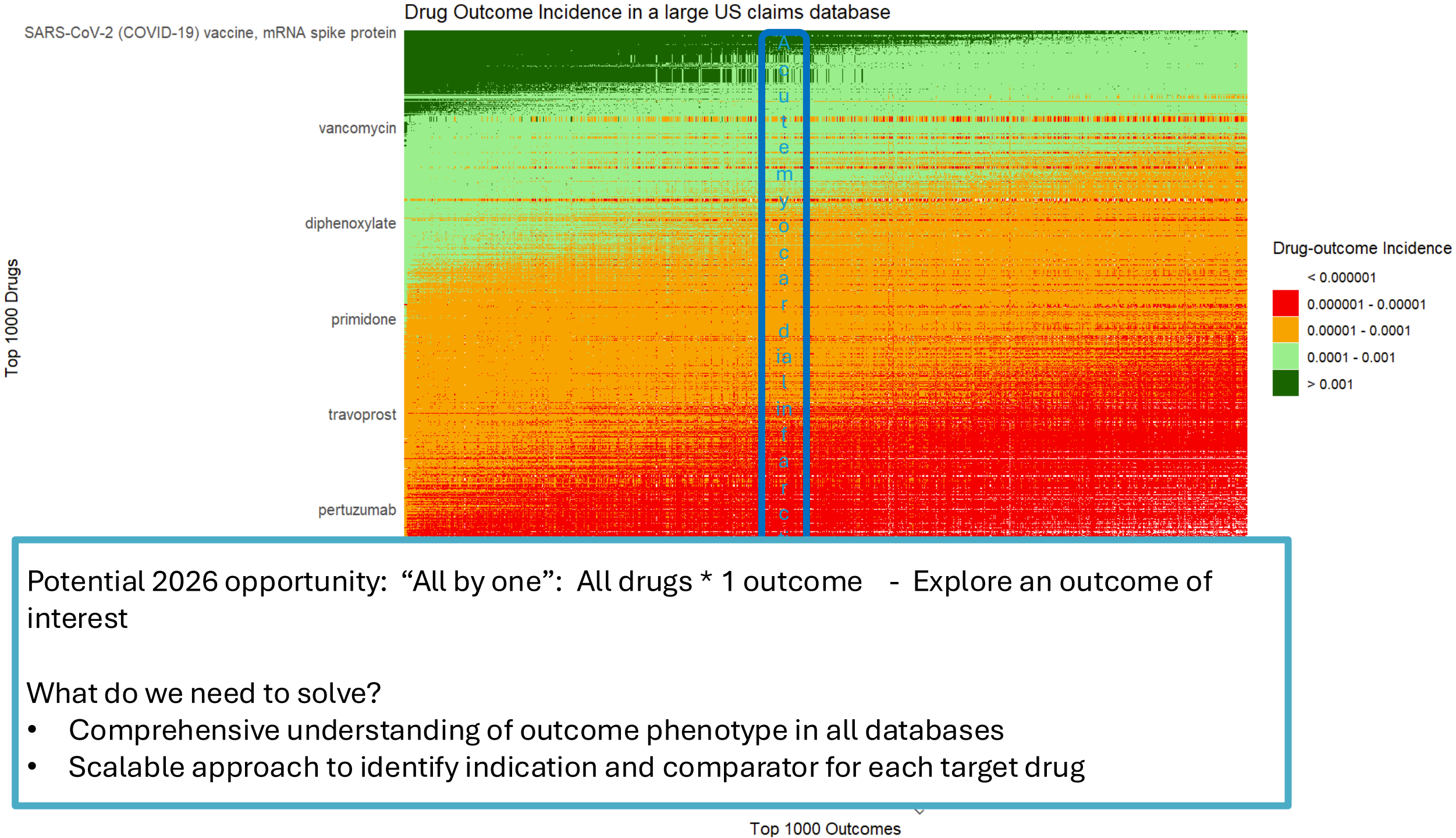
ertuzumab
ciclesonide
17 T * 22 O
58 T * 58 O
22 T * 32 O
LEGEND Depression 2016-2018
LEGEND Hypertension 2018-2019
LEGEND T2DM 2021-2024
Disease due to Coronaviridae
Benign neoplasm of skin
Respiratory finding
Visual disturbance
Disorder of prostate
Lumbosacral spondylosis without myelopathy
Mass of right breast
Top 1000 Outcomes
Drug-outcome Incidence
< 0.000001
0.000001 - 0.00001
0.00001 - 0.0001
0.0001 - 0.001
> 0.001



Future opportunity: "All-by-all": All Ts * All Os

Given where we are and where we want to go, what are the critical solves:

- Define the universe of exposures and outcomes
- Develop scalable methods and computational infrastructure to generate results
- Create process and system for sharing findings



Potential 2026 opportunity: “All by one”: All drugs * 1 outcome - Explore an outcome of interest

What do we need to solve?

- Comprehensive understanding of outcome phenotype in all databases
- Scalable approach to identify indication and comparator for each target drug

www.nature.com/scientificreports

scientific reports

Check for updates

OPEN

Dispensed prescription medications and short-term risk of pulmonary embolism in Norway and Sweden

Dagfinn Aune[1,2,3]✉, Ioannis Vardaxis[4], Bo Henry Lindqvist[4], Ben Michael Brumpton[5,6,7], Linn Beate Strand[8], Jens Wilhelm Horn[8,9], Inger Johanne Bakken[10], Pål Richard Romundstad[8], Kenneth J. Mukamal[11], Rickard Ljung[12], Imre Janszky[8,13] & Abhijit Sen[8,14]

Scandinavian electronic health-care registers provide a unique setting to investigate potential unidentified side effects of drugs. We analysed the association between prescription drugs dispensed in Norway and Sweden and the short-term risk of developing pulmonary embolism. A total of 12,104 pulmonary embolism cases were identified from patient- and cause-of-death registries in Norway (2004–2014) and 36,088 in Sweden (2005–2014). A case-crossover design was used to compare individual drugs dispensed 1–30 days before the date of pulmonary embolism diagnosis with dispensation in a 61–90 day time-window, while controlling for the receipt of other drugs. A BOLASSO approach was used to select drugs that were associated with short-term risk of pulmonary embolism. Thirty-eight drugs were associated with pulmonary embolism in the combined analysis of the Norwegian and Swedish data. Drugs associated with increased risk of pulmonary embolism included certain proton-pump inhibitors, antibiotics, antithrombotics, vasodilators, furosemide, anti-varicose medications, corticosteroids, immunostimulants (pegfilgrastim), opioids, analgesics, anxiolytics, antidepressants, antiprotozoals, and drugs for cough and colds. Mineral supplements, hydrochlorothiazide and potassium-sparing agents, beta-blockers, angiotensin 2 receptor blockers, statins, and methotrexate were associated with lower risk. Most associations persisted, and several additional drugs were associated, with pulmonary embolism when using a longer time window of 90 days instead of 30 days. These results provide exploratory, pharmacopeia-wide evidence of medications that may increase or decrease the risk of pulmonary embolism. Some of these findings were expected based on the drugs' indications, while others are novel and require further study as potentially modifiable precipitants of pulmonary embolism.

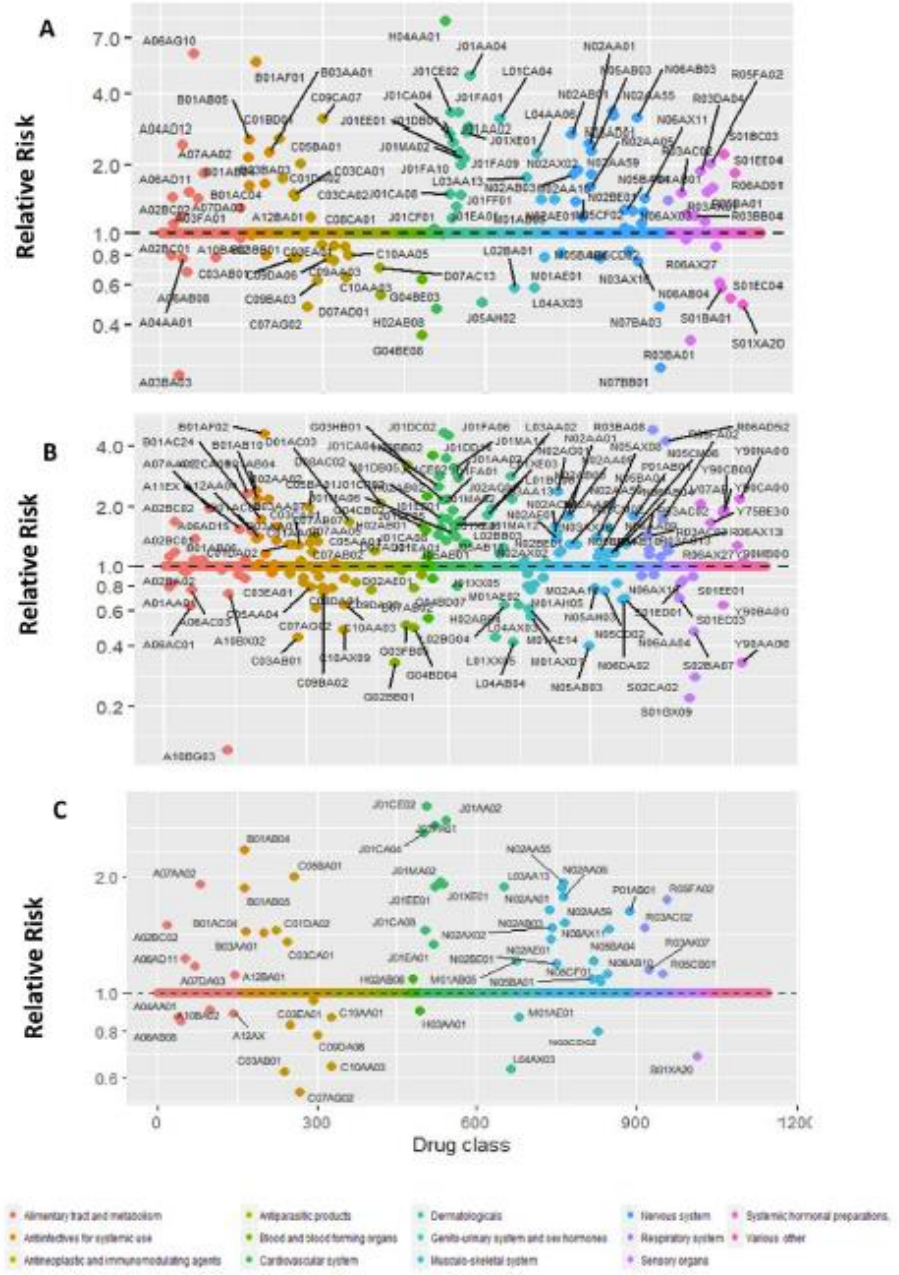


Figure 1. Case-crossover analysis of dispensed prescription medication use and risk of pulmonary embolism. The above plot illustrates (**A**) unique drug types which were selected in Norway, (**B**) unique drug types which were selected in Sweden, and (**C**) 59 drugs which were common hits from both the countries. Y-axis displays relative risk on the log scale, X-axis displays all the prescribed drugs studied grouped by the anatomical therapeutic chemical (ATC) classification.

29Aug2024

https://www.nature.com/articles/s41598-024-69637-4

Received: 16 December 2024 | Revised: 15 January 2025 | Accepted: 19 Ja
DOI: 10.1002/bcp.16406

ORIGINAL ARTICLE

Acute cardiovascular effects ass
prescription medications: A Dar

Saad Hanif Abbasi[1] | Lars Christian Lund[1]
Martin Thomsen Ernst[1] | Anton Pottegård[1]

20Feb2025 *Br J Clin Pharmacol.* 2025;91:1947–

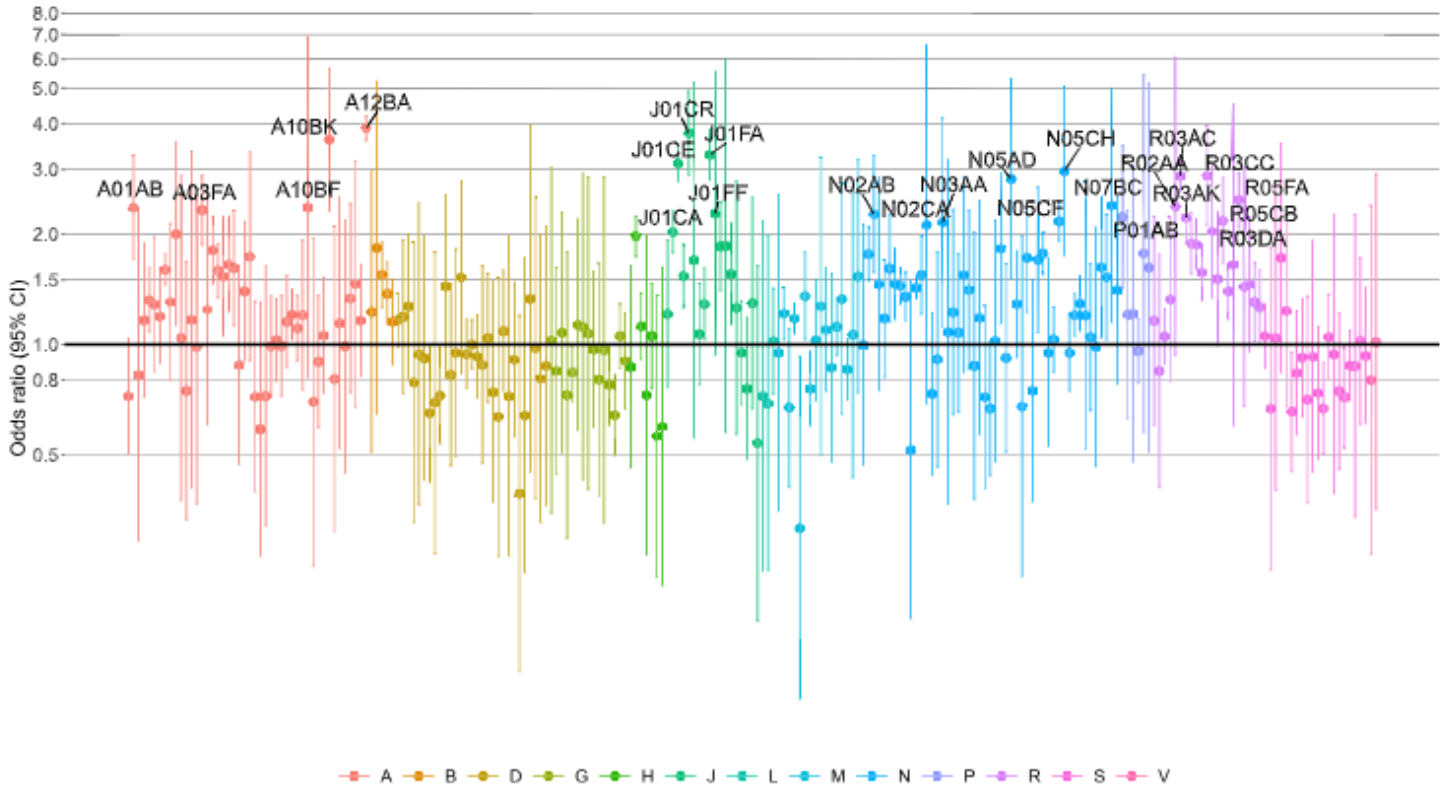


FIGURE 3 Associations of major drug classes (ATC level 4) with heart failure given as odds ratios (OR) with 95% confidence intervals (CI). Only drug classes with an OR of above 2 are labelled. The letters (A, B, D, G, H, J, L, M, N, P, R, S and V) correspond to drug classes based on the Anatomical Therapeutic Chemical (ATC) classification system, where each letter represents a specific anatomical or therapeutic group. A: Alimentary tract and metabolism; B: Blood and blood-forming organs; D: Dermatologicals; G: Genitourinary system and sex hormones; H: Systemic hormonal preparations, excluding sex hormones and insulins; J: Anti-infectives for systemic use; L: Antineoplastic and immunomodulating agents; M: Musculo-skeletal system; N: Nervous system; P: Antiparasitic products, insecticides, and repellents; R: Respiratory system; S: Sensory organs; V: Various. A01AB: Anti-infectives and antiseptics for local oral treatment; A03FA: Propulsives; A01AB: Alpha glucosidase inhibitors; A10BK: Sodium-glucose co-transporter 2 (SGLT2) inhibitors; A12BA: Potassium; J01CA: Penicillins with extended spectrum; J01CE: Beta-lactamase sensitive penicillins; J01CR: Combinations of penicillins, incl. beta-lactamase inhibitors; J01FA: Macrolides; J01FF: Lincosamides; N02AB: Phenylpiperidine derivatives; N02CA: Ergot alkaloids; N03AA: Barbiturates and derivatives; N05AD: Butyrophenone derivatives; N05CF: Benzodiazepine related drugs; N05CH: Melatonin receptor agonists; N07BC: Drugs used in opioid dependence; P01AB: Nitroimidazole derivatives; R02AA: Antiseptics; R03AC: Selective beta-2-adrenoreceptor agonists; R03AK: Adrenergics in combination with corticosteroids or other drugs, excluding anticholinergics; R03CC: Selective beta-2-adrenoreceptor agonists; R03DA: Xanthines; R05CB: Mucolytics; R05FA: Opium derivatives and expectorants.

Pharmacoepidemiology and Drug Safety

ORIGINAL ARTICLE OPEN ACCESS

High-Throughput Screening Tree-Based Scan Statistic to Associated With Hospitaliza Liver Injury

Vincent Lo Re III[1,2] | Craig W. Newcomb[2] | Dean M. Ca
Judith C. Maro[7]

4Dec2025

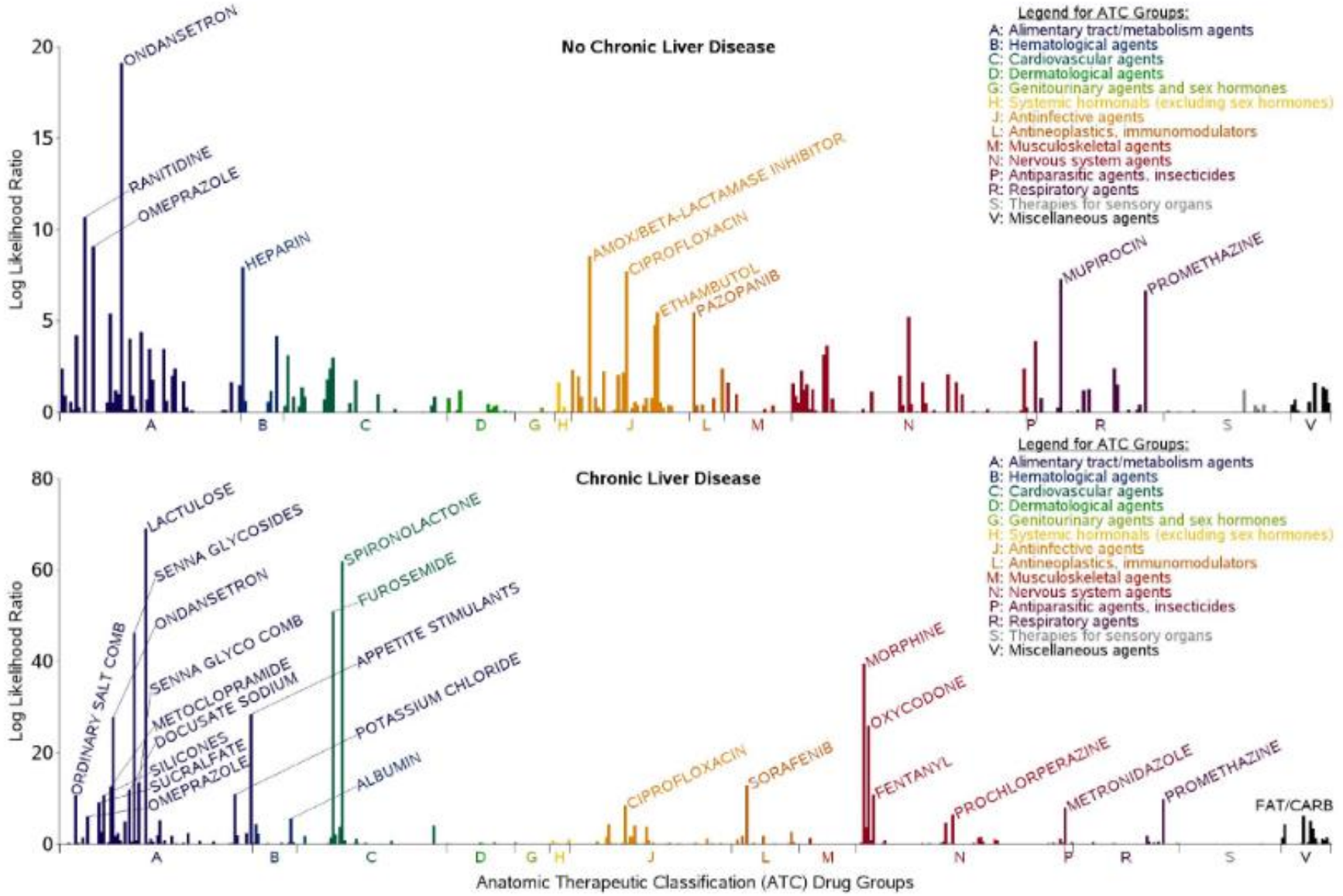


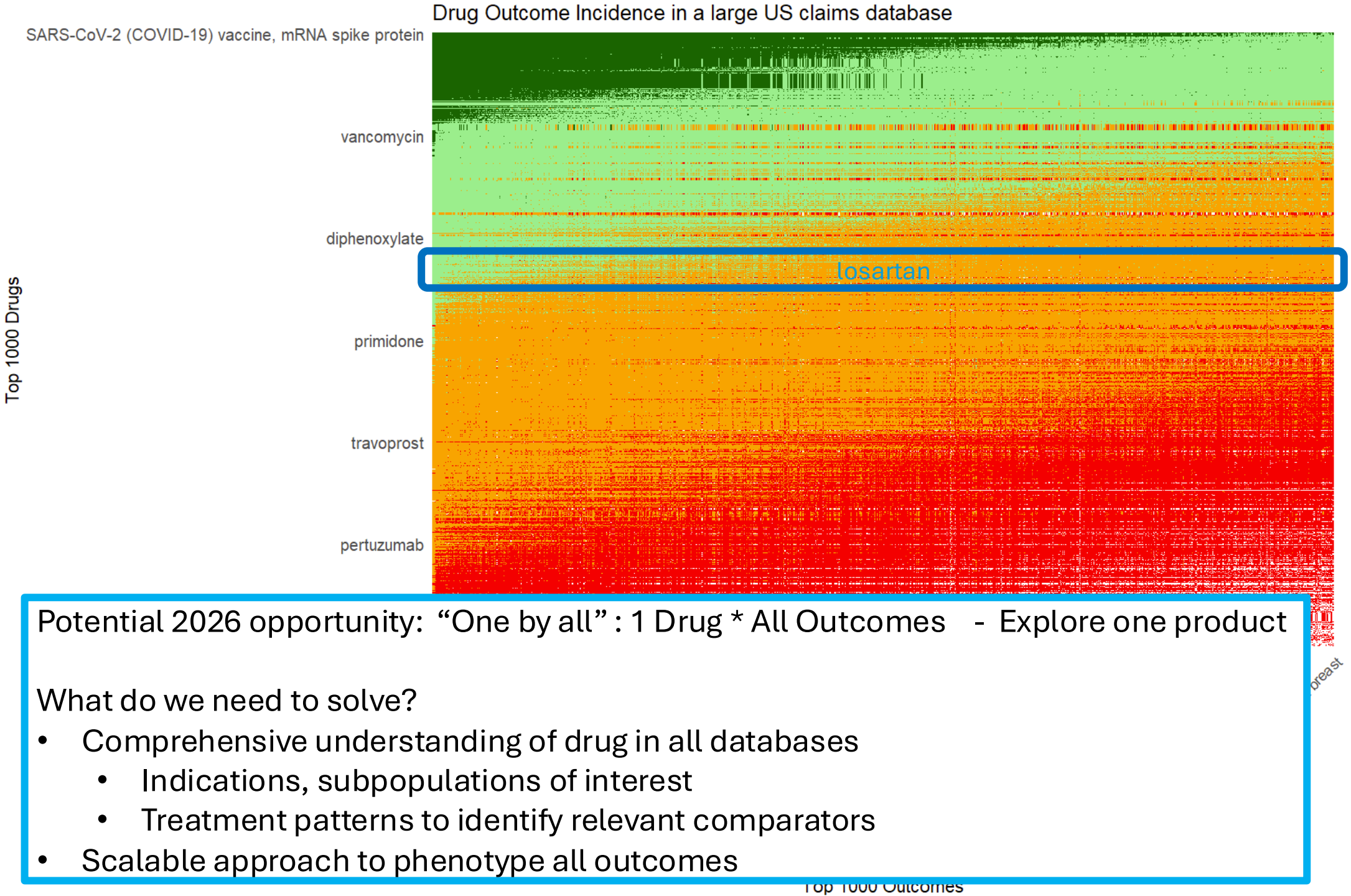
FIGURE 2 | Log likelihood ratio for drugs in the Anatomic Therapeutic Classification drug groups by chronic liver disease status. Peaks with labels qualify as alerts. ATC, Anatomic Therapeutic Classification; carb, carbohydrates; CLD, chronic liver disease; comb, combination; glyco, glycoside.

Open methodological questions raised by these ‘all-by-one’ studies

- What are the operating characteristics of the case-crossover design?
- For any drug alert, how do we know there isn’t residual bias?
- How confident are we that these results could be replicated in other databases?

Potential opportunity for our community

- What could we learn if we:
  - Run a network study across the OHDSI Evidence Network for one outcome of shared interest
  - Apply best practices that are implemented using OHDSI HADES packages, including comparative cohort and SCCS designs
  - Share all results that pass objective diagnostics
- What do we need to do before we can learn:
  - Develop and evaluate the outcome phenotype across the Network
  - Identify indication(s) and comparator(s) for each target exposure



Potential 2026 opportunity: "One by all" : 1 Drug * All Outcomes - Explore one product

What do we need to solve?

- Comprehensive understanding of drug in all databases
  - Indications, subpopulations of interest
  - Treatment patterns to identify relevant comparators
- Scalable approach to phenotype all outcomes

THE LANCET

Comprehensive comparative effectiveness first-line antihypertensive drug classes: a s multinational, large-scale analysis

Marc A Suchard, Martijn J Schuemie, Harlan M Krumholz, Seng Chan You, RuiJun Chen, Nicole Pratt George Hripcsak, Patrick B Ryan

Summary

Background Uncertainty remains about the optimal monotherapy for hyperten mending any primary agent among the first-line drug classes thiazide or thiazide enzyme inhibitors, angiotensin receptor blockers, dihydropyridine calcium chan calcium channel blockers, in the absence of comorbid indications. Randomise choice.

Methods We developed a comprehensive framework for real-world evidence t and safety evaluation across many drugs and outcomes from observational dat while minimising inherent bias. Using this framework, we did a systematic cohort design to estimate the relative risks of three primary (acute myocardia failure, and stroke) and six secondary effectiveness and 46 safety outcomes co global network of six administrative claims and three electronic health record residual confounding, publication bias, and p-hacking using large-scale proper outcomes, and full disclosure of hypotheses tested.

Findings Using 4·9 million patients, we generated 22 000 calibrated, propensi comparing all classes and outcomes across databases. Most estimates revealed classes; however, thiazide or thiazide-like diuretics showed better primary effec enzyme inhibitors: acute myocardial infarction (HR 0·84, 95% CI 0·75–0·95), 0·74–0·95), and stroke (0·83, 0·74–0·95) risk while on initial treatment. Saf thiazide-like diuretics over angiotensin-converting enzyme inhibitors. The n blockers were significantly inferior to the other four classes.

Interpretation This comprehensive framework introduces a new way of doing scale. The approach supports equivalence between drug classes for initiating keeping with current guidelines, with the exception of thiazide or thiazide-like converting enzyme inhibitors and the inferiority of non-dihydropyridine calciu

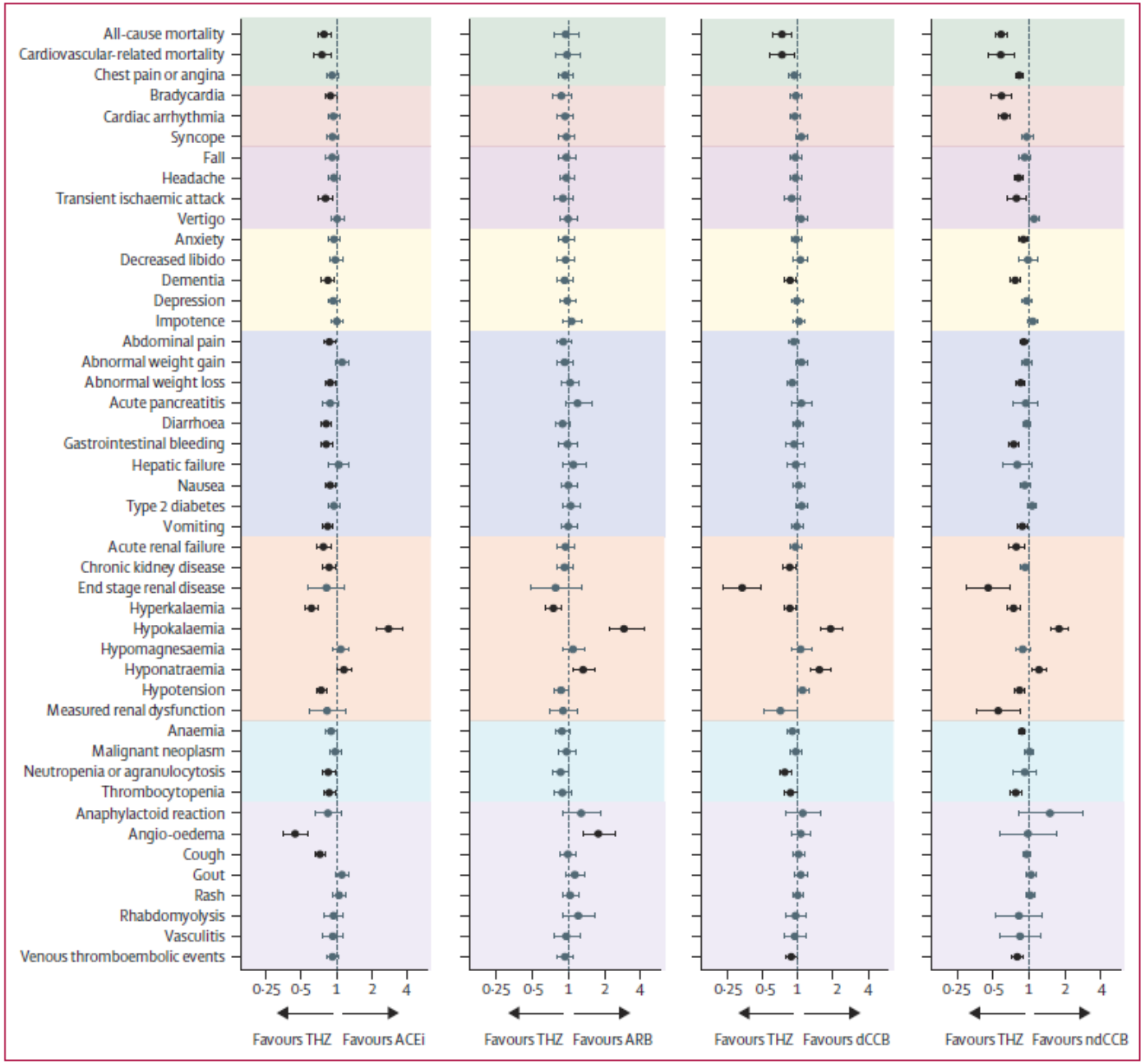


Figure 2: **Meta-analytic safety profiles comparing THZ to ACEi, ARB, dCCB, and ndCCB new users across 46 outcomes listed on product labels**
Points and lines identify HR estimates with their 95% CIs, respectively. Outcomes in grey signify that the CI covers HR of 1 (null hypothesis of no differential risk). THZ=thiazide or thiazide-like diuretics. ACEi=angiotensin converting-enzyme inhibitors. ARB=angiotensin receptor blockers. dCCB=dihydropyridine calcium channel blockers. ndCCB=non-dihydropyridine calcium channel blockers. HR=hazard ratio.

Hypertension
Volume 78, Issue 3, September 2021; Pages 591-603
https://doi.org/10.1161/HYPERTENSIONAHA.120.16667

Table 2. Primary Effectiveness Outcomes for ACE Inhibitors Compared With ARBs (on-Treatment, PS Stratification, Excluding NHIS/NSC)

Outcome	HR (95% CI)	*P* value	Calibrated HR (CI)	Calibrated *P* value
Acute myocardial infarction	1.10 (1.04–1.17)	<0.01	1.11 (0.95–1.32)	0.19
CVEs	1.04 (0.99–1.10)	0.12	1.06 (0.90–1.25)	0.49
Heart failure	1.02 (0.94–1.11)	0.64	1.03 (0.87–1.24)	0.68
Stroke	1.06 (1.00–1.12)	0.06	1.07 (0.91–1.27)	0.40

ABSTRACT: ACE (angiotensin-converting enzyme) inhibitors and angiotensin receptor blocke recommended first-line treatments for hypertension, yet few head-to-head studies exi effectiveness and safety of ACE inhibitors versus ARBs in the first-line treatment of h retrospective, new-user comparative cohort design to estimate hazard ratios using t confounding and bias, specifically large-scale propensity score adjustment, empirical calib included all patients with hypertension initiating monotherapy with an ACE inhibitor or ARB 8 databases from the United States, Germany, and South Korea. The primary outcomes v heart failure, stroke, and composite cardiovascular events. We also studied 51 secondar angioedema, cough, syncope, and electrolyte abnormalities. Across 8 databases, we ident treatment with ACE inhibitors and 673 938 patients with ARBs. We found no statistically sig outcomes of acute myocardial infarction (hazard ratio, 1.11 for ACE versus ARB [95% CI, ratio, 1.03 [0.87–1.24]), stroke (hazard ratio, 1.07 [0.91–1.27]), or composite cardiovas [0.90–1.25]). Across secondary and safety outcomes, patients on ARBs had significantly pancreatitis, and GI bleeding. In our large-scale, observational network study, ARBs do not differ statistically significantly in effectiveness at the class level compared with ACE inhibitors as first-line treatment for hypertension but present a better safety profile. These findings support preferentially prescribing ARBs over ACE inhibitors when initiating treatment for hypertension.

Table 3. Secondary and Safety Outcomes for ACE Inhibitors vs ARBs (on-Treatment, PS Stratification)

Outcome	HR (95% CI)	*P* value	Calibrated HR (95% CI)	Calibrated *P* value
Abdominal pain	1.00 (0.96–1.03)	0.87	1.01 (0.88–1.19)	0.87
Abnormal weight gain	0.82 (0.79–0.86)	<0.01	0.84 (0.74–0.96)	0.04
Abnormal weight loss	1.18 (1.11–1.25)	<0.01	1.18 (1.01–1.41)	0.04
Acute pancreatitis	1.32 (1.09–1.60)	<0.01	1.32 (1.04–1.70)	0.02
Acute renal failure	1.13 (1.08–1.18)	<0.01	1.14 (0.98–1.35)	0.10
Anaphylactoid reaction	1.31 (1.00–1.72)	0.05	1.31 (0.98–1.79)	0.07
Anemia	0.96 (0.92–0.99)	0.02	0.97 (0.84–1.14)	0.76
Angioedema	3.53 (2.99–4.16)	<0.01	3.31 (2.55–4.51)	<0.01
Anxiety	0.98 (0.95–1.00)	0.03	0.99 (0.86–1.16)	0.91
Bradycardia	0.96 (0.86–1.08)	0.52	0.98 (0.82–1.18)	0.84
Cardiac arrhythmia	0.96 (0.91–1.02)	0.22	0.98 (0.84–1.15)	0.82
Chest pain or angina	0.99 (0.97–1.01)	0.23	1.00 (0.87–1.17)	0.92
Chronic kidney disease	1.00 (0.93–1.08)	0.98	1.01 (0.87–1.20)	0.84
Cough	1.32 (1.23–1.42)	<0.01	1.32 (1.11–1.59)	<0.01
Decreased libido	0.96 (0.90–1.03)	0.29	0.98 (0.84–1.16)	0.83
Dementia	1.12 (1.06–1.18)	<0.01	1.13 (0.97–1.34)	0.14
Depression	1.02 (0.99–1.05)	0.20	1.03 (0.90–1.21)	0.65
Diarrhea	1.06 (1.02–1.09)	<0.01	1.07 (0.92–1.25)	0.40
End stage renal disease	0.87 (0.62–1.20)	0.39	0.88 (0.63–1.25)	0.50
Fall	1.03 (0.96–1.10)	0.46	1.04 (0.89–1.23)	0.64
Gastrointestinal bleed	1.18 (1.11–1.25)	<0.01	1.18 (1.01–1.41)	0.04
Gout	1.00 (0.97–1.04)	0.83	1.02 (0.88–1.19)	0.81
Headache	0.97 (0.94–1.00)	0.04	0.98 (0.86–1.15)	0.87
Hepatic failure	1.02 (0.89–1.17)	0.74	1.03 (0.86–1.27)	0.71
Hospitalization with preinfarction syndrome	1.02 (0.90–1.15)	0.77	1.03 (0.86–1.25)	0.74
Hyperkalemia	1.17 (1.04–1.30)	0.01	1.17 (0.98–1.42)	0.09
Hypokalemia	0.95 (0.89–1.03)	0.21	0.97 (0.83–1.15)	0.74
Hypomagnesemia	0.96 (0.89–1.04)	0.36	0.98 (0.84–1.16)	0.83
Hyponatremia	1.12 (1.06–1.19)	<0.01	1.13 (0.97–1.34)	0.13
Hypotension	1.13 (1.09–1.17)	<0.01	1.14 (0.98–1.35)	0.10
Impotence	1.06 (1.01–1.12)	0.02	1.07 (0.92–1.27)	0.37
Malignant neoplasm	0.97 (0.89–1.05)	0.39	0.98 (0.84–1.16)	0.85
Measured renal dysfunction	0.87 (0.66–1.14)	0.31	0.88 (0.66–1.20)	0.44
Nausea	1.10 (1.06–1.13)	<0.01	1.11 (0.95–1.30)	0.20
Neutropenia or agranulocytosis	0.96 (0.89–1.02)	0.18	0.97 (0.84–1.15)	0.76
Rash	0.96 (0.93–1.00)	0.04	0.98 (0.85–1.15)	0.82
Rhabdomyolysis	1.10 (0.91–1.34)	0.32	1.11 (0.88–1.43)	0.37
Syncope	1.02 (0.96–1.07)	0.56	1.03 (0.89–1.21)	0.71
Thrombocytopenia	1.01 (0.96–1.06)	0.69	1.02 (0.88–1.20)	0.76
Type 2 diabetes	1.04 (0.99–1.08)	0.12	1.05 (0.90–1.24)	0.54
Vasculitis	1.01 (0.85–1.20)	0.88	1.03 (0.83–1.29)	0.80
Venous thromboembolism	0.97 (0.90–1.04)	0.35	0.98 (0.84–1.16)	0.84
Vertigo	0.95(0.92–0.99)	0.01	0.97 (0.84–1.13)	0.73
Vomiting	1.15 (1.11–1.19)	<0.01	1.15 (0.99–1.36)	0.07

Circulation

CLINICAL PRACTICE GUIDELINES

2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

Developed in Collaboration With and Endorsed by American Academy of Physician Associates; American Association of Nurse Practitioners; American College of Clinical Pharmacy; American College of Preventive Medicine; American Geriatrics Society; American Medical Association; American Society of Preventive Cardiology; Association of Black Cardiologists; National Medical Association; Preventive Cardiovascular Nurses Association; and the Society of General Internal Medicine.

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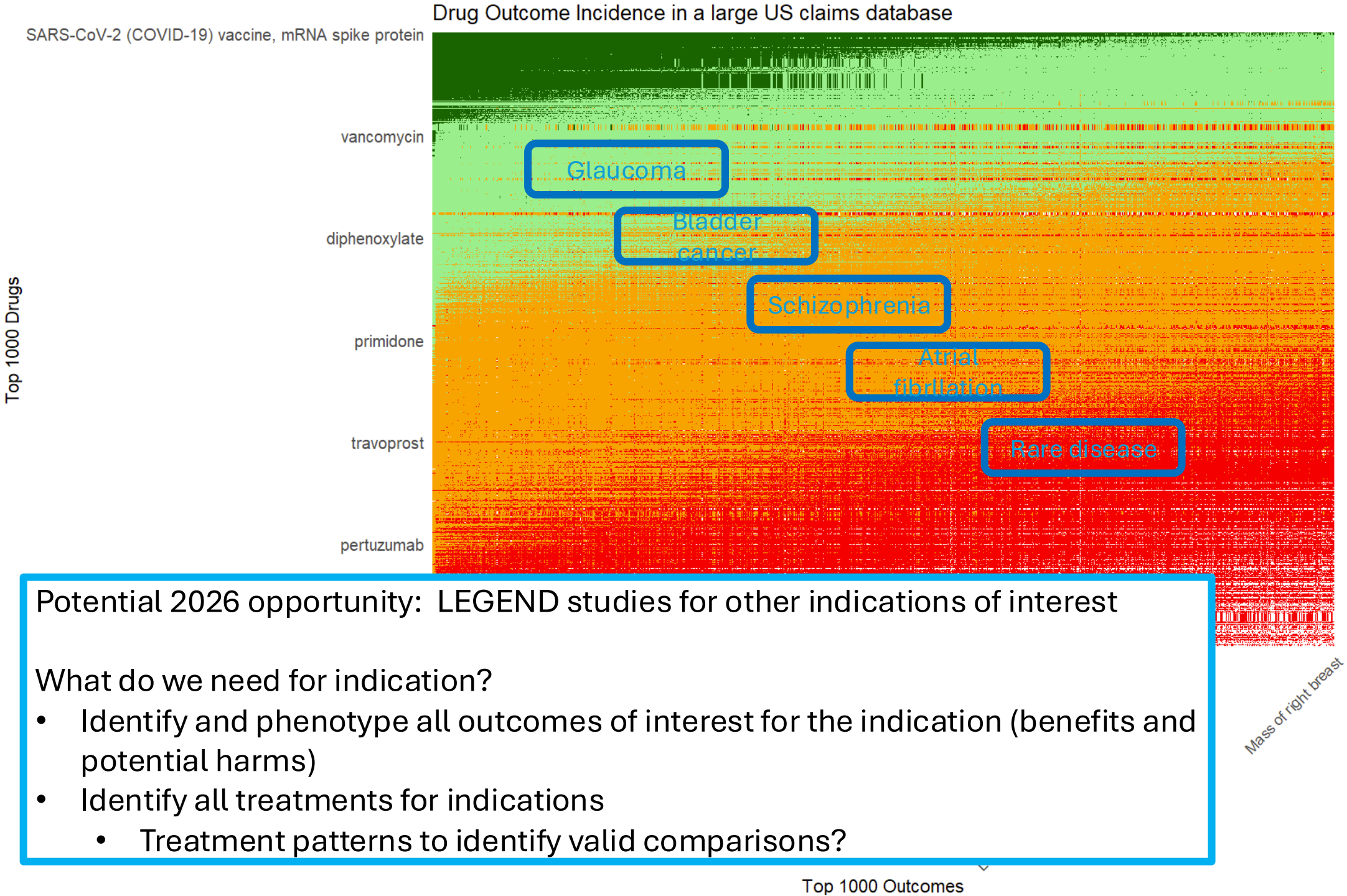
5.2.3. Initial Medication Selection for Treatment of Primary Hypertension

Recommendation for Initial Medication Selection for Treatment of Primary Hypertension
Referenced studies that support the recommendation are summarized in the Evidence Table.

COR	LOE	Recommendation
1	A	1. For adults initiating antihypertensive drug therapy, thiazide-type diuretics, long-acting dihydropyridine CCB, and ACEi or ARB are recommended as first-line therapy to prevent CVD.[1,2]

Potential opportunity for our community

- What could we learn if we:
  - Run a network study across the OHDSI Evidence Network for one drug of shared interest
  - Apply best practices that are implemented using OHDSI HADES packages, including comparative cohort and SCCS designs
  - Share all results that pass objective diagnostics
- What do we need to do before we can learn:
  - Develop and evaluate a more comprehensive universe of outcome phenotypes



Potential 2026 opportunity: LEGEND studies for other indications of interest

What do we need for indication?

- Identify and phenotype all outcomes of interest for the indication (benefits and potential harms)
- Identify all treatments for indications
  - Treatment patterns to identify valid comparisons?

Potential opportunity for our community

- What could we learn if we:
  - Run a network study across the OHDSI Evidence Network for one or more indications of shared interest within our clinical subspecialty workgroups
  - Apply best practices that are implemented using OHDSI HADES packages, including comparative cohort and SCCS designs
  - Share all results that pass objective diagnostics
- What do we need to do before we can learn:
  - Develop and evaluate exposure and outcome phenotypes relevant to the indication

Themes from 2025 OHDSI Global Symposium post-its

What people are *currently doing*

- OMOP conversions + early network studies
- Methods development
- Domain-specific analyses
- Teaching or learning OHDSI foundational skills

What people *WANT to be doing*

- Advanced analytics (AI/ML, causal inference, trajectories)
- Larger network studies
- Contributing phenotypes and methods
- Engaging in international collaboration
- Establishing local OHDSI hubs

Where people *NEED HELP*

- Vocabularies + concept sets
- ETL and data quality
- Study execution (ATLAS/HADES)
- Methods mentoring
- Concrete examples and reproducible code

Collaboration opportunities

2026 OHDSI Global Symposium

Oct. 20-22 • New Brunswick, N.J. • Hyatt Regency Hotel

The 12th annual OHDSI Global Symposium will return to the Hyatt Regency Hotel in New Brunswick, N.J., Oct. 20-22, 2026. All pertinent information will be added to this page when available. Currently, the OHDSI steering group is seeking proposals for both plenaries and tutorials. **The deadline for both is January 30, 2026; more details are below.**

2026 OHDSI Global Symposium Call for Plenary Sessions

Symposium plenaries provide opportunities to share innovative, community-developed content to empower researchers to generate reliable real-world evidence. The community is currently seeking proposals for our #OHDSI2026 plenaries. These sessions will be 60 minutes in duration and must touch on at least two of following pillars of our community:

- Open community data standards
- Methodological research
- Open-source development
- Clinical applications

Plenary sessions must also involve three or more on-stage participants across at least two organizations. Sessions may include a combination of keynote talks, panel discussions, interactive activities, and more. We strongly encourage using multiple formats and synthesizing completed research, current perspectives and future calls-to-action to maximize community engagement.

The deadline for proposal submissions is January 30, 2026. Please use the link below to submit your proposal by answering the following questions:

- Name(s) of plenary session organizers:
- Your email address(es):
- Short (2,500 character max) description / abstract of your proposed session:
- Which pillars are you targeting:
- One sentence “pitch” of your session to excite the community:
- Names and roles of individuals who have tentatively agreed to participate in your session:

Submit Your Plenary Proposal by Jan. 30, 2026

2026 OHDSI Global Symposium Call for Tutorials

Tutorial sessions aim to deliver educational content, led by community members who wish to train our global collaborators on scientific, technical, and other skills that can support advancing OHDSI's mission and the effective use of real-world data and the generation and dissemination of reliable real-world evidence. Examples of prior tutorials offered are provided here: https://www.ohdsi.org/tutorials.

Tutorial sessions are 4 hours in duration. Registrants for your tutorial will be requested to pay a registration fee. The fees will be used to offset the costs of the symposium and other OHDSI expenses. Sessions may include a combination of talks, interactive activities, and more. We strongly encourage using multiple formats to maximize community engagement. Your session must include at least three people from at least two different organizations.

The deadline for tutorial proposal submissions is January 30, 2026. Please use the link below to submit your proposal by answering the following questions:

- Name(s) of tutorial session organizers:
- Your email address(es):
- Short (2,500 character) description / abstract of your proposed session:
- Names and roles of individuals who have tentatively agreed to participate in your session:

Submit Your Tutorial Proposal by Jan. 30, 2026

OHDSI Europe Symposium 2026

February 6th, 2026: Deadline for abstract submissions

Columbia DBMI Summer School

The 2026 Summer School in Observational Health Data Science & Informatics, AI, and Real World Evidence

COLUMBIA | COLUMBIA UNIVERSITY DEPARTMENT OF BIOMEDICAL INFORMATICS

OHDSI

June 22–26, 2026, Columbia Biomedical Informatics

The Columbia OHDSI Summer School provides health professionals, researchers, and industry practitioners with an immersive, hands-on training to working with real-world health data and generating real-world evidence (RWE). Participants will explore the types of healthcare data captured during routine clinical care—such as electronic health records and administrative claims—and learn how to standardize these data using the OMOP Common Data Model to support collaborative, distributed research as part of a data network.

Over the course of the week, participants will engage with three real-world analytic use cases:

- **Clinical characterization** – using descriptive epidemiology to study disease natural history and treatment patterns
- **Population-level estimation** – applying causal inference to assess drug safety and comparative effectiveness
- **Patient-level prediction** – leveraging machine learning for early disease detection and precision medicine

Participants will be guided through the full RWE study lifecycle: from designing observational studies tailored to each use case, to applying open-source tools form the OHDSI community, and executing analyses across real-world data sources.

The curriculum combines foundational lectures on analytical methods with hands-on, interactive, faculty-led group exercises. In addition, participants will have dedicated time to develop and advance their own study concepts with personalized feedback and mentoring.

OHDSI LATAM 2026

Workgroups led by community

Ask to workgroup leads for 2026

- Prepare your 2026 Objectives and Key Results (OKRs)
  - Consider one OKR aligned to shared community goal
- Present your OKRs on Feb3 or 10 Community Call so that other collaborators can be aware of what you aim to achieve and identify where they can contribute
- Maintain open schedule cadence, record/minute meetings so folks who miss synchronous connections can catch up
- Schedule one Community Call update to showcase your workgroup's goals and accomplishments
- Share your work at OHDSI symposia and other scientific conferences and publications


DAMON
HOLLAND
HATHAWAY
PATTINSON
NYONG'O
ZENDAYA
THERON
A FILM BY CHRISTOPHER NOLAN
THE ODYSSEY
07.17.26
SHOT ENTIRELY WITH IMAX FILM CAMERAS